ADDENDUM #~~3~~ 2

LICENSING CONTRACTOR FOR DIRECT SERVICE PROVIDER AGENCIES AND NON-WAIVER CASE MANAGEMENT AGENCIES PROVIDING HOME AND COMMUNITY-BASED SERVICES

RFP # 305PUR-DHHRFP-WCSII-MVA
SEPTEMBER 26, 2011 2:00 PM CDT

ADDENDUM TO INCLUDE ATTACHMENTS TO THE RFP

Attachment # 6 – Complaint Procedures

Attachment #7 – Licensing and Monitoring Forms

ATTACHMENT 6

LOUISIANA
Department of
HEALTH and
HOSPITALS

HEALTH STANDARDS SECTION

Complaint Procedure

ORIGINATED 2002; REVISED OCTOBER, 2004; REVISED DECEMBER, 2006

COMPLAINT PROCEDURE – STATE OF LOUISIANA

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COMPLAINT PROCEDURE – STATE OF LOUISIANA

I. Introduction

These complaint investigation guidelines are provided to assist surveyors in conducting complaint investigations. The instructions given are applicable to all types of providers although some examples may be provider or supplier specific. **These guidelines are not absolute and/or all inclusive**. They are to be utilized as a supplement to any current survey procedures and protocols.

II. Purpose of Complaint Investigation

The purpose of a complaint investigation is to gather information about the complaint to determine if:

- The existence of a specific *allegation has occurred or is likely to have occurred;
- There is a State or Federal Requirement that is not met;
- The complaint situation has been resolved or corrected.

A Complaint is an allegation of noncompliance with a Federal and/or State Regulation. The complaint report is made to the State Agency or Regional Office by anyone other than the administrator or authorized official for a provider or supplier that alledges the noncompliance.

*An **ALLEGATION** is defined as an assertion of improper care or treatment against a Medicare, Medicaid, CLIA, or State Licensed participating program that could result in the citation of a State or Federal deficiency.

The computer data base that will be used for all intake and maintenance of complaint data will be ASPEN Complaint Tracking System, also known as **ACTS**. Refer to the ACTS training manual, ACTS procedure manual and a power point training module that are posted on the HSS Intranet at http://hss_intranet/ for information on the technical aspects of this complaint tracking system.

III. Timeliness of Complaint Reporting – The Louisiana Revised Statute §40:2009.14 A (3) (c) defines an "outdated report" as one pertaining to an incident that occurred one hundred twenty or more days prior to its being reported to the office. This statute regarding an "outdated report" only applies to a licensed only provider. If the provider is also certified, the more stringent federal requirement supersedes. The federal requirement (S&C 04-09) indicates that allegations about nonrecurring events that occurred more than twelve months prior to the intake date will not require the state agency to conduct an investigation. However, the state agency is not precluded from conducting an investigation to detrmine current compliance status based on concerns identified during the intake or triage process.

IV. Investigative Process

The investigative process consist of the following tasks:

A. Offsite Preparation
B. Entrance Conference
C. Information Gathering
D. Information Analysis & Decision Making
E. Exit Conference

Remarks along with the new complainants name and address.

- If received **after the final decision making has begun for both Standard & Complaint Surveys**:
    - The surveyor should get the details of the complaint from the complainant and then contact the appropriate State Office Complaint Program Manager with these details. The Program Manager will determine (after conferring with the Field Office Manager) how the surveyor is to proceed with the new complaint allegations. *In the case of an **Off-hours survey**, the surveyor is to contact the On-call Manager instead of the State Office Complaint Program Manager for the decision of how to proceed.*

***For Joint Accredited Providers** – You can only incorporate the new allegations into the present complaint survey if it involves conditions that have already been approved/authorized on the CMS-2802 form. If not, contact the State Office Complaint Program Manager for further guidance.

2. **GENERAL INSTRUCTIONS REGARDING COMPLAINT INTAKE**:
    a. **Complete the Complaint Intake Information Report** in the ASPEN Complaint Tracking System (ACTS) – see *Exhibit "A" on page 17* for an example of the report. *Exhibit "B" on pages 18 – 20* describes the information that is to be collected during the ACTS Complaint Intake process.
    b. **Information to collect from the complainant** - Comprehensive information should be collected during the intake process to allow for proper triage to occur. This information includes the following:
        - Information about the complainant (e.g., name, address, telephone, etc.), unless they elect to remain anonymous; *(Anonymity means that no identifying information regarding the complainant is collected by the state agency)*
        - Individuals involved and affected, witnesses and accusers;
        - Allegation category(ies) (e.g., abuse, neglect, dietary, nursing services, etc.);
        - Specifics of the allegation including the date and time of the allegation;
        - The complainant's views about the frequency and pervasiveness of the allegation;
        - Name of the provider/supplier including location (e.g. unit, room, floor) of the allegation, if applicable;
        - How/why the complainant believes the allegation occurred;
        - Whether the complainant initiated other courses of action, such as reporting to other agencies, discussing issues with the provider, and obtaining a response/resolution; and

- What regulatory requirements, CoPs, or standards are related to the complaint; and
- If current facility data has a relationship to the complaint allegations (i.e. multiple complaints, change of ownership, staffing, etc…);
- the required priority timeline for the complaint using the following definitions *(see Exhibit "C" on pages 21 – 23 for more details):*
    - Immediate Jeopardy (IJ) - 2 (two) working days - A situation that has caused, or is likely to cause serious injury, harm, impairment or death to a resident whereby immediate corrective action is necessary.
    - Harm (High) – 10 (ten) working days - A situation that may have caused harm (physical or mental damage, injury, hurt) that negatively impacts the individuals mental, physical, and/or psychosocial status.
    - Harm (Medium) - 30 (thirty) calendar days- A situation has caused or may cause harm (physical or mental damage, injury, hurt) that is of limited consequence and does not significantly impair the individual's function.
    - Discomfort (Low) (Next Onsite) - A situation that may have caused physical, mental and/or psychosocial discomfort (to make uncomfortable or uneasy, annoyance). If the determination is made to code the complaint at this level, the Complaint Intake person is to finalize the complaint in the ACTS system at the time of intake by selecting "referred" as the reason closed.

Also consider the following questions when determining the priority assignment for the complaint:

- **Harm Level**
    - Has harm or injury occurred?
    - Is harm/injury serious requiring immediate corrective action?
    - Has harm/injury impaired resident's function?
    - Is there potential for harm that could impair the resident's functioning?
    - Has resident experienced discomfort?
- **The Credibility of the Information Provided by the Complainant**
    - How much first hand knowledge does complainant have about situation? Is information hearsay? Is complainant able to provide details about situation? Is there someone who can provide first hand knowledge of the situation?
    - Does the complainant provide comprehensive and specific or vague and general information?

- Is complainant able to provide general information regarding the harm or injury and the individuals involved with the area of concern?
- Has the facility been made aware of the concern?

f. **Forwarding Complaint Intake to appropriate Field Office for investigation**: Print out the ACTS Complaint Intake Information Report and scan it to your email. Email this report as an attachment to the appropriate Field Office (FO). Indicate the name of the facility, timeframe of the complaint, and the complaint number in this email.

3. SURVEYOR PLANNING OF THE INVESTIGATION:

Before going to the facility, plan what information you need to obtain during the complaint investigation based on the information you have already acquired. Consider practical methods to obtain that information.

a. **Thoroughly review complaint allegation details and notes** on the ACTS Complaint Intake Information Report for the complaint(s) that you are assigned to investigate.

b. **Review facility information for** :
   - Allegations of Noncompliance (next on-site)
   - Outstanding Deficiencies that could be reviewed on this visit
   - Any information about the facility that you think would be helpful to know when planning your investigation such as Oscar Reports, Quality Indicator Reports, AS400 information, ACO information (i.e. is facility due for any standard survey activity), facility demographics, past non-compliance, and other site locations.

c. **Contact the complainant** (if not anonymous) to discuss the details of the complaint allegations (unless otherwise instructed by State Office).
   - The first phone call attempt to discuss details of the complaint allegation(s) with the **complainant** is to be made prior to going on-site for the investigation. Be sure to use all available numbers if you are having problems getting in touch with the complainant.
   - At least three (3) phone call attempts are to be made.
     i. If the first phone call attempt is unsuccessful, two (2) more attempts are to be made with the last attempt occurring no later than the decision making process of the investigation and prior to leaving the facility.
     ii. A phone contact attempt is to be made no sooner than two (2) hours from a previous attempt.
     iii. Unsuccessful phone contact attempts are to be appropriately documented on the Complaint Narrative Cover Sheet as to the dates and times attempts were made.
   - A successful phone contact is to be appropriately documented on the Complaint Narrative Cover Sheet as to the date and time of contact.

complaint to the creation of the survey by marking a check next to "A – Complaint Investig." under the section entitled "Type of Survey" and mark a check next to "D- Other Survey" under the section entitled "Extent" In this case, you would also check the boxes that are indicative of the type and extent of the survey other than the complaint survey.

- If the **complaint is conducted independently of any other survey**, you must create the shell for the complaint survey and indicate the type of survey by marking a check next to "A-Complaint Investig." and indicate the extent of the survey by marking a check next to "D-Other Survey".
- Procedure to follow when you are conducting **a revisit/follow-up survey to a complaint in addition to a new complaint survey**, and deficiencies are found in both surveys: The ASPEN system will not allow a 2567 from a follow-up survey to be linked to a complaint in the ACTs. Each complaint for which an onsite survey is required must have a 2567 linked to it in order to close the complaint in ACTs. The following instructions will guide the surveyor on how to write/cite deficiencies that are found when conducting a complaint follow-up (f/u) and a new complaint survey at the same time. Following these instructions will allow for the new complaint in ACTs to be closed and will also allow for us to issue only one Statement of Deficiencies to the provider. This procedure is for all triaged onsite complaints INCLUDING "next onsite" complaints.
    a. The surveyor is to create a follow-up survey to the original complaint survey. This means that the 2567 the surveyor is creating to cite deficiencies from the f/u survey will have an event ID with the last two numbers of "12".
    b. The surveyor then cites the deficiencies related to the complaint f/u on this 2567.
    c. The surveyor will create a "new event ID" for the new complaint that is being investigated at the same time that the survey for the f/u is being conducted. This 2567 will have an event ID # that has the numbers "11" as the last two numbers.
    d. The surveyor will cite any deficiencies for the new complaint on the 2567 with the new event ID #.
    e. The surveyor will then COPY and PASTE the deficiencies from the 2567 that was written for the new complaint onto the 2567 for the f/u. The 2567 for the f/u will now contain deficiencies from both the f/u and the new complaint survey. This allows for only one 2567 to be issued to the provider.
    f. On the 2567 for the f/u survey (which now contains both sets of deficiencies) annotate under "initial comments" that

services, etc., as necessary to adequately assess compliance with applicable requirements. This sample allows the surveyor to determine the scope of the facility practices related to the complaint situation.

- **For follow-ups** to complaints, the sample size would equal 50% of the original complaint sample (rounded to the nearest whole number).

2. **General Guidance** - The order and manner in which you gather information will depend on the type of complaint you are investigating. It is not enough to determine whether the events related to the complaint happened. You need to determine what facility practice led to the complaint situation and if any requirements were not met. It is also important to determine if other consumers are involved.
   - Gather information in order of priorities. **Obtain the most critical information first.** As you obtain this information, use what you have learned to determine what information needs verification or further clarification as you continue your investigation.
   - Utilize as many sources of information gathering as possible. These sources should include **observations, interviews, and record reviews** (including pertinent documents i.e. policy/procedures, meeting minutes, staffing sheets, logs...).
   - If while gathering information specific to the complaint, there are other findings concerning care and services that require investigation, immediately notify the FO Assistant Manager or FO Manager to inform them of the possible **need to expand the investigation**. If this involves a JCAHO complaint, authorization must be obtained from CMS, so contact the Hospital Program Manager for further direction.

Record Review –

- If a consumer is named in the allegation, review the consumers record. Focus on the condition of the consumer before and after the incident. If there are care issues, see if all of the assessments, planning, interventions, and evaluations of care have been done as specified by the regulatory requirements for that provider type.
- To determine whom you need to interview, identify individuals who were involved in the consumer's care (i.e. direct care staff). Look at staff schedules or other logs to identify care assignments for a particular shift or time frame.
- If the complaint concerns a facility practice or process, review records to identify possible trends or patterns Use all needed written information sources (i.e., laboratory practices, usual facility procedures in providing care, and care schedules of consumers).

Observations -

- Observe the physical environment, situations, procedures, patterns of care, delivery of services to consumers, and interactions that are related to the area of the complaint.
- Observations should be made in the units or departments where the complaint incident occurred.
- Have observations verified by the consumer, family and/or staff member. During observations, if problems are identified, verify with staff at that time

2. Based on the information you have obtained in your complaint investigation, **decide the following:**
    - Is the complaint substantiated? -- Did the situation actually occur at some time?
    - Is the facility out of compliance with the regulation that pertains to the complaint? Does your investigation provide information indicating that a requirement is not met? Is this an isolated situation or a facility/agency problem?
    - Is there a Condition of Participation (CoP) not met that would require other areas of practice to be reviewed?
    - Is there an Immediate Jeopardy Situation (see appendix Q of the State Operations Manual)?
    - Has the facility practice or procedure that contributed to the incident causing the complaint been changed to achieve and/or maintain compliance?

3. **Contact State Office** for the following situations:
    - Immediate Jeopardy
    - Substandard Quality of Care (for nursing homes)
    - Conditions of Participation/Conditions for Coverage not met
    - You need guidance in determining the deficiencies to cite or the severity of the findings

E. Task 5 - Exit Conference

1. Provide **identifier list** (HSS-ALL-01) to provider designee.

2. **Advise the provider designee** of any areas of deficient practice.
    - Do not discuss these results in a manner that reveals the identify of the complainant.
    - Provide information in a manner that is understandable to those present.
    - Provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings.

3. **Inform the facility** of what to expect:
    - Time frames to receive statement of deficiencies
    - Time frames to respond
    - Inform the provider if the findings are indicative of termination action (See *Note: For EMTALA)
    - Inform the provider of the procedure to complete their plan of correction, if applicable.

4. **Complete the Exit Conference Acknowledgment Statement (HSS-ALL-13).**

- Type the complaint number and note any tag numbers that are cited for the complaint. For example: *Complaint #4HNH6234 was investigated during this standard survey. F281 & F314 were cited for this complaint.* This will distinguish which tags were specifically cited as the result of the complaint allegations.
- Remember when you are entering the tag number into ACO, that you choose the option "complaint investigation" for the tags that are cited during the survey as a result of the complaint investigation. This will ensure that these tags will be linked into the ACTs system as a part of the complaint.

o Investigation of a Next On-site during Standard or Complaint Investigation:
- Type the next onsite complaint number and list tag numbers (if any were cited) for this next onsite in the Initial Comments of the Statement of Deficiencies.

o Tag 000 - INITIAL COMMENTS should be used only as instructed.

4. Mail applicable letter with the Statement of Deficiencies to the provider if the deficiencies written will not place the provider on a termination track.

a. Non-Termination Track

- The Field Office will respond to the provider if deficiencies are written and the provider is not on track. (This includes those nursing home complaints that do not result in deficiencies, but an "A" form only.) The following non-termination letters are to be sent out by the Field Office:
- HSS-PLO7 for Licensure complaints for Nursing Homes
- HSS-PLO6 for Federal complaints for Nursing Homes
- HSS-PLO3 for Licensure complaints for all other provider types.
- HSS-PLO8 for Federal complaints for all other provider types except EMTALA complaints. (*Note: for all EMTALA complaints, do not print or mail deficiency statements to the provider. Contact the Hospital Program Manager for direction.*)
- Send a copy of the Required Components for the Plan of Correction/IDR Information (HSS-ALL-30) to accompany the letters.

*Send the completed investigation packet to the appropriate State Office Program Manager within 10 calendar days from the date of exit. The packet should include:

o Health Standards Section Survey Tracking Form
o Complaint Narrative Cover Sheet and Narrative Report
o Copy of the letter sent to the provider, if applicable
o Copy of Significant Finding form, if applicable
o Copy of completed Exit Conference Acknowledgment Form (HSS-ALL-13)
o Copy of the Survey Identifier List (HSS-ALL-01)
o Surveyor Worksheets and other supporting documentation such as:
- Copies of appropriate portions of the medical records **that support deficiencies cited**.

- 90 day Temination – Facilities other than NH
    - Email notification to the state office program manager that the Statement of Deficiencies and the complaint narrative report are ready for review within 6 calendar days from the date of exit.
    - Mail the survey packet to state office within 14 calendar days of exit.
- Out of Compliance (D level or above - not IJ) NH or for Hospital's with a Loss of Deemed Status
    - Email notification to the state office program manager that the Statement of Deficiencies and the complaint narrative report are ready for review within 6 calendar days from date of exit.
    - Mail the survey packet to state office within 14 calendar days of exit.
- All other surveys - all facilities
    - Mail the survey packet to state office within 10 calendar days from the date of exit
    - Facility receives the letter and the Statement of Deficiencies from the FO, copy of letter enclosed in survey packet. (see 6a)

State Office Staff Responsibilities:

1. Review the Statement of Deficiencies and the Complaint Narrative Report to determine if the evidence supports the results that were concluded for the investigation and that the investigation was thorough.
2. Add any additional allegations received by the survey team during the course of the investigation into the ACTs System under allegations.
3. Add State Office hours to the CMS-670 in the ACO system.
4. Review the complaint survey packets for completeness.
5. Assure that a PoC is received within appropriate time frames and that it is acceptable.
6. Provide written notification of the results of the complaint investigation to the provider and the complainant, unless the complainant is anonymous. For *EMTALA*, CMS will notify the provider and the SO Program Manager will notify the complainant once CMS makes the final determination.
7. Print the Statement of Deficiencies and notify the provider. Send the appropriate termination letter.
8. Complete the Form CMS-562 for all federal complaints.
9. Route to Field Office for follow-up visit or do a desk review, if applicable.
10. Complete a LIC-2/CMS-2567B and CMS-670 for desk reviews, if applicable.
11. Link the complaint to the survey in ACTS.
12. Upload the complaint survey, if applicable. Resolve any upload errors.
13. Close the complaint survey.

