

CB/COG TRAINING FOR COMPLIANCE REVIEWS

January & February 2012

Pre- Review Documents

**90-Day Notification E-Mail/Letter Content
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Letter for Non-Responsive Providers Pre-Review**

Sample 90 Day Notification E-mail Content

Good day. Every provider delivering waiver services through the Ohio Department of Developmental Disabilities (DODD) must have a compliance review at least once every three years. This e-mail is being sent to you because you/your agency have been selected for the next review cycle. A provider compliance review of services provided by you/your agency will be conducted in MONTH, YEAR.

PRELIMINARY INFORMATION REQUIRED FOR THE REVIEW

- Please provide the name(s) of individual(s) served by you within the past year until the present time.
- Please provide the name(s) of staff in your agency
- Confirmation of the contact information we have on record for you is also needed. Please provide your current address and telephone number.

As previously stated, provider compliance reviews are a requirement in order to provide waiver services through the Ohio Department of Developmental Disabilities (DODD). If you no longer wish to provide services, please respond by relinquishing your certification via letter or e-mail. Voluntarily withdrawing your certification means that if you wish to provide services through DODD in the future, you will have to re-apply. If you want to maintain your certification, you are required to have the compliance review. Failure to do so can escalate into actions up to and including having your certification revoked.

Thank you very much and if you have any questions, please don't hesitate to contact me.

**Sample Grid for Individuals and Staff
Review Assignment and Sample Size**

Individuals Served	Number of Individual Records	Number of Personnel Records
1-2	1	1
3-7	2	2
8-10	3	3
11-15	4	5
16-20	5	6
21-35	5	6
36-50	6	7
51-74	7	8
Over 75	10%	10%

INDIVIDUAL SAMPLE KEY

Date of Review:	County:	Reviewer(s) Name:
Provider/Facility Name:		Provider/Facility #

***THIS KEY IS CONFIDENTIAL AND NOT SUBJECT TO PUBLIC RECORDS REQUESTS
PURSUANT TO OHIO REVISED CODE 5123.62(T); 5123.89 AND 5126.044(B)***

Individual's Reference # for Report	SAMPLE INDIVIDUAL NAME	WAIVER RECIPIENT Y/N (Type: IO/Level One)
ID #1		
ID #2		
ID #3		
ID #4		

In order to protect the privacy of individuals, this document is being provided:

- 1. To identify individuals for which we are requesting information**
- 2. As a "Reference Table" to be used by county boards and/or providers to reference individuals when receiving reports**

STAFF SAMPLE KEY

Date of Review:	County:	Reviewer(s) Name:
Provider/Facility Name:		Provider/Facility #

Staff Name	Date of Hire

This document is being provided:

- 1. To identify staff for which we are requesting information**

Date

Provider Name
Provider Address
City, State Zip Code

RE: Compliance Review
Facility/Provider #
County:

Dear **Provider**,

This letter will serve as notification that the **Name of Entity (CB or COG)** will conduct a compliance review on **date and time**.

Enclosed you will find the following documents:

01. Individual Sample Key - names of individuals to be included in the review
02. Staff Sample Key - names of staff to be included in the review (**Agency reviews only**)
03. Required Documents List - documents to be made available during the review: (**Agency or Independent Provider List**)
04. Provider Questionnaire – provider will complete a form for each individual in the sample/have forms available at the time of the review.
05. CMO Review Tool / Self-Review Tool – The Reviewer will complete this tool during the onsite review. It is being provided to you for self-review and preparation.

If you have questions contact me at **reviewer phone number**.

Sincerely,

Reviewer Signature

Review Name,

Contact information

Title
Office
Address
Phone
E-mail

Provider Questionnaire

1	Type of Provider	<input type="checkbox"/> Licensed Waiver Facility Facility # <input type="checkbox"/> Waiver Provider Provider # <input type="checkbox"/> County Board	
2	Individual's Name	<i>This information will be redacted in the case of a public records request</i>	
3	Name/Title of Person Completing Form		
4	County		

Provider Questionnaire

Provider – Please complete and have available on the day of the review.

1	Did you participate in the development of the ISP?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes/Somewhat <input type="checkbox"/> No
2	Did you receive a copy of the service plan prior to the effective date? Agency Tool 2.15 Independent Tool 2.15	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Do you believe the individual has opportunities to participate in community activities of his/her choice? Agency Tool 2.10 Independent Tool 2.10	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes/Somewhat <input type="checkbox"/> No <input type="checkbox"/> Does Not Apply
4	Is transportation available when the individual chooses to go out or needs to get somewhere? Agency Tool 2.9 Independent Tool 2.9	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes/Somewhat <input type="checkbox"/> No <input type="checkbox"/> Does Not Apply
5	Do you believe the individual is safe? Agency Tool 2.6 & 2.7 Independent Tool 2.6 & 2.7	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes/Somewhat <input type="checkbox"/> No
6	Do you believe the individual's needs are being met? Agency Tool 2.14 Independent Tool 2.14	<input type="checkbox"/> Yes <input type="checkbox"/> No If No, describe:
7	Additional Comments:	

REQUIRED DOCUMENTS LIST AGENCY PROVIDERS

Below is a list of documentation that will be reviewed during the DODD Compliance Review.
Please have these documents available at the beginning of the onsite review.
Additional documents may be requested during the onsite review.

