

Home and Community Based Services Provider Survey Handbook



Developmental Disabilities Division

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I. INTRODUCTION

Survey Purpose

The survey is just one part of the larger Developmental Disability (DD) Division's quality management system, used in conjunction with information from other quality management processes, and the process is transparent. The goal is to provide assurances to The Centers for Medicare and Medicaid Services (CMS) that DD licensed providers are providing and meeting conditions set forth by the DD Division; and to ensure improvement and sustainability of waiver services.

The survey is a quality mechanism used for waiver services provided by DD licensed providers. Information gathered through the survey is based on observation, record review, and interview. The purpose of the survey is to:

- determine the provider's organizational performance of service delivery and improvement;
- ensure quality services to individuals and services are received as identified in plans;
- assess compliance with state, federal, and waiver requirements;
- identify trends and strategies for system-wide improvements;
- identify and encourage positive practices; and
- remediate and develop strategies for improvement where there are issues identified.

In addition, the survey may provide any CMS required performance measure data; ensuring that waiver assurances, CMS Home and Community-Based Services (HCBS) Final Rule, other regulatory requirements are met, and that remediation activities for non-compliance issues are implemented when necessary. Remediation activities are designed to correct identified problems at the individual, provider, or system level. The survey may aggregate statewide data, review trends, patterns, and outcomes, and identify improvement opportunities and practices to be adopted, modified, or eliminated. The goal is these activities will provide mechanisms to system and continuous improvements, leading to quality improvement.

Development of the Survey

The surveyor process was developed by the DD Division in collaboration with a stakeholder workgroup. The workgroup was established to provide recommendations to the DD Division toward the development of the surveyor process for DD licensed providers; which included areas monitored, methods, policies & procedures, overall quality picture, and remediation of issues. The workgroup consisted of providers from across the state, Developmental Disabilities Program Administrator's (DDPA's), Health Facilities /Title XIX, and members of the DD Division.

The following entities were taken in to account to establish the elements of the survey and help define quality in the DD system: the workgroup recommendations, CMS requirements, and state requirements, along with employing the HCBS Quality Framework, Council for Quality and Leadership (CQL), and Title XIX standards. Additionally, the DD Division conducted pilot surveys to ensure the survey areas and methods are operational.

Developmental Disabilities Division

The Developmental Disabilities Division (DD Division) is a Division within the North Dakota Department of Human Services (DHS). The services of DD Division provides support and training to individuals and families in order to maximize community and family inclusion, independence, and self-sufficiency; to prevent institutionalization; and to enable institutionalized individuals to return to the community. To achieve this goal, the Developmental Disabilities

Division contracts with organizations to provide an array of residential services, day services, and family support services. The Developmental Disabilities Division provides the programmatic oversight to ensure services and supports are accountable to people with developmental disabilities and their families.

MISSION

The mission of the Department of Human Services is to provide quality, efficient and effective human services, which improves the lives of people.

DHS website: <https://www.nd.gov/dhs/>

DD Division website: <https://www.nd.gov/dhs/services/disabilities/dd.html>

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is the agency that is responsible for the Federal administration of the Medicaid, Medicare, and State Children’s Health Insurance Programs that provide health services for families with children, people who are pregnant, elderly, or disabled. The 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may offer home and community-based services (HCBS). The 1915(c) HCBS Waiver are one of many options available to states to provide the provision of long term care services in a participants own home or community as an alternative to institutional care.

CMS is responsible for ensuring the quality of Medicaid Waiver programs. CMS must review and approve all waiver proposals and amendments submitted by each State; ascertaining that the waiver is effective, will meet health and safety needs, and is cost-effective. The State must commit to operate a HCBS Waiver in accordance with applicable statutory requirements and regulatory requirements, especially the assurances specified in 42 CFR §441.302. Performance Measures are identified by the state and data is compiled and analyzed within to assess the processes and outcomes.

The intent of the CMS HCBS final rule is to ensure that individuals receiving long-term services and supports through HCBS programs under the 1915(c), 1915(i), and 1915(k) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated and appropriate settings. States that operate programs under these authorities must assure that waiver services provided in current setting comply with the final rules.

CMS Waiver Assurances and Subassurances (Version 3.5)

1. **Administrative Authority:** The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
2. **Level of Care (LOC) :** The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/re-evaluating an applicant’s/waiver participant’s level of care consistent with care provided in a hospital, Nursing Facility (NF), or Intermediate Care Facility for Individuals with Intellectual Disabilities ICF/IID.
 - Subassurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
 - Subassurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.
3. **Qualified Providers:** The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.
 - Subassurance: The state verifies that providers initially and continually meet required licensure

and/or certification standards and adhere to other standards prior to their furnishing waiver services.

- Subassurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
- Subassurance: The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

4. Service Plan: The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for the waiver participants.

- Subassurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.
- Subassurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
- Subassurance: Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.
- Subassurance: Participants are afforded choice between/among waiver services and providers.

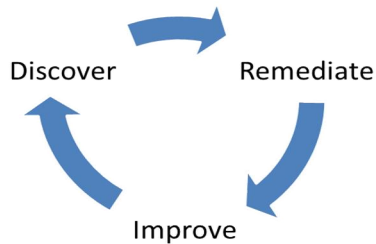
5. Health and Welfare: The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

- Subassurance: The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.
- Subassurance: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.
- Subassurance: State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.
- Subassurance: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

6. Financial Accountability : The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program

- Subassurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
- Subassurance: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

The State is expected to have, at the minimum, systems in place to measure and improve its performance in meeting the waiver assurances through a quality improvement strategy (QIS) and follow a continuous quality improvement process, which describes how the state will continually assess the waiver, meet regulations, and identify opportunities for improvement. States annually provide the information and evidence to CMS about the quality of all HCBS Waiver programs and services based on the Assurances and Performance Measures. CMS performs reviews to assure States are meeting the federal requirements and verifies that State assurances are being upheld in their day to day operations. The monitoring focuses on ensuring the State is able to identify and remediate performance issues related to individual service recipients, providers, and the system as a whole. The quality improvement strategy involves continuous monitoring of the implementation of each waiver assurance and methods for remediation or addressing identified problems and areas of noncompliance.



Link to CMS website: <https://www.cms.gov/>

Home and Community-Based Waiver Overview

Waivers are to meet applicable statutory and regulatory requirements, especially the assurances specified in 42 CFR §441.302. Continuation of a waiver requires a determination by CMS that, while the waiver has been in effect, the state has satisfactorily met the waiver assurances and other Federal requirements.

The waiver services that an individual will receive must be incorporated into a written person-centered service plan (PCSP). A state may claim Federal Financial Participation (FFP) only for the waiver services that have been authorized in the participant’s PCSP. The PCSP must also include the non-waiver services and supports that are used to meet the needs of the participant in the community. In its application, the state must specify how the PCSP is developed, including how the plan addresses potential risks to the individual. Effective PCSP development processes are essential in order to ensure that waiver participants will receive the services and supports that they need in order to function successfully in the community and to assure their health and welfare. Monitoring the implementation of the PCSP is also a critical waiver operational activity. The requirements related to the PCSP are as follows:

- Waiver services must be furnished in accordance with the PCSP. Whenever the services that are furnished to a participant change, the service plan must be revised. A state may provide for processes to authorize the provision of waiver services on an emergency basis, provided that the service plan is revised to reflect the additional services.
- The PCSP must be inclusive of all the services and supports that are furnished to meet the assessed needs of a participant, including services that are funded from sources other than the waiver (e.g., services that are obtained through the State Medicaid plan, from other public programs and/or through the provision of informal supports). In other words, the PCSP should provide a complete picture of how participant needs are met.
- The PCSP must include the specific waiver services that will be furnished to a participant, the number of hours, duration, and frequency.

A waiver’s design must provide for continuously and effectively assuring the health and welfare of waiver participants. The renewal of a waiver is contingent on CMS determining that the state has effectively assured the health and welfare of waiver participants during the period that the waiver has been in effect. Processes that are important for assuring participant health and welfare include (but are not necessarily limited to):

- Specifying the qualifications of waiver providers and verifying that providers continuously meet these qualifications;
- Periodically monitoring the implementation of the PCSP and participant health and welfare;
- Identifying and responding to alleged instances of abuse, neglect and exploitation that involve waiver participants; and,
- Instituting appropriate safeguards concerning practices that may cause harm to the participant or restrict participant rights.

The state is expected to have, at the minimum, systems in place to measure and improve its performance in meeting the waiver assurances that are set forth in 42 CFR §441.301 and §441.302. These assurances address important dimensions of waiver quality, including assuring that PCSPs are designed to meet the needs of waiver participants and that there are effective systems in place to monitor participant health and welfare. While the QIS must address the waiver assurances as a prerequisite, it can extend to aspects of waiver operations the state deems critical in achieving the waiver’s purpose, and meeting the expectations of waiver participants and stakeholders.

Quality Assurance

CMS defines Quality Assurance (QA) as *“The process of looking at how well a service is provided. The process may include formally reviewing the services furnished to a person or group of persons, identifying and correcting problems, and then checking to see if the problem was corrected.”*

QA entails more than just policing compliance with minimum standards or operating requirements. It must also encompass a commitment toward improvements. To achieve desired outcomes, integration of QA and Quality Improvement activities are needed. The following chart describes these activities.

<u>Quality Assurance</u>	<u>Quality Improvement</u>
Measurement of performance against defined standards, requirements, objectives/outcomes, or established targets.	Continuously monitoring processes/systems.
Reviews, inspections, etc. Provider driven. Problem focused.	Identifying potential problems before they develop, establishing best practices. Client enhancement driven. Proactive.
May be focused more to individuals, or a certain group. Few have responsibility.	Incorporates more processes and systems. Everyone is responsible.
Implementation of corrective actions up to minimum standards by understanding and correcting the causes to prevent future similar problems.	Using analyzed data to remedy processes/outcomes at the individual, provider, and/or system level that lead to continuous improvement.
Periodic review of performance data resulting in modifications to operational plans or performance objectives to improve minimum expectations in the delivery of supports and services.	Concurrent data collection about the conduct of process, the delivery of services, and direct individual experiences to improve continuously.

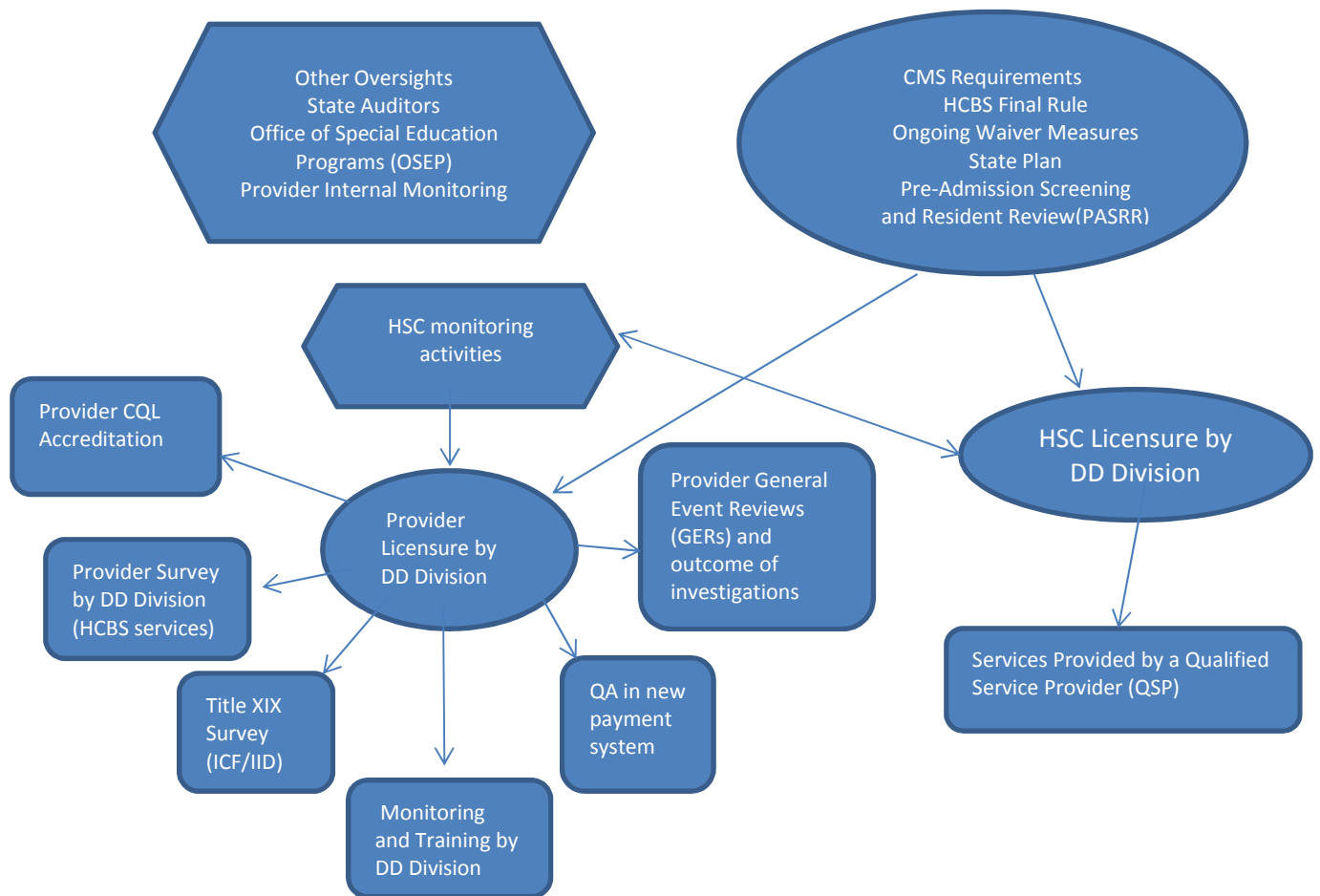
Quality is everyone’s responsibility. The DD Division applies quality through several entities and in the everyday operation of the programs. We all play an important role in delivering quality services to the individuals we support. The entities involved may entail different roles and responsibilities which incorporate a unique component to the monitoring and oversight. However, a common goal is shared; the individual’s health, welfare, and satisfaction.

State and Federal Agencies responsible for funding HCBS programs have statutory and fiduciary responsibilities to monitor and assess the quality of services for which they are paying. They monitor to confirm funds are being appropriately spent, resources are allocated efficiently, and that high quality care and services are being provided.