(EXHIBIT "B")

INTAKE INFORMATION

Printed: Date the intake program manager printed the Intake Information from ACTS

Due Date: Latest date the onsite complaint investigation should begin.

Priority: *(The federally required priority assignment for the complaint investigation)* Immediate Jeopardy; Non-Immediate Jeopardy – High; Non-Immediate Jeopardy – Medium; Non-Immediate Jeopardy – Low; Administrative Review/Offsite Investigation; Referral – Immediate; Referral – Other; No action necessary. The priority will drive the timeline that the complaint investigation must be completed within. *(See definitions of these priority assignments in Exhibit "C", pages 22- 24 of this procedure.)*

Intake Number: Automatically assigned by the ACTs system.

Facility ID:

Provider Number: Provider Number assigned by CMS for certification.

PROVIDER INFORMATION:

Includes the provider name, address, city, state, zip, country, telephone number, state assigned license number, type of entity, medicaid number, and the name of administrator.

INTAKE INFORMATION:

Intake Number: Automatically assigned by the ACTs system

Taken by – Staff: State Office person entering the complaint in the ACTs system

Location Received: Office receiving the complaint – in most instances this will be state office

Intake Type: Complaint –

A complaint is a report made to the SA or RO (CMS) by any method other than self-reporting, that alleges noncompliance with Federal and/or State laws and regulations.

Intake Subtype:

a. Federal COPs, CFCs, RFPs, EMTALA: The allegation relates to noncompliance with the Federal condition(s) of participation (COPs), condition(s) for coverage (CFCs), requirement(s) for participation (RFPs), or EMTALA requirement(s). This would include allegations of noncompliance with Federal requirements only or both Federal and State requirements.

b. State-only, licensure: The allegation is related to noncompliance with State licensure requirements only.

SA Contact: (for state office use only)

RO Contact: (for state office use only)

Responsible Team: Field Office responsible for completing the investigation

Source: Several options may appear in this section-

Resident/Patient/Client; Entity Self-Reported; Current Staff; Former Staff; Anonymous; Family; Friend; Ombudsman; State Survey Agency; Other State Agency; CMS; Medicare Intermediary/Carrier; Other Health Provider; Quality Improvement Organization; Physician; Coroner; Congressional Inquiry; Media; Other

ALLEGATIONS

Category:

- The category that the complaint allegations relate to such as Quality of Care, Resident/Patient/Client Rights, Quality of Life, Physical Abuse, etc…

Sub-category:

- More specific than the category as related to the allegation such as Client Services not performed per POC or Physician, Resident not treated with Dignity/Respect, Call Bell not answered timely by staff, Offensive odors in facility, etc…

Seriousness:

- Chosen from a list of critical, moderate, mild and is determined by the seriousness of the allegation.

Details:

- Numbered **ALLEGATIONS** received during complaint intake that link the **specifics of the complaint** to a *specific regulatory requirement.* For example: Allegation #1: The facility failed to *assess and monitor* **diabetic** *residents for changes in* **foot** *condition.*
- The intake Program Manager may add brief notes below the numbered allegation to give additional information, support the reason for the allegation, and/or give guidance to the surveyor. These are not considered a part of the actual allegation.
- Only write the numbered allegation on the Complaint Narrative under the required component "Allegations", not the additional "Note:" information.

Sexual assault/sexual harassment/coercion;
Falls resulting in fracture (e.g., handrails not secured);
Inappropriate use of restraints resulting in injury;
Inadequate staffing which negatively impacts on resident health and safety; and
Failure to obtain appropriate care or medical intervention, i.e., failure to respond to a significant change in the resident's condition.

Non-Immediate Jeopardy – Medium *(harm or potential of more than minimal harm that does not significantly impair mental, physical and /or psychosocial status) (State Agency Action Code = "P" for Federal Complaint or "L" for Licensing Complaint - Timeline for the Complaint Investigation = Within thirty (30) calendar days of receipt of the complaint)* – Intakes are assigned this priority if a provider's or supplier's alledged noncompliance with one or more requirements or conditions has caused or may cause harm that is of limited consequence and does not significantly impair the individual's mental, physical and/or psychosocial status to function. An onsite survey should be scheduled to review these intakes.

Non-EMTALA, and non-immediate jeopardy complaints for providers/suppliers with deemed status require an onsite survey within 45 calendar days after approval by the RO. *(State Agency Action Code = "Y")*

Non-Immediate Jeopardy – Low (discomfort) *(State Agency Action Code = "N" - Timeline for the Complaint Investigation = Next Onsite Visit to the Facility)* - Intakes are assigned this priority if a provider's or supplier's alleged noncompliance with one or more requirements or conditions may have caused physical, mental and/or psychosocial discomfort that does not constitute injury or damage. An onsite investigation may not be scheduled, but the allegation would be reviewed at the next onsite survey. **A narrative report and a 670 are <u>not required</u> for this type of allegation. Include the next onsite visit complaint number on the survey tracking form and write the number in the Initial Comments of the 2567 if one is written. This will alert the program manager that this allegation has been investigated.**

Administrative Review/Offsite Investigation – *(State Agency Action Code = "A)* - This priority is used for complaint and incident intakes triaged as not needing an onsite investigation. However, further investigative action (written/verbal communication or documentation) initiated by the SA or RO to the provider is gathered and the additional information is adequate in scope and depth to determine that an onsite investigation is not necessary; however, the SA has the discretion to review the information at the next onsite survey.

The state office program manager will fax a written notice to the facility administrator/designee requesting this additional information and assign a 2 to 5 working day (depending upon the complexity of the information being requested) deadline to submit the information. The information received from the facility will be reviewed by the program manager and a determination will be made as to the need for an onsite visit. If no onsite visit is needed, the program manager will submit the results of the Administrative Review in writing to the facility and the complainant. The complaint must then be closed out in the ACTS system. If a field office investigation is warranted, the state office program manager will reassign the priority assignment under the same number, change the date and add to the intake details including the rational for the complaint priority being changed from Administrative to an onsite visit.

(EXHIBIT "D")

DESCRIPTION OF ABBREVIATIONS FOR TYPE OF FACILITY

Abortion Clinic	AB
Adult Day Care	AD
Adult Day Health Care	WA
Alcohol and Drug Abuse	SA
Ambulatory Surgical Centers	AS
Brain Management	BR
Case Management	CM
CLIA	CL
Comprehensive Outpatient Rehab Facilities	CO
Continuing Care Retirement Community	CR
Emergency Medical Transportation	ET
End Stage Renal Disease	ES
Family Support Services	FM
Home Health	HH
Hospital	HO
Hospice	HP
Intermediate Care Facility for the Mentally Retarded	MR
Mental Health	MH
Mobile X-Ray	MX
Non-Emergency Medical Transportation	NE
Nursing Home	NH
Outpatient Physical Therapy/Outpatient Speech Therapy	RA
Personal Care Attendant	PC
Pain Management Clinics	PM
Psychiatric Residential Treatment Facility	PR
Respite Care	RP
Rural Health Clinic	RH
Supervised Independent Living	SL

PAGE ____ OF ____

FACILITY NAME:	
COMPLAINT NUMBER:	

(Required components: **OPENING REMARKS, ALLEGATIONS, FINDINGS, RESULTS**; Optional component: **CLOSING STATEMENT**)

Surveyor Name:	**Surveyor Name:**

HSS-CM-01 . PAGE 2

Types of records reviewed: List the specific names of all documents and records reviewed during the complaint investigation. If the list exceeds the space available, continue on a separate page.

Conclusions: Type each allegation by number on the appropriate line to indicate the conclusion of the investigation. Use the information gathered in the complaint and the definitions listed on pages 30 - 31 to make this determination.

Tags cited as a result of this complaint: Write any tag number that was written as a result of this complaint. If the complaint was investigated during a standard survey, only document the tag numbers that were cited as a result of this complaint.

"THE NARRATIVE REPORT"

(Do not use proper names in the Narrative Report. Use the assigned identifier numbers in the narrative report, just as you would when writing a Statement of Deficiencies (2567.)

Upper left corner of page: Begin each page of the narrative with Page ___ of ___, the name of the facility, and the complaint number. The narrative cover sheet will be considered page 1.

***REQUIRED COMPONENTS:** All narratives **must** include "opening remarks", "allegations", "findings:", and "results:".

***OPTIONAL COMPONENTS:** The narrative **may** include a "closing statement".

Surveyor(s) Signature: The surveyor(s) will include his/her name with title on the last page of the narrative.

***WHEN TYPING THE COMPONENT HEADINGS, PLEASE TYPE THEM IN ALL CAPITAL LETTERS AND IN BOLD.**

OPENING REMARKS: Indicate the title of the staff person(s) the entrance conference was held with. Document all dates of the onsite visit and list the names of any other entity that was visited while investigating this complaint. Include any other **pertinent** information that is relevant to the investigation and is not contained anywhere else in the narrative report. For example: information that is not included on the cover page, historical information about the resident/client/patient that had an impact on the outcome of the investigation, Power of Attorney status as it relates to the investigation, judicial interdictions, etc...

ALLEGATIONS: Only write the numbered allegation on the Complaint Narrative under the required component "Allegations", not the additional "Note:" information.

- Referral to appropriate agency – After investigation, the complaint/incident was referred to the appropriate agency.

Substantiated Options:

1. **Substantiated with deficiencies** - complaint investigations in which the allegation reported is verified and federal and/or state deficiencies were cited that are related to the allegation being investigated.

2. **Substantiated with no deficiencies** – complaint investigations in which the allegation reported occurred and is verified, but the allegation:
   - *a.* was unavoidable,
   - *b.* has no regulatory basis,
   - *c.* requires referral to another agency, and/or
   - *d.* the surveyor is able to determine that the facility took immediate action to correct the situation and put in a quality assurance plan to assure the situation is resolved. Therefore, no deficiencies are cited.

DEFINITION:

- **Findings Unsubstantiated:**
  - An **unsubstantiated** allegation is an allegation where evidence cannot support that the allegation did occur.
    - Allegation did not occur – Evidence indicates that the allegation did not occur
    - Lack of sufficient evidence – The surveyor is unable to verify that the allegation occurred due to insufficient evidence. The evidence is inconclusive.
    - Referral to appropriate agency – After investigation, the complaint/incident was referred to the appropriate agency.

Unsubstantiated Options:

1. **Unsubstantiated/unable to verify with no deficiencies** – the surveyor determined that the allegation(s) did not occur, or that there was a lack of evidence to verify that the allegations occurred. No deficiencies were cited
2. **Unsubstantiated/unable to verify with unrelated deficiencies** –the surveyor determined that the allegation(s) did not occur, or that there was a lack of evidence to verify that the allegation(s) occurred, but deficiencies were observed and cited in other areas that are not related to the original allegation(s) being investigated.

***Continue with each allegation. Also write any additional allegation(s) given during interview with the complainant.

CLOSING STATEMENT (optional): Any additional information not covered above. Example: Unrelated deficiencies written during this investigation, recommendations to state office to make a referral to a professional board or other agency, etc...

SURVEYOR NAME: List names of all surveyors involved in the complaint investigation.

FACILITY NAME:	Justin Wilson Hotdogs, Inc.
COMPLAINT NUMBER:	#4HNH8374

(Required components: **OPENING REMARKS, ALLEGATIONS, FINDINGS, RESULTS**; Optional component: **CLOSING STATEMENT**)

OPENING REMARKS: An unannounced visit was made to the facility on 8/21/04, at 8:30 a.m. and the entrance conference was held with the Assistant Director of Nursing. The Administrator and the Director of Nursing were not in the facility at the time of the entrance conference. The onsite visit at the facility was held on 8/21/04, and 8/22/04. The complainant stated during phone contact that the date of the resident's appointment with the psychiatrist was on 8/10/04, and not 8/12/04, as indicated on the "Complaint Intake Information". According to the complainant, her older sister was the person the facility notified in the event of a problem. The consumer, resident #3, was admitted to the facility 12/7/96, by judicial interdiction. The resident's accumulative diagnoses included Paranoid Schizophrenia, Schizoid Affective Disorder, Extrapyramidal Symptoms (EPS), Dementia, and Insulin Dependent Diabetes Mellitus. .

ALLEGATION #1: Facility fails to assess and monitor diabetic residents for changes in foot condition.

FINDINGS: The resident (#3) was first diagnosed with Hyperglycemia (High Blood Sugar) on 1/13/03, and was placed on oral hypoglycemic medications on 1/15/03, but refused the finger stick blood glucose tests. On 1/15/03, the finger stick blood glucose was 368 and on 1/18/03, it was 325. On 1/17/03, the physician discontinued the oral diabetic medication and ordered insulin to be started. The resident continued to be controlled on the insulin for the past year.

Observation of the resident's feet on 8/21/04, at 9:25 a.m. revealed dry, scaly brown patches on the soles of her feet. During interview on 8/21/04, at 10:15 a.m. LPN S4 stated that CNA S1 reported to her about the resident's feet and asked her to look at them. Review of the skin assessment documentation revealed the resident was identified as being at risk for pressure sores and a skin assessment was being done weekly. Review of the Weekly Skin Assessment sheets revealed the resident's skin was intact without breakdown during January 2004, and the first two weeks of February. On 7/19/04, LPN S4 documented "Has dry soles on feet. NNO (no new orders) noted no Breaks in skin". An interview with CNA S3, who was caring for the resident on 8/21/04, revealed that she looks at the resident's skin before putting her into the whirlpool and after she rinses all of the soap off of the resident. If any red or broken areas were noted she would report it immediately so the nurse could look at the resident in the whirlpool room. The facility has a working system in place to assess all residents, but especially those residents identified at risk for skin breakdown.

Record review revealed the primary care physician saw the resident on 7/25/04, ordered a Dermatology appointment, and documented the resident's feet had "dry soles". A dermatology physician appointment was made for 7/31/04. Review of the resident's clinical record also revealed a podiatrist had been seeing the resident as early as 2/25/02, and as recent as 4/28/03, and 6/30/04, for care of her toe nails ("Diseases of nails") and calluses. There is no mention in the podiatrist's progress notes of any other problems with the resident's feet.

RESULTS: Unsubstantiated/unable to verify with no deficiencies.

ALLEGATION #2: Facility failed to assure that the resident was taken to physician appointment as scheduled.

FINDINGS: ----------

RESULTS: Substantiated with no deficiencies. The facility did not assure that the resident was taken to the physician appointment because the resident refused to go. The facility addressed the issue of resident refusal by meeting with the resident to discuss the importance of following up with the physician at the appointment. They then discussed this with the responsible party and notified the physician. The physician indicated that as long as she was taking her prescribed medications and not having current behavioral problems it was okay to reschedule the appointment in a month.

ALLEGATION #3: Facility failed to …

FINDINGS: ----------

RESULTS: Substantiated with deficiencies written at Tag F309.

Surveyor Name: Susie Surveyor, RN	Surveyor Name: Sam Surveyor, RPH

(EXHIBIT "G")
DEPARTMENT OF HEALTH AND HOSPITALS
HEALTH STANDARDS SECTION

COMPLAINT NARRATIVE COVER SHEET

EXIT DATE:	8/22/2004	COMPLAINT NUMBER:	#4HNH8374
CONSUMER NAME & IDENTIFIER #	Susymae Smith Resident #3		
FACILITY:	Justin Wilson Hotdogs, Inc.		
STREET ADDRESS:	1234 Mustard Street	CITY/STATE/ZIP:	General Electric, NY 12345
ADMINISTRATOR (Full Name):	Oscar Mayer		
PHONE #	225-342-2482	FAX #	225-342-5292

COMPLAINANT CONTACTED:
__X__ YES **DATE:** 8/20/04 **TIME:** 10:00 p.m.

_____ NO **REASON:**

If additional allegations given, list # assigned to them:

Interviewees:	Types of records reviewed:
Oscar Mayer, Administrator Violet Sky, LPN Assistant Director of Nursing (ADON) Kylie Landry, RN Director of Nursing (DON) Suzette Sanchez, LPN, Wound Care Nurse (S4) Betsy Jones, Social Services India Kare, Secretary Jency Laird, CNA (S1) Catina LeDay, CNA (S2) Lancy Thibodeaux, CNA (S3) LucyJo Smith, Complainant Verna Luci, Niece of sampled resident #6 Jane Thomas (#1) Beatrice Latey (#2) Susymae Smith (#3) Liz Mont (#4) Ethel Rae (#5) Bernice Jolla (#6)	Clinical Record Policy/Procedure Manuals Certified Nursing Assistant Sign-In/Assignment Book Physician Appointment Book

On the basis of all information gathered, we have reached the following conclusion (list by allegation #):

____3_____ **Substantiated with deficiencies** ____2_____ **Substantiated with no deficiencies**

_____ **Unsubstantiated/unable to verify with unrelated deficiencies** ____1_____ **Unsubstantiated/unable to verify with no deficiencies**

Tags cited as a result of this complaint : F309

FINDINGS: The information within the narrative report is written to reflect the facts collected during the investigation <u>as it relates to the allegations regarding the consumer or issues named in the complaint</u>.

The facts collected during the investigation that relates the allegations to the other sampled consumers or issues are not documented in the Findings Section on the narrative, but are reflected in the surveyor worksheets for that particular consumer.

The findings should include interviews, observations, and record reviews which supports the decision by the surveyor in determining the complaint investigation results. The findings should reflect the information that assisted the surveyor in determining 1) if the existence of the specific allegation occurred or is likely to have occurred; 2) if there is a state or federal requirement that is not met; 3) if the complaint situation has been resolved or corrected.

Be specific by focusing on the allegation as it relates to the regulations.

RESULTS: The information gathered by the surveyor during the complaint investigation is used to determine the results. Document whether each ALLEGATION is **<u>**substantiated with deficiencies, substantiated with no deficiencies, unsubstantiated/unable to verify with no deficiencies, or unsubstantiated/unable to verify with unrelated deficiencies</u>. Indicate if a deficiency was written, and if so, write the tag number in this section.

If the investigation determines that the allegation for the consumer named in the complaint is unsubstantiated, but a tag(s) is being cited for the same allegation for any of the sampled consumers, then the complaint investigation result is said to be substantiated with deficiencies. An explanation should be made within the results to show that although noncompliance could not be shown for the consumer named in the complaint, the complaint was substantiated for other sampled residents with deficiencies written.