ISP for Individuals in Sample	
1. Current and previous service plan, including addendums/revisions	
MEDICATIONS for Individuals in Sample	
2. Current Self-Medication Assessment	
3. Name and credentials of the nurse providing delegation	
4. Evidence of nurse supervision of delegation <ul style="list-style-type: none"> A. Log Notes B. Nursing Notes C. Any documentation used by delegating nurse to evidence supervision 	
5. Any special conditions identified by the nurse	
6. On-going nursing assessments	
7. Statement of delegation	
8. Annual staff skills checklist	
9. Copy of Medication Administration Records (MAR) for the last 3 months	
10. Copy of Physician's orders	
11. Current and previous nursing Quality Assurance	
BEHAVIOR SUPPORT for Individuals in Sample	
12. Behavior Support Plan if not integrated into the Service Plan	
13. Date of plan implementation	
14. Behavior assessment if not integrated into the Service Plan	
15. Informed consent for aversive interventions	
16. Evidence that the provider notified DODD of time out or restraint interventions within 5 working days of approval of the plan	
17. List of Behavior Support/Human Rights Committee Members or verification that provider uses County Board HRC	
18. Human Rights approval for aversive interventions (including rights restrictions)	
19. Date of behavior support committee review	
20. Evidence that plans with aversive interventions are reviewed every 30 days (status reports) <i>*Please provide the last 3 status reports</i>	
21. Evidence that all staff responsible for plan implementation were trained on aversive interventions	
MONEY MANAGEMENT for Individuals in Sample	
22. Evidence that individuals have access to their funds as stipulated in the service plan	
23. Evidence that cash accounts, savings accounts and checking accounts are reconciled at least every 60 days by someone who does not handle the individual funds	

Division of Legal and Oversight, 1810 Sullivant Avenue, Columbus, Ohio 43222-1055
Voice: (614) 466-6670 Fax: (614) 644-6676 For the hearing impaired: (800) 750-0750 Toll free: (877) 464-6733 Website: www.dodd.ohio.gov
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24. Copies of receipts for each individual in the sample for the last 3 months	
25. Copies of bank statements for the last 3 months	
26. Copies of account transaction records for the last 3 months	
27. Copies of the last 3 account reconciliations	
28. Inventory for personal items with a value of \$50.00 or more	
DOCUMENTATION for Individuals in Sample	
29. Copy of waiver service delivery documentation sheets for the last 3 months (day waiver program and residential)	
30. Copy of Behavior Support Documentation for the last 3 months	
31. Copy of MUI reports for the last 3 months	
32. Follow-up for MUI reports submitted	
MUI	
33. Copy of the UI Log(s) and evidence of monthly UI reviews for the last 3 months	
34. Copy of Most Recent Quarterly MUI Report	
PERSONNEL / BACKGROUND CHECKS for Staff in Sample	
35. Date of hire	
36. Date of initial direct contact with individuals	
37. Evidence that the CEO or administrator had a bachelor's degree and at least one year of full-time paid work experience or 4 years of full-time paid work experience as a supervisor of programs or services for individuals with developmental disabilities	
38. Copy of BCII or FBI check	
39. Evidence that the BCII check was received by the employer within 60 days of employee hire	
40. Evidence that the employer initiated the BCII check prior to direct contact with any individual	
41. Evidence that the employer initiated the FBI check prior to direct contact with any individual (applies only if staff person lived outside of Ohio anytime during the 5 years previous to employment)	
42. Evidence that the provider ensured that only employees without disqualifying offenses provided direct services	
43. Evidence that the signed attestation statement verifying the employee will notify the employer in writing within 14 days if ever charged or convicted of a disqualifying offense prior to direct contact with any individual	
44. Evidence of signed statement attesting that the employee has never been charged, convicted or plead guilty to a disqualifying offense prior to direct contact with any individual	
45. Evidence of abuser registry check	
46. Evidence of nurse aide registry check	
47. Evidence that age is 18 years and older	
48. Evidence of High School Diploma or GED	
TRAINING/CERTIFICATION FOR STAFF IN SAMPLE	
49. Evidence of appropriate certifications (if the staff person administers medication)	
50. Evidence of appropriate licenses/certifications	
51. Copy of current CPR card	