DHS must assure that services delivered are appropriate, beneficial, and aim to achieve good outcomes for the individual. DD licensed providers must meet certain standards that promote quality and ensure health and welfare. In addition, providers are required to provide services in accordance with state and federal standards, and in accordance with the individualized service plans.

The following diagram displays the monitoring activities conducted and the relationships they have to each other.

ACCOUNTABILITY AND QUALITY ASSURANCE



II. APPLICABLE SERVICES

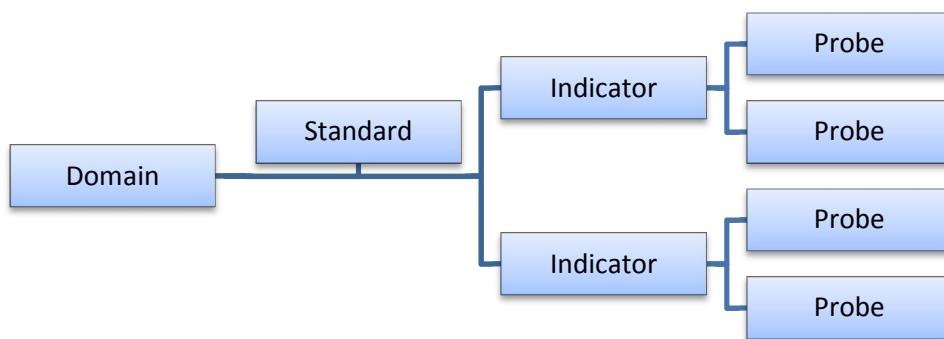
The State of North Dakota administers several Home and Community Based Waivers. The DD Division currently provides day to day oversight over one waiver: The Traditional DD Waiver is for individuals with Intellectual or Developmental Disabilities. All DD licensed providers with waiver services will be subject to the survey process.

The following is a listing of home and community based services (HCBS) within the waiver which will be reviewed:

- Residential Habilitation (previously Congregate Care, Family Care Option III, Individualized Supported Living Arrangement, Minimally Supervised Living Arrangement, Transitional Community Living Facility)
- Independent Habilitation (previously Family Care Option III, Individualized Supported Living Arrangement, Minimally Supervised Living Arrangement)
- Day Habilitation (previously Day Supports)
- Prevocational Services
- Small Group Employment Support
- Individual Employment Support

III. SURVEY DOMAINS AND STANDARDS

The survey measures provider performance in five Domains that constitute the major sections of the survey. Standards are the compliance to be met for each Domain. Each Standard is divided into Indicators, based on person-centered processes and/or organizational capacity. Numerous Probes are listed, which establish expectations that should be present. Providers are cited deficiencies for the Standards which are not in compliance, and will require a Plan of Correction. This relationship is illustrated below.



The five Domains and corresponding Standards are as follows:

1. Service Planning, Delivery and Implementation
 - Individuals have opportunities to be fully involved in their lives.
 - Individuals are receiving services and supports according to their plan
2. Rights
 - The rights of individuals are promoted, exercised, and protected
3. Provider Capabilities and Qualifications
 - Staff are trained to perform their duties effectively, efficiently, and competently
 - Background checks are completed for all employees
4. Health and Welfare
 - Medications are managed effectively and appropriately
5. Financial Management
 - Individuals funds are managed appropriately

The *Interpretive Guidelines* provide the details for the Survey Domains, Standards, Indicators, Probes, and Measurements. *Interpretive Guidelines* also provide information on the regulations and policies applicable to the Domains and Standards.

The Interpretive Guidelines are intended to be helpful to both the provider whose services are being reviewed and to the surveyor conducting the review. The guidance may include questions and methods that the surveyor will engage in to collect the information. The guidance does not limit the surveyor from asking other questions or using other information gathering activities that may be necessary due to circumstances that occur during the review.

For detailed information on this section, refer to the “*Interpretive Guidelines*”- **Appendix A**

IV. SURVEY PROCEDURES

Provider Notification

The DD Surveyor will conduct an announced visit to each DD licensed provider at least once every three years. The provider Chief Executive Officer (CEO) will be notified in writing one month prior of the scheduled on-site visit. The provider will be informed of the dates of the survey and the expectations of the provider during the process. The sample of individuals may be shared with the providers one week prior to the on-site visit to provide notification to the individuals of the upcoming visit. Contacts may be made with providers to complete other necessary arrangements. The length of a survey visit will typically be three days, but may vary depending on the size of the agency, the number of service types and people supported. The DD Division reserves the right to conduct an unannounced visit at any time.

Provider Responsibilities

Providers should relay to the surveyor any unique circumstances that may be relevant prior to meeting the individuals or conducting the survey. It is not the duty of the provider to obtain permission from the individual and/or the legal decision maker for the survey but the provider may inform them of the upcoming survey and its purpose. The surveyor will ask permission of the individual and/or legal decision maker upon completion of survey duties. Providers will determine the best method of distributing information about the survey. It is the responsibility of the provider CEO to inform the agency’s Board of Directors about any information regarding the HCBS Provider Survey, including but not limited to the report of findings, deficiencies, and the plan(s) of correction.

Prior to the survey, the surveyor will supply to the provider a list of requested items that are needed in order to conduct the survey along with timelines. An agency staff member should be identified as a liaison during the survey process. The surveyor shall have access to the provider and individual records and files according to North Dakota Administrative Code (NDAC).

- NDAC 75-04-01-25 Access to records. The applicant shall affirm the right of duly authorized representatives of the department to inspect the records of the applicant, to facilitate verification of the information submitted with an application for licensure, and to determine the extent to which the applicant is in compliance with the rule of the department.
- NDAC 75-04-01-26 Denial of access to facilities and records. Any applicant or licensee which denies the department, or designee, access to a facility or its records, shall have its license revoked or its application denied.

For more information, refer to the “*Provider Request of Information Sample Letter*”- Appendix B

New Providers

Providers receiving their initial licensure for home and community based services by the DD Division, will receive a one-time initial informal survey within six-nine months after services begin for the first individual. A different sampling methodology may be completed from the cycle review survey. The survey will still ensure providers are meeting requirements but will focus on technical assistance, providing recommendations for improvement versus deficiencies and completing a POC. Providers must correct any health and welfare issues, and ensure follow up on any recommendations. The Regional Human Service Center (HSC) will be informed of the provider’s results and recommendations to support the provider as needed. Depending on the initial findings, there may be additional follow up. The providers will be added to the cyclical survey schedule after the completion of the initial survey.

Off-Cycle Visits

If concerns arise any time between visits, it will be at the discretion of the DD Division to conduct another review, visit, or a conference call(s) based on findings. The visits or follow up may occur to any provider and be announced or unannounced. The review may be conducted for the agency or a particular location(s). Additionally, depending on the circumstances, conference calls may occur periodically. The HCBS Survey components may be utilized or a focus survey may be conducted, where the review is targeted to any specific identified issue(s) to determine the extent or prevalence of the issue. A different sampling methodology may be completed from the cycle review survey. A report of findings and plan of correction may be developed accordingly. This intervention provides issue resolution and increased capacity to promote the health and welfare of individuals.

Additional reviews or follow-up may result from, but is not limited to:

- Monitoring;
- health & safety concerns;
- immediate jeopardy;
- multiple incidents;
- unresolved complaints or concerns;
- survey outcomes;
- changes that significantly or negatively impacts services (i.e. addition of services);
- condition level deficiencies or other citations/ concerns with Title XIX reviews; or
- other issues that may have come to the attention of the DD Division.

Sample Size and Methodology

A variety of methodologies will be used to complete the sampling for individuals, staff record review, and guardian interviews. The selection of individuals and records to review will be randomized where possible to ensure broad coverage of information gathered. The provider will be selected by the surveyor based on the 3 year review cycle.

If a provider offers services in more than one region, DHS Decision Support Services (DSS) will randomly select a region. A region is selected by assigning a computer generated random number to each region. The region with the highest value is then chosen for the survey for that provider, with 1 being the highest possible value. Following each 3 year cycle of the survey, a new region will be chosen for each provider, until all regions have been visited once for each provider. Once all regions of a provider are surveyed the random selection will restart. If a provider that provides supports in

multiple regions has less than 5 individuals in one region, the sample may combine regions, depending on the locations of the individuals within each region. The selection process will ensure that each region will have its opportunity to be surveyed.

Any new services started between the cyclical survey schedules have the potential to be added to the survey. Sampling identifies the minimum number of each sample size, however at the surveyor's discretion, the sample sizes can be expanded for any portion of the survey.

Individuals- A random sample of individuals receiving services will be selected among the provider's home and community based services. The sample will consist of a minimum of 5 individuals, unless a provider is serving fewer than 5 individuals. To the best degree possible, the sample will be reflective of the broad spectrum of services delivered by the provider.

Once a provider and region is selected for the survey, DSS will gather a list, from Therap, of all individuals receiving services in the HCBS Waiver for that provider in the selected region. From this region, every individual receiving services is given a random ID number and then this random ID is sorted in ascending order. The surveyor is given an ordered list of individual names and the respective services they receive.

The individuals are selected based on the ascending order in each service, assuring that each service is sampled. The selection will continue in this manner until the minimum of 5 individuals have been selected. Alternate individuals will be selected if an individual is not available or refuses to participate in survey.

An individual may be included in both samples for a residential service and day service within the surveyed provider. Providers may not request individuals to be included, or not to be included in the sample. If a provider is seeking input or feedback related to a specific individual, their needs or concerns shall be addressed at that time and with the assistance of the appropriate HSC.

Although there will be focus on individuals selected in the sample, during on-site observations all individuals and staff in the environment will be observed. Those observations will contribute to the overall findings and outcomes of the survey. Therefore, other individuals can be included in the sample any time throughout the survey. This may occur based on, but not limited to; observations, concerns, and individuals not allowing access into their home. If additional or supplemental individuals are included, the desk review for those individuals may be concluded after the on-site survey.

Staff Orientation and Annual Trainings- A record review of staff will be completed at the selected provider region. Each staff member is categorized according to their date of hire of either less than 3 years (New Staff) or greater than 3 years (Veteran Staff). Two samples will be obtained, one for new staff and one for veteran staff. There will be a minimum of 10 staff in each sample. The sample for veteran staff will be a review of the last 2 years of annual training records. The sample for new staff will be a review of their orientation trainings and background checks. Both reviews will include first aid and CPR. Based on each three year survey cycle, different orientation and annual training components may be reviewed.

Provider will send in a current staff list according to the surveyor's request. All staff members are given a computer generated random ID value, and then the ID value is sorted in ascending order. The proportion of staff that are DSP (Direct Support Professional) vs other professional staff will be calculated for each provider by DSS. At least 1 staff member is in the other professional category. For example if a provider has 75% DSP, 6 of the 8 staff sampled will be direct support staff and 2 other professional staff. Two backup staff members will be provided to the surveyor in each sample to use if needed.

Staff Medication Certification Verification- The provider will provide the surveyor with Medication Administration Records (MAR) from the sample individuals for the last 3 months. The surveyor will compile the staff names from the MARs while on site. Then, the surveyor will generate a random ID in excel for each staff member. A minimum of ten staff members will be randomly selected.

Guardians- Prior to the on-site review, the guardians for the selected individual sample will be interviewed. The guardians will be contacted in order of the individual's random ID value, until 3 have been reached or an attempt has been made to reach guardians of all individuals within the sample.

For detailed information on this section, refer to the "*Interpretive Guidelines*"- **Appendix A**

Entrance Discussion

Surveys may begin with a brief entrance discussion with the provider at the beginning of the review with appropriate provider staff and the surveyor. The time may be utilized for introductions, responsibilities, explanation/logistics of the survey, sample of individuals chosen for the review, materials needed to complete the review, and schedules finalized. The provider may also utilize the time to provide general information about the organization, including management and quality improvement strategies. The list of needed items from the provider will be finalized to assist in the review.

Exit Discussion

Upon completion of the on-site visit, a brief exit discussion will be held. It is a time for the surveyor and the provider to provide feedback. The provider may invite staff they deem necessary to attend, and the surveyor will ensure that the Regional HSC Developmental Disabilities Program Administrator (DDPA) or their designees are invited. Strengths, trends, preliminary findings and recommendations will be reviewed. This is also an opportunity to provide more information if needed. Information will be considered from the provider when the surveyor is making conclusions. If the provider maintains that a practice in question is acceptable, the provider must provide reference material or sources that support the position. The exit discussions are preliminary results, the survey report will contain the final results. There may be circumstances that require further review of specific issues and will not be reported on at that time. Deficiencies may be discussed during the exit, but are not final and subject to change based on DD Division approval.

V. SURVEY PROCESS

The data gathered throughout the provider survey is based on record review, observation, discussion, and interview. The survey considers the delivery of services as outlined in the individual's plan, based on individualized needs and according to Federal and State regulations.

Naturally, incidents may occur during the survey which could be reportable. It is the expectation that provider staff will still complete a GER. If it is discovered that a GER was not completed, the surveyor will communicate with provider personnel.

Unsatisfactory findings may dictate the need for an expanded survey review. The review may be expanded to include additional individuals, locations, and/or staff records at the discretion of the surveyor.

Record Review

Various record reviews will be completed in a number of methods. Prior to the start of the on-site visit, the surveyor gathers and reviews information off-site to prepare for the visit. This will include sample selection, preparation activities,

information provided by the provider, and individual information contained within Therap. Additional organizational information will be obtained through a CQL Self-Assessment review, Title XIX deficiency review, and Regional HSC feedback. The off-site review will provide the surveyor with information that can be reviewed prior to the on-site, as well as reviewed in combination with the on-site activities; providing background information and allowing time to collect and analyze data. The offsite review will allow greater flexibility with on-site individual and staff activities to facilitate a more efficient review.

In addition to the off-site desk review component, records will be reviewed on-site. The on-site review may encompass staff records, provider policy and procedures, additional individual record information, and any items needed for clarification.

Reviewing the individual's records assists the surveyor to better understand the individual, their capabilities and needs, and the role of services. The record review also assists the surveyor in assessing and verifying how the provider is meeting the individual's needs and other requirements.

Observations

The observation process will encompass general impressions of the whole setting and delivery of services, including a focus on an individual sample. Observations provide an opportunity to display the interactions and relationships between staff and individuals, allowing staff to display skills acquired. Observations will focus on opportunities to exercise choice, participation in activities with as much independence and self-determination possible, and implementation of supports and services. Inquiring questions about day to day activities and services may also occur.