If the result is substantiated with no deficiencies, the surveyor should indicate in this section of the narrative why no deficiencies are written (unavoidable, no regulatory basis, not under jurisdiction of Health Standards Section but was referred to another agency, and/or the facility took immediate action to correct the situation and put in a quality assurance plan to assure the situation was resolved – past non-compliance (not of an eggregious nature) and corrected).

DEFINITION:

- **Findings Substantiated**:
    - A **<u>substantiated</u>** allegation is an allegation that did occur and is verified by evidence. *An allegation is considered substantiated based on the finding about the individual or specific situation named by the complainant in his or her allegation; **or** other residents or patients reviewed or similar situations, even if the noncompliance was corrected for the specific individual(s) named by the complainant in the allegation.* One or more of the following may also occur:
        - Federal deficiencies related to the allegation are cited
        - State deficiencies related to the allegation are cited
        - No deficiencies related to the allegation are cited

(EXHIBIT "F")

Directions for Completion of the Narrative Cover Sheet/Narrative Report

Exit Date: Date of the exit conference for the complaint investigation.

Complaint Number: This is the State Complaint ID number that is found on the ACTS complaint Intake Information report.

Consumer name & identifier number: Name of the consumer that the complaint allegations are regarding. Also include the identifier number for this consumer that is assigned during the complaint investigation.

Facility: Complete name of the entity being investigated.

Street Address: Geographical address of the entity, including city, state, and zip code.

Administrator: Full name of the administrator of the entity.

Phone # & Fax #: The phone number and fax number for the entity.

Complainant notified: Put an "X" on the appropriate line. Also include the date and time of your call to the complainant. If unable to reach the complainant document the reason the complainant was not notified. If someone other than the complainant responds to the phone call make a note of this in the Opening Remarks. (See Complaint Procedure - Task 1 - Offsite Preparation for further directions.)

Additional allegations: If you receive additional allegations from the complainant during your interview with them, give each additional allegation a number. This number should be in sequence and should follow the last numbered allegation on the complaint route sheet. List the new allegations by number in this section.

Interviewees: List the names, titles, and "S" identifier numbers (if applicable) for any staff persons you interviewed. Also list the names and sample identifier numbers of any consumer you interview. If the interviewee wanted to remain anonymous, then it would be appropriate to document that person as "anonymous". In this case, you may indicate if this person was a staff member, family member, other consumers, etc...

(EXHIBIT "E")

DEPARTMENT OF HEALTH AND HOSPITALS
HEALTH STANDARDS SECTION

COMPLAINT NARRATIVE COVER SHEET

EXIT DATE:		COMPLAINT NUMBER:	
CONSUMER NAME & IDENTIFIER #			
FACILITY:			
STREET ADDRESS:		CITY/STATE/ZIP:	
ADMINISTRATOR (Full Name):			
PHONE #		FAX #	

COMPLAINANT CONTACTED:
_____ YES DATE: TIME:

_____ NO REASON:

If additional allegations, list # assigned to them:

Interviewees:	Types of records reviewed:

On the basis of all information gathered, we have reached the following conclusion (list by allegation #):

_____ Substantiated with deficiencies _____ Substantiated with no deficiencies

_____ Unsubstantiated/unable to verify with unrelated deficiencies _____ Unsubstantiated/unable to verify with no deficiencies

Tags cited as a result of this complaint :

HSS-CM-01 - COMPLAINT NARRATIVE *(Revised 2004)*

Referral – Immediate *(State Agency Action Code = "R")* – Complaints/incidents are assigned this priority if the seriousness of a complaint/incident and/or State procedures requires referral or reporting to another agency, board, or network without delay for investigation.

Referral – Other *(State Agency Action Code = "R")* – Complaint/incidents assigned this priority indicate referral to another agency, board, or network for investigation or for informational purposes.

Note: All referrals will be made through the State Office Program Manager.

When the SA refers the complaint to another agency or entity (e.g., law enforcement, Ombudsman, licensure agency, etc.) for action, **the SA must request a written report on the results of the investigation**. Regardless of who conducts the investigation, the SA has the responsibility to assess the provider's or supplier's compliance with Federal conditions or requirements and the time frames for investigation are not altered by the referral to another agency.

No action necessary – Adequate information has been received about the complaint or incident intake such that the SA can determine with certainty that no further investigation, analysis, or action is necessary.

For all cases except EMTALA, that do not allege immediate jeopardy, and at the SAs discretion an intake may not require a new onsite investigation if, at a previously completed survey, the same events were investigated; the previously completed survey evaluated the appropriate individuals, including those identified in the intake; and the situation did not worsen.

State Monitoring – *(State Agency Action Code = "M")* - State monitoring of a facility may be coded for unusual situations that the survey agency becomes aware of through sources other than a complainant. At the discretion of the program manager, surveyors will do an onsite inspection to determine facility compliance with the situation. The surveyor should contact the program manager if concerns are identified that would require a complete investigation. At this time, the monitor would become a complaint and a complaint number would be required. The **timeline** for the state monitor would **be coordinated between the state office program manager and the field office manager**.

(EXHIBIT "C")

ACTS PRIORITY DEFINITIONS & TIMELINES

Immediate Jeopardy *(State Agency Action Code = **"I"** Timeline for the Complaint Investigation = Within **two (2) working days** of receipt of the complaint)* – Section 42 CFR 489.3 defines immediate jeopardy 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." Intakes are assigned this priority if the intake information indicates immediate corrective action is necessary because a provider's or supplier's alleged noncompliance with one or more conditions or requirements may have caused, or is likely to cause, serious injury, harm, impairment or death to a resident, patient or client. Immediate jeopardy, immediate and serious threat, and serious and immediate threat are interchangeable terms.

In situations where a determination is made that immediate jeopardy may be present and ongoing, the SA is required to investigate within two working days of receipt of the information except: 1) For all **Medicare deemed providers/suppliers** complaint and incident intakes, the SA investigates a complaint within **two working days of receipt of the Form CMS-2802**, Request for Validation of Accreditation Survey, from the RO if the RO determines that the complaint involves potential immediate jeopardy to patient health and safety; 2) For hospital **EMTALA** complaints, the investigation is completed **within five working days after receipt of the authorization from the RO**; 3) For restraint/seclusion death reports, the SA completes the investigation within five working days of receipt of telephone authorization from the RO. (Appendix Q of the State Operations Manual (SOM) contains the Guidelines for Determining Immediate Jeopardy.)

Non-Immediate Jeopardy – High *(harm that impairs mental, physical and/or psychosocial status) (State Agency Action Code = **"H"** Timeline for the Complaint Investigation = Within ten **(10) working days** of receipt of the complaint)* – Intakes are assigned this priority if a provider's or supplier's alleged noncompliance with one or more requirments or conditions may have caused harm that negatively impacts the individual's mental, physical and/or psychosocial status and is of such consequence to the person's well being that a rapid response by the SA is indicated. Usually, specific rather than general information (such as, descriptive identifiers, individual names, date/time/location of occurrence, description of harm, etc.) factors into the assignment of this level of priority.

Regarding allegations pertaining to residents in nursing homes, if the SA makes the determination that a higher level of actual harm may be present, the investigation is to be **initiated within 10 working days of its receipt**. The initiation of these types of investigations is generally defined as the SA beginning an onsite survey. It is often difficult to distinguish between those allegations that would require an investigation within 10 working days (higher level of actual harm). The following are some examples of allegations that indicate that a higher level of actual harm may be present:

Resident is intimidated/threatened;
Resident is physically abused– spitting/slapping/sticking with sharp object/pushing/pinching.
Unexplained/unexpected death, with circumstances indicating that there was abuse or neglect;

Received Start & Received End: Date and Time Complaint actually received and completed.

Received by: Method in which the complaint intake was received – Email; In Person; via Telephone; Written; Media; Hotline; Fax; Other

State Complaint ID: 8 or more characters (alpha and numeric) used to identify the complaint.

- Example number = 4HNH8374
- 4 = Year 2004 (last digit in the current year)
- H= Priority Assignment (H = Non Immediate Jeopardy - High; see Priority Timelines in Exhibit "C")
- NH= Type of Facility (Refer to the listing of facility abbreviations in Exhibit "D")
- 8374 = Complaint Number (this is the last group of numbers of the ACTS Complaint Intake Number excluding the preceding zeros that appear at the upper right side of the Compliant Intake Report Form (LA00008374).
- Explanation of 4HNH8374 – This complaint was taken in 2004 (4), is coded as a Non-Immediate Jeopardy High (H) which has a 10 working day timeline, is for a Nursing Home (NH) provider, and 8374 is the last group of numbers, excluding the preceding zeros, of the ACTS Complaint Intake Number.

CIS Number:

External Control #: A CMS assigned number for EMTALA complaints

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COMPLAINANTS:

Includes the name, address, work phone, home phone, cell phone, unless anonymous

Confidentiality Requested: "N" = NO or "Y" =YES

N – Complainant has given a verbal disclosure that they do not wish to remain anonymous.

Y – Complainant verbalized that he/she wishes to remain anonymous.

RESIDENTS: Includes the name, admission date if available, location of the resident, discharge date if applicable and the room number.

INTAKE DETAIL:

Date of Alleged Event: month, date, year of the Alleged Event

Time: time of Alleged Event

Shift: shift the Alleged Event occurred on

Standard Notes: This section will include **all** the detailed notes that the Complaint Intake Program Manager receives during the dialogue with the complainant. **Do Not** type all of this information on the Complaint Narrative. This information gives the complainant's side of the story and is to be used for information only.

When the complaint is received by State Office in writing, this section will contain the note "Complaint received in writing, see attached". A copy of the written detail from the complainant will be attached to the Complaint Intake Report. **Do Not** copy all of this information onto the Complaint Narrative.

Extended RO Notes: (entered by CMS Regional Office Staff)

Printed: 01/03/2007
Due Date: 08/23/2004
Priority: Non-IJ High

INTAKE INFORMATION

(EXHIBIT "A")

Intake Number: LA00008374
Facility ID: TEST1
Provider Number:

PROVIDER INFORMATION:

Name: JUSTIN WILSON HOTDOGS INC
Address: 1234 MUSTARD ST.
City/State/Zip/County: GENERAL ELECTRIC, NY, 12345, SCHENECTADY
Telephone: (225) 342-2482
License #: 19
Type: TESTLTC
Medicaid #:
Administrator: OSCAR MAYER

INTAKE INFORMATION:

Intake Number: LA00008374
Taken by - Staff: HUGUET, MARGARET
Location Received: STATE OFFICE
Intake Type: Complaint
Intake Subtype: Federal COPs, CFCs, RFPs, EMTALA, CLIA
SA Contact:
RO Contact:
Responsible Team: THIBODAUX REGION
Source: Family
Received Start: 08/13/2004 At 14:44
Received End: 08/13/2004 At 14:44
Received by: Telephone
State Complaint ID: 4HNH8374
CIS Number:
External Control #:

COMPLAINANTS:

Name	Address	Work Phone	Home Phone	Cell Phone
LUCYJO SMITH (Primary)	1234 ABC LANE THIBODAUX, LA	(985)123-4567	(985)891-0111	

Confidentiality Requested : N
Link ID: 04E051

RESIDENTS/PATIENTS/CLIENTS:

Name	Admitted	Location	Discharged	Room	Link ID
SUSYMAE SMITH					641217

INTAKE DETAIL:

Date of Alleged Event: 08/12/2004 Time: 1:00 PM Shift: Day

Standard Notes: The resident was admitted to the facility with no skin problems on her feet. She has recently been diagnosed with diabetes and the facility should have been doing foot checks. She now has black spots on the bottom of both her feet. The facility was not even aware of it until the complainant pointed it out to them. They have ignored the problem and have not even notified the physician.
The resident had an appointment with her psychiatrist on 8/12/04. When the complainant visited at 3pm the resident was still dressed in her gown. She was asked about the appointment and told the complainant she did not go to the doctor that day. The complainant is concerned because the resident has behavioral problems and really needs to be seen by the psychiatrist. The resident was judicially committed to the facility according to the complainant.

Extended RO Notes:

Extended CO Notes:

ALLEGATIONS:

Category: Resident/Patient/Client Neglect
Sub-category: Assess/Monitor
Seriousness: Critical
Details: Allegation #1.) Facility fails to assess and monitor diabetic residents for changes in foot condition.

Note: She has recently been diagnosed with diabetes and the facility should have been doing foot checks. She now has black spots on the bottom of both of her feet. The facility was not even aware of it until the complainant pointed it out to them.

Category: Administration/Personnel
Sub-category:
Seriousness: Critical
Details: Allegation #2.) Facility failed to assure that resident was taken to the physician appointment as scheduled.

Note: The resident had an appointment with her psychiatrist on 8/12/04. When the complainant visited at 3pm the resident was still dressed in her gown. She was asked abou the appointment and told the complainant she did not go to the doctor that day. The complainant is concerned because the resident has behavioral problems and really needs to be seen by the psychiatrist.

- Copies of pertinent policies and procedures **that support deficiencies cited**.
- Documents requested specifically by the Program Manager

b. **Termination Track & EMTALA** (For Nursing Homes S/S Level "D" – "L" (Non-Substantial Compliance) or for Condition Level tags for other Provider Types)

- An email should be sent to the Program Manager (see 6c for timelines) when the Statement of Deficiencies and the Complaint Narrative Report for the complaint survey are ready for review. This email should include: The name of the facility, provider number, complaint number, Event ID number, and the highest Scope and Severity Level for Nursing Homes.
- The Program Manager will indicate to the Field Office any revisions required on the Statement of Deficiencies. Field Office staff will make revisions if applicable.
- The Program Manager will instruct the Field Office when the Statement of Deficiencies has been reviewed and the completed Investigation Packet can be mailed to State Office. If this instruction is not given within 14 days of the email notification of "ready for review" date, then proceed to mail the packet to State Office.
- The Investigation Packet should include the same information as listed in the last bullet * of (6a.) above.
- The State Office Program Manager will be responsible for forwarding the Statement of Deficiencies and the termination letter to the appropriate entity(s).

c. **Timelines for emailing state office notification that Statement of Deficiencies is ready for review and timelines for submission of the Investigation Packet** *(See Memo 03-S-032 for more detailed information on processing times):*

- Immediate Jeopardy – Nursing Home (NH)
  - Still exists at time of exit
    - Email notification to the state office program manager that the Statement of Deficiencies and the complaint narrative report are ready for review within 2 working days from the date of exit.
  - Lifted prior to leaving facility
    - Email notification to the state office program manager that the Statement of Deficiencies and the complaint narrative report are ready for review within 6 working days from date of exit.
    - Mail the survey packet to state office within 14 calendar days of the exit.
- Immediate Jeopardy – Facilities other than NH
    - Email notification to the state office program manager that the Statement of Deficiencies and the complaint narrative report are ready for review within 2 working days from date of exit.

*Note: FOR EMTALA - The state agency must inform the hospital that the CMS Regional Office (RO) will make the final compliance determination and the determination is often made with information obtained after the onsite investigation. The SA **does not** venture an opinion on what determination the CMS RO might make. The provider designee should be instructed that they will receive a letter from CMS RO concerning the results of the investigation.

F. Task 6 – Documentation

Survey Staff Responsibilities:

1. Prepare the Complaint Narrative Cover sheet and the Narrative Report *(Exhibit "E" on pages 25 - 26)* that includes the original complaint allegations reported during the Complaint Intake process, the specifics of the investigation and findings that are related to the consumer the complaint is referring to *(see instructions on page 29)*, and the conclusions resulting from the investigation. See directions for completion of the Complaint Narrative (HSS-CM-01) in *Exhibit "F" on pages 27 - 30.* Please note that the specifics of the investigation and the findings related to the other sampled consumers should be written in the surveyor worksheets for those particular consumers and not on the complaint narrative.

2. Any supportive documentation (surveyor worksheets and copies of supporting documents) should be attached to this report.

3. Prepare the Statement of Deficiencies.
   - Write the deficiency statement following the Principles of Documentation.
   - Information to be included in **Tag 000 - INITIAL COMMENTS** are as follows:
     - No Deficiencies:
       - Type the complaint number(s) and a statement indicating that there were no deficient practices identified related to the complaint(s). (For example: *Complaint #4HNH8374 was investigated and no deficiencies were cited.*)
       - The "No Deficiency - Statement of Deficiencies" is printed, but is **not** given to the provider. It is simply used as a tracking mechanism that allows State Office to link the investigation to the complaint intake in ACTS.
     - Single Complaint with deficiencies:
       - Type the complaint number only. (For example: *Complaint #4HNH8374*)
     - Multiple Complaints investigated on the same date using the same event ID number and 670, with deficiencies:
       - Type each complaint number being investigated and list any tag number cited for that particular complaint number. This will delineate for the reviewer which tags were cited for each complaint number. For Example: *F157 was cited for complaint #4HNH6312; F272 and F281 were cited for complaint #4INH5421; and no deficiencies were cited for complaint #4HNH8374.*
     - Investigation of a Complaint(s) during a Standard Survey:

that the observation is correct. For example, when finding an out-dated medication in the pharmacy, ask the pharmacist if they agree that the drug is out-dated.

Interviews -

- Interview the complainant and persons named in the complaint, then any other witnesses or staff involved (i.e. ex-employees, physicians, consultants, etc...). To maintain the confidentiality of your witnesses, change the order of interviews if necessary. You may not want to interview the complainant first, as that may identify the person to the facility as the complainant.
- It may be necessary to re-interview complainant or others when new or conflicting information has been identified.
- Inform the interviewee that you will document information during the interview. If it is impossible to interview the complainant in person, you may conduct a telephone interview. Interview the consumer advocate or ombudsman, if applicable.
- If unable to interview a key person due to such reasons: no longer employed at the facility; not on duty at the time of investigation; etc... the surveyor must make attempts to contact that person and document such in the narrative. These attempts can be made by checking the facility records to get the last known contact information, looking in the telephone directory, etc... Document these attempts in the narrative.