52. Copy of current First Aid card	
53. Evidence that direct service staff, hired after 10/1/09 received initial training prior to providing services to individuals that included: <ul style="list-style-type: none"> i. Overview of serving individuals with disabilities ii. Overview of basic principles and requirements of providing HCBS waiver services iii. Initial Rights Training iv. Initial MUI Training v. Universal Precautions 	
54. Evidence that the staff person, prior to implementation, received training on the individual's ISP/BSP	
55. Evidence that the staff person had initial training on the actions to take in the event of a fire or other emergency	
56. Evidence of annual fire safety and emergency response for each location the employee provides services	
57. Evidence of annual MUI/UI training	
58. Evidence notification about the conduct for which an individual can be included on the abuser registry	
59. Evidence of annual training on the rights of individuals with DD	
60. Evidence that the provider staff had annual training in fire and emergency response	
61. Evidence that CEO or administrator has a bachelor's degree or 2 years of paid experience in developmental disabilities, health care, social services or the specific services for which the applicant seeks certification	
DRIVERS / ATTENDANTS / TRANSPORTATION	
62. Copy of Driver's Abstract (if direct support professional is responsible for transporting individuals)	
63. Copy of valid driver's license (if direct support professional is responsible for transporting individuals)	
64. Copy of driver's Physical- non-medical transportation only (per trip only)	
65. Copy of driver's Drug Test- non-medical transportation only	
66. Copy of annual driver's annual driver's abstract- non-medical transportation only	
67. Copy of current insurance policy for vehicles that are used for individuals identified in sample- (non-medical transportation only)	
68. Copy of Annual Vehicle inspections for vehicles that are used for individuals identified in the sample- (non-medical transportation only)	
69. One Week's Worth of Pre-Trip Inspection Sheets for vehicles that are used for individuals identified in the sample- (non-medical transportation only)	
PHYSICAL ENVIRONMENT	
70. All current required inspections <ul style="list-style-type: none"> A. Fire (if required) B. Water C. Sewer D. Other: 	
71. Emergency/Fire plan	
72. Written record of fire and tornado drills for the last 12 months.	

(if required via the ISP)	
73. If a time out room is utilized, please provide the logs	

REQUIRED DOCUMENTS LIST INDEPENDENT PROVIDERS

Below is a list of documentation that will be reviewed during the Compliance Review.

Please have these documents available.

Additional documents may be requested on the day of the review.

ISP for Individuals in Sample	
1. Current and previous service plan, including addendums/revisions	
MEDICATIONS for Individuals in Sample	
2. Current Self-Medication Assessment	
3. Copy of Medication Administration Records (MAR) for the last 3 months	
4. Copy of Physician's orders	
If Delegated Nursing is required, have the following available:	
5. Evidence of nurse supervision of delegation <ul style="list-style-type: none"> a. Log Notes b. Nursing Notes c. Any documentation used by delegating nurse to evidence supervision 	
6. Name and credentials of the nurse providing delegation	
BEHAVIOR SUPPORT for Individuals in Sample	
7. Behavior Support Plan if not integrated in the Service Plan	
8. Date of plan implementation	
9. Behavior assessment if not integrated in the Service Plan	
10. Informed consent for aversive interventions	
11. Human Rights approval for aversive interventions	
12. Date of behavior support committee review	
13. Evidence that plans with aversive interventions are reviewed every 30 days (status report)	
14. Evidence the provider was trained on aversive interventions	
MONEY MANAGEMENT for Individuals in Sample	
15. Copies of receipts for each individual in the sample for the last 3 months.	
16. Copies of bank statements for the last 3 months.	
17. Copies of account transaction records for the last 3 months.	
18. Copies of the last 3 account reconciliations	
DOCUMENTATION for Individuals in Sample	
19. Copies of service delivery documentation for the last 3 months.	
20. Copies of Behavior Support documentation for the last 3 months.	
21.	
TRAINING/CERTIFICATION FOR PROVIDER	
22. Evidence of annual MUI/UI training	
23. Evidence of annual individual rights training	

24. Evidence of training on current ISP/BSP	
25. Evidence of First Aid certification	
26. Evidence of CPR certification	
27. Evidence of Medication Administration Certification	
28. Evidence of fire/emergency training (if applicable)	
MUI	
29. Evidence of county board notification of MUIs and UIs for past 3 months	
30. Evidence that notifications were made to other parties (law enforcement, guardian, Children Services, SSA, etc.), if applicable	
DRIVERS / TRANSPORTATION	
31. Evidence of valid driver's license (if responsible for transporting individuals)	
32. Evidence of Driver's Abstract (if responsible for transporting individuals)	
33. Evidence of Driver's Physical (non-medical PER TRIP transportation only)	
34. Evidence of Driver's Drug Test (non-medical transportation only)	
35. Copy of current insurance policy for vehicles that are used to transport individuals	
36. Copy of annual vehicle inspection (non-medical transportation only)	
37. Copies of daily vehicle inspections (non-medical transportation only)	
PHYSICAL ENVIRONMENT	
38. Emergency/Fire plan (if required in ISP)	
39. Written record of fire and tornado drills for the last 12 months if specified in the ISP.	