Times of observations are completed throughout the day, based on individual schedules. The individual, the provider, and the surveyor will arrange the observation prior to conducting the onsite visit. Each site and/or individual typically will be observed one time, unless a need arises for further observation.

All visits will be conducted with sensitivity and attempts to keep disruption of daily routines to a minimum. The individual's schedules and activities should continue as planned. It is not a time for a formal discussion with individuals but to observe them in their environment. Respect will be shown for the individual's home and privacy. The surveyor shall ask permission to visit upon arriving. Individuals have the right to refuse participation with the survey. The surveyor may continue the visit with other individuals in the setting, while respecting any wishes of non-participation. If an individual who is in the sample wishes not to participate, the surveyor will utilize the supplemental list. For any individuals or settings that the surveyor was not able to access, the Regional HSC will be notified to communicate and ensure Quality Assurance activities are in place.

Interviews and Discussions

Individuals, staff, and guardians/legal decision maker are important sources of information and interviews can assist in determining the provider's performance and provide clarifying information. Open communication is promoted throughout the survey to ensure understanding and to achieve the full value from the survey. The surveyor may also interview other relevant team members.

Individuals-Throughout the survey, the surveyor may have discussions, whenever possible and appropriate, with individuals by informal conversations in the location where services are being provided and observed. It is the individual's choice whether or not to talk with the surveyor, but their services and supports will continue to be reviewed through observation, documentation and/or discussions with others. The questions are based on topic areas and will be suited toward the individual's situation and communication. Staff may be present, if the individual chooses, for comfort level or for staff to assist with communication.

Topic areas for individuals include, but are not limited to, questions related to:

- privacy,
- decisions and choices,
- dignity and respect,
- personal possessions,
- relationships and community activities,
- medications,
- environment, and
- finances.

Staff- Throughout the survey, the surveyor will interact and may question various provider staff to request further information or obtain clarification. The exchanges will assist in understanding, clarifying roles, and provide information on how services are provided. Prior to the exit discussion, the surveyor may visit with provider staff (Managers, Program Coordinators, Quality Assurance, Nurse) to provide more information and assist in understanding of any discovered issues or concerns.

Guardian/Legal Decision Maker - The surveyor will interview guardians/legal decision makers, as their perspective is important to obtain in assessing quality services. Guardians/legal decision makers have the option to participate in the interview, which will be conducted via phone during the off-site desk review. Interviews are kept confidential, but the surveyor may address any concerns that may arise with the provider. If concerns arise during the interview with a guardian, it is not the surveyor's role to mediate those concerns.

VI. DETERMINATION OF COMPLIANCE

Deficiencies

A Deficiency is an identified issue of sufficient severity and/or scope in which requires corrective action. Findings are evaluated and based on the scope and severity in relation to the impact on the delivery and quality of services. Decisions will be made based on the information gathered and reviewed for all services sampled during the time of survey, including the off-site desk review and interviews. Each Standard is divided into Indicators. The Interpretive Guidelines offers a non-inclusive list of Probes, which represent practices in conjunction to the requirements, to determine if providers are meeting standards. Some may be not applicable (N/A) to an individual and/or service being reviewed.

A deficiency may be determined within the sampling of services; however deficiencies are applicable to all services within the agency resulting in an agency citation as the provider will need to identify if a practice is occurring throughout the agency. Repeat deficiencies from previous surveys will be noted. A provider may be found to have a deficiency when there is potential for causing harm or the provider exhibits lack of appropriate services and practices that are not in the best interests of the individuals. Deficiencies identified due to lack of appropriate services and practices may include, but are not limited to, the following:

- Individuals do not attend, or rarely attend, their planning meetings to develop their own program;
- Individual services are not implemented with the needs and wants described in the individual's plan;
- Individuals do not have opportunities to participate in the community or are limited and unnecessarily restricted, including banks, libraries, parks, restaurants, movies, etc.;
- Supports fail to teach individuals necessary skills to participate in the community;

- Individuals have limited opportunities to make choices about their lives or to participate productively in their life and practice skills.

If information is missing, the provider will be asked to locate and provide any missing information. If necessary, the provider will be asked for additional information and clarification about particular findings before determinations are made. A reasonable effort will be made to allow the provider to validate compliance.

All findings are evaluated to determine whether a provider has a deficiency in meeting standards and regulatory compliance, which are identified as having sufficient severity and/or scope in which requires corrective action. The frequency of occurrences (scope) can vary depending on each situation. In some situations, just one occurrence may be life threatening, or a few random occurrences may have minimal impact. The severity is the seriousness and the degree to which the issue compromises the individual's health and welfare.

Scope and Severity Levels

Scope Levels:

- **Isolated**-when 1 or a very limited number of individuals are affected and/or 1 or a very limited number of staff are involved and /or the situation has occurred only occasionally, in limited number of locations
- **Pattern**-When more than a very limited number of individuals are affected and/or more than a very limited number of staff are involved and/or the situation has occurred in several locations. The pattern is not found to be pervasive throughout the agency but impacts a number of individuals or group.
- **Widespread**-When the problem is pervasive, affecting a sufficient number of individuals and/or staff or represents a systemic failure.

Severity Levels:

- **Low Impact**-potential for causing no more than a minor negative impact on the individuals and/or the provider exhibits lack of appropriate services and practices that are not in the best interests of the individuals. No actual harm or minimal potential for harm.
- **Medium Impact**-results in minimal harm and/or the provider exhibits lack of appropriate services and practices that are not in the best interests of the individuals. No actual harm, but potential for more than minimal harm.
- **High Impact**- results in a negative outcome and/or the provider exhibits lack of appropriate services and practices that are not in the best interests of the individuals. Actual harm that is not life threatening.
- **Immediate Jeopardy**-a situation in which immediate corrective action is necessary because the provider's deficiency has caused or is likely to cause serious injury, serious harm, or death. Provider practices establish a reasonable degree of predictability of similar actions, situations, practices or incidents occurring in the future. Life threatening harm or death.

		Scope		
		Isolated	Pattern	Widespread
Severity	Low Impact	A	B	C
	Medium Impact	D	E	F
	High Impact	G	H	I
	Immediate Jeopardy	J	K	L

<input type="checkbox"/>	Recommendation for improvement
<input checked="" type="checkbox"/>	Plan of Correction (POC)

Required actions will be based on the identified issues and deficiencies.

1. **No action**-requirements are being met
2. **Recommendations for improvement** -not all requirements are met; improvements are identified, and it does not result in a deficiency. Specific actions may be recommended or criteria are identified as needing to be met, however, no formal follow-up is required by the provider. Regional DDPM’s may follow-up during their face to visits, depending on the area, and the items may be scrutinized during the next monitoring visit.
3. **Plan of Correction (POC)**-deficiency is cited. Provider will develop a plan of correction addressing the deficient areas, with follow-up completed on the corrections.

Immediate Jeopardy (IJ)

CMS State Operations Manual Appendix Q – Guidelines for Determining Immediate Jeopardy was referenced and utilized to provide guidelines in determining if circumstances pose an Immediate Jeopardy to an individual’s health and welfare for this survey. These guidelines assist Federal and State Survey, Certification Personnel, and Complaint Investigators in recognizing situations that may cause or permit Immediate Jeopardy. Some adaptations were developed to pertain to the DD Division.

Immediate Jeopardy is defined as “A situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.”

- Only one individual needs to be at risk and serious harm, injury, impairment, and death does not have to occur.
- Serious harm, injury, impairment, or death does NOT have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy.
- Individuals must not be subjected to abuse by anyone including, but not limited to, provider staff, consultants or volunteers, family members or visitors.
- Serious harm can result from both abuse and neglect. Psychological harm is as serious as physical harm.

- When a surveyor has established through review that an individual harmed another individual receiving care and services from the provider due to the entity’s failure to provide care and services to avoid physical harm, mental anguish, or mental illness, this should be considered neglect.
- Any time a surveyor suspects abuse or neglect, it should consider Immediate Jeopardy.

Upon recognizing a situation may constitute Immediate Jeopardy, the review process must proceed until it confirms or rules out Immediate Jeopardy. The serious harm, injury, impairment or death may have occurred in the past, may be occurring at present, or may be likely to occur in the very near future as a result of the jeopardy situation. After determining that the harm meets the definition of Immediate Jeopardy, the following points are considered regarding provider compliance:

- The provider either created a situation or allowed a situation to continue which resulted in serious harm or a potential for serious harm, injury, impairment or death to an individual(s).
- The provider had an opportunity to implement corrective or preventive measures.

If, during the course of a survey, the DD Surveyor discovers a situation where IJ is identified, the surveyor will notify a designee in the DD Division. Depending on the IJ situation, the surveyor may need to remain on site until the situation is resolved. Information gathered will contain who was involved, what occurred, when did it occur, where did the potential IJ occur, and why did it occur. To make a decision toward IJ, sufficient information is gathered and validated to address the 3 components of IJ:

- Harm-actual and potential;
- Immediacy-is the harm or potential harm likely to occur in the very near future if immediate action is not taken; and
- Culpability-which includes if the entity created the situation or knew about the situation, allowed the situation to continue, and had the opportunity to implement corrective or preventive measures, including if the situation was thoroughly investigated.

After recognizing Immediate Jeopardy and completing the review, the surveyor will then cite the provider with IJ and contact the CEO upon the decision with the specific details and individual(s) at risk. The provider should begin immediate removal of the risk to the individual(s), and immediately implement corrective measures to prevent repeat jeopardy situations. Based on the situation, the provider will correct the IJ as soon as possible taking all actions necessary, and in some cases may require immediate elimination. The provider will submit evidence of their implementation of their corrective measures and the provider’s response must ensure that the situation will be addressed systemically in order to prevent recurrence. The provider’s response must include time lines for completion and staff member’s responsible for completion.

The remainder of the survey will be completed and may be extended based on the findings. Any IJ cited will be reported and reflected in the survey results along with the status of either IJ removed; IJ removed deficient practice corrected; IJ removed deficient practice present; IJ not removed. Validation that the IJ situation has been resolved is completed.

For detailed information on this section, refer to the **“DD Division Immediate Jeopardy Triggers and Procedures”- Appendix C.**

VII. Survey Report of Findings

The DD Surveyor has 15 business days from the exit meeting to send the survey report of findings to the provider. The survey report along with the POC must be signed by the Provider CEO and be received by the DD Division within 20

business days of the notice date. This report will also be sent to the Regional HSC(s) and other entities the DD Division deems necessary. The survey report of findings may contain but is not limited to:

- Information on the provider and the services sampled;
- All domains, standards, and indicators contained in the survey with determination of compliance;
- Determination of standard compliance and/or summary of recommendations or deficiencies. Repeat deficiencies will be identified if they are significant in nature, which will need to be addressed by the provider;
- Acknowledgment of provider strengths;
- Summary of concerns discovered not in the purview of the survey.

During the survey, other items of concern may be observed or discovered that are not in the purview of the areas monitored. Not only will these items be included in an addendum section of the report, but will also be discussed with the provider and shared within the DD Division Staff as applicable. This awareness not only integrates quality but further provides positive outcomes for individuals.

VIII. Plan of Correction (POC)

If the survey determines that there are deficiencies, a plan of correction is required by the provider to address the deficient areas, resolve the noncompliance, and to avoid recurrence. The provider's POC shall be applied to all individuals in their waiver services, not just to the individual(s) and services cited in the survey as the deficient practice may be occurring throughout the agency. The DD Division may also request a POC based on findings from additional reviews or other identified issues.

During the POC process, agencies are encouraged to translate the identified deficient practices into goals that will strengthen the program and improve outcomes (ex. Lead to system improvements with communication, ongoing monitoring, record keeping, etc.). Additionally, agencies can benefit from sharing the results, both good and bad; and celebrate the successes not only from the survey, but from the continued monitoring of findings. When monitoring the results to see if changes worked, the focus will be on the outcomes versus putting emphasis on the process.

Depending on the nature of the findings, the following are some considerations for providers and additional items to include and may incorporate into the POC:

- The Interdisciplinary Team typically concentrates on resolving individual issues and the agency QA focus on systemic/organizational issues;
- Specify the desired outcome and necessary action steps to reach the desired outcome successfully;
- Remediation may need to occur at all levels of the system;
- Systemic findings will typically lead to development of system-wide remediation strategies;
- Instruction or in-service of staff alone may not be a sufficient plan of correction. This is a good first step toward correction, but additional steps should be taken to ensure the deficiency is corrected and will not recur;
- Review values, missions, and statement goals;
- Evaluate agency processes, policies and procedures for needed changes;
- Brainstorm resources that will be applied;
- Consider reviewing results/information from other sources or internal monitoring that may be relevant;
- If needed, coordinate the POC with other plans that address agency improvement efforts, such as strategic plans and quality improvement. This helps in developing a comprehensive plan for the agency, improve the likelihood of attaining and reaching higher outcomes, and avoid moving in too many directions and spreading resources too thin;

- Determine what QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Providers may need to make changes to their Quality Assurance Systems and Plans;
- Providers may request assistance from outside entities, such as but not limited to the Regional HSC, DD Division, to assist in brainstorming.

POC Timelines

- POC must be received by the DD Division within 20 business days from the date of the survey report of findings and signed by the provider CEO.
- The DD Division may accept, modify, or reject the provider’s POC within 15 business days. Providers will be notified of their POC status.
- If a POC is unacceptable, the provider will have 5 business days to resubmit their POC to the DD Division. The DD Division may assist with recommendations as necessary.
- At any time a provider may request, and the DD Division may grant, one fifteen business day extension to submit their POC to the DD Division for good cause and risk management must be assured.
- All deficiencies must be corrected within 45 calendar days from the POC approval date.

POC Format

The Plan of Correction must contain and address each of the following items:

- 1) Must be addressed for each deficiency cited;
- 2) Describe the corrective action for those individuals affected during the survey;
- 3) Describe how others will be identified of having the potential to be affected;
- 4) Describe how the deficiency will be corrected not only on an individual level but also agency wide (the desired outcomes and necessary action steps);
- 5) Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction should be integrated into the agency quality assurance system;
- 6) Person’s responsible for implementing the plan;
- 7) When the deficiency will be corrected;
- 8) POC must be signed by the provider CEO.