Documentation of information gathered -

- Use the CMS-807 Surveyor Notes Worksheet to record information gathered during the complaint investigation. Use other surveyor worksheets such as the CMS-805 for nursing homes (completing only those areas of the worksheet that assist you to focus on the allegations) and CMS-1515 for Home Health, as appropriate.
- Documentation of interviews and observations should include names, locations, names of witnesses, dates, and times.
- Obtain copies of documents that support decision making.
- When making document copies be sure to identify the original date of the documentation and indicate the date and time the copies were made (if multiple copies are made, then indicate the date copied in the surveyors notes).
- Document the names, dates, and times requests were made for regulatory required documents that are missing, incomplete, or nonexistent.

D. Task 4 - Analysis of Information and Decision Making

1. Before you begin your **decision making process**, review all of your information. Decide if there is any other information you still need.
    - Decide if you have enough information to determine if the complaint is substantiated.
    - Identify any inconsistencies or contradictions between interviews, observations, and record reviews.
    - If inconsistencies or contradictions are found, collect additional data as applicable to get information needed to resolve them.

a complaint was conducted and indicate the complaint number. Examples: Complaint # 6NNH18939, Deficiencies cited at F 153 and F 204; or Complaint #6PHH8439, Deficiencies cited at G 156, and G 158.

g. A 670 must be done for both event ID#s (the f/u and the next onsite complaint)

f. Assemble Complaint Survey Packet.

B. Task 2 – Entrance Conference

Onsite complaint investigations should always be **unannounced**.

1. **Introduce complaint team** to Provider Designee.
2. **Advise the Provider Designee** of the general purpose of the visit.
   a. It is important to let the facility know why you are there, but to also protect the confidentiality of complainant and principals involved in the complaint. According to the Louisiana Revised Statute at 40:2009.14, *when the nature of the complaint or allegation is furnished to the health care provider, it shall not identify the complainant or the consumer unless the individual has consented to the disclosure either in writing or in a documented telephone conversation with an employee of the department. If disclosure is considered essential to the investigation or if the investigation results in judicial proceeding, the complainant shall be given the opportunity to withdraw the complaint.*
   b. Do not disclose information that will cause you to lose opportunities for pertinent observations, interviews, and record reviews.
   c. Ask the facility for information you will need to review and let them know when (set a time limit) you will need it (i.e., staffing schedules, list of transfers to the hospital). Do not delay the process while waiting for this information.
   d. It is appropriate to let the provider know on Entrance Conference when you are also looking at "areas of concerns" that are based on a Next Onsite complaint.

C. Task 3 - Information Gathering

1. **Sample Selection** – When selecting the sample use the following except when otherwise directed in the appropriate program protocol manual.
   - Choose a **minimum** sample of 5 or 25 % of the sample selection scale used for standard surveys (rounded to the nearest whole number), whichever is greater. (All complaint surveys except EMTALA & ICF/MR's – See the next 2 bullets below.)
     - For EMTALA complaint investigations, refer to Appendix "V".
     - For ICF/MR complaint investigations choose a sample size of 50% of the sample selection used for a standard survey (rounded to the nearest whole number).
   - In some cases you may need to **expand the sample** to determine the scope of the problem.
   - Choose a sample of consumers that have similar characteristics as those mentioned in the complaint allegations. The sample could be based upon an area of the facility such as a specific wing. The type of sample chosen is dependent on the allegations. Review appropriate samples of consumers, rooms, records,

- Once the phone contact is made with the complainant, clarify any allegations that are unclear.
- Obtain as much information as you can about the complaint before you begin to plan your investigation.
- If the complainant informs the surveyor that they **now want to be anonymous**, the surveyor should inform him/her that all identifying information will be removed from the complaint and he/she will not be receiving a written final report. The surveyor should make of note of this in the Opening Remarks of the Complaint Narrative Report.
- If the complainant decides to ***withdraw the complaint***, the surveyor will notify the program manager for further direction. If the direction is given to the surveyor to abort the survey, the surveyor will forward a memo to the program manager indicating the date, time, person spoken to, and the interview with the complainant regarding the withdrawal.

d. **Develop a plan for investigation** of the complaint and make decisions such as:
   - When a complaint investigation is to be conducted by more than one team member, a determination should be made as to who will be the team leader and what role each team member will take in planning and conducting the investigation.
   - Determine if you need to go to more than one facility to gather information. If so, determine which facility you will visit first.
   - Review the related regulatory requirements or standards, including Interpretive Guidelines, that pertain to the complaint. For example, if the complaint is about abuse, review the regulatory requirements in the area of abuse or consumer's rights for the provider type you will be investigating.
   - Prepare a list of the information to obtain (such as policies, procedures, staffing time sheets, incident/accident reports, layout of the facility, etc...).
   - Plan what interviews, observations and record reviews will need to be done to obtain the necessary information. Interviews should include **all** persons (professional and non-professional) who may have knowledge of the situation (such as the attending physician, emergency room staff, coroner, Emergency Medical Services staff, CNAs, maintenance or housekeeping staff, family members, visitors, residents, etc...). Some questions can be planned as preparation for interviews. Write these down to help organize your thoughts and direct you to other questions that are important to ask.
   - Determine if obtaining the information in a particular sequence is critical to the investigation.

e. **Create the Shell/Event ID** for the Complaint Survey - When a complaint survey is conducted the survey must be created in ACO.
   - If the **complaint survey is conducted during another survey type (excluding a revisit/follow-up)**, you simply add the

- What is pattern of complaints for complainant? Has complainant complained about same issue in the past? Was issue substantiated previously?

- **Time Frame of Concern**
  - When did concern occur?
  - When was facility surveyed in relation to concern?
  - Was concern cited during survey?
  - Was named resident on sample during survey?
  - Have there been past complaints investigated involving the identified concern?
- **Other Information**
  - Are there other outstanding complaints regarding the same concern? Is there a pattern of complaints regarding issue?
  - What does Minimum Data Set information indicate for named resident?
  - Has facility reported information regarding concern?
  - Have other reports regarding issue been provided-police reports, social services reports, ombudsman reports, death certificates, and autopsies?
- **Questions to consider for Non IJ Medium** Triage Level Considerations:
  - Impact of Reported Harm or Injury?
  - Did the individual experience harm or injury?
  - What harm or injury did the individual experience?
  - Has the harm or injury had limited consequence or insignificant impairment to the individual's physical or mental functioning?
  - What was the limited affect the harm or injury had on the individual's function?
  - Are there any other limited adverse affects to the individual?
  - Is the named individual still in facility and affected by harm or injury?
  - Is the named individual at risk for harm or injury that is of limited consequence to the individual's function?
  - Did other individuals experience harm or injury that was of limited consequence or that did not significantly impair their physical or mental function?
  - Are other individuals at risk for harm or injury that is of limited consequence or that would not significantly impair their physical or mental function?
  - Was this an isolated event?
  - Are circumstances still present putting individuals at risk for harm of limited consequence?
- **Quality and Degree of Information**

- The complainant's expectation/desire for resolution/remedy, if appropriate.

c. **Questions to ask the complainant**:
   - Is confidentiality/anonymity desired?
   - If confidentiality/anonymity is not desired, then ask what is your name, address, and telephone number?
   - What is the name of the person you are calling about? How are you related to this person?
   - Is anyone else involved, such as other staff, volunteers, family members, other patients or residents, visitors?
   - Are there any witnesses?
   - Have you taken any actions? Did you speak to the Administrator, Manager, or any staff of the facility?
   - Are law enforcement agencies involved?
   - Has the facility tried to address the situation?
   - Do you know if this has happened before to the same individual, or to others?

d. **Information to provide to the Complainant**: An effective complaint intake process provides information to assist the complainant in resolving his/her conflicts. The information provided to the complainant should be communicated verbally during the initial telephone discussions when receiving the complaint allegations. Provide the following information:
   - The state agency procedure for handling intakes including regulatory authority and any considerations pertaining to confidentiality;
   - the course of action the state agency will take and the anticipated time frames;
   - results of the complaint investigation will be mailed to the complainant in letter format following the investigation unless the complainant elected to remain anonymous; and
   - information about other appropriate agencies (such as ombudsman) that could provide assistance including the name and telephone numbers of a contact person.

e. **Use the Intake information to determine**:
   - The complaint category, which could be: abuse/neglect; rights; environment; care and services; dietary; funds; staffing; or dumping; etc... for purposes of completion of documentation for federal and state data bases;
   - Whether the complaint should be retained in the SA or sent to CMS (i.e. accredited hospital or other accredited facilities). If the complaint situation falls under another agency's jurisdiction, **refer** appropriately (Nursing Boards, Fire Marshal's Office, Department of Labor, etc.);
   - If a complaint survey needs to be initiated or if the situation can be resolved by an adminstrative complaint investigation;

F. Documentation

A. Task 1- Off-Site Preparation

Offsite Preparation encompasses responsibilities for state office staff & survey staff.

1. **COMPLAINT INTAKE RESPONSIBILITY:**
   a. State Office will be the central point of entry for all complaints.
   b. If field office staff are contacted at the field office by a complainant for the intial intake of a complaint, please refer complainant to state office. There are designated Program Managers assigned with the responsibility of the intake of complaints for each specific provider type. You may do one of the following:
      - Give the complainant the phone number for the appropriate state office program manager; or
      - forward the call to the appropriate state office program manager; or
      - take the name and phone number and refer this information to the appropriate state office program manager.
   c. Written complaint allegations that are received by this state agency are to be entered into the ACTs system by the state office program manager, regardless of the format in which they are received (fax, email, regular mail). These allegations are to be reviewed to determine if they meet the requirements of an investigation. If the allegations do not contain any regulatory violation or is in an area that this agency has no jurisdiction for investigation, it is to be scanned and entered into the ACTs system and then a letter to the complainant is formulated in ACTs and some notation is to be made as to the disposition of the complaint. The priority then is chosen as referred or no action necessary, whichever is appropriate (see Exhibit "C" – ACTs Priority Definitions & Timelines).
   d. If surveyors are approached during an onsite survey (complaint, standard, follow-up, etc...) by someone wanting to lodge a complaint the surveyor should proceed as follows:
      - If received **prior to the final decision making process**:
        - During a **Standard Survey** - the surveyor should get the details of the complaint, add the recipient named in the complaint to the survey sample, and incorporate the allegations as an area of focus for the present survey.
        - During a **Complaint Survey** *(other than Joint Accredited Facilities- see *)* – the surveyor should get the details of the complaint, add the recipient named in the complaint to the survey sample, and investigate the new allegations during the present onsite visit. Document the details of the new complaint in the Opening Remarks of the Complaint Narrative Report for the present complaint survey. If the new complainant indicates the desire for a complaint report, the surveyor should indicate this in the Closing

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HSS SO Sharepoint Site

HSS Forms

WAIVER PROGRAM FORMS

Select a View

All Documents

Explorer View

Actions

- Alert me
- Export to spreadsheet
- Modify settings and columns

New Document | Upload Document | Up | New Folder | Filter | Edit in Datasheet

Type	Name	Modified	Modified By	Checked Out To
	Case Management	4/3/2009 1:55 PM	Margie Huguet	
	Family Support Services	8/23/2007 9:55 AM	Margie Huguet	
	Personal Care Attendant	9/8/2009 1:05 PM	Margie Huguet	
	Respite Care CBR	8/23/2007 9:55 AM	Margie Huguet	
	Supervised Independent Living	5/18/2009 8:06 AM	Margie Huguet	

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HSS Forms

WAIVER PROGRAM FORMS/Case Management

Select a View

All Documents

Explorer View

Actions

- Alert me
- Export to spreadsheet
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Type	Name	Modified	Modified By	Checked Out To
	EPSDT Satisfaction Survey	10/5/2009 3:29 PM	Lashonda Watts	
	HSS-CM-02 Survey Tracking Form	4/3/2009 2:03 PM	Margie Huguet	
	HSS-CM-03 Licensing Survey Report Form	8/23/2007 10:47 AM	Margie Huguet	
	HSS-CM-04 Recipient Home Visit Form 2	8/23/2007 10:56 AM	Margie Huguet	
	HSS-CM-05a Monitoring Visit Worksheet 5 07	8/23/2007 10:59 AM	Margie Huguet	
	HSS-CM-05b Monitoring Visit Worksheet ADDITIONAL DPS WORKERS 05 07	8/23/2007 10:59 AM	Margie Huguet	
	HSS-CM-05c EPSDT Monitoring Visit Worksheet ADDITIONAL On Site Review 4 02 09	4/3/2009 1:58 PM	Margie Huguet	
	HSS-CM-05c2 EPSDT SATISFACTION SURVEY final 8-2-07 Updated	4/3/2009 1:54 PM	Margie Huguet	
	HSS-CM-05d EPSDT Monitoring Flow Chart 4 02 09	4/3/2009 1:54 PM	Margie Huguet	
	HSS-CM-05d EPSDT Monitoring Flow Chart Instructions 4 02 09	4/3/2009 1:54 PM	Margie Huguet	
	HSS-CM-05f EPSDT On-Site Survey Referral To PAL Udated FINAL 4 02 09	4/3/2009 1:54 PM	Margie Huguet	
	HSS-CM-06 RFPContracted Case Management Support Coordination Only	8/23/2007 11:01 AM	Margie Huguet	
	HSS-CM-07 Waiver Consent for Home Visit	8/23/2007 11:02 AM	Margie Huguet	Marion D. Self

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

HEALTH STANDARDS
SURVEY TRACKING FORM

LOUISIANA
Department of HEALTH and HOSPITALS

CASE MANAGEMENT

SECTION I

A. PROVIDER NAME :	B. PROVIDER NUMBER:
C. SURVEY DATE: ___/___/___	D. TEAM LEADER OF SURVEY:
E. DATE SENT TO STATE OFFICE: ___/___/___	F. FIELD OFFICE: _____

SECTION II

SURVEY TYPE: (Please check all that apply)

☐ Complaint #_____ ☐ Complaint generated from licensing Survey

☐ Licensing: ☐ Initial ☐ Annual ☐ Follow Up

SECTION III

Surveyor / Team Recommendations

A. NOT IN SUBSTANTIAL COMPLIANCE	B. SUBSTANTIAL COMPLIANCE
☐ No License	☐ All Deficiencies Cleared
☐ Provisional License	☐ Full License
☐ License Revocation	☐ No Deficiencies
	☐ Standard Deficiencies
	☐ Provider Notified -Letter mailed ___/___/___
	☐ Other _____

****** FOR STATE OFFICE USE ONLY ********

Date Received by State Office: ____/____/____

Provider Notified-Date: ____/____/____

*SECTION IV - * - IF APPLICABLE*

INITIAL LICENSING SURVEY

____ *LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ *HSS-CM-03 LICENSING SURVEY REPORT FORM (2 pages)*
____ **HSS-CM-05c ADDITIONAL ONSITE REVIEW SURVEYOR WORKSHEET - EPSDT SUPPORT COORD. MONITORING*
____ *STATE 670 - SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ *HSS-ALL-01-IDENTIFIER LIST*
____ **HSS-PLO1- LETTER*
____ *HSS 1513L – DISCLOSURE OF OWNERSHIP*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*

ANNUAL LICENSING SURVEY

____ *LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ *HSS-CM-03 LICENSING SURVEY REPORT FORM (2 pages)*
____ *HSS CM-04 RECIPIENT HOME VISIT & INTERVIEW SURVEY FORM*
____ *HSS-CM-05a-SURVEYOR WORKSHEET FOR THE 5% MONITORING VISIT*
____ **HSS-CM-05b ADDITIONAL DSP AGENCIES SURVEYOR WORKSHEET FOR THE 5% MONITORING VISIT*
____ *HSS-CM-05c ADDITIONAL ONSITE REVIEW SURVEYOR WORKSHEET - EPSDT SUPPORT COORD. MONITORING*
____ **HSS-CM-5c2 EPSDT SATISFACTION SURVEY*
____ **HSS-CM-05f ONSITE SURVEY REFERRAL TO PAL*
____ **HSS-CM-06 RFP CONTRACTED CASE MANAGEMENT/SUPPORT COORDINATOR ONLY*
____ *HSS-CM-07 CONSENT FOR HOME VISIT*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ *HSS-ALL-01-IDENTIFIER LIST*
____ **HSS-PLO1- LETTER WITH HSS-ALL-30a & 30b NOTIFICATION FOR POC AND IDR PROCESS*
____ *HSS 1513L – DISCLOSURE OF OWNERSHIP*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*

MAIL/ON-SITE FOLLOW-UP

____ *HSS-ALL-01-IDENTIFIER LIST*
____ *STATE 670 - SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ **HSS-CM-03 LICENSING SURVEY REPORT FORM (2 pages)*
____ **HSS-CM-05c ADDITIONAL ONSITE REVIEW SURVEYOR WORKSHEET - EPSDT SUPPORT COORD. MONITORING*
____ **HSS-CM-5c2 EPSDT SATISFACTION SURVEY*
____ **HSS-CM-05f ONSITE SURVEY REFERRAL TO*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ **LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ **LIC 2 STATE FORM - POST LICENSING AND SURVEY SUMMARY (LIC Revisit Form)*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-PL-14- LETTER*
____ **HSS-PL-15- LETTER*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*

COMPLAINT SURVEY

____ *HSS-CM-01- COMPLAINT NARRATIVE COVER SHEET*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ **LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ **HSS-CM-03 LICENSING SURVEY REPORT FORM (2 pages)*
____ **HSS-CM-05c ADDITIONAL ONSITE REVIEW SURVEYOR WORKSHEET - EPSDT SUPPORT COORD. MONITORING*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ *HSS-ALL-01- IDENTIFIER LIST*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ **HSS-PLO3- LETTER*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*

SURVEYOR SIGNATURE:

_____

EMPLOYEE FORWARDING TO STATE OFFICE SIGNATURE:

_____

DEPARTMENT OF HEALTH & HOSPTIALS
HEALTH STANDARDS SECTION (HSS)
CASE MANAGEMENT/SUPPORT COORDINATION– LICENSING SURVEY REPORT

AGENCY INFORMATION

Name:		**Field Office:**
Telephone:	**License#:**	**State ID#:**
Geographical Address:		
Mailing Address:		
Authorized Representative:		**Title:**

SURVEY INFORMATION

Type: ____ Initial ____ Standard for Participation (SFP) ____ Annual ____ Follow-up

____ Complaint ____ Other: _____

Survey Date ____/____/____
(exit date)

Deficiencies Written: ____Yes – LIC ____Yes – 2567 ____No
(write any remarks/comments on CMS-807-surveyor notes and submit with this form)

Citations (reference section#): _____

_____

_____

Significant Findings (reference section#): _____

_____

_____

SURVEYOR/TEAM RECOMMENDATIONS

____ No License ____Provisional License ____License Revocation ____Full License ____Medicaid Enrollment

Surveyor Signature: _____ Date: _____

Surveyor Signature: _____ Date: _____

CASE MANAGEMENT/SUPPORT COORDINATION

Compliance with Licensing and Standards for Participation (SFP)

For Initial Surveys: 1st determine if the requirements that are typed in BOLD and targeted population requested below are met. Bold areas must be met for initials. For Annual Surveys: Proceed to review all requirements that are listed below.