Date

Name of SSA Director/Designee

Address

City, Ohio Zip

RE: Compliance Review

County: **Name of County**

Dear **Name of SSA Director**,

This letter will serve as notification that **Name of the Provider** will have a review conducted by the **Name of Entity (CB or COG)** on **Date of Review**.

Enclosed you will find the Sample Key which includes the names of individuals who have been selected for the review and the SSA Questionnaire that will need to be completed and returned to the reviewer by **Due Date**.

Please submit the SSA Questionnaire(s) to:

Reviewer Name
Address
City, State Zip Code
Or
E-mail address

If you have questions contact me at **reviewer phone number**.

Sincerely,

Reviewer Signature

Reviewer Name,
Contact information

Title
Office
Address
Phone
E-mail

SSA Questionnaire

1	Type of Provider	<input type="checkbox"/> Licensed Waiver Facility <input type="checkbox"/> Waiver Provider <input type="checkbox"/> County Board Facility/Provider Name: _____ Facility/Provider #: _____
2	Individual's Name	<i>This information will be redacted in the case of a public records request</i>
3	SSA Name	

SSA Questionnaire

SSA – Please complete and return to the reviewer by the due date.

1	Were you contacted by the provider when there has been a significant issue for this individual? Agency Tool 2.14 Independent Tool 2.14	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes/Somewhat <input type="checkbox"/> No <input type="checkbox"/> Does Not Apply- No significant issues have occurred
2	Were negative outcomes identified in QA/RNQA reviews addressed in the service plan? Agency Tool 6.5 & 6.6 Independent Tool 6.5 & 6.6	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes/Somewhat <input type="checkbox"/> No <input type="checkbox"/> Does Not Apply
3	How do you monitor services for the individual? Agency Tool 6.10 Independent Tool 6.10	
4	Does the individual have any unmet needs at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe: _____
5	Do you have any concerns regarding the condition of the individual's home and/or work environments?	
6	Additional Comments:	

PROCESS FOR NON-RESPONSIVE PROVIDERS – PRE-REVIEW

If the Reviewer has not been received a response from the Provider within 14 days after the 90 day notification, the Reviewer will do the following:

1. Contact the provider via phone and email to ensure they received the notification letter and attachments.

- Include a delivery receipt with email
- Save a copy of the email electronically
- Keep summary of dates of phone contacts and whether a message was left
- Wait 7 days for a response
- If no response after 7 days, move to step 2

2. Contact the provider a second time via email and phone

- Include a delivery receipt with the email
- Save a copy of the email electronically and note the date of the phone call
- Wait 7 days for a response, then move to step 3

3. Make 3rd email and phone call requesting response to schedule a review

- The email should request that the provider contact the reviewer immediately regarding their failure to respond to request for a compliance review
- Save a copy of the email electronically and note the date of the phone call
- Wait 7 days for a response, then move to step 4 if there's been no response

4. Reviewer sends letter to provider offering last chance to respond and to schedule a review

- "Last Chance" template letter completed by Reviewer and sent to provider
- Letter is sent via email and US Mail
- The letter gives a 7 day deadline to submit POC
- Copies of letters, emails, delivery receipts, summary of attempts to contact, and the "last chance" letter should be maintained by the reviewer for use by DODD
- If the provider does not respond to the letter, move to step 5.

5. Reviewer sends email to DODD contact

- Reviewer emails DODD and provides copies of letters, emails, delivery receipts, summary of attempts to contact, and the "last chance" letter
 - DODD will review information submitted and make a determination on whether the provider will be referred for sanctions

Date

Provider Name
Provider Address

RE: Compliance Review
County:
DODD Number:

Dear Fill in Provider Name,

This letter is to provide a final opportunity for you to cooperate with the Provider Compliance review that FILL IN REVIEWER ENTITY has attempted to schedule.

In spite of multiple documented attempts to contact you regarding a Compliance Review, you have failed to respond to requests to schedule the review. DODD rule 5123: 2-9-08 "Compliance Reviews of Certified HCBS Waiver Providers" requires your cooperation with provider compliance reviews as a condition of your continuing certification.

If you would like to maintain your certifications as a waiver provider, please contact me within 7 days of this letter. If I do not receive a response to this letter within 7 days, your provider certification will be referred to DODD for further action. Please call me at INSERT PHONE NUMBER or email me at INSERT EMAIL ADDRESS.

If you are no longer interested in maintaining your certifications, please submit this in writing. The letter relinquishing your certifications should include your name, provider number, certifications and the effective date.

Sincerely,

Reviewer Name, Title
Agency