The plan of correction form (SNF 136) can be found on the ND State Website under forms at <https://apps.nd.gov/itd/recmgmt/rm/stFrm/eforms/Doc/sfn00136.pdf>.

POC Follow-up

The DD Division will verify that all deficiencies identified in the POC have been remediated. Follow-up will be completed by the DD Division through a variety of methods, including but not limited to, documentation review, communications with the provider, Regional HSC assistance, or additional on-site visits. Follow-up on-site visits may occur based on the severity of the deficiency. Upon completion of the POC, the provider and the Regional HSC will be notified within 15 business days by the DD Surveyor.

Technical Assistance

Providers may choose to receive technical assistance from the DD Division as a result of survey findings or anytime they wish. Technical assistance may also be recommended by the DD Division for, but not limited to, IJ situations; deficiencies that limit the scope of practice related to individual's planning & implementation; health and welfare; provider capabilities and qualifications; or other identified issues or trends that if not resolved could result in health and welfare issues.

IX. Sanctions

Reasons for Sanctions

The DD Division is authorized to impose one or more sanctions when any one of the circumstances listed below are present:

- Incomplete plans of corrections;
- Failure to correct deficiencies;
- Failure to cooperate with surveyors, licensing, CQL;
- Failure to comply with applicable laws and standards;
- Operating without an appropriate licensure;
- Immediate Jeopardy.

Types of Sanctions

Sanctions may include, but are not limited to:

- Change or termination of licensure status per NDAC 75.04.01;
- Regional HSC intervention;
- Technical assistance;
- Required training that is purchased by the provider and approved by the DD Division;
- Additional monitoring from other oversight agencies/entities;
- Plan of Correction;
- State Monitoring Plan.

X. Provider Survey Contact Information

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Glossary of Terms

Abuse-Any willful act or omission of a caregiver or any other person, which results in physical injury, mental anguish, unreasonable confinement, sexual abuse or exploitation, or financial exploitation of a vulnerable adult.

- a. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish of any person with developmental disabilities;
- b. Knowing, reckless, or intentional acts or failures to act which cause injury or death to a developmentally disabled or mentally ill person or which placed that person at risk of injury or death;
- c. Rape or sexual assault of a developmentally disabled or mentally ill person;
- d. Corporal punishment or striking of a developmentally disabled or mentally ill person;
- e. Unauthorized use or the use of excessive force in the placement of bodily restraints on a developmentally disabled or mentally ill person; and
- f. Use of bodily or chemical restraints on a developmentally disabled or mentally ill person which is not in compliance with federal or state laws and administrative regulations.

Activity of Daily Living (ADL)-Self-care activities performed daily such as: bathing, dressing, toileting, transferring to and from a bed or chair, mobility, continence, and eating/feeding.

Assurance-the commitment by a state to operate a home and community based service waiver program in accordance with statutory requirements.

Center for Medicare and Medicaid Services (CMS)—The federal agency that runs the Medicare program, in addition, CMS works with the States to run the Medicaid program and to make sure that the beneficiaries in these programs are able to get high quality health care.

Council for Quality and Leadership (CQL)-accredits providers of DD licensed services in the State of North Dakota who provide services and supports to individuals with intellectual and developmental disabilities. Currently providers licensed by the DD Division are required to be accredited by CQL as part of the licensing standards.

Day Habilitation – (formerly known as Day Supports)- This support is made available through the Traditional IID/DD HCBS Waiver to eligible individuals. Day habilitation services provide assistance to the individual with acquisition, retention, or improvement in self-help, socialization and adaptive skills, enabling the individual to attain or maintain his or her maximum functional level. Day Habilitation services are typically provided in non-residential settings.

Deficiency-is an identified issue of sufficient severity and/or scope in which requires corrective action; when a standard is not in compliance.

Department of Human Services (DHS)-is the North Dakota state agency providing oversight and services to adults and aging individuals; child support; children and family Services, public assistance programs including heating assistance, supplemental nutrition and food stamps, Medicaid and medical services, mental health and substance abuse services, and services to individuals with disabilities.

Developmental Disabilities Division (DD Division)—A division within the Department of Human Services charged with administering the system of services and supports to individuals with intellectual and developmental disabilities in the State of North Dakota.

Developmental Disabilities Program Administrator (DDPA)—Employee of the Department of Human Services responsible for the regional oversight of the DD Program Management services and DDPM’s located in the human service centers. There is one DDPA for each of the eight regional human service centers.

Developmental Disabilities Program Manager (DDPM)—Employee of the Department of Human Services (state Medicaid agency) responsible to provide coordination and monitoring of Medicaid and general fund services provided to individuals with intellectual and/or developmental disabilities. DD Program Managers are located in the eight regional human service centers. Every individual who is receiving DD Program Management services has an assigned DD Program Manager.

Exploitation—when committed by a caretaker or relative of, or any person in a fiduciary relationship with, a person with developmental disabilities or mental illness, means:

- a. The taking or misuse of property or resources of a person with developmental disabilities or mental illness by means of undue influence, breach of fiduciary relationship, deception, harassment, criminal coercion, theft, or other unlawful or improper means;
- b. The use of the services of a person with developmental disabilities or mental illness without just compensation; or
- c. The use of a person with developmental disabilities or mental illness for the entertainment or sexual gratification of others under circumstances that cause degradation, humiliation, or mental anguish to the person with developmental disabilities or mental illness.

General Event Report (GER)—Refers to a report in Therap that is generated to report an atypical incident or occurrence involving an individual(s) receiving DD licensed services to the state DD Division, regional DD Program Management and the Protection and Advocacy project. A GER will be completed in situations that include but not limited to events that result in treatment or care for physical or mental health beyond first aid, unauthorized use of seclusion, chemical or physical restraint, alleged sexual abuse or inappropriate sexual contact of a person with a disability, death, suspected abuse, neglect or exploitation based on the reporting determination guidelines. There are three levels of GER: low, medium and high.

Harm—the existence of a loss or detriment of any kind resulting from the incident:

- **Emotional** – (i.e., that which affects negatively an individual’s emotional wellbeing and state of mind).
- **Psychological** – (i.e., humiliation, harassment, threats of punishment or deprivation, name calling, sexual coercion, intimidation).
- **Physical** – (i.e., any physical motion or action such as striking, pinching, kicking, punching, pushing, etc.)
- **Financial** – (i.e., that which affects a person’s state of financial affairs).

Harm is Evident—is a loss or detriment of any kind which is noticeable or apparent to observation:

- **Emotional**—i.e., crying, unusual behaviors for that person, behaviors associated with a person when upset such as pacing, self-injury etc.
- **Psychological**—i.e., person becomes passive, withdrawn, aggressive, fearful of people, places, objects etc.

- **Physical**—i.e., bruise marks, injuries, individual displays defensive reaction to an imaginary threat, etc.
- **Financial**—failing to complete required forms for assistance programs/benefits; failing to complete transactions as requested by the person/guardian; person’s money not being used for their own well-being; overdrafts not reimbursed by the responsible party, etc.
- **Title XIX Guidelines**—since many persons residing in ICF/IID are unable to communicate feelings of fear, humiliation, etc., the assumption must be made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, is also viewed as abusive by the person residing in the ICF/IID, regardless of that person’s perceived ability to comprehend the nature of the incident.

Home and Community Based Services (HCBS) - refers to the array of services within the Home and Community Based Medicaid Waiver that are essential and appropriate to sustain individuals in their homes and communities, and to delay unwanted out of home placement or prevent institutional care.

Home and Community Based Services (HCBS) Medicaid Waiver—An agreement between DHS and the Center for Medicare and Medicaid Services (CMS) which provides options for a continuum of home and community based services in the least restrictive environment. The waiver allows states to use funds that would have been used to pay for institutional care, for a wide variety of home and community-based services for individual who were living in institutions or at risk of entering institutions.

Human Service Center (HSC)—The North Dakota Department of Human Services operates eight regional human service centers. Each serves a designated multi-county area, providing counseling and mental health services, substance abuse treatment, disability services, and other human services.

Immediate Jeopardy (IJ)—A situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

Independent Habilitation —This service is made available to eligible individuals through the Traditional IID/DD HCBS Waiver. It is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant’s ability to independently reside and participate in an integrated community. Independent Habilitation is formalized training and staff supports on a regular, but not on a daily basis for fewer than 24-hours per day.

Individual Employment Support – This service is made available to eligible individuals through the Traditional IID/DD HCBS Waiver. This service is long-term ongoing supports to assist participants in maintaining paid employment in an integrated setting or self-employment. Designed for participants who need intensive ongoing support to perform in a work setting, this service can include on- or off-the-job employment-related support for those needing intervention to assist them in obtaining or maintaining employment, in accordance with their person-centered service plan. Supports are provided on an individual basis.

Instrumental Activities of Daily Living (IADL)—considered more complex tasks than those comprised by activities of daily living (ADLs). Performance of tasks such as these requires mental/cognitive (memory, judgment, intellectual ability) and/or physical ability. IADL are usually identified as preparing meals, shopping, managing money, doing housework and laundry, taking medication, self-transportation, and using the telephone.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDD)—(Formerly known as ICF/MR) a residential facility operated pursuant to federal regulations and serving people with intellectual disabilities and related

conditions. The programming provided in this type of residence is for individuals with extensive needs. Each client must receive a continuous active treatment program, which includes an aggressive and consistent program of training, health services, and related services so that the client acquires the ability to function with as much self-determination and independence as possible.

Level of Care (LOC)—Refers to CMS rules which require an individual to be eligible for care in an institution to be eligible for the HCBS waiver. This does not mean that the person has to live in an institution nor go to an institution, just be eligible for the type of care provided in an institution e.g. a Nursing Facility or ICF/IID.

Neglect- The failure of a caregiver to provide essential services necessary to maintain the physical and mental health of another person in the caregiver's care.

- a. Inability of a person with developmental disabilities or mental illness to provide food, shelter, clothing, health care, or services necessary to maintain the mental and physical health of that person;
- b. Failure by any caretaker of a person with developmental disabilities or mental illness to meet, either by commission or omission, any statutory obligation, court order, administrative rule or regulation, policy, procedure, or minimally accepted standard for care of persons with developmental disabilities or mental illnesses;
- c. Negligent act or omission by any caretaker which causes injury or death to a person with developmental disabilities or mental illness or which places that person at risk of injury or death;
- d. Failure by any caretaker, who is required by law or administrative rule, to establish or carry out an appropriate individual program or treatment plan for a person with developmental disabilities or mental illness;
- e. Failure by any caretaker to provide adequate nutrition, clothing, or health care to a person with developmental disabilities or mental illness;
- f. Failure by any caretaker to provide a safe environment for a person with developmental disabilities or mental illness; and
- g. Failure by any caretaker to maintain adequate numbers of appropriately trained staff at a facility providing care and services for persons with developmental disabilities or mental illnesses.

North Dakota Administrative Code (NDAC)-are rules of the department.

North Dakota Century Code (NDCC)-are the state laws.

Office of Special Education Programs (OSEP)-is dedicated to improving results for infants, toddlers, children and youth with disabilities ages birth through 21 by providing leadership and financial support to assist states and local districts. The *Individuals with Disabilities Education Act of 2004 (IDEA)* authorizes formula grants to states and discretionary grants to institutions of higher education and other non-profit organizations to support research, demonstrations, technical assistance and dissemination, technology and personnel development and parent-training and information centers.

Performance Measure-gauge used to assess the performance of a process or function of any organization.

Person-Centered Service Plan (PCSP)—The DD Division identifies PCSP as a section of the Overall Service Plan, however for the purpose of this handbook PCSP is a generic term identifying the person’s entire plan. This definition is in line with CMS.

Policy Issuance (PI)—North Dakota Department of Human Services policy.

Pre-Admission Screening and Resident Review (PASRR)—is a federal requirement that every person who seeks admission to a nursing facility be screened by the state for evidence of an intellectual disabilities/related condition or mental illness. If either exists, the screening is intended to determine if nursing facility care is necessary, and if so, to determine if specialized services are needed.

Prevocational Services—This support is made available through the Traditional IID/DD HCBS Waiver to eligible individuals. These services are formalized training, experiences, and staff supports designed to prepare participants for paid employment in integrated community settings. They are structured to develop general abilities and skills that support employability in a work setting and may include: training in effective communication within a work setting, workplace conduct and attire, following directions, attending to tasks, problem solving, and workplace safety. Services are not directed at teaching job specific skills, but at specific habilitative goals outlined in the participant’s person-centered service plan.

Provider Controlled Residential Setting— A setting is provider controlled when the setting in which the person resides is a specific physical place that is rented by a DD Licensed provider of HCBS and the provision of services is controlled by that provider (e.g. individual can only receive services from provider renting the setting)

Provider Owned Residential Setting - A setting is provider owned when the setting in which the person resides is a specific physical place that is owned or co-owned by a DD Licensed provider of HCBS. Provider owned settings include all residential settings that are owned by a DD license provider. The provider owned settings may or may not be managed by another party. Provider owned setting would also include a setting that a provider co-owns with a 3rd party.

Qualified Service Provider (QSP)—An individual or agency that has met all of the standards/requirements and has been designated by the Department of Human Services as a provider.

Quality Assurance (QA)—the process of looking at how well a service is provided. The process may include formally reviewing the services furnished to a person or group of persons, identifying and correcting problems, and then checking to see if the problem was corrected.

Quality Improvement—the performance of discovery, remediation and quality improvement activities in order to ascertain whether the waiver meets the assurances, corrects shortcomings, and pursues opportunities for improvement.

Residential Habilitation (formerly known as MSLA, TCLF, Congregate Care, ISLA, FCOIII) – Formalized training and supports provided to participants who require some level of ongoing daily support. This service is made available to eligible individuals through the Traditional IID/DD HCBS Waiver and is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant’s ability to independently reside and participate in an integrated community to enable the participant to reside as independently as possible in the community.

Risk of Harm—when there is a strong likelihood that if the action were allowed to continue, a person receiving services would be harmed.

Scope-the extent of the occurrence. The frequency of occurrences (scope) can vary depending on situation to situation in determining the impact of findings. In some situations, just one occurrence may be life threatening, while on the other hand, a few random occurrences may have minimal impact.

Severity-the seriousness and the degree to which the issue compromises the individual's health and welfare.