SECTION	CATEGORY Licensing Standards (Manual July 1, 2002)	MET	NOT MET	N/A	SECTION	CATEGORY Medicaid Standards for Participation (SFP) (Part XV, Subpart 7. Targeted Case Management Chapter 101 General Provisions)10301-11905, 1036-1044	MET	NOT MET	N/A
Sections 1-3	**Providers General Responsibilities**				10301	Provider requirements-Core Elements			
(Sect. 3)3.0-3-15	License				1.	License and Medicaid Certification			
	Advisory Board/Governing Body				2.	Provider Enrollment Requirements			
	Authority to Operate, Contracts & Insurance (general liability & professional of $150,000 each)				3.	Case Management Manual			
	Agency Organizational Chart & Lines of Authority				4.	Specific Terms of Contract Agreement for **Contracted Case Management only (if applicable)**			
	Administrative File				10503 (A-F)	**Provider Responsibilities (All)**			
	Financial Accounting & Fiscal Accountability				**10505-10507**	**Staff Education, Experience & Training**			
	Record Keeping, Documentation Records: Administrative, Personnel & Recipient				Chapter 107 10701	Medicaid Reimbursement			
	Confidentiality & Security of Files (HIPAA)				Chapter 109 1090 (A-C)	*Infant and Toddlers*			
	Personnel				**10903-10905**	**Staff Qualifications & Training**			
	Education ,Experience				Chapter 111	*Nurse Family Partnership*			
	Orientation & Training				11103	Recipient Qualifications			
	Staff Coverage & Supervision				11105	Staff Qualifications			
	Quality Improvement Plan present & submitted to OAAS or OCDD				Chapter 113	*EPSDT (Early Periodic Screening, Diagnosis & Treatment)*			
Section 4-5	Target, Waiver Population & Covered Services				11303	Recipient Qualifications			
Section 6	**Staffing Requirements**				Chapter 115-	*High Risk Pregnant Women*			
Section 7	Financial Services				11503	Recipient Qualifications			
Section 8	**Record Keeping**				Chapter 117	*Mentally Retarded /Developmentally Disabled*			
Contracted	Contracted Case Management only				Chapter 119	*HIV*			
	RFP: 7 Additional Requirements				11903-11905	*Recipient & Provider Regulations*			

Surveyor Name:	Field Office:	Date:

CASE MANAGEMENT
SURVEYOR WORKSHEET

Case Management Agency:	Case Manager:		
Direct Service Provider:	Type of Waiver, EPSDT, or LT-PCS:		
REQUIREMENT	**RESPONSE**		**COMMENTS**
A. Case Management:	**Y**	**N**	
1. A current 90L is maintained in the recipient's record with Level of Care (LOC) represented.			
2. The current approved CPOC is maintained in the recipient's record.			
3. CPOC is based on personal outcomes and unique needs of the recipient/guardian and other information gathered in the case management participant/person centered planning and supports assessment.			
4. Quarterly Home Visits are made and the CPOC is reviewed and updated at least quarterly.			
5. Quarterly Progress notes support CPOC (documentation of coordination of services and contacts are maintained in the recipient's record.			
6. Recipient safeguards are in place for home and community-based services.			
7. Recipient is satisfied with their services and desired outcomes.			
REQUIREMENT	**RESPONSE**		**COMMENTS**
B. Direct Service Provider (s) (DSP):	**Y**	**N**	
1. DSP has a copy of the current CPOC.			
2. DSP has a current service plan and is in compliance with the CPOC.			
3. Progress notes support CPOC.			
4. DSP has documentation the communication between the Case Management Agency and other DSP or community providers.			
5. DSP complies with staffing requirements.			
6. Recipient safeguards are in place for home and community-based services.			
7. Recipient is satisfied with their services and desired outcomes.			
Surveyor Signature:	**Field Office:**		**Date:**

ADDITIONAL DSP AGENCY SURVEYOR WORKSHEET

Case Management Agency:	Client Name:		
Direct Service Provider:	Type of Waiver, EPSDT, or LTPCS:		
REQUIREMENT	**RESPONSE**		**COMMENTS**
C. Direct Service Provider (s) (DSP):	**Y**	**N**	
1. DSP has a copy of the current CPOC.			
2. DSP has a current service plan and is in compliance with the CPOC.			
3. Progress notes support CPOC.			
4. DSP has documentation the communication between the Case Management Agency and other DSP or community providers.			
5. DSP complies with staffing requirements.			
6. Recipient safeguards are in place for home and community-based services.			
7. Recipient is satisfied with their services and desired outcomes.			
REQUIREMENT	**RESPONSE**		**COMMENTS**
Comments:			
Surveyor Signature:	**Field Office:**		**Date:**

RECIPIENT HOME VISIT & INTERVIEW SURVEY FORM

RECIPIENT NAME:	MEDICAID #:	Type of Waiver, EPSDT, or LT-PCS:
Case Management Agency:	Case Manager:	Direct Service Provider:

REQUIREMENT	RESPONSE		COMMENTS
	Y	N	
1. Current CPOC and Service plan are in the home.			
2. Does recipient know how to access: a.) Case Manager/Support Coordinator? b.) DSP Agency? c.) Help line/Complaint line #1-800-660-0488?			
3. Services and Supports are implemented in accordance with the recipients needs and represented in the current CPOC.			
4. DSP effectively serving recipients needs.			
5. Recipient feels safe and secure in their home and community.			
6. Recipient is aware of their rights and how to exercise them.			
7. Recipient is satisfied with their services.			
8. Recipient is satisfied with Case Management.			

Interview with Participant: Comments:

Interview with Case Manager: Comments:

Surveyor Signature:	Field Office #:	Date:

DEPARTMENT OF HEALTH AND HOSPITALS
HEALTH STANDARDS SECTION

CONSENT FOR HOME VISIT

RECIPIENT NAME:	ADDRESS:

By this document, I hereby consent to have State health survey personnel conduct a home visit to ensure that the State requirements are met and to assist in evaluating the effectiveness and quality of waiver services/state plan services that I receive from the _____.
(Name of Agency/Provider)

I understand that consent for this visit is mandatory. By signing this consent, none of my rights to confidentiality or privacy are waived.

RECIPIENT, OR REPRESENTATIVE OF THE RECIPIENT, SIGNATURE:	DATE:

RFP CONTRACTED CASE MANAGEMENT
SUPPORT COORDINATOR ONLY

Case Management Agency:

REQUIREMENT	RESPONSE		COMMENTS
RFP – CONTRACT REQUIREMENTS	**Y**	**N**	
1. The agency has on file a signed contract.			
2. The agency maintains on file a copy of its subcontract agreements.			
3. The agency has a plan to monitor subcontractors.			
4. The agency provides the recipient freedom of choice of service providers.			
5. The agency monitors each service provider quarterly.			
6. The agency maintains records of the quarterly monitoring of the service provider that is signed and dated by the case manager.			
7. The agency employs a full time project manager.			

SURVEYOR NOTES:

Surveyor Signature:	**Field Office:**	**Date:**

State Of Louisiana
Department of Health and Hospitals
BHSF - Health Standards

EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT

I, hereby, acknowledge the following:

_____ **I have been given the opportunity to provide additional information, as necessary, regarding areas of deficient practice identified at the exit conference for the - standard - follow-up - complaint (#_____) - survey on _____.**

_____ **I have received a copy of the resident identifier list. (If applicable)**

_____ **I have received the Statement of Deficiencies that was left on-site and have been informed that the Plan(s) of Correction need(s) to be submitted to the State Office in Baton Rouge within 10 working days (if applicable) .**

Facility Name	**Provider Number**
_____	_____
Facility Representative	**Surveyor**
_____	_____
Date	**Date**

HEALTH STANDARDS SECTION

THE REQUIRED COMPONENTS FOR A PLAN OF CORRECTION MUST CONTAIN THE FOLLOWING 5 COMPONENTS:

Address how corrective actions were accomplished for those residents/clients/patients found to have been affected by the deficient practice; (refer to the survey identifier list)

Describe how other residents/clients/patientswho have the potential to be affected by the deficient practice will be identified; and what will be done for them.

The measures that will be put in place or the system changes that will be made to ensure that the deficient practice will not recur.

Indicate how the facility plans to monitor it=s performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. Indicate how the corrective measures will be monitored. What quality assurance program will be put into place? Monitoring must include who (what discipline), how (chart audits, direct observations, specific procedures), how often (daily, weekly, twice a month), and what will be done if problems are discovered.

Include dates when corrective action will be completed.

The SIGNED (including position and title) and DATED Plan of Correction must be answered on the ORIGINAL 2567 form and/or LIC-1/state form and mailed to the attention of the specific program desk (nursing home, home health, ICF/MR, E.S.R.D, etc...) to:

MAILING ADDRESS
Health Standards Section
P.O. Box 3767
Baton Rouge, La. 70821-3767

FEDERAL EXPRESS ADDRESS
Health Standards Section
500 Laurel Street, Suite 100
Baton Rouge, La. 70801

INFORMAL DISPUTE RESOLUTION PROCESS

Purpose: The purpose of this informal process is to give providers one opportunity to refute cited deficiencies after any survey.

The Informal Dispute Resolution Process (IDR) allows you to present your concerns to employees of the Health Standards Section who have not been involved in either your facility=s survey or the identification of the deficient practices listed on the survey form 2567or Lic 1. This is an informal process and it is not necessary for your attorney to be present, however, if you wish for your attorney to be included in the informal dispute resolution, please advise this office (225-342-6136).

The IDR process may be accomplished by:

1. Submitting a written request for IDR, indicating tags disputed and reasons for dispute.

2. A. Submitting documentation for paper review that you think demonstrates that deficiencies written by the survey team were written in error;

   OR

   B. Participation in a face to face meeting and submitting documentation in the meeting that you think demonstrates that deficiencies written by the survey team were written in error.

IDR=s requested for surveys done as a result of a complaint are conducted as paper reviews.

Facilities **may not** use the IDR process to delay the formal imposition of remedies **or** to challenge any other aspect of the survey process, including the:

- Scope and severity assessments of deficiencies with the exception of scope and severity assessments that constitute substandard quality of care or immediate jeopardy;
- Remedy (ies) imposed by the enforcing agency;
- Alleged failure of the survey team to comply with a requirement of the survey process;
- Alleged inconsistency of the survey team in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process.

For Nursing Homes Only:
Only deficiencies are disputable. Disputing only some of the instances (findings) of the deficiency rather than the existence of the deficiency itself would be tantamount to disputing the scope of a deficiency which is not a disputable issue under the informal dispute resolution process.

PLEASE NOTE:
The informal dispute process does not postpone the termination action, and does not exempt the facility from submitting a plan of correction.

DEPARTMENT OF HEALTH & HOSPITALS - HEALTH STANDARDS SECTION

SURVEY STAFF IDENTIFIER (ID) LIST

Facility Name:_____ Provider #: _____ Survey Date: _____

*The Staff Identifier List is **CONFIDENTIAL.** **DO NOT give the provider a copy of this list.***

ID Code	Staff Name	ID Code	Staff Name

Add an extra "F" to the coding system for each subsequent follow-up visit.

Key: For Staff Identifier Codes

Identifiers – Standard & Complaint Surveys	1st Visit Coding System	Follow-Up Visit Codes
Staff – Use Job title if only 1 staff assigned the title	DON, ADON, RD, …	DON, ADON, RD, …
Staff – Use if Job Title is assigned to multiple staff	**S1, S2, S3, S4, S5, …	**SF1, SF2, SF3, SF4, SF5,…

DEPARTMENT OF HEALTH & HOSPITALS - HEALTH STANDARDS SECTION

SURVEY IDENTIFIER (ID) LIST

(Staff Identifiers are CONFIDENTIAL and WILL NOT appear on this list)

Facility Name:_____ Provider #: _____ Survey Date:_____

ID Code	Sample Selection Name	ID Code	Sample Selection Name	ID Code	Sample Selection Name

KEY: FOR IDENTIFIER CODES

Identifiers - **Standard & Complaint Surveys**	1st Visit Coding System	Follow-Up Visit Codes
Sample Selection Recipients	1, 2, 3, 4, 5, 6, 7, 8, 9,...	F1, F2, F3, F4, F5, F6, F7, ...
Random Selection	R1, R2, R3, R4, R5,...	RF1, RF2, RF3, RF4,...
Confidential interview of staff, recipient, family	Confidential interview	Confidential interview
Rooms	a, b, c, d, ... aa, bb, cc, dd, ee,...	Fa, Fb, Fc, Fd, Fe, ...Faa, Fbb, Fcc, Fdd, ...
Drug Pass	D1, D2, D3, D4, D5, D6, D7...	DF1, DF2, DF3, DF4, DF5, DF6, DF7,...

Add an extra F to the coding system for each subsequent follow-up visit.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

NOTIFICATION OF DETERMINATION OF IMMEDIATE JEOPARDY (IJ)

Provider Name: _____ Sate ID #: _____

An Immediate Jeopardy situation has been found to exist in this agency. Immediate Jeopardy is interpreted as Aa crisis situation in which the health and safety of individual(s) are at risk@. It is defined as Aa 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@ (42CFR Part 441.302 State Assurances) in the very near future if immediate action is not taken.

The Immediate Jeopardy Situation is:

_____
_____
_____
_____
_____
_____
_____
_____

This agency should begin immediate removal of the risk to individuals, and immediately implement corrective measures to prevent repeat Jeopardy situations. This agency is also encouraged to provide a written plan of action that documents the immediate corrective measures that will be used to ensure the removal of the situation, to the survey team while they are still on-site.

Date of Notification: _____ Time of Notification: _____

Notification of IJ situation made to: _____
(Signature & Title of Agency Representative)

Notification of IJ situation made by: _____
(Signature of Survey Team Member)

Complete this section if the Immediate Jeopardy (IJ) situation is lifted prior to the completion of the survey.

The IJ situation was lifted at _____ on _____
(time) *(date)*

Notification of removal of the IJ situation made to : _____
(Signature & Title of Agency Representative)

Notification of removal of the IJ situation made by: _____
(Signature of Survey Team Member)

HSS-WAIVER-34 IJ Notification (8/08)

OFFICE OF MANAGEMENT AND FINANCE • BUREAU OF HEALTH SERVICES FINANCING • HEALTH STANDARDS SECTION
500 LAUREL STREET – SUITE 100 (70801-1811) • P.O. BOX 3767 • BATON ROUGE, LOUISIANA 70821-3767
PHONE #: VOICE 225/ 342-0138 • FAX#: 225/ 342-5292

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

BUREAU OF HEALTH SERVICES FINANCING
HEALTH STANDARDS SECTION

Disclosure of Ownership and Control Interest Statement

1. Identifying Information

Name of Entity	D/B/A	EIN#
Street Address	City, County, State	
Telephone #	Zip Code	

II. (a) List names, addresses and phone numbers for persons or group of persons, or the Employer Identification Number (EIN) for organizations having direct or indirect ownership or a controlling interest (≥ 10%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity.

Name	Address	EIN

II. (b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation

☐ Unincorporated Associations ☐ Other (specify)

II. (c) If the disclosing entity is a corporation, list names, addresses, and phone numbers of the Directors under Remarks.

II. (d) Are any owners of the disclosing entity also owners of other licensed health care facilities? ☐ Yes ☐ No
(proprietorship, partnership, or Board Members). If yes, list names, addresses, and phone numbers of individuals and facility provider numbers.

Name	Address	Provider Number

III. Has there been a change in ownership or control within the last year? ☐ Yes ☐ No
If yes, give date

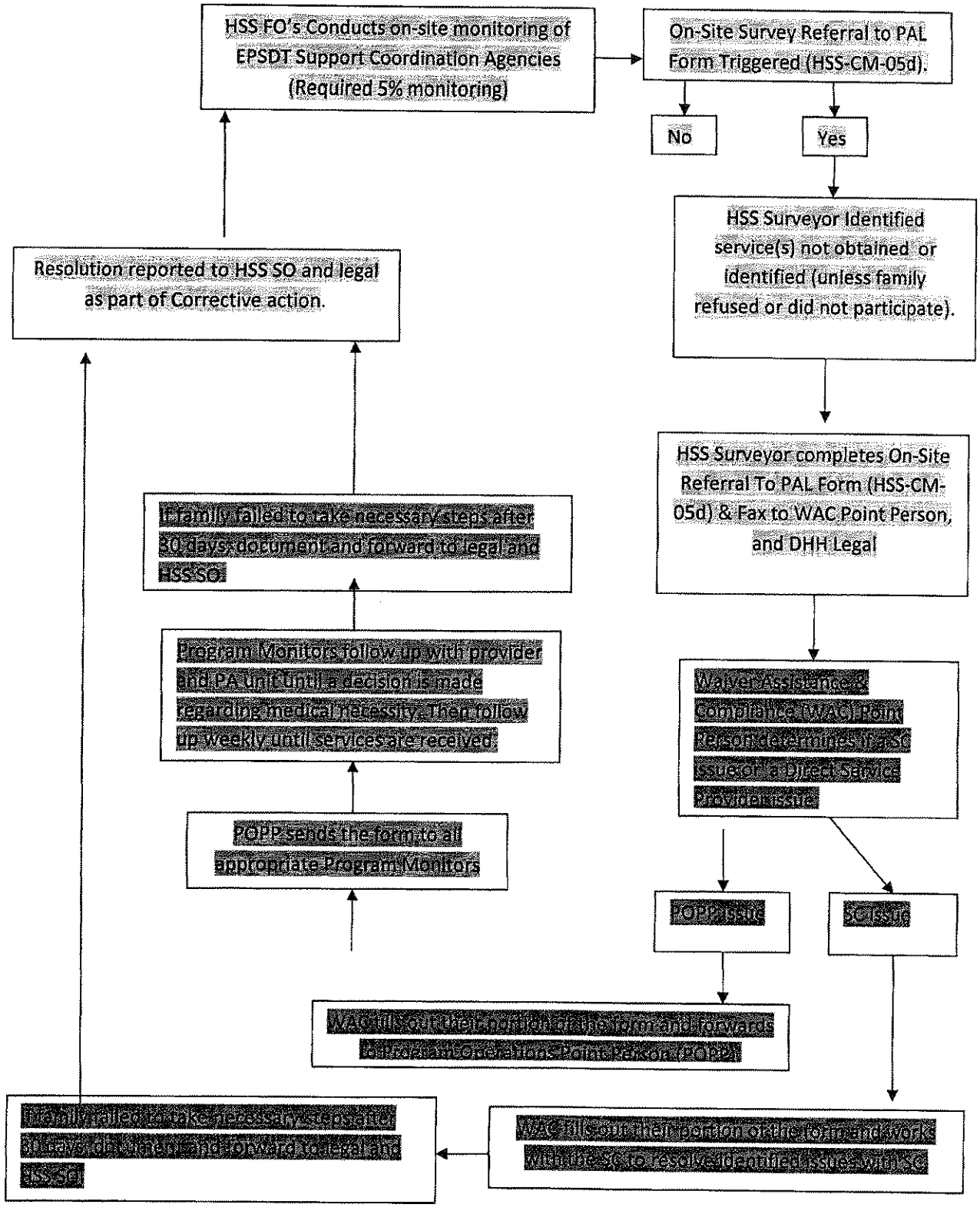
WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS, IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE LOUISIANA STATE AGENCY

Name and Title of Authorized Representative (Typed)

Signature	Date

Remarks

Additional Case Management Forms Specific to EPSDT



HSS-CM-05d EPSDT Monitoring Flow Chart (revised 04/02/09)

Instructions For The Health Standards EPSDT Support Coordination Monitoring On-Site Survey Referral To PAL Form HSS-CM-05f and the Associated EPSDT Monitoring Flow Chart with Instructions

Instructions for Health Standards Section (HSS)

These instructions are for the EPSDT Clients for whom an On-Site Survey Referral Form To PAL (HSS-CM- 05f) is triggered.