Small Group Employment Support-This service is made available through the Traditional IID/DD HCBS Waiver to eligible individuals in maintaining paid employment in an integrated setting. Services include on- and off-the-job employment-related support for small groups of participants needing intervention to assist them in obtaining and maintaining employment as a group, in accordance with their person-centered service plans. Supports are provided to groups of two (2) to eight (8) employed participants.

State Monitoring Plan-a plan developed by the DD Division which identifies the items to be remediated and will be individualized to the provider. The plan ensures corrective actions are implemented and sustained.

Title XIX-regulations under the Social Security Act for the Medicaid program which are carried out by the Centers for Medicare & Medicaid Services.



Home and Community Based Services Provider Survey Interpretive Guidelines

Interpretive Guidelines Overview

The Interpretive Guidelines for the provider survey provides information on regulations, policy, expectations, and processes. It is intended to serve as a guide for implementation of the survey, establish guidance for the requirements, and be a transparent process between providers and the State.

The principal focus of the survey is on the “outcome” of the provider’s implementation of services. Providers develop their processes, but the practice must comply with the requirements and produce the outcomes. The survey will consist of record review, observations, and interviews. The guide may include questions and methods that the Surveyor will engage in to collect the information. The guide does not limit the surveyor from asking other questions or using other information gathering activities that may be necessary due to circumstances that occur during the review. In the presence of problems or concerns, a more in-depth review will occur.

The following Interpretive Guidelines lays out the survey Domains, Standards, Indicators, Probes, and Measurements. Correlation is made to the CMS Waiver Assurances and Subassurances, along with any Federal and State Rules/Regulations. If a Domain is not correlated to any CMS Waiver Assurances or Subassurances, it is considered Supplemental. Additionally, the requirements encompass and incorporate CQL’s expectations and philosophies found within their Basic Assurances and Personal Outcome Measures.

The Interpretive Guidelines are broken down into the following sections and contain the compliance principles and the “probes” or questions that are useful in understanding what the DD Surveyor looks for when making decisions about compliance:

- Domain-Each Domain constructs the major sections for the survey;
- Standard-This is the compliance to be met and are listed under the corresponding Domain;
- Indicators-The specific person-centered processes and/or organization capacity related to the Standard;
- Probes-Expectations and best practice that should be present and to identify the presence of an Indicator. This is not an exhaustive or all-inclusive list and not all probes will apply to each service or may need to be adapted for the service;
- Guidance-Federal and State Rules, Regulations, and policy which are correlated to each Standard;
- Measurements/sources-The survey process for each Standard.

<p>CMS Assurance: The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.</p> <p>CMS Subassurance: Service plans address all member's assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.</p> <p>CMS Subassurance: Service plans are updated/revised at least annually or when warranted by changes in waiver participant needs.</p> <p>CMS Subassurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.</p>		
<p>Domain 1: Service Planning, Delivery, and Implementation</p>		
<p>STANDARD 1A: Individuals have opportunities to be fully involved in their lives.</p>		
Guidance	Indicators	Measurement/sources
<p>OSP Instructions</p> <p>-Principles and values of the planning process and implementation.</p> <p>441.301(4) Home and Community Based Settings (CMS Final Rule 03/17/14)</p> <p>(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the</p>	<p>1A-1: Individuals are developing or maintaining skills and independence to their maximum level.</p> <p>PROBES:</p> <ul style="list-style-type: none"> • Supports focus on activities that are provided to assist with the acquisition, maintenance, improvement, or skills in the area of self-help, independence, socialization, activities of daily living, communication, community living, choice making, employment, and social skills • New skills and appropriate behaviors are encouraged and reinforced 	<p>Procedure for Residential Habilitation, Independent Habilitation, Prevocational Services, Small Group Employment Support, Independent Employment Support, and Day Habilitation.</p> <ul style="list-style-type: none"> • A random sample of individuals receiving services will be selected among the provider's home and community based services. • Off-site desk review may contain the active plan and any other necessary records in Therap to gather information of plan highlights and expected observations. • Obtain daily schedule of individuals from provider (times, other locations). • The surveyor and provider will work

<p>same degree of access as individuals not receiving Medicaid HCBS.</p> <p>(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.</p> <p>(v) Facilitates individual choice regarding services and supports, and who provides them.</p> <p>Waiver Service Definitions for the current waiver period.</p> <p>Day Habilitation Manual 816-05-60-05 “Day Habilitation”</p> <p>Day Habilitation is a service provided to eligible individuals through the Home and Community-Based Waiver for Individuals with Intellectual Disabilities and Developmental Disabilities. Day Habilitation Services provide assistance to the individual with acquisition, retention or improvement in self-help, socialization and adaptive skills, enabling the individual to attain or maintain his or her maximum potential.</p>	<ul style="list-style-type: none"> • Individual’s routines, activities, and environments facilitate acquisition of skills and independence. They are integrated into a daily rhythm and according to individual’s preferences and choice. • Support and activities are relevant to the needs and interests of the individual, & goals are identified in the plan. • Services and activities are organized around the goals, preferences, and needs of the individuals. • There are positive reinforcements, guidance/prompting, environmental changes, or any other changes to conditions to assist toward positive behaviors, teach and reinforce appropriate behaviors or there are positive techniques, strategies, and supports. • Positive behavior supports and least restrictive methods are utilized. (Restrictive techniques are used according to their plan) • Restrictive techniques are not used in lack of programming, for disciplinary purposes, or for the convenience of staff. • Supports and skill development address job attainment, job success, career changes, retention, and advancement. 	<p>together to arrange observation times for individuals.</p> <ul style="list-style-type: none"> • On-site observations and visits conducted. All individuals in the environment will be observed in addition to the sample and may be added as supplemental individuals in the survey. • Interviews with guardians and discussions with individuals
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<p>“Personal Outcomes” Day Habilitation programs provide flexibility to address personal outcomes identified in each individual's OSP development process. Services addressing individual's priorities for outcomes in vocational or avocational pursuits should not be encumbered by programming boundaries. Within the context of the single program, methods, strategies, activities, and service environments should be developed and, followed by staff, that are individualized to best support and promote desired outcomes.</p> <p>“Meaningful Day” An individual’s Meaningful Day can be defined as an individual’s connections between their desired outcomes, (as defined in the individual’s overall service plan, (OSP), and the reliance that is built with other people who are in their family, their community, people who have become their friends and neighbors, people in their social groups, people who are colleagues as well as those who provide paid services.</p> <p>Economic, health and social science research has demonstrated how our lives are enhanced by social ties with other people — our families, friends, neighbors, social groups and co-workers. Increases in these social contacts have been associated</p>	<p>1A-2: Individuals are included, encouraged, and supported while actively participating in activities.</p> <p>PROBES:</p> <ul style="list-style-type: none"> • Individuals are involved or engaged in performing activities, Activities of Daily Living and Instrumental Activities of Daily Living ADL’s/IADL’s, and use their environment • Individuals are able to get around and use the environment to the best of their ability (tv, appliances, work equipment, etc.) • Adaptive equipment and assistive technology is utilized for individuals to function with increased independence. • Staff respond and communicate to the individual based on their style, need, and identified behavior (including the use of sign language, primary language, communication devices, etc) • Activities and materials are age-appropriate, adaptive, and functional. • There is evidence of participation in activities as identified in the plan and according to skill levels (e.g. staff are not completing for individuals) 	
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<p>with improved mental and physical health; lower rates of social problems such as juvenile delinquency, teen pregnancy, and deteriorating neighborhoods; and greater access to economic security. People who belong to organized social groups live longer than those who don't.</p> <p>Someone's meaningful day does not, exclusively, denote activities that happen between 9am to 5pm weekdays. Community activities, which may constitute someone's meaningful day, often occur in evenings and on weekends.</p> <p>“Meaningful Activities” Meaningful Activities are those undertakings that assist the individual to accomplish their outcomes by participating in functions and activities of community life that are desired and chosen by the general population.</p>	<ul style="list-style-type: none"> • Staff provides support which promotes skills and independence. They are teaching, mentoring, verbally/physically involved with individuals, and encouraging individual's independence/self-determination to the best of their abilities. • Activities are engaging, purposeful and meaningful to the individuals (includes activities participated in during down time, staff responses) • Individuals are being supported and engaged in a routine and activities that are typical to the environment, time of day, and what is important to and for the person. (Activities follow a normal pattern of life.) • Individual's preferences, choices, interests, and desires are reflected in their daily routines and activities. 	
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<p>Examples of Meaningful Activities might be purposeful and meaningful work or work tasks; substantial and sustained opportunity for optimal health, self-empowerment and personalized relationships; skill development and/or maintenance; and social, educational and community inclusion activities that are directly linked to the vision, goals and desired personal outcomes documented in the individual’s Overall Service Plan. Successful Meaningful Day Supports are measured by whether or not the individual achieves his/her desired outcomes as identified in the individual’s Overall Service Plan.</p> <p>Attachment F of the Day Habilitation Manual: Daily Plans and Schedules</p> <p>Individuals’ schedules should incorporate the full day and at least 85% of the schedule should incorporate each individual’s meaningful day activities.</p> <ul style="list-style-type: none"> • Staff provides support which promotes skills and independence. They are teaching, mentoring, verbally/physically involved with individuals, and encouraging individual’s independence/self-determination to the best of their abilities. • Activities are engaging, purposeful and meaningful to the individuals (includes 		
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<p>activities participated in during down time, staff responses)</p> <ul style="list-style-type: none"> • Individuals are being supported and engaged in a routine and activities that are typical to the environment, time of day, and what is important to and for the person. (Activities follow a normal pattern of life.) • Individual’s preferences, choices, interests, and desires are reflected in their daily routines and activities. 		
<p>STANDARD 1B: Individuals are receiving services and supports according to their plan.</p>		
<p>Guidance</p>	<p>Indicators</p>	<p>Measurements/sources</p>
<p>OSP Instructions</p> <p>-Principles and values of the planning process and implementation.</p> <p>Home and Community Based Waiver Instructions, Technical Guide and Review Criteria (Version 3.5) Appendix D: Participant-Centered Planning and Service Delivery</p> <p><u>Appendix D-1: Service Plan Development</u></p> <p>A well-designed process for developing and implementing waiver participant service plans is perhaps the most critical component of the waiver program.</p>	<p>1B-1: Services and supports are implemented as identified in their plan.</p> <p>PROBES:</p> <ul style="list-style-type: none"> • Objectives/supports and other services are implemented with the needs and wants described in the plan. • The provider is implementing all objectives/supports and other services identified in the plan. • Implementation is taking place-plan activities are being provided, individuals are working on skills and programs identified in their plan, the needed materials/supplies are in use, and 	<p>Procedure for Residential Habilitation, Independent Habilitation, Prevocational Services, Small Group Employment Support, Independent Employment Support, and Day Habilitation</p> <ul style="list-style-type: none"> • A random sample of individuals receiving services will be selected among the provider’s home and community based services. • Off-site desk review may contain the active plan and any other necessary records in Therap to gather information of plan highlights and expected observations. • Obtain daily schedule of individuals from provider (times, other locations).

<p>Service planning is the process through which each waiver participant’s needs, goals and preferences are identified and strategies are developed to address those needs, goals and preferences. It is the process through which the participant exercises choice and control over services and supports and through which risks are assessed and planned for. A well designed process incorporates and maximizes the resources and supports present in the person’s life and community. It is important that the planning process also enables and supports each participant (and/or family or legal representative, as appropriate) to fully engage in and direct the planning process to the extent he/she chooses. It is through the planning process that roles and responsibilities are clarified for participants who direct their own services.</p> <p>The service plan (plan of care) identifies the waiver services as well as other services and supports that a person needs in order to live successfully in the community and, therefore, avoid institutionalization. In accordance with 42 CFR §441.301 (b)(1)(i), all waiver services must be furnished pursuant to a written service plan that is developed for each waiver participant. The service plan must reflect the full range of a participant’s service needs and include both the</p>	<p>individuals are actively engaged.</p> <ul style="list-style-type: none"> • Materials, supplies, assistive devices, adaptive equipment, etc. are available, utilized, and in good working order to provide needed services and supports. • Behavior supports and interventions are delivered according to the plan. • Activities support the accomplishment of the identified objectives or supports. • Staff is aware of health and safety risks and potential considerations. • Staff responds to the expressed needs of the individuals. (ie. Showing signs of distress, illness, need for repositioning, etc) • Staff is participating in their job duties and activities that benefit and involve individuals (relate to individual care, plans, health and welfare). • Plans address areas and needs which are current and accurate. 	<ul style="list-style-type: none"> • Surveyor and provider will work together to arrange observation times for individuals. • On-site observations and visits conducted. All individuals in the environment will be observed in addition to the sample and may be added as supplemental individuals in the survey. • Interviews with guardians and discussions with individuals.
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<p>Medicaid and non-Medicaid services along with informal supports that are necessary to address those needs. The service plan commits the state to provide the Medicaid services and supports that are specified in the plan.</p> <p>When non-waiver services and supports are included in the service plan, the waiver administering agency is not responsible for ensuring their availability or actual delivery. As necessary and appropriate, activities should be undertaken to link, refer or advocate for such services. When non-waiver services and supports are needed to meet the needs of the participant, their provision must be monitored during the implementation of the service plan.</p> <p>CMS encourages and supports the use of person/family-centered planning methods in service plan development. Such methods actively engage and empower the participant and individuals selected by the participant in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant (and/or family, if applicable). Person/family-centered planning is an integral element of participant direction of services.</p>		
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<p>The service plan must contain, at a minimum: the services that are furnished, the amount and frequency of each service, and the type of provider to furnish each service.</p> <p>The service plan must be revised as necessary to add or delete services or modify the amount and frequency of services. Service plans must be reviewed at least annually or whenever necessary due to a change in the participant's needs.</p> <p>42 CFR 441.301 Contents of a request for waiver(CMS Final Rule 03/17/14)</p> <p>(c) (2) The Person-Centered Service Plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:</p> <p>(ii) Reflect the individual's strengths and</p>		
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<p>preferences.</p> <p>(iii) Reflect clinical and support needs as identified through an assessment of functional need.</p> <p>(iv) Include individually identified goals and desired outcomes.</p> <p>(v) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.</p> <p>(vi) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.</p> <p>(xiii) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:</p>		
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<p>(A) Identify a specific and individualized assessed need.</p> <p>(B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.</p> <p>(C) Document less intrusive methods of meeting the need that have been tried but did not work.</p> <p>(D) Include a clear description of the condition that is directly proportionate to the specific assessed need.</p> <p>(E) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.</p> <p>(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.</p> <p>(G) Include informed consent of the individual.</p> <p>(H) Include an assurance that interventions and supports will cause no</p>		
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<p>harm to the individual.</p> <p>North Dakota Administrative Code 75-04-01-20(1)(a)</p> <p>Guarantees each client a person centered service plan pursuant to the provisions of North Dakota Century Code 25-01.2-14</p> <p>North Dakota Administrative Code 75-04-01-20(1)(i)</p> <p>Guarantees the client freedom from corporal punishment, imposition of isolation, seclusion, chemical, physical, or mechanical restraint, except as prescribed by North Dakota Century Code section 25-01.2-10 or these rules, and guarantees the client freedom from psychosurgery, sterilization, medical behavioral research, pharmacological research, and electroconvulsive therapy, expect as prescribed by North Dakota sections 25-01.2-09 and 25-01.2-11.</p> <p>North Dakota Administrative Code 75-04-01-20(1)(n)</p> <p>Assures that residential provider agency will coordinate with the developmental and remedial services outside the</p>		
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<p>residential setting in which a client lives</p> <p>North Dakota Administrative Code 75-04-01-20(1)(o)</p> <p>Assures that adaptive equipment, where appropriate for personal hygiene, self-care, mobility, or communication is provided in the service for use by individuals with disabilities consistent with the person-centered service plan.</p> <p>Day Habilitation Manual 816-05-60-05</p> <p>“Personal Outcomes”</p> <p>Day habilitation programs provide flexibility to address personal outcomes identified in each individual's OSP development process. Services addressing individual's priorities for outcomes in vocational or avocational pursuits should not be encumbered by programming boundaries. Within the context of the single program, methods, strategies, activities, and service environments should be developed and, followed by staff, that are individualized to best support and promote desired outcomes.</p>		
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<p>“Overall Support Plan” An Overall Service Plan, (OSP), contains individual, family and support team demographic information and a list of outcomes that are specific to the individual’s desires and needs. The case plan is also included in the Overall Service Plan.</p> <p>“Case Plan”A plan developed between an individual eligible for Developmental Disabilities Program Management and the Case Manager which identifies the services which are necessary to support the individual in order to attain their outcomes, the providers chosen to deliver of services; and details of the quantity and frequency to be provided. It is a section of the Overall Service Plan.</p>		
<p>Supplemental- Does not address any HCBS Assurances and/or Subassurances</p>		
<p>Domain 2: Rights</p>		
<p>STANDARD 2A: The rights of individuals are promoted, exercised, and protected.</p>		
<p>Guidance</p>	<p>Indicators</p>	<p>Measurements/sources</p>

<p>DD Bill of Rights</p> <p>CFR 441.301(4) Home and Community Based Settings (CMS Final Rule 03/17/14)</p> <p>(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.</p> <p>(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.</p> <p>(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.</p> <p>(v) Facilitates individual choice regarding services and supports, and who provides them.</p> <p>(vi) In a provider-owned or controlled residential setting, in addition to the qualities at § 441.301(c)(4)(i) through (v),</p>	<p>2A-1: Individuals have time, space, and opportunity for privacy.</p> <p>PROBES</p> <ul style="list-style-type: none"> • Individuals have time to be alone, and a place to go for privacy. • Individuals have privacy during visits with family and friends without restricted hours and meeting locations. • Individuals have privacy during telephone conversations, open & read own mail. • Confidentiality of information is maintained. (conversations, memos, etc.) Personal information is not publically displayed. • Privacy is ensured during personal cares, when requested or desire is shown for it. • People knock before entering individual's rooms, bathroom, home, etc. <p>2A-2: Individuals are actively involved in decisions and make their own choices.</p> <p>PROBES:</p> <ul style="list-style-type: none"> • Individuals are encouraged and actively participate in making decisions in their life, activities, schedules, etc. • Individuals are provided with options for age appropriate and meaningful activities. • Individuals are indicating how they want assistance/supports in what they are doing and staff are listening to them 	<p>Procedure for Residential Habilitation, Independent Habilitation, Prevocational Services, Small Group Employment Support, Independent Employment Support, and Day Habilitation.</p> <ul style="list-style-type: none"> • A random sample of individuals receiving services will be selected among the provider's home and community based services. • Off-site desk review may contain the active plan and any other necessary records in Therap to gather information of plan highlights and expected observations. • Obtain daily schedule of individuals from provider (times, other locations) . • Surveyor and provider will work together to arrange observation times for individuals. • On-site observations and visits conducted. All individuals in the environment will be observed in addition to the sample and may be added as supplemental individuals in the survey. • Interviews with guardians and discussions with individuals
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<p>the following additional conditions must be met:</p> <p>(B) Each individual has privacy in their sleeping or living unit:</p> <p>(1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.</p> <p>(3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.</p> <p>(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.</p> <p>(D) Individuals are able to have visitors of their choosing at any time.</p> <p>(F) Any modification of the additional conditions, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.</p> <p>North Dakota Century Code 25-01.2</p> <p>-02 Appropriate treatment, services, and habilitation-Treatment in the least restrictive appropriate setting</p> <p>-03 Presumption of incompetence prohibited-Discrimination prohibited-Deprivation of constitutional, civil, or legal rights prohibited</p> <p>-04 Mail, telephone, and visitation rights-Application to residential institution or</p>	<ul style="list-style-type: none"> • Individuals have choices in their routine and options in integrated settings including their home, work, and community. • Staff offers a variety of options and choices (what to eat, wear, etc.) • Individuals make and receive phone calls when they chose and to whom • The individual’s room is decorated with their personal items/decorations • Individuals are included in decisions about them, regardless of their communication <p>2A-3: Individuals have access to personal possessions.</p> <p>PROBES:</p> <ul style="list-style-type: none"> • Individuals mail is unopened • Individual’s personal possessions are based on their needs, interests, and preferences. • Individuals have access to their personal possessions including food, money, hygiene items, and clothing. • Individuals have freedom of movement and have access to all areas of their home, work, or day program (without violating others privacy) • Individuals have access to personal funds. <p>2A-4: Individuals are treated with dignity and respect</p> <p>PROBES:</p> <ul style="list-style-type: none"> • People first language is present, Interactions 	
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<p>facility</p> <p>-05 Personal Property-Application to residential institution or facility</p> <p>-06 Labor-Wages-Money-Application to residential institution or facility</p> <p>-07 Medical and Dental Services-Application to residential institution or facility</p> <p>-08 Medication-Chemical restraints</p> <p>-09 Punishment-Isolation-Physical restraint-psychosurgery-Sterilization-Shock treatment</p> <p>-10 Seclusion or physical restraint-Facility administrator to be notified</p> <p>-11 Psychosurgery, sterilization, or research-Court order required-Hearing-Right to attorney at public expense-Application to residential institution or facility</p> <p>-12 Diet-application to residential institution or facility</p> <p>-13 Education</p> <p>-14 Individualized habilitation or education plan-Contents</p> <p>-15 Right to refuse services</p> <p>-16 Notice of rights</p> <p>-17 Enforcement of rights</p> <p>-18 Authority to adopt rules</p> <p>North Dakota Administrative Code 75-04-01-20(1)(b) Guarantees that each client, client authorized representative, or advocate</p>	<p>are respectful, attentive, positive, non-stigmatizing, and are appropriate to age and sex.</p> <ul style="list-style-type: none"> • Staff respects the individual’s choice & preference (including ethnic & culturally responsive-responsive to beliefs, styles, languages, etc.) • The individual is involved in conversations about themselves, is acknowledged when communicating (i.e. active listening skills) • Individuals are not referred to by their disability, diagnosis or condition • Hygienic practices are supported and encouraged (e.g. Clothes are clean & fit properly, hair combed, face free of food debris, utilizing utensils) • Staff are respecting the residence as the individuals home • Signs, notes, house rules, etc. which are not appropriate are not posted <p>*If individuals are unable to exercise rights, it may be considered a rights restriction, which needs to be addressed in their plan, and taken through the appropriate committees.</p>	
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<p>receives written notice of the client’s right in the manner provided by North Dakota Century Code 25-01.2-16</p> <p>North Dakota Administrative Code 75-04-01-20(1)(d) Guarantees the client the right to receive authorized services and supports included in his or her person-centered services plan in a timely manner and the opportunity to fully participate in the benefits of community living, vote, worship, interact socially, freely communicate and receive guests, own and use personal property, unrestricted access to legal counsel, and guarantees that all rules regarding such conduct are posted or made available pursuant to North Dakota Century Code 25-01.2-03, 25-01.2-04, and 25-01.2-05.</p> <p>North Dakota Administrative Code 75-04-01-20(1)(f) Guarantees the confidentiality of all client records.</p> <p>North Dakota Administrative Code 75-04-01-20(1)(g) Guarantees that the client received adequate remuneration for compensable labor, that subminimum wages are paid only pursuant to title 29, Code of Federal Regulations, part 525, et seq., that the client has the right to seek employment in</p>		
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<p>integrated settings, that restrictions upon client access to money are subject to the provisions of a person-centered service plan, that assets managed by the applicant on behalf of the client inure solely to the benefit of that client, that each client has money management plan or documented evidence of the client’s capacity to manage money, and that, in the event the applicant is a representative payee of a client, the informed consent of the client is obtained and documented.</p>		
<p>STANDARD 2B: Individuals in provider-owned or provider controlled residential settings have a lease or other legally enforceable agreement providing eviction protections.</p>		
Guidance	Indicators	Measurement/sources
<p>CFR 441.301(4) Home and Community Based Settings (CMS Final Rule 03/17/14)</p> <p>(vi) In a provider-owned or controlled residential setting, in addition to the qualities at §441.301(c)(4)(i) through (v), the following additional conditions must be met:</p> <p>(A)The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the</p>	<p>2B-1: Individuals in provider-owned residential setting have a signed lease, residency agreement, or other form of written agreement.</p> <p>Probes:</p> <ul style="list-style-type: none"> • Lease, residency agreement, or other form of written agreement is signed by individual and/or legal guardian. • Individual has a lease, residency agreement, or other form of written agreement that is current and provides eviction protections. • The individual’s lease, residency agreement, or other form of written agreement does not contain items that 	<p>Procedure for provider-owned residential settings.</p> <p>The lease, residency agreement, or other form of written agreement is established for any home, apartment units, apartment buildings, group home, room, etc. which is <u>provider-owned</u>.</p> <ul style="list-style-type: none"> • A random sample of individuals receiving services will be selected among the provider’s home and community based services. • Verification of provider lease will be based on provider submission of the current lease.

<p>State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.</p> <p>NDCC 47-16 LEASING OF REAL PROPERTY</p> <p>NDCC 47-32 Eviction</p>	<p>conflict with the landlord tenant laws, eviction laws, and CMS Final Rule.</p> <p>2B-2: Individuals in provider controlled residential setting have a signed lease, residency agreement, or other form of written agreement.</p> <p>Probes:</p> <ul style="list-style-type: none"> • Lease, residency agreement, or other form of written agreement is signed by individual and/or legal guardian. • Individual has a lease, residency agreement, or other form of written agreement that is current and provides eviction protections. • The individual's lease, residency agreement, or other form of written agreement does not contain items that conflict with the landlord tenant laws, eviction laws, and CMS Final Rule. 	<ul style="list-style-type: none"> • Providers submit all current leases for sample individuals at the on-site surveyor visit. • Surveyor will verify lease via off site desk review upon returning to the office to ensure it matches the current sample on file for provider and no changes have been made without notification to DD. <p>Procedure for provider controlled residential settings.</p> <p>The lease, residency agreement, or other form of written agreement is established for any home, apartment units, apartment buildings, group home, room, etc. which is <u>provider controlled</u>.</p> <ul style="list-style-type: none"> • A random sample of individuals receiving services will be selected among the provider's home and community based services. • Verification of provider lease, residency agreement, or other form of written agreement will be based on provider submission of the current lease. • Providers submit all current leases, residency agreement, or other form of written agreement for sample individuals at the on-site surveyor visit. <p>Surveyor will verify lease, residency agreement, or other form of written agreement via off site</p>
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		desk review upon returning to the office to ensure it matches the current sample on file for provider and no changes have been made without notification to DD.
<p>Assurance: The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.</p> <p>CMS Subassurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.</p> <p>CMS Subassurance: The State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.</p>		
Domain 3: Provider Capabilities and Qualifications		
STANDARD 3A: Staff are trained to perform their duties effectively, efficiently, and competently.		
Guidance	Indicators	Measurements/sources
<p>Home and Community Based Waiver Instructions, Technical Guide and Review Criteria (Version 3.5) Appendix C: Participant Services</p> <p><u>Appendix C-3: Waiver Services Specification</u></p> <p>Provider Requirements: The waiver assurances at 42 CFR 441.302(a) require that (a) there are adequate standards for all types of providers that provide services under the waiver and (b) that the standards must be met when services are</p>	<p>3A-1: Provider Level I orientation training contains the minimum components as required by Division Policy.</p> <p>PROBES:</p> <ul style="list-style-type: none"> • Evidence of provider orientation training is in accordance with Division Policy. <ul style="list-style-type: none"> a) Overview of DD/ID services in North Dakota (which would cover nature of ID/DD, Title XIX certifications, CMS Final Rule, CQL accreditations, people first language, active support/active treatment principles, etc.); b) Human and legal rights; c) General overview of person-centered 	<p>Procedure for Residential Habilitation, Independent Habilitation, Prevocational Services, Small Group Employment Support, Independent Employment Support, and Day Habilitation</p> <ul style="list-style-type: none"> • Verification of provider orientation training components will be based on provider submission of orientation checklist. • Providers submit all currently employed waiver program staff list prior to on-site surveyor arrival. <ul style="list-style-type: none"> ○ Program staff is defined as DSP (Direct Support Professional), and