1. Conduct EPSDT Case Management Annual Survey that includes the 5% required EPSDT Monitoring.

2. During the Survey the HSS Surveyor identifies services were not obtained within 60 days of request, prior authorized or identified.

3. Reminders for when to complete an On-Site Referral Form To PAL (HSS-CM-05f)
   a) When a service is requested in the CPOC has not had a Prior Authorization decision within 60 days from the date of the request (If you check "NO" on the Additional On-Site Survey Work Sheet for EPSDT Coordination Monitoring (HSS-CM-05c), Page 5, Number G, 8, 9 & 10 or if you check "NO" on the EPSDT Satisfaction Survey Form (HSS –CM-05c2), Page 1, Number 5). This applies even if the family has not selected a provider which may or may equal a deficiency.
   b) When the Support Coordinator (SC) fails to identify a needed service or item (If you check "NO"
      a. On the HSS-CM-05c, Page 1, E.3 and or Page 1, F. 5). If the family informs you for the first time during an interview or during completion of the EPSDT Satisfaction Survey HSS-CM-05c2, if you check "NO" for Page 1, Number 4, they are interested in a service or an item then notify the SC and complete the HSS-CM-05f).
   c) When a service that that has been Prior Authorized is not being received according to the Approved Comprehensive Plan of Care (CPOC) for that service. (If you check "NO" on the HSS-CM-05c Page 4, F. 5).
   d) When SC failed to track an identified service(s) (unless documents/documentation indicate the service (s) is approved and is being received. (If you check "NO" on the HSS-CM-05c, Page 3, G. 4 or 5).
   e) Remember it does not apply if the family has refused the services and in these cases there is documentation in the file supporting the family refusal for service(s).

4. The HSS Surveyor will complete the HSS On-Site Referral To PAL Form (HSS-CM-05f) and Fax a copy to both:
   Randy Davidson WAC Section Headquarters at Fax 225-376-4687 and to
   Rene Huff Attorney, DHH Legal, at Fax 225-342-2232.

5. After faxing the On-Site Survey Referral to PAL Form (HSS-CM-05f Form), include the Original HSS-CM-05f Form documenting the Survey Packet for HSS State Office.

6. HSS shall contact legal if there is no resolution to the service needs identified in the **Health Standards Support Coordination Monitoring ON-SITE SURVEY REFERRAL** forms within 60 days. (if you have not received notification of a resolution on the identified service from WAC or Program Operations 60 days from the date of the ON-SITE SUREVY REFERRAL email Rene Huff)

7. HSS shall include the results of these efforts in the survey files for the appropriate agencies.

Instructions For The Health Standards EPSDT Support Coordination Monitoring On-Site Survey Referral To PAL Form HSS-CM-05f and the Associated EPSDT Monitoring Flow Chart with Instructions

Instructions for Waiver Assistance and Compliance

1. WAC point person will review the **ON-SITE SURVEY REFERRAL** form when it is received to assess actions that need to be taken with SC. Start an **EPSDT Support Coordination Status of Service** form for each service identified on the Health Standards form. This means there could be several **EPSDT Support Coordination Status of Service** forms for every **ON-SITE SURVEY REFERRAL form received.**

2. On the same day, the WAC point person will contact the SC and SC supervisor, to address identified problems. Track and record all contacts and activities relative to each service separately on a contact tracking log. If at any point in the process this is determined to be a provider or service issue the **EPSDT Support Coordination Status of Service** form should be forwarded to the POPP via email.

3. On day two WAC point person shall contact the guardian, parent or recipient if they are over 18 years old, to identify issues and service needs. Track and record these contacts on a contact tracking log.

4. Once all of the problems with Support Coordination activities relative to the services identified on the **ON-SITE SURVEY REFERRAL** form are evaluated with the **EPSDT Support Coordination Status of Service** form is filled out and signed, forward to the **POPP**, unless it is determined that the family doesn't wish to pursue the services. If the SC reports that the family does not wish to pursue the services, the SC shall document this conversation and obtain a statement with a signature from the family. WAC shall contact the family to confirm this statement and attached the supporting documentation from the SC to the **EPSDT Support Coordination Status of Service** form.

5. If the family cannot be reached, after three attempts are made at contact, contact legal. Legal will contact Plaintiff's counsel and inform them that the family cannot be reached and that all contact will cease until the family contact DHH. If the family has failed (without good cause) after 30 days to take necessary steps to obtain services, DHH program staff may cease its efforts with out prejudicing future request. Please document this in your tracking log if it occurs and forward all of the forms and information to Health Standards and Legal via email. If the family has failed after 60 days even with good cause to take necessary actions, DHH program staff may cease its efforts. (The family shall be notified and they shall be informed as to how they can start the process in the future and WAC is only responsible for notice if the family fails while they are working the case).

6. Obtaining the information should be accomplished as soon as possible (this is the goal). It may take longer if a medical appointment is needed to obtain information or a provider has not been selected. Document all of this; if the decision as to Prior Authorization can be made by the PAU without the involvement of the POPP then WAC shall fill out the second section of the **EPSDT Support Coordination Status of Service** form and forward to HSS and legal via email.

7. If any portion of the request is denied the POPP will forward the **EPSDT Support Coordination Status of Service** form and all attachments to WAC, and Legal immediately via email. WAC will determine if Appeal rights are offered through a follow up contact with the SC and the family. WAC will document this on the form and in the contact tracking log. If WAC determines the SC did not explain Appeal right or offer assistance a complaint shall be filled with Health Standards.

Instructions For The Health Standards EPSDT Support Coordination Monitoring On-Site Survey Referral To PAL Form HSS-CM-05f and the Associated EPSDT Monitoring Flow Chart with Instructions

Instructions for Program Operations Point Person (POPP)

1. Once the forms are forwarded to the POPP it must be assigned to all appropriate program staff. This should happen on the day after receipt of the referral received. All contacts and activities for each of the services shall be documented and tracked on a contact tracking log. The POPP must check with the program staff weekly as to the status of the request.

2. On the day that it is assigned, the program staff shall check MMIS to see if there is a PA request in the system. If there is none, the provider should be contacted that same day.

3. Contacts to provider and family shall be made no latter than day three to determine why the PA has not been received and identify any other issues there may be with the PA request being submitted. They should also inform the family and provider that they will work with the provider and the family to resolve the issues until there is a PA decision.

4. Once a request had been submitted MMIS shall be checked daily until a decision has been made on the PA.

5. Document all contacts on a separate contact tracking log. Documents the date of decision, what services were approved, and in what amount on the **EPSDT Support Coordination Status of Service** form. Sign **EPSDT Support Coordination Status of Service** form. Send to legal and HSS via email the same day the services are approved. Attach the notice of decision from the PAU to the **EPSDT Support Coordination Status of Service** form.

6. If any portion of the request is denied forward the **EPSDT Support Coordination Status of Service** form and all attachments to WAC, and Legal immediately via email. WAC will determine if Appeal rights are offered through a follow up contact with the SC and the family.

7. If any services are approved the program staff shall contact the family weekly until services begin. Document contact on the contact tracking log and indicate the date services began on the **EPSDT Support Coordination Status of Service** form. Forward the form, and all attachments to Health Standards, legal, and copy the POPP via email.

8. If the family has failed (without good cause) after 30 days to take necessary steps to obtain services , DHH program staff may cease its efforts with out prejudicing future request. If the family has failed after 60 days even with good cause to take necessary actions, DHH program staff may cease its efforts. (The family shall be notified and they shall be informed as to how they can start the process in the future) Please document this in your tracking log if it occurs and forward, all of the forms and information to, Legal and the POPP via email.

ADDITIONAL ON-SITE REVIEW
SURVEYOR WORKSHEET FOR EPSDT SUPPORT COORDINATION MONITORING

Name:	Age:	CPOC Dates:
Case Management /Support Coordination Agency:		**Case Mgr/Support Coordinator:**

REQUIREMENT	Response			Document, Resource & Satisfaction
E. EPSDT Services :	Y	N	N A	
1. SC Agency selected & EPSDT participant contacted within 3 days? (For new initial cases or changes in SC).	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Documents**: FOC Form (Appendix N), EPSDT Timeline & Documentation Participant Contacts (Appendix T-1), **Resource:** EPSDT SC Handbook pg 21.
2. SC explained, recommended & documented EPSDT services including the following: a). Scheduling assistance b). Referrals c). Kid Med visit (interperiodic screens/well check ups) d). PCS services e). EHH services f). Medical equipment & supplies g). Psychological services h). Behavioral services i). Mental Health services.	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	**Comment:** Refer to Surveyor Worksheet (807) **Documents:** Statement of Eligibility (SOE), Appendix A,B,C,D,D2,E,F,G,H,I,J,K (Rights & Responsibilities),L,M,O (CPOC Section 5 page 6, Approval page pg 7 Appendix O/LSCIS),P, T1, V, EPSDT Quarterly Checklist & Progress Summary (Appendix O/LSCIS), Informal & Non formal information. **Resource: EPSDT SC** Handbook pages 1-27 **Satisfaction:** EPSDT Satisfaction Survey #1,2 & 3
3. SC established & documented services needed.	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Documents:** CPOC (Appendix O/LSCIS), Appendix T-1, V,Intake & Assessment documents & other formal or non formal information, documents, or assessments, MD orders, Statement of Eligibility (SOE), 1508 Evaluations, IEP, etc., **Resource:** EPSDT SC Handbook 1-27 **Satisfaction Survey:** EPSDT Satisfaction Survey # 4. **If checked NO on Page 1,#4 of SS Initiate a Referral to PAL Form HSS-CM-05f.** **If checked NO on E3 of this form Initiate a Referral to PAL Form HSS-CM-05f.**
4. SC reviewed & documented the following at the initial, quarterly or annual CPOC meeting. a).SC Responsibilities b).Rights & Responsibilities c).HIPAA & Confidentiality d).Availability of Formal & Informal services e).Complaint process for filing a complaint against SC or Provider (Contacting HSS 1-800-660-0488) f). Statewide Toll-Free Complaint Line (1-800-660-0488)	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	**Comment:** **Document:** Appendix A-M, P, Appendix O/LSCIS (CPOC), T1, V, W, X, EPSDT Quarterly Review checklist & Progress Summary **Resource:** EPSDT SC Handbook pages1-27, 28-45 **Satisfaction:** EPSDT Satisfaction Survey # 6

ADDITIONAL ON-SITE REVIEW
SURVEYOR WORKSHEET FOR EPSDT SUPPORT COORDINATION MONITORING

g). Medicaid Services Chart h).SC Agency 24 hour Toll-Free number	☐	☐	☐	
REQUIREMENT	**Response**			**Document, Resource & Satisfaction**
5. SC documented giving the participant the EPSDT Case Mgt Recipient/ Family Survey.	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** EPSDT Participant Satisfaction Survey **Resource:** EPSDT SC Handbook page 45 **Satisfaction:** EPSDT Satisfaction Survey # 7 & 9
F. EPSDT Intake, Assessment & CPOC:	**Y**	**N**	**N A**	
1. SC contacted participant monthly to assure implementation of services.	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Appendix T1, EPSDT Quarterly Review checklist & Progress Summary, PA Tracking Log, & EPSDT Service Log **Resource:** EPSDT SC Handbook pages 21-27 **Satisfaction:** EPSDT Satisfaction Survey # 8
2. SC completed a Face to Face visit with the participant/family each quarter. At the Quarterly meeting did they review or identify: a).Service needs & current status review of CPOC b).Additional services needed or requested c).Scheduling issues d).SC completion of the EPSDT Quarterly Checklist & Progress Summary. e).SC provided participant/family the Participant Complaint Form to complete and forward to DHH Health Standards when a complaint is identified. f). SC detects or identifies the participant has a dissatisfaction with the provider the SC assists to resolve the dissatisfaction & informs the participant/family of his/her rights & right to change providers.	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** : Appendix A-M, Appendix O/LSCIS, (CPOC), P, T1, V, W, X, EPSDT Quarterly Review checklist & Progress Summary **Resource:** EPSDT SC Handbook 1-20, 21-27 & 41-45 **Satisfaction:** EPSDT Satisfaction Survey # 6
3. SC made changes to the CPOC when: a).Updates & changes based on services or amount of services b).New strategies are needed with services & providers c).New information obtained from a medical appointment, assessment (psychological or behavioral services assessment) etc. d).Goals & objectives are added or revised e).Revisions to the Typical Weekly Schedule	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Appendix O/LSCIS (CPOC), V, W, EPSDT Quarterly Review checklist & Progress Summary, **Resource:** EPSDT SC Handbook pages 21-30,33-38,41-43
4. SC submits the initial or annual CPOC for approval within 35 calendar days of referral to the SC Agency	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Appendix O/LSCIS (CPOC), T1, V, W, X, EPSDT Quarterly Review checklist & Progress Summary,

ADDITIONAL ON-SITE REVIEW
SURVEYOR WORKSHEET FOR EPSDT SUPPORT COORDINATION MONITORING

				CIMIS Log **Resource:** EPSDT SC Handbook Page 26
REQUIREMENT	**Response**			**Document, Resource & Satisfaction**
5. SC identified all necessary services and takes steps necessary to insure that needed services are provided (Unless family refuses).	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Appendix A ,B, F, O, P **Resource:** EPSDT SC Handbook page 21-27 **Satisfaction:** EPSDT Satisfaction Survey # 5 **If checked NO on F5 of this form Initiate a Referral to PAL Form HSS-CM-05f.**
6. Were all identified service(s) obtained? If No, identify the reason why they have not been obtained and the steps taken necessary to insure the needed service(s) are provided (Unless family refuses service).	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Appendix A, B, C,D,D2,E,F,G,H,I,J,K (Rights & Responsibilities),L,M,O (CPOC Section 5 page 6, Approval page pg 7 Appendix O/LSCIS),P, T1, V, EPSDT Quarterly Checklist & Progress Summary (Appendix O/LSCIS), Informal & Non formal information. **Resource:** EPSDT SC Handbook page 21-27
G. EPSDT Prior Authorization: (For services requiring PA only)	**Y**	**N**	**N A**	
1. SC completed the **Referral to Provider form** once participant chose a provider. (For initial PA & a change in providers)	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Appendix T2 **Resource:** EPSDT SC Handbook page 28-30, 31,
2. SC documented requesting that the provider place their name and contact information on the **Request for Prior Authorization form**?	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Request for Prior Authorization Appendix R-1,T-2 **Resource:** EPSDT SC Handbook page 31-35
3. SC obtained a copy of the **Request for Prior Authorization packet**?	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Request for Prior Authorization Appendix R-1,T2 **Resource:** EPSDT SC Handbook page 31-35
4. SC Properly Documented Activities on **EPSDT Prior Authorization Tracking Log:**	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Appendix O/LSCIS Prior Authorization Tracking Log (Prior to LSCIS = Form BHSF-PF-03-014), CMIS Service report (from SC) **Resource:** EPSDT SC Handbook page 31-35 **If checked NO on G4 of this form Initiate a Referral to PAL Form HSS-CM-05f.**
5. EPSDT Prior Authorization Tracking Log (separate entry on the CMIS system) was created for each service that required Prior Authorization? a.) Type of service and amount expressed in hours (Hours per week) b.) Date of Request and Date of Choice of Provider c.) Provider Name d.) Date of Referral to Provider (within 3 days of date of Choice of Provider) e.) New Provider (change in provider) and Referral if required f.) Referral to PAL (if required)	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Referral to Provider Appendix Q BHSF-PF-03016, PA Approval, Denial, or Partially Approved Appendix R-2, Refer to PAL Appendix S (BHSF-PH-03-015), Appeals Brochure, Appeal Form Appendix L, Document: EPSDT), T2 **Resource:** EPSDT SC Handbook pages 28-35,36-37, 37-41 **If checked NO on G5Lof this form Initiate a Referral to PAL Form HSS-CM-05f.**