<p>furnished.</p> <p>Provider Qualifications: Provider standards or qualifications are the criteria that a provider must meet in order to provide the waiver service:</p> <ul style="list-style-type: none"> • A license issued under the authority of state law, • A certificate issued by a state agency or other recognized body. For example, a certificate may be issued as a result of a quality review of the provider or by a recognized accreditation organization; and, <p>Other standards specified by the state. These other standards may be in addition to a required license or certificate and must be specified.</p> <p>One or more of these types of qualifications must be specified for each service.</p> <p>CMS has not promulgated minimum provider qualifications for waiver services. States have latitude in establishing appropriate qualifications. Like other Medicaid services, waiver services are subject to any relevant requirements</p>	<p>plan development and team concepts;</p> <p>d)Basic health and safety concerns;</p> <p>e)Agency specific information (which would cover an overview of the agency’s services, tour of all facilities, an overview of the agency’s relationship to the state service delivery system, and review of policies and procedures of the agency, as well as those specific to the staff member’s intended work site);</p> <p>f)Current abuse and neglect policies and reporting requirements*;</p> <p>g)Prohibited procedures in the State of ND;</p> <p>h)OSHA (Bloodborne pathogens)*;</p> <p>i)Emergency evacuations*;</p> <p>j)PHI/HIPAA*;</p> <p>k)Code of conduct;</p> <p>l)Confidentiality*;</p> <p>m)DSP code of ethics*;</p> <p>n)Therapeutic responses or a similar positive behavioral supports curriculum must be trained on with ANY new or returning staff to the organization within the first 90 days of employment, or in the case of a behavioral program setting, within the first 30 days AND prior to working alone, unsupervised in this setting. *</p>	<p>other professional staff (QDDP (Qualified Developmental Disabilities Professional), Nurse, etc.).</p> <ul style="list-style-type: none"> ○ Staff list compiled shall be according to region/location of the survey. <ul style="list-style-type: none"> • Staff orientation and annual training sample will be randomly selected from the list provided by the provider. • Verification of orientation, annual trainings, first aid, and CPR training records will be based on staff training on-site record review. <ul style="list-style-type: none"> ○ Documentation is required (i.e. signature pages or certificates). Dates only will not be acceptable. • Upon arrival of on-site visit, surveyor will give the provider the list of the staff chosen for the random sample <ul style="list-style-type: none"> ○ If staff training files are kept off site, arrangements needs to be made to gets staff training files to surveyor. • Survey will cycle on the orientation and annual training that will be verified. • Individual specific OSP training may not be verified in staff training records review but will be monitored during on-site observations and verified as needed. • Annual training will be verified by reviewing the last 2 years of trainings. • CPR and First Aid will verify the most
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<p>contained in state law. However, provider qualifications must be reasonable and appropriate in light of the nature of the service. They must reflect sufficient training, experience, and education to ensure that individuals will receive services from qualified persons in a safe and effective manner.</p> <p>A state may provide that additional qualifications may be incorporated into the service plan in order to meet the unique or specific needs of the participant. In addition, participants who exercise the Employer Authority may require that the workers whom they hire to have skills or characteristics that the participant judges are important to meeting the participant's particular needs. However, a state may not provide that provider qualifications will be solely specified in the service plan or by the participant. In other words, a state must establish the essential minimum qualifications that a provider must meet in order to be deemed a qualified provider and the state must ensure that those requirements are met when the service is provided.</p> <p>DD Division Policy for Training-DD</p>	<p>*All staff must be trained at least annually, and as needed, on these specific items.</p> <p>3A-2: There is evidence that Level I orientation was completed according to Division Policy for new hires and rehires. (mandatory for all new employees, full and part time, as well as returning employees)</p> <p>PROBES:</p> <ul style="list-style-type: none"> • Evidence of orientation level I training is in accordance with Division Policy. • Orientation Level I training is completed within 30 days of the start date. • Therapeutic Intervention or similar positive behavior support is completed in within the first 90 days of employment, or in the case of a behavioral program setting, within the first 30 days AND prior to working alone, unsupervised in this setting. <p>3A-3: There is evidence that required annual training was completed according with Division Policy.</p> <p>PROBES:</p> <ul style="list-style-type: none"> • Evidence of annual training is in accordance 	<p>current completion date for new and veteran staff.</p> <ul style="list-style-type: none"> • Orientation training will be verified by comparing staff's start date to training completion date for timeliness. • Interviews with guardians and discussions with individuals. • Verification for staff competency outcome will be obtained by on-site observations and visits in Residential Habilitation, Independent Habilitation, Prevocational Services, Small Group Employment Support, Independent Employment Support, and Day Habilitation settings.
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<p>Licensed Providers</p> <p>North Dakota Administrative Code 75-04-01-20(1)(p)</p> <p>Assures that all service staff demonstrate basic professional competencies as required by their job descriptions and complies with all required trainings, credentialing, and professional development activities.</p>	<p>with Division Policy.</p> <ul style="list-style-type: none"> • First aid and CPR are completed as required. • Annual training is completed timely. Annually is defined as 365 calendar days. <p>3A-4: Staff exhibit competency and knowledge for the individuals</p> <p>PROBES:</p> <ul style="list-style-type: none"> • Staff demonstrates knowledge and skills about the individual’s needs, interventions, programs, risks, etc. • Staff received individual specific training related to the individual which they provide services for • Evidence of staff trained accordingly, is observed by individuals being provided services, supports, care, and treatment effectively and according to their plan • Staff are able to match the needs of the individuals and learning styles 	
<p>STANDARD 3B: Background checks are completed for all employees.</p>		
<p>Guidance</p>	<p>Indicators</p>	<p>Measurements/sources</p>
<p>Home and Community Based Waiver Instructions, Technical Guide and Review Criteria (Version 3.5) Appendix C:</p>	<p>3B-1: There is evidence of background checks completed on all staff hired in accordance with Division Policy.</p>	<p>Procedure for Residential Habilitation, Independent Habilitation, Prevocational Services, Small Group Employment Support,</p>

<p>Participant Services</p> <p>Appendix C-2: General Service Specifications</p> <p>(a)Criminal History/Background Investigations As a safeguard, most states require that individuals who provide direct support and/or other services to waiver participants undergo a pre-employment criminal history check and/or background investigation. Here, identify the types of positions for which such checks or investigations are required, the entity that have been conducted in accordance with the state’s policies (e.g., as part of the certification of workers or as part of the periodic review of provider agencies).</p> <p>(b)Abuse Registry Screening:</p> <p>As an additional safeguard, many states maintain abuse registries and require that workers who furnish direct services to waiver participants and other positions to undergo pre-employment screening through such a registry.</p> <p>DD Division Policy for Employee Background Checks</p>	<p>PROBES:</p> <ul style="list-style-type: none"> The provider has done a complete background check per the DD Division policy. <p>3B-2: There is evidence of child abuse and neglect central registry checks completed on all staff hired in accordance with Division Policy.</p> <p>PROBES:</p> <ul style="list-style-type: none"> The provider has completed the Child Abuse and Neglect Central Registry check for all staff hired. <p>3B-3: Background/registry checks that did not come back clear were verified by the DD Division as not having a direct bearing in accordance with Division Policy.</p> <p>PROBES:</p> <ul style="list-style-type: none"> A criminal background check verifies that each employee is free from convictions that have a direct bearing. If background check was not clear, the provider sent all information per policy to the DD Division for review. Staff were not employed or retained by the provider who had direct bearing offences. 	<p>Independent Employment Support, and Day Habilitation.</p> <ul style="list-style-type: none"> Providers submit all currently employed waiver program staff list prior to on-site surveyor arrival. The past 3 years of new employees hired where background checks were completed will be sampled and reviewed. <ul style="list-style-type: none"> Program staff is defined as DSP, and other professional staff (QDDP, Nurse, etc.). Staff list compiled shall be according to region/location of survey. Upon arrival of on-site visit, surveyor will provide the provider with the list of the staff chosen for the random sample. Verification of background and abuse registry records will be based on staff on-site record review (proof of actual documentation is required) Background and abuse registry dates completed. Verification of the DD Division approval as not having a direct bearing per policy. If during survey, it is discovered that a background and/or registry check was not completed or they did not forward the results to the DD Division on background check that indicated a record of any kind, provider must complete the process immediately and submit verification to the
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<p>North Dakota Administrative Code 75-04-01-06 Disclosure of criminal records</p> <p>North Dakota Administrative Code 75-04-01-06.1 Criminal conviction-effect on operation of provider agency or employment by provider agency.</p>		<p>surveyor.</p>
<p>STANDARD 3C: QDDP staff is qualified to develop services plans.</p>		
Guidance	Indicators	Measurements/sources
<p>CFR 441.301(b)(2) Contents of request for a waiver. (b) If the agency furnishes home and community-based services, as defined in § 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must – (2) Describe the qualifications of the individual or individuals who will be responsible for developing the individual plan of care.</p> <p>HCBS Community Waiver</p> <p>DD Division Policy for Qualifications for staff responsible for Waiver Service Plan (Person Centered Services Plan) Development</p>	<p>3C-1: Per Division Policy, QDDP staff has the required qualifications for service plan development.</p>	<p>Procedure for Residential Habilitation, Independent Habilitation, Prevocational Services, Small Group Employment Support, Independent Employment Support, and Day Habilitation.</p> <ul style="list-style-type: none"> • Providers submit the names of all current Waiver QDDP staff. • Surveyor will determine the sample and notify the provider. A sample will consist of all those who have been hired as a QDDP since the previous survey. • The provider will submit the documentation of qualifications for the sample prior to the on-site visit. • Documentation may include but is not limited to the following; copy of degree/diploma, documentation showing experience, Developmental Disability module certification.

		<ul style="list-style-type: none"> Off-site desk review will be completed to verify the documentation meets requirements in the Division Policy.
<p>CMS Assurance: The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.</p> <p>Subassurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.</p>		
Domain 4: Health and Welfare		
STANDARD 4A: Medications are managed effectively and appropriately.		
Guidance	Indicators	Measurements/sources
<p>Medications Training Module (North Dakota Center for Persons With Disabilities 2011)</p> <p>Home and Community Based Waiver Instructions, Technical Guide and Review Criteria (Version 3.5) Appendix G: Participant Safeguards</p> <p>Appendix G-3: Medication Management and Administration (c) (ii) State Policy When waiver providers administer medications to participants who are unable to self-administer, states typically have adopted formal policies (in law and/or regulation) that govern this practice.</p> <p>The response to this item should</p>	<p>4A-1: There is evidence that only staff who are med certified assist individuals with medication administration.</p> <p>PROBES:</p> <ul style="list-style-type: none"> Medication administration module and practicum was completed by staff administrating medications. <p>4A-2: Medications are stored to ensure appropriate access, security, separation, and environmental conditions.</p> <p>PROBES:</p> <ul style="list-style-type: none"> Medications are stored separate from other individuals. Controlled substances are locked. (schedule III-V are locked , schedule II are double 	<p>Procedure for Residential Habilitation, Independent Habilitation, Prevocational Services, Small Group Employment Support, Independent Employment Support, and Day Habilitation.</p> <ul style="list-style-type: none"> Upon arrival, the provider will give surveyor Medication Administration Records (MAR) from the sample individuals for the last 3 months, including a master list identifying all staff on the MARs for those 3 months. Surveyor will generate a random sample from the MARs. Verification of medication certified staff will be based on staff on-site record review (proof of actual documentation required) Verification of medication storage

<p>summarize the applicable policies, including whether administration is restricted to licensed medical personnel or may be performed by non-medical waiver provider personnel. In the case of the latter, the summary should identify the training/education that such personnel must have in order to administer medications and the extent of oversight by licensed medical professionals that is performed. The summary also should describe the state's policies with respect to waiver providers overseeing the self-administration of medications by waiver participants.</p>	<p>locked)</p> <ul style="list-style-type: none"> • Internal and external medications are stored separately. • Medications are refrigerated as required. • Locking of medication storage area is based on the needs of the individuals. • Medications have a pharmacy label that is legible (not worn, illegible, or missing). <p>4A-3: Medication administration procedures are appropriately applied and medications are delivered safely.</p> <p>PROBES:</p> <ul style="list-style-type: none"> • Standard precautions (or infection control procedures) are utilized during medication administration (staff and individuals) • Individuals are involved in the medication process to the best of their abilities. 	<p>and administration will occur during on-site observation and visit.</p> <ul style="list-style-type: none"> • Discussions with individuals.
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<p>North Dakota Administrative Code 75-04-01-20(1)(h) Guarantees the client access to appropriate and timely medical and dental care and adequate protection from infectious and communicable diseases, and guarantees effective control and administration of medication; as well as prevention of drug use as a substitute for programming.</p>	<ul style="list-style-type: none">• Positive interactions are promoted.• Medication administration techniques are individualized based on the unique needs of the individuals and comply with certification procedures.• The individual is informed of procedures and what medication they are taking and why.• Privacy and confidentiality is upheld during medication administration.	
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SUPPLEMENTAL- Does not address any HCBS Assurances and/or Subassurances		
Domain 5: Financial Management		
STANDARD 5A: Individual's funds are managed appropriately.		
Guidance	Indicators	Measurements/sources
<p>North Dakota Administrative Code 75-04-05-20 Personal incidental funds</p> <p>North Dakota Administrative Code 75-04-01-20(1)(g) Guarantees that the client received adequate remuneration for compensable labor, that subminimum wages are paid only pursuant to title 29, Code of Federal Regulations, part 525, et seq., that the client has the right to seek employment in integrated settings, that restrictions upon client access to money are subject to the provisions of a person-centered service plan, that assets managed by the applicant on behalf of the client inure solely to the benefit of that client, that each client has money management plan or documented evidence of the client's capacity to manage money, and that, in the event the applicant is a representative payee of a client, the informed consent of the client is obtained and documented.</p>	<p>5A-1: There is no evidence of misuse of individual funds or substantiated financial exploitation.</p> <p>If Not Met-the provider has responded to any trends/patterns and demonstrates it has a system in place to protect the fiscal interests of the individuals.</p>	<p>Procedure for Residential Habilitation, Independent Habilitation, Prevocational Services, Small Group Employment Support, Independent Employment Support, and Day Habilitation.</p> <ul style="list-style-type: none"> • Off-site desk review of GER's & Protective Services Investigations (PSI) database of whole agency for any financial exploitation of the past year (1 year). • Verify if any identified patterns and trends are being addressed by the provider, which includes follow-up. • Interviews with guardians & discussions with individuals.

<p>Guarantees that the client received adequate remuneration for compensable labor, that subminimum wages are paid only pursuant to title 29, Code of Federal Regulations, part 525, et seq., that the client has the right to seek employment in integrated settings, that restrictions upon client access to money are subject to the provisions of a person-centered service plan, that assets managed by the applicant on behalf of the client inure solely to the benefit of that client, that each client has money management plan or documented evidence of the client's capacity to manage money, and that, in the event the applicant is a representative payee of a client, the informed consent of the client is obtained and documented.</p>		
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Appendix B

Provider Request of Information Sample Letter

[Click here to enter a date.](#)

Provider CEO
Provider Name
Address

During the course of the survey, the items listed below will be needed. Items requested prior to the survey can be sent to the contact listed via mail, Therap S-comm, or secure email:

DD Surveyor
ND Department of Human Services
DD Division, Ste 1A
1237 W Divide Ave
Bismarck, ND 58501

Provider will send the following items to the Surveyor prior to on-site visit by [Click here to enter a date.](#):

- Sampled individual's daily home and day services schedules with times and locations, once sample is received;
- List of agency contact personnel (See Attachment);
- Agency waiver program staff list for the region identified. Include name, dates of hire, and title. Program staff includes DSP, QDDP, Nurse and other professional staff for Residential Habilitation, Independent Habilitation, Prevocational Services, Small Group Employment Support, Independent Employment Support, and Day Habilitation (See attachment for example format, excel format is preferred);
- Agency New Staff Orientation Checklist.

Provider will provide the following items upon arrival (or prior) to Surveyor:

- MARs with signature sheets of past 3 months for sampled individuals; including a master list identifying all staff on the MARs for those 3 months;
- Leases for sampled individuals in provider owned settings;
- Access to individual files as requested;
- Agency personnel training records (orientation, annual, first aid, CPR, med certification);
- Agency personnel background checks and abuse registry records. (includes Board of Nursing, CNA, and Certified Nurse Registry);
- Additional items as needed:
 - _____
 - _____.

Thank you in advance for your cooperation,
DD Surveyor

DD DIVISION IMMEDIATE JEOPARDY TRIGGERS AND PROCEDURES

Introduction

CMS State Operations Manual Appendix Q – Guidelines for Determining Immediate Jeopardy was referenced and utilized to provide guidelines in determining if circumstances pose an Immediate Jeopardy to an individual's health and welfare. These guidelines assist Federal and State Survey and Certification personnel and Complaint Investigators in recognizing situations that may cause or permit Immediate Jeopardy. Some adaptations were developed to pertain to the DD Division.

Immediate Jeopardy is defined as "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."

- Only one individual needs to be at risk and serious harm, injury, impairment, or death does not have to occur.
- Serious harm, injury, impairment, or death does NOT have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy.
- Individuals must not be subjected to abuse by anyone including, but not limited to, provider staff, consultants or volunteers, family members or visitors.
- Serious harm can result from both abuse and neglect. Psychological harm is as serious as physical harm.
- When a surveyor has established, through review, that an harmed another individual receiving care and services from the provider due to the entity's failure to provide care and services to avoid physical harm, mental anguish, or mental illness, this should be considered neglect.
- Any time a survey cites abuse or neglect, it should consider Immediate Jeopardy.

Upon recognizing a situation may constitute Immediate Jeopardy, the review process continues until it confirms or rules out Immediate Jeopardy. The serious harm, injury, impairment or death may have occurred in the past, may be occurring at present, or may be likely to occur in the very near future as a result of the jeopardy situation. After determining that the harm meets the definition of Immediate Jeopardy, consider the following points regarding provider compliance:

- The provider either created a situation or allowed a situation to continue which resulted in serious harm or a potential for serious harm, injury, impairment or death to individuals.
- The provider had an opportunity to implement corrective or preventive measures.

Triggers

This guide lists issues with associated triggers based on the *CMS State Operations Manual Appendix Q – Guidelines for Determining Immediate Jeopardy*. Triggers will assist the surveyor in considering if Immediate Jeopardy accompanies each issue. Triggers describe situations that will cause the surveyor to consider if further review is needed to determine

the presence of Immediate Jeopardy. The listed triggers do not automatically equal Immediate Jeopardy. The surveyor must use professional judgment to determine if the situation has caused, or is likely to cause, serious harm, injury, impairment or death. These triggers are general examples and are not all-inclusive.

ISSUE	TRIGGERS
Failure to protect from abuse.	<ol style="list-style-type: none"> 1. Serious injuries such as head trauma or fractures; 2. Non-consensual sexual interactions; e.g., sexual harassment, sexual coercion or sexual assault; 3. Unexplained serious injuries that have not been investigated; 4. Staff striking or roughly handling an individual; 5. Staff yelling, swearing, gesturing or calling an individual derogatory names; 6. Bruises around the breast or genital area; or suspicious injuries; e.g., black eyes, rope marks, cigarette burns, unexplained bruising.
Failure to Prevent Neglect	<ol style="list-style-type: none"> 1. Lack of timely assessment of individuals after injury; 2. Lack of supervision for individual with known special needs; 3. Failure to carry out doctor's orders; 4. Repeated occurrences such as falls which place the individual at risk of harm without intervention; 5. Access to chemical and physical hazards by individuals who are at risk; 6. Access to hot water of sufficient temperature to cause tissue injury; 7. Non-functioning call system without compensatory measures; 8. Unsupervised smoking by an individual with a known safety risk; 9. Lack of supervision of cognitively impaired individuals with known elopement risk; 10. Failure to adequately monitor individuals with known severe self-injurious behavior; 11. Failure to adequately monitor and intervene for serious medical/surgical conditions; 12. Use of chemical/physical restraints without adequate monitoring; 13. Improper feeding/positioning of individual with known aspiration risk; or 14. Inadequate supervision to prevent physical altercations.
Failure to protect from psychological harm	<ol style="list-style-type: none"> 1. Application of chemical/physical restraints without clinical indications; 2. Presence of behaviors by staff such as threatening or demeaning, resulting in displays of fear, unwillingness to communicate, and recent or sudden changes in behavior by individuals; or 3. Lack of intervention to prevent individuals from creating an environment of fear.
Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed.	<ol style="list-style-type: none"> 1. Administration of medication to an individual with a known history of allergic reaction to that medication; 2. Lack of monitoring and identification of potential serious drug interaction, side effects, and adverse reactions; 3. Administration of contraindicated medications; 4. Pattern of repeated medication errors without intervention; 5. Lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction; or 6. Lack of timely and appropriate monitoring required for drug titration (therapeutic levels).

	7. Administration of medication or treatments to wrong individual
Failure to provide adequate nutrition and hydration to support and maintain health.	<ol style="list-style-type: none"> 1. Food supply inadequate to meet the nutritional needs of the individual; 2. Failure to provide adequate nutrition and hydration resulting in malnutrition; e.g., severe weight loss, abnormal laboratory values; 3. Withholding nutrition and hydration without advance directive; or 4. Lack of potable water supply.
Failure to provide safety from fire, smoke and environment hazards and/or failure to educate staff in handling emergency situations.	<ol style="list-style-type: none"> 1. Nonfunctioning or lack of emergency equipment and/or power source; 2. Smoking in high risk areas; 3. Incidents such as electrical shock, fires; 4. Ungrounded/unsafe electrical equipment; 5. Widespread lack of knowledge of emergency procedures by staff; 6. Widespread infestation by insects/rodents; 7. Lack of functioning ventilation, heating or cooling system placing individuals at risk; 8. Use of kerosene space heaters or unsafe space heater conditions; 9. Improper handling/disposal of hazardous materials, chemicals and waste; 10. Locking exit doors in a manner that does not comply with Life Safety Code or prevents readily egress in an emergency; 11. Obstructed hallways and exits preventing egress; 12. Lack of maintenance of fire or life safety systems; or 13. Unsafe dietary practices resulting in high potential for food borne illnesses.

Procedures

This guide lists procedures based on the CMS State Operations Manual Appendix Q – Guidelines for Determining Immediate Jeopardy. The DD Division will be familiar with the recommended Key Components of and provider’s systemic approach to prevent abuse and neglect. The Seven Key Components include: screening, training, prevention, identification, investigation, protection, and reporting/response. ***See Code of Federal Regulations CMS Seven components to Abuse Prevention.***

Review to Determine Immediate Jeopardy

The review is conducted in an impartial, objective manner to obtain accurate data sufficient to support a reasonable conclusion.

- Observations are thoroughly documented. Be specific in noting time, location and exact observations.
- Any discussions must be clear and detailed. Include the full name of the person, time and date. Any other people present should be indicated.
- Obtain copies of relevant documentation supporting the Immediate Jeopardy (e.g., nurses’ notes, and investigation reports). Record review may be used to support observations and discussions.
- If the situation involves a potential criminal action, the surveyor should be aware that any physical evidence must be preserved for law enforcement agencies.

DD Division Actions

- Notify the DD Division designee immediately when an Immediate Jeopardy situation is suspected. The designee will assist in the investigative efforts.
- Ensure immediate risk management steps are in place.

- Depending on the IJ situation, the surveyor may need to remain on site until the situation is resolved.
- Ensure provider reports to P&A or other entities for further investigation and follow up as needed.
- Gather information to address who, what, when, where and why, such as:

WHO: Who was involved in the Immediate Jeopardy situation: staff, individuals receiving care and services, and others?

Does the individual(s) at risk have special needs? Has this happened to other individuals? If yes, how many? Are there others to whom this is likely to occur? If so, how many and who? Which provider staff knew or should have known about the situation?

WHAT: What harm has occurred, is occurring, or most likely will occur?

How serious is the potential/actual harm? How did the situation occur? What was the sequence of events? What attempts did the provider make to assess, plan, correct, and re-evaluate regarding the potential/actual harm? What did the provider do to prevent any further occurrences of the same nature?

WHEN: When did the situation first occur?

How long has the situation existed? Has a similar occurrence happened before? Has the provider had an opportunity to correct the situation? Did the provider thoroughly investigate the event? Did you agree with the facility's conclusion after their investigation? Did the provider implement corrective measures to prevent any further similar situations? Did they follow up and evaluate the effectiveness of their measures?

WHERE: Where did the potential/actual harm occur? Is this an isolated incident or a provider wide problem?

WHY: Why did the potential/actual harm occur?

Was the Immediate Jeopardy preventable? Is there a system in place to prevent further occurrences? Is this a repeat deficient practice? Is there a pattern of similar deficient practices?

Validation of the gathered information with the provider will then occur. ***Refer to CMS IJ Decision Making Tool***

Decision-Making

The information gathered is used to evaluate the provision of related care and services, occurrence frequency, and the likelihood of repetition. The DD Division needs to have gathered and validated sufficient information to address the three components of Immediate Jeopardy to begin the decision process. Decide if you have enough information to make a decision. If not, continue the review. Identify and clarify any inconsistencies or contradictions between interviews, observations and record reviews.

Decide if any other agencies need to be notified, e.g., Law Enforcement Agency, Protection and Advocacy, Nurse's Aide Registration Board. Any criminal act needs to be reported to the local law enforcement agency. The provider should be encouraged to make the report, if needed. The surveyor would assume this responsibility if the provider refuses.

Components of Immediate Jeopardy

- Harm

- Actual - Was there an outcome of harm? Does the harm meet the definition of Immediate Jeopardy, e.g., has the provider's noncompliance caused serious injury, harm, impairment, or death to an individual?
- Potential - Is there a likelihood of potential harm? Does the potential harm meet the definition of Immediate Jeopardy; e.g., is the provider's noncompliance likely to cause serious injury, harm, impairment, or death to an individual?
- Immediacy - Is the harm or potential harm likely to occur in the very near future to this individual or others in the provider, if immediate action is not taken?
- Culpability
 - Did the provider know about the situation? If so when did the provider first become aware?
 - Should the provider have known about the situation?
 - Did the provider thoroughly investigate the circumstances?
 - Did the provider implement corrective measures?
 - Has the provider re-evaluated the measures to ensure the situation was corrected?
 - Note: The DD Division must consider the provider's response to any harm or potential harm that meets the definition of Immediate Jeopardy. The stated lack of knowledge by the provider about a particular situation does not excuse a provider from knowing and preventing Immediate Jeopardy. The DD Division will use knowledge and experience to determine if the circumstances could have been predicted. The Immediate Jeopardy review should proceed until the DD Division has gathered enough information to evaluate any prior indications or warnings regarding the jeopardy situation and the provider's response. The crisis situations in which a provider did not have any prior indications or warnings, and could not have predicted a potential serious harm, are very rare.

After recognizing Immediate Jeopardy and completing the review, the surveyor will then cite the provider with IJ and contact the CEO upon the decision with the specific details and individual(s) at risk. The provider should begin immediate removal of the risk to the individual(s), and immediately implement corrective measures to prevent repeat Jeopardy situations. Based on the situation, the provider will correct the IJ as soon as possible taking all actions necessary, and in some cases may require immediate elimination. The provider will submit evidence of their implementation of their corrective measures and the provider's response must ensure that the situation will be addressed systemically in order to prevent recurrence. The provider's response must also include time lines for completion and staff member's responsible for completion.

The remainder of the survey will be completed and may be extended based on the findings. Validation that the IJ situation has been resolved will be completed. Any IJ cited will be reported and reflected in the survey results along with the status of either:

- IJ removed- Only onsite confirmation of implementation of the provider's corrective action justifies a determination that the IJ has been removed;
- IJ removed deficient practice corrected- If the provider is able to remove the IJ and correct associated deficient practices before the surveyor exits;
- IJ removed deficient practice present- If the provider is able to employ immediate corrective measures that remove the IJ, but an associated deficient practice still remains;
- IJ not removed-If the provider is unable or unwilling to remove the IJ before the surveyor's exit.

Appendix D



PLAN OF CORRECTION HCBS SURVEY
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES DIVISION
SFN 136 (8-2016)

Clear Fields

Completion of this Plan of Correction (POC) must be accomplished and submitted to the Developmental Disabilities Division within twenty (20) business days of the date of the survey report of findings and signed by the provider CEO. POC should outline the necessary action(s) to be undertaken.

Agency:

Deficiency Statement:

Describe the corrective action for those individuals affected during the survey:

Describe how others will be identified of having the potential to be affected:

Describe how the deficiency will be corrected, not only on an individual level, but also agency wide (the desired outcomes and necessary action steps):

Add Deficiency Statement

Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a Quality Assurance (QA) plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction should be integrated into the agency QA system:

Completion Date:

Person(s) Responsible for Implementation:

Signature:	Title:	Date:
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