ADDITIONAL ON-SITE REVIEW
SURVEYOR WORKSHEET FOR EPSDT SUPPORT COORDINATION MONITORING

g.) Reminder Notice to Provider for Renewal: 45-60 days prior to the date the services are scheduled to expire.	☐	☐	☐	
REQUIREMENT	**Response**			**Document, Resource & Satisfaction**
h). **Prior Authorization approval and dates** **Approved:** SC recorded the specific number of hours or amounts of services approved. and follow up with the participant to make sure that services began? **Denied:** SC recorded reason if denied or partially denied. i.) **Appeal information:** SC reviewed the appeals brochure, recorded the date, and documented whether or not the participant requested assistance with the appeal (reason why if they did not assist), and the date the appeal request was sent to DHH. j.) SC created **a new EPSDT Prior Authorization Tracking Log** (new CMIS entry) after the **Reminder Notice for Renewal** is sent to the provider? (The date the reminder notice is sent to the provider is the date of referral for a new tracking log). k.) SC created a new Tracking Log (CMIS entry) when there were requests for a change in a service? l.) **Participant contacts**: SC made contact with the participant as needed or at least monthly until each service included in the CPOC was fully implemented, including the receipt of all prior authorized services?	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	**Document:** Referral to Provider Appendix Q BHSF-PF-03016, PA Approval, Denial, or Partially Approved Appendix R-2, Refer to PAL Appendix S (BHSF-PH-03-015), Appeals Brochure, Appeal Form Appendix L, Document: EPSDT), T2 **Resource:** EPSDT SC Handbook pages 28-35,36-37, 37-41 **Resource:** EPSDT SC Handbook pages Appeals 37-41 **If checked NO on G5L of this form Initiate a Referral to PAL Form HSS-CM-05f.**
6.**Provider Contacts**: SC contacted the provider as needed (for initial cases, renewals or changes) but at a minimum: a.) 15 calendar days from the referral? b.) If SC did not receive a copy of the Request for Prior Authorization within 35 calendar days of referral; contacted the provider again to ensure the request has been sent to the Prior Authorization Unit? c.) If a notice of decision has not been received 15 days after the date the provider said they submitted it, or a call from the PAL has not been received, did SC contacted the provider?	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Document: EPSDT CMIS Service Log BHSF-PF-05-002 & Appendix T-2 **Resource:** EPSDT SC Handbook page 28-35
7.SC **documented contacts with the PAL** as needed or at a minimum: a.) Sent the "Referral to Medicaid PAL" form BHSF-PF-03-015 if the provider had not sent in a Prior Authorization Packet within 35 days of the referral to the provider? b.) SC has not received a decision within 60 days of the POC completion date? c.) Alert the PAL to a participant's change in provider? d.) Alert the PAL that a renewal/approval has not been received and the previous PA has expired? e.). Alert the PAL if a provider is not providing services as prior authorized in the POC and the problem cannot be resolved? f.) Alert the PAL & DHH promptly if they could not find a provider to submit a PA request, or if the provider could not find a worker. g.) SC received phone call from the PAL requesting additional documentation for a PA request? If yes, did SC assist in assembling the information?	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Appendix S (prior to LSCIS =BHSF-PF-03-015), PAL Referrals Appendix T-3 **Resource:** EPSDT SC Handbook page 31-35

h.) If a notice of Insufficient Documentation was received by SC, did SC respond with documentation requested or notify the PAL of an appointment scheduled to get documentation?	☐	☐	☐	
REQUIREMENT	**Response**			**Document, Resource & Satisfaction**
8. Services that were deemed needed were obtained within 60 days from the date of the request? For initials or new services unless the family declined the service(s). (Request = date of actual request OR date of CPOC).	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Appendix S (prior to LSCIS =BHSF-PF-03-015) Appendix T3 **Resource:** EPSDT SC Handbook page 31-35 **Satisfaction Survey (SS):** Cross reference with #5 EPSDT Satisfaction Survey. **If checked NO on the SS Page 1,#5 Initiate a Referral to PAL Form HSS-CM-05f.** **If checked NO on G 8 of this form Initiate a Referral to PAL Form HSS-CM-05f.**
9.SC reported all decisions that had not been received for any prior authorized Medicaid service 60 days following the POC, selection of the service provider or renewal request, the participant's name and the type of service to DHH for the EPSDT Quarterly Report?	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** CPOC Appendix O, S, T3, Prior Authorization Tracking Log BHSF-PF-03-014, EPSDT CMIS Service Log BHSF-PF-05-002 **Resource:** EPSDT SC Handbook page 27-35 **If checked NO on G9 of this form Initiate a Referral to PAL Form HSS-CM-05f.**
10. Was there a final determination on all requests for services on the CPOC by prior authorization of the services or by a determination that the service was not medically necessary or is not coverable by Medicaid?	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document:** Prior Authorization Tracking Log BHSF-PF-03-014, Appendix O, R 1-4, S,Q, T2, T3, Y, L **Resource:** EPSDT SC Handbook 28-37, Appeals 37-41 **If checked NO on G10 of this form Initiate a Referral to PAL Form HSS-CM-05f.**
REQUIREMENT	**Response**			**COMMENTS**
H. EPSDT OTHER	**Y**	**N**	**N A**	
1. SC assists in planning & obtaining services for the participant (age 201/2 years old during the period covered by the CPOC) before and after they age out of EPSDT.	☐	☐	☐	**Comment:** Refer to Surveyor Worksheet (807) **Document: Appendix O/LSCIS (CPOC),** EPSDT Quarterly Review checklist & Progress Summary **Resource:** EPSDT SC Handbook page 42-44
Surveyor Name:				**Field Office:**
Surveyor Signature:				**Date:**

HEALTH STANDARDS EPSDT PARTICIPANT SATISFACTION SURVEY

Participant's name: _____
Caregiver's name: _____
Agency name: _____
Support Coordinator's name: _____
Participant's Region: _____
In person_____ Telephone_____ (check one)

REQUIREMENT	RESPONSE			COMMENT
1. Were you involved in the planning and development of the Plan of Care (CPOC)?	YES	NO	NA	
2. SC explained and suggested EPSDT services/Medicaid services for Children including the following: ➢ if answered No look in SC case record				
a. Scheduling assistance				
b. Referrals				
c. KIDMED visits (Interperiodic screens)				
d. Personal care services				
e. Extended home health service				
f. Medical equipment and supplies				
g. Psychological services				
h. Behavioral services				
i. Mental health services				
3. Are you able to get to your medical appointments?				
4. Did the SC establish what services were needed? ➢ if no ask what service and then look at the POC				
5. Were the services that were deemed needed obtained within a reasonable period of time from the date of the request? (unless family declined the service) ➢ for initials or new services				
6. Did the SC review the following at the intake meeting/ annual CPOC meeting:				
a. Support Coordination Responsibilities				
b. Right and Responsibilities				
c. HIPAA and Confidentiality				
d. Availability of formal and non-				

HEALTH STANDARDS EPSDT PARTICIPANT SATISFACTION SURVEY

formal services ➢ formal: paid service ➢ non-formal: unpaid service				
e. Complaint process for filing a report against support coordinators and/or providers. ➢ contacting HS				
f. Did your SC inform you of the State wide Toll Free Complaint Line (1-800-660-0488)? ➢ Contacting HSS				
g. Review of the Medicaid Services Chart				
h. Did your SC inform you of the agency's toll-free, 24-hour telephone number ➢ ability to reach someone in an emergency? ➢ Were calls to this number if any returned within 1 working day?				
7. Did the SC give the participant the EPSDT Case Management Recipient/Family Survey? ➢ SRI form				
8. Does your SC contact you monthly and ask if services are being provided as needed? ➢ if no check SC records				
9. Are you satisfied with your current services?				

Additional Comments:

Surveyor's name: _____ **Field Office:** _____

Surveyor's Signature: _____ **Date:** _____

Health Standards Support Coordination Monitoring

ON-SITE SURVEY REFERRAL TO PAL

Survey #	
Agency Name:	**Region #**
Support Coordinator Name:	**Date of Referral**
Recipient Name:	**MID#**

Documentation Issue

1). Surveyor has identified that the Documentation in the file indicates needed services **were not obtained, prior authorized, or identified** (unless the family declined the service or did not follow through with steps needed to obtain the services)? List service(s) not obtained:

_____

_____

a).Why have **needed services not been obtained?**

b).What steps have been taken to insure the **needed services** are provided?

c). Referral to PAL:

- ☐ **On -Site Referral To PAL Form (HSS-CM-05f) completed, and faxed to:**
- ☐ **WAC Headquarters at (225) 376-4687 and to**
- ☐ **DHH Legal at (225) 342-2232.**
- ☐ **After faxing form, Include the Original On-Site Referral To PAL Form in Survey Packet**

Surveyor Name Signature:	Date:
Support Coordinator Name Signature:	Date:

HSS SO Sharepoint Site

HSS Forms

WAIVER PROGRAM FORMS/Family Support Services

New Document | Upload Document | Up | New Folder | Filter | Edit in Datasheet

Type	Name	Modified	Modified By	Checked Out To
	HSS-FM-02	8/23/2007 10:43 AM	Margie Huguet	
	HSS-FM-03 Licensing Survey Report Form	8/23/2007 10:47 AM	Margie Huguet	

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

HEALTH STANDARDS
SURVEY TRACKING FORM

LOUISIANA
Department of HEALTH and HOSPITALS

FAMILY SUPPORT & SERVICES

SECTION I

A. PROVIDER NAME :	**B. PROVIDER NUMBER:**
C. SURVEY DATE: ___/___/___	**D. TEAM LEADER OF SURVEY:**
E. DATE SENT TO STATE OFFICE: ___/___/___	**F. FIELD OFFICE:** _____

SECTION II

SURVEY TYPE: (Please check all that apply)

☐ **Complaint #**_____ ☐ **Complaint generated from licensing Survey**

☐ **Licensing:** ☐ **Initial** ☐ **Annual** ☐ **Follow Up**

SECTION III

Surveyor / Team Recommendations

A. NOT IN SUBSTANTIAL COMPLIANCE	**B. SUBSTANTIAL COMPLIANCE**
☐ **No License**	☐ **All Deficiencies Cleared**
☐ **Provisional License**	☐ **No Deficiencies**
☐ **License Revocation**	☐ **Standard Deficiencies**
	☐ **Provider Notified -Letter mailed** ___/___/___
	☐ **Other** _____

****** FOR STATE OFFICE USE ONLY ********

Date Received by State Office: ____/____/____

Provider Notified-Date: ____/____/____

SECTION IV
** - IF APPLICABLE*

INITIAL LICENSING SURVEY

____ *LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ *HSS-ALL-01- IDENTIFIER LIST*
____ *HSS-FM-03 LICENSING SURVEY REPORT FORM (2 pages)*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ **HSS-PLO1- LETTER*
____ *HSS 1513L – DISCLOSURE OF OWNERSHIP*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*
____ *STATE FIRE MARSHAL*

ANNUAL LICENSING SURVEY

____ *LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ *HSS-ALL-01- IDENTIFIER LIST*
____ *HSS-FM-03 LICENSING SURVEY REPORT FORM (2 pages)*
____ *HSS CM-04 RECIPIENT HOME VISIT & INTERVIEW SURVEY FORM*
____ *HSS-CM-07 CONSENT FOR HOME VISIT*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ **HSS-PLO1- LETTER WITH HSS 30a AND 30b NOTIFICATION FOR POC AND IDR PROCESS*
____ *HSS 1513L – DISCLOSURE OF OWNERSHIP*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*
____ *STATE FIRE MARSHAL*

MAIL/ON-SITE FOLLOW-UP

___ *HSS-ALL-01- IDENTIFIER LIST*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ **LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ **LIC 2 STATE FORM - POST LICENSING AND SURVEY SUMMARY (LIC Revisit Form)*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-PL-14- LETTER*
____ **HSS-PL-15- LETTER*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*

COMPLAINT SURVEY

____ *HSS-CM-01- COMPLAINT NARRATIVE COVER SHEET (ACO)*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ **LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ *HSS-ALL-01- IDENTIFIER LIST*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ **HSS-PLO3- LETTER*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*

SURVEYOR SIGNATURE:

_____

EMPLOYEE FORWARDING TO STATE OFFICE SIGNATURE:

_____

DEPARTMENT OF HEALTH & HOSPTIALS
HEALTH STANDARDS SECTION (HSS)
FAMILY SUPPORT SERVICES – LICENSING SURVEY REPORT

AGENCY INFORMATION

Name:		**Field Office:**
Telephone:	**License#:**	**State ID#:**
Geographical Address:		
Mailing Address:		
Authorized Representative:		**Title:**

SURVEY INFORMATION

Type: ____ Initial ____ Standard for Participation (SFP) ____ Annual ____ Follow-up

____ Complaint ____ Other: _____

Survey Date ____/____/____
(exit date)

Deficiencies Written: ____Yes – LIC ____Yes – 2567 ____ No
(write any remarks/comments on CMS-807-surveyor notes and submit with this form)

Citations (reference section#): _____

_____

_____

Significant Findings (reference section#): _____

_____

_____

SURVEYOR/TEAM RECOMMENDATIONS

____ No License ____Provisional License ____License Revocation ____Full License ____Medicaid Enrollment

Surveyor Signature: _____ Date: _____

Surveyor Signature: _____ Date: _____

FAMILY SUPPORT SERVICES

Compliance with Licensing and Standards for Participation (SFP)

For Initial Surveys: 1st determine if the requirements that are typed in BOLD below are met. Bold areas must be met for initials.
For Annual Surveys: Proceed to review all requirements that are listed below.

SECTION	CATEGORY Licensing Standards	MET	NOT MET	N/A	SECTION	CATEGORY Medicaid Standards for Participation (SFP) (LAC 50:XXI Chapter 1; Subpart 1)	MET	NOT MET	N/A
0.14	General Responsibilities Facility Accessibility				**101 A – L**	**STANDARDS FOR PARTICIPATION**			
30.1 – 30.41	Core Standards				(A)	Provider requirements			
30.2 – 30.3.11	**Advisory Board/Governing Body**				(B)	General Provisions			
30.4	**Accessibility of Executive**				(C)	Physical Facility & Equipment			
30.5	**Authority to Operate**				(D)	Provider Training			
30.6	**Administrative File**				(E)	Personnel/Human Resources/ Staff			
30.7 – 30.9	Agency Org. Communication				1	Program Director Requirements			
30.10 – 30.12	**Accounting & Fiscal Accountability**				2	DSP Staff Requirements			
30.13 – 30.19	**Confidentiality & Security of Files**				3	Policies & Procedures & Back Up Staff			
30.20 – 30.24.7	**Records (Administrative & Client)**				4	QA/QI Plan (approved plan)			
30.25 – 30.25.5	Program Description				5	Submit QA/QI Plan to OAAS or OCDD			
30.28 – 30.29	Transportation				6	Billing			
30.30	External Professional Services				(F)	Licensing Documentation Reqs.			
30.31 – 30.34	Staff Plan Recruitment				(G)	Fiscal Accountability			
30.35 – 30.37	**Orientation & Training**				(H)	Records & Documentation			
30.38	Evaluation				(I)	Discharges & Transfers			
30.39 – 30.40	**Personnel Practices**				(J)	Emergency Situations/Emergency Preparedness Plan			
30.41	**Abuse Reporting**				(K)	Recipient Rights			
32.1.1 – 32.10	Family Support Additional Requirements				(L)	Agreement with Case Management			
32.1.1 – 32.2.5	**Program Purpose**								
32.3.0 – 23.6.3	**Eligibility**								
32.7 – 32.10	Time Limitations								

Surveyor Name:	Field Office:	Date:

HSS SO Sharepoint Site

HSS Forms

WAIVER PROGRAM FORMS/Personal Care Attendant

Select a View

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New Document | Upload Document | Up | New Folder | Filter | Edit in Datasheet

Type	Name	Modified	Modified By	Checked Out To
	HSS-PC-02 Survey Tracking Form	7/13/2009 10:29 AM	Becky Blair	
	HSS-PC-03 Licensing Survey Report Form	5/18/2009 8:05 AM	Margie Huguet	

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

HEALTH STANDARDS
SURVEY TRACKING FORM

LOUISIANA
Department of HEALTH and HOSPITALS

PERSONAL CARE ATTENDANT

SECTION I

A. PROVIDER NAME :	B. PROVIDER NUMBER:
C. SURVEY DATE: ___/___/___	D. TEAM LEADER OF SURVEY:
E. DATE SENT TO STATE OFFICE: ___/___/___	F. FIELD OFFICE: _____

SECTION II

SURVEY TYPE: (Please check all that apply)

☐ Complaint #_____ ☐ Complaint generated from licensing Survey

☐ Licensing: ☐ Initial ☐ Annual ☐ Follow Up

SECTION III

Surveyor / Team Recommendations

A. NOT IN SUBSTANTIAL COMPLIANCE	B. SUBSTANTIAL COMPLIANCE
☐ No License	☐ All Deficiencies Cleared
☐ Provisional License	☐ No Deficiencies
☐ License Revocation	☐ Standard Deficiencies
	☐ Provider Notified -Letter mailed ___/___/___
	☐ Other _____

**** FOR STATE OFFICE USE ONLY ******

Date Received by State Office: ____/____/____

Provider Notified-Date: ____/____/____

SECTION IV
** - IF APPLICABLE*

INITIAL LICENSING SURVEY

____ *LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ *HSS-ALL-01- IDENTIFIER LIST*
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____ **HSS-PLO1- LETTER*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*
____ *HSS 1513L – DISCLOSURE OF OWNERSHIP*
____ *STATE FIRE MARSHAL*

ANNUAL LICENSING SURVEY

____ *LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ *HSS-ALL-01- IDENTIFIER LIST*
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____ *HSS-CM-07 CONSENT FOR HOME VISIT*
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____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ **HSS-PLO1- LETTER WITH HSS 30a & 30b NOTIFICATION FOR POC AND IDR PROCESS*
____ *HSS 1513L – DISCLOSURE OF OWNERSHIP*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*
____ *STATE FIRE MARSHAL*

MAIL/ON-SITE FOLLOW-UP

____ *HSS-ALL-01- IDENTIFIER LIST*
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____ **HSS-PL-15- LETTER*
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COMPLAINT SURVEY

____ *HSS-CM-01- COMPLAINT NARRATIVE COVER SHEET (ACO)*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
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____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ *HSS-ALL-01- IDENTIFIER LIST*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ **HSS-PLO3- LETTER*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*

SURVEYOR SIGNATURE: _____

EMPLOYEE FORWARDING TO STATE OFFICE SIGNATURE: _____

DEPARTMENT OF HEALTH & HOSPTIALS
HEALTH STANDARDS SECTION (HSS)
PERSONAL CARE ATTENDANT – LICENSING SURVEY REPORT

AGENCY INFORMATION

Name:		**Field Office:**
Telephone:	**License#:**	**State ID#:**
Geographical Address:		
Mailing Address:		
Authorized Representative:		**Title:**

SURVEY INFORMATION

Type: ____ Initial ____ Standard for Participation (SFP) ____ Annual ____ Follow-up

____ Complaint ____ Other: _____

Survey Date ____/____/____
(exit date)

Deficiencies Written: ____Yes – LIC ____Yes – 2567 ____ No
(write any remarks/comments on CMS-807-surveyor notes and submit with this form)

Citations (reference section#): _____

_____

_____

Significant Findings (reference section#): _____

_____

_____

SURVEYOR/TEAM RECOMMENDATIONS

____ No License ____Provisional License ____License Revocation ____Full License ____Medicaid Enrollment

Surveyor Signature: _____ Date: _____

Surveyor Signature: _____ Date: _____

PERSONAL CARE ATTENDANT

Compliance with Licensing and Standards for Participation (SFP)

For Initial and Annual Surveys: Review all requirements listed below in the Licensing Standards and the Medicaid Standards for Participation. Determine if each category is MET or NOT MET. Long Term-Personal Care Services (LT-PCS) requires Licensing Surveys only. The Medicaid Standards for Participation are not applicable to the LT-PCS program.

SECTION	CATEGORY	MET	NOT MET	N/A	SECTION	CATEGORY	MET	NOT MET	N/A
	LICENSING STANDARDS				7772	Required Staffing			
7701	Personal Care/Additional Reqs.				7773	Evaluation			
7703. A.1-2	Care Planning				7775	Personnel Practices			
7705 A-E	Qualifications of Team Members				7777	Abuse Reporting			
7707 A-C	Personal Care Basic Activities				7779-7785	Basic Client Rights			
7709 A-F	Initial Application Process								
7711 A-G	Surveys				**101 A – L**	**MEDICAID STANDARDS FOR PARTICIPATION (SFP) (LAC 50:XXI Chapter 1; Subpart 1)**			
7713 A-G	Issuance of a License				(A)	Provider requirements			
7729 A-E	Construct/Renovation/Conversion				(B)	General Provisions			
7735	General Requirements				(C)	Physical Facility & Equipment			
7736 A-C	Operational Requirements				(D)	Provider Training			
7737-7739	Advisory Board/Governing Body				(E)	Personnel/Human Resources/ Staff			
7741	Accessibility of Executive				1	Program Director Requirements			
7743	Authority to Operate				2	DSP Staff Requirements			
7745. A-A.9	Administrative File				3	Policies/Procedures/Back Up Staff			
7747 A-C	Agency Org. Communication				4	QA/QI Plan (approved plan)			
7749 A-C	Accounting/Fiscal Accountability				5	Submit QA/QI Plan to OAAS or OCDD			
7751 A-G	Confidentiality & Security of Files				6	Billing			
7753 A-E.7	Records (Administrative/Clients)				(F)	Licensing Documentation Reqs.			
7755 A-C	Program Description				(G)	Fiscal Accountability			
7757 A-B	Transportation				(H)	Records & Documentation			
7759 A	External Professional Services				(I)	Discharges & Transfers			
7761	Personnel Practice				(J)	Emergency Situations/Emergency Preparedness Plan			
7763-7767	Staff Plan (Recruitment/Screening)				(K)	Recipient Rights			
7769-7771	Orientation & Training				(L)	Agreement with Case Management			

Surveyor Name:	Field Office:	Date:

HSS SO Sharepoint Site

HSS Forms

WAIVER PROGRAM FORMS/Respite Care CBR

Select a View

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Actions

- Alert me
- Export to spreadsheet
- Modify settings and columns

New Document | Upload Document | Up | New Folder | Filter | Edit in Datasheet

Type	Name	Modified	Modified By	Checked Out To
	HSS-RP-02	8/23/2007 10:45 AM	Margie Huguet	
	HSS-RP-03 Licensing Survey Report Form	8/23/2007 10:49 AM	Margie Huguet	

Being Revised

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

HEALTH STANDARDS
SURVEY TRACKING FORM

LOUISIANA
Department of HEALTH and HOSPITALS

RESPITE/CENTER BASED RESPITE (CBR)

SECTION I

A. PROVIDER NAME :	B. PROVIDER NUMBER:
C. SURVEY DATE: ___/___/___	D. TEAM LEADER OF SURVEY:
E. DATE SENT TO STATE OFFICE: ___/___/___	F. FIELD OFFICE: _____

SECTION II

SURVEY TYPE: (Please check all survey types that apply and circle the appropriate provider type – Respite or CBR)

☐ Complaint #_____ ☐ Complaint generated from licensing Survey

☐ Licensing ☐ Annual (Respite or CBR)

☐ Initial (Respite or CBR) ☐ Follow Up (Respite or CBR)

SECTION III

Surveyor / Team Recommendations

A. NOT IN SUBSTANTIAL COMPLIANCE	B. SUBSTANTIAL COMPLIANCE
☐ No License	☐ All Deficiencies Cleared
☐ Provisional License	☐ Full License
☐ License Revocation	☐ No Deficiencies
	☐ Standard Deficiencies
	☐ Provider Notified -Letter mailed ___/___/___
	☐ Other _____

**** FOR STATE OFFICE USE ONLY ******

Date Received by State Office: ____/____/____

Provider Notified-Date: ____/____/____

SECTION IV

* - *IF APPLICABLE*

INITIAL LICENSING SURVEY

____ *LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ *HSS-RP-03 LICENSING SURVEY REPORT FORM (2 pages)*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ *HSS-ALL-01- IDENTIFIER LIST*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ **HSS-PLO1- LETTER*
____ *HSS 1513L – DISCLOSURE OF OWNERSHIP*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*
____ **STATE FIRE MARSHAL APPROVAL FOR RESPITE AND CBR*
____ **OFFICE OF PUBLIC HEALTH APPROVAL FOR CBR*

ANNUAL LICENSING SURVEY

____ *LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ *HSS-RP-03 LICENSING SURVEY REPORT FORM (2 pages)*
____ *HSS CM-04 RECIPIENT HOME VISIT & INTERVIEW SURVEY FORM*
____ *HSS-CM-07 CONSENT FOR HOME VISIT*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ *HSS-ALL-01- IDENTIFIER LIST*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ **HSS-PLO1- LETTER WITH HSS 30a and 30b NOTIFICATION FOR POC AND IDR PROCESS*
____ *HSS 1513L – DISCLOSURE OF OWNERSHIP*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*
____ **STATE FIRE MARSHAL APPROVAL*
____ **OFFICE OF PUBLIC HEALTH APPROVAL FOR CBR*

MAIL/ON-SITE FOLLOW-UP

____ *HSS-ALL-01- IDENTIFIER LIST*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ **LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ **LIC 2 STATE FORM - POST LICENSING AND SURVEY SUMMARY (LIC Revisit Form)*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-PL-14- LETTER*
____ **HSS-PL-15- LETTER*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*

COMPLAINT SURVEY

____ *HSS-CM-01- COMPLAINT NARRATIVE COVER SHEET (ACO)*
____ *STATE 670- SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ **LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ *HSS-ALL-01- IDENTIFIER LIST*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ **HSS-PLO3- LETTER*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*

SURVEYOR SIGNATURE: _____

EMPLOYEE FORWARDING TO STATE OFFICE SIGNATURE: _____

DEPARTMENT OF HEALTH & HOSPTIALS
HEALTH STANDARDS SECTION (HSS)
RESPITE CARE/CBR – LICENSING SURVEY REPORT

AGENCY INFORMATION

Name:		**Field Office:**
Telephone:	**License#:**	**State ID#:**
Geographical Address:		
Mailing Address:		
Authorized Representative:		**Title:**

SURVEY INFORMATION

Type: ____ Initial ____ Standard for Participation (SFP) ____ Annual ____ Follow-up

____ Complaint ____ Other: _____

Survey Date ____/____/____
(exit date)

Deficiencies Written: ____Yes – LIC ____Yes – 2567 ____No
(write any remarks/comments on CMS-807-surveyor notes and submit with this form)

Citations (reference section#): _____

_____

_____

Significant Findings (reference section#): _____

_____

_____

SURVEYOR/TEAM RECOMMENDATIONS

____ No License ____Provisional License ____License Revocation ____Full License ____Medicaid Enrollment

Surveyor Signature: _____ Date: _____

Surveyor Signature: _____ Date: _____

RESPITE CARE/CBR

Compliance with Licensing and Standards for Participation (SFP)

For Initial Surveys: 1st determine if the requirements that are typed in BOLD below are met. Bold areas must be met for initials.
For Annual Surveys: Proceed to review all requirements that are listed below.

SECTION	CATEGORY Licensing Standards	MET	NOT MET	N/A	SECTION	CATEGORY Medicaid Standards for Participation (SFP) (LAC 50:XXI Chapter 1; Subpart 1)	MET	NOT MET	N/A
0.14	General Responsibilities Facility Accessibility				101 A – L	STANDARDS FOR PARTICIPATION			
30.1 – 30.41	Core Standards				(A)	Provider requirements			
30.2 – 30.3.11	**Advisory Board/Governing Body**				(B)	General Provisions			
30.4	**Accessibility of Executive**				(C)	Physical Facility & Equipment			
30.5	**Authority to Operate**				(D)	Provider Training			
30.6	**Administrative File**				(E)	Personnel/Human Resources/ Staff			
30.7 – 30.9	Agency Org. Communication				1	Program Director Requirements			
30.10 – 30.12	**Accounting & Fiscal Accountability**				2	DSP Staff Requirements			
30.13 – 30.19	**Confidentiality & Security of Files**				3	Policies & Procedures & Back Up Staff			
30.20 – 30.24.7	**Records (Administrative & Client)**				4	QA/QI Plan (approved plan)			
30.25 – 30.25.5	Program Description				5	Submit QA/QI Plan to OAAS or OCDD			
30.28 – 30.29	Transportation				6	Billing			
30.30	External Professional Services				(F)	Licensing Documentation Reqs.			
30.31 – 30.34	Staff Plan Recruitment				(G)	Fiscal Accountability			
30.35 – 30.37	**Orientation & Training**				(H)	Records & Documentation			
30.38	Evaluation				(I)	Discharges & Transfers			
30.39 – 30.40	**Personnel Practices**				(J)	Emergency Situations/Emergency Preparedness Plan			
30.41	**Abuse Reporting**				(K)	Recipient Rights			
34.1.1 – 34.16.1	**Respite/CBR Additional Requirements (Reqs.)**				(L)	Agreement with Case Management			
34.1.1 – 34.1.2	**Service Plan**								
34.2 – 34.10.1	**Daily Aspects of Care/Healthcare**								
34.11 – 34.11.9	**Safeguards**								
34.12 – 34.16.1	**CBR Facility Requirements**								

Surveyor Name: | Field Office: | Date:

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

HEALTH STANDARDS
SURVEY TRACKING FORM

SUPERVISED INDEPENDENT LIVING

SECTION I

A. PROVIDER NAME :	B. PROVIDER NUMBER:
C. SURVEY DATE: ___/___/___	D. TEAM LEADER OF SURVEY:
E. DATE SENT TO STATE OFFICE: ___/___/___	F. FIELD OFFICE: _____

SECTION II

SURVEY TYPE: (Please check all that apply)

☐ Complaint #_____ ☐ Complaint generated from Licensing Survey

☐ Licensing: ☐ Initial ☐ Annual ☐ Follow Up

SECTION III

Surveyor / Team Recommendations

A. NOT IN SUBSTANTIAL COMPLIANCE	B. SUBSTANTIAL COMPLIANCE
☐ No License	☐ All Deficiencies cleared
☐ Provisional License	☐ Full License
☐ License Revocation	☐ No Deficiencies
	☐ Standard Deficiencies
	☐ Provider Notified -Letter mailed ___/___/___
	☐ Other _____

****** FOR STATE OFFICE USE ONLY ********

Date Received by State Office: ____ / ____ / ____

Provider Notified-Date: ____/____/____

SECTION IV
** - IF APPLICABLE*

INITIAL LICENSING SURVEY

____ *LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ *HSS-SL-03 LICENSING SURVEY REPORT FORM (2 pages)*
____ *STATE 670 - SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ *HSS-ALL-01- IDENTIFIER LIST*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ **HSS-PLO1- LETTER*
____ *HSS 1513L – DISCLOSURE OF OWNERSHIP*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*
____ *STATE FIRE MARSHAL APPROVAL (SIL FACILITY)*

ANNUAL LICENSING SURVEY

____ *LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES (ACO)*
____ *HSS-SL-03 LICENSING SURVEY REPORT FORM (2 pages)*
____ *HSS CM-04 RECIPIENT HOME VISIT & INTERVIEW SURVEY FORM*
____ *HSS-CM-07 CONSENT FOR HOME VISIT*
____ *STATE 670 - SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT*
____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ *HSS-ALL-01- IDENTIFIER LIST*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ **HSS-PLO1- LETTER*
____ *HSS 1513L – DISCLOSURE OF OWNERSHIP*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*
____ *MEDICAID STANDARDS FOR PARTICIPATION CHECKLIST (19 pages)*
____ **STATE FIRE MARSHAL APPROVAL (SIL FACILITY)*

MAIL/ON-SITE FOLLOW-UP

____ *HSS-ALL-01- IDENTIFIER LIST*
____ *STATE 670 - SURVEY TEAM COMPOSITION/WORKLOAD REPORT (ACO)*
____ **CMS 807 – SURVEYOR NOTES WORKSHEETS*
____ **LIC 1 STATE FORM - STATEMENT OF DEFICIENCIES*
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____ *HSS-ALL-13- EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT (LIC Revisit Form)*
____ **HSS-PL-14- LETTER*
____ **HSS-PL-15- LETTER*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*

COMPLAINT SURVEY

____ *HSS-CM-01- COMPLAINT NARRATIVE COVER SHEET*
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____ **HSS-ALL-04- SIGNIFICANT FINDINGS FORM*
____ **HSS-PLO3- LETTER*
____ **HSS-ALL-34 IJ NOTIFICATION FORM*

SURVEYOR SIGNATURE:

_____

EMPLOYEE FORWARDING TO STATE OFFICE SIGNATURE:

_____

HSS SO Sharepoint Site

HSS Forms

WAIVER PROGRAM FORMS/Supervised Independent Living

Select a View

All Documents

Explorer View

Actions

- Alert me
- Export to spreadsheet
- Modify settings and columns

New Document | Upload Document | Up | New Folder | Filter | Edit in Datasheet

Type	Name	Modified	Modified By	Checked Out To
	HSS-SL-02 Survey Tracking Form	1/8/2010 1:01 PM	Suzelle Coward	
	HSS-SL-03 Licensing Survey Report Form	5/18/2009 8:16 AM	Margie Huguet	

Being Revised

DEPARTMENT OF HEALTH & HOSPTIALS
HEALTH STANDARDS SECTION (HSS)
SUPERVISED INDEPENDENT LIVING LICENSING SURVEY REPORT

AGENCY INFORMATION

Name:		**Field Office:**
Telephone:	**License#:**	**State ID#:**
Geographical Address:		
Mailing Address:		
Authorized Representative:		**Title:**

SURVEY INFORMATION

Type: ____ Initial ____ Standard for Participation (SFP) ____ Annual ____ Follow-up

____ Complaint ____ Other: _____

Survey Date ____/____/____
(exit date)

Deficiencies Written: ____Yes – LIC ____Yes – 2567 ____ No
(write any remarks/comments on CMS-807-surveyor notes and submit with this form)

Citations (reference section#): _____

_____

_____

Significant Findings (reference section#): _____

_____

_____

SURVEYOR/TEAM RECOMMENDATIONS

____ No License ____Provisional License ____License Revocation ____Full License ____Medicaid Enrollment

Surveyor Signature: _____ Date: _____

Surveyor Signature: _____ Date: _____

SUPERVISED INDEPENDENT LIVING

Compliance with Licensing and Standards for Participation (SFP)

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22.1 – 24.12	Core Standards				(A)	Provider requirements			
22.1 – 22.2.11	**Advisory Board/Governing Body**				(B)	General Provisions			
22.3	**Accessibility of Executive**				(C)	Physical Facility & Equipment			
22.2 – 22.4.1	**Authority to Operate**				(D)	Provider Training			
22.19 – 22.19.9	**Administrative File**				(E)	Personnel/Human Resources/ Staff			
22.40 - 22.42	Agency Org. & Staff Communication				1	Program Director Requirements			
22.6 - 22.8	**Accounting**				2	DSP Staff Requirements			
22.12 – 22.18	**Confidentiality & Security of Files**				3	Policies & Procedures & Back Up Staff			
22.9 – 22.11	**Records: Administrative**				4	QA/QI Plan (approved plan)			
22.20 – 22.24	**Records: Client**				5	Submit QA/QI Plan to OAAS or OCDD			
22.5 – 22.5.7	Program Description				6	Billing			
22.25 – 22.25.1	Transportation				(F)	Licensing Documentation Reqs.			
22.36 – 22.38	Numbers & Qualifications of Staff				(G)	Fiscal Accountability			
22.39	External Professional Services				(H)	Records & Documentation			
22.26 – 22.29	Staff Plan Recruitment				(I)	Discharges & Transfers			
22.30.1 – 22.33	**Orientation & Training**				(J)	Emergency Situations/Emergency Preparedness Plan			
22.33	Evaluation				(K)	Recipient Rights			
22.34 – 22.35	**Personnel Practices**				(L)	Agreement with Case Management			
23.9 – 23.93	**Abuse Reporting**								
23.1	**SIL Care Additional Reqs.**								
23.1 – 23.11	**SIL Living/Physical Environment**								
24.7 – 24.12	**Service**								
22.36 – 22.39	**Numbers & Qualifications of Team Members**								
24.1 – 24.6.5	**Direct Services**								

Surveyor Name:	Field Office:	Date: