COMMONWEALTH of VIRGINIA

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MEMORANDUM

To: DBHDS Licensed Providers of Developmental Services
From: Jae Benz, Director, Office of Licensing
Cc: Veronica Davis, Associate Director for State Licensure Operations
Mackenzie Glassco, Associate Director of Quality & Compliance

Date: January 5, 2023; Revised 1/17/23
Re: Annual Inspections for Providers of Developmental Services

Purpose: The purpose of this memo is to remind providers of developmental services that, as is customary, the annual unannounced inspections begin again at the start of each calendar year. In January 2020, the Office of Licensing began sharing a checklist of the minimum requirements licensing specialists review during a provider's annual inspection as well as what document the LS will look at to determine compliance.

In accordance with V.G.3 of the Settlement Agreement, the Commonwealth is tasked with ensuring the licensing process assesses the adequacy of supports and services provided to individuals with developmental disabilities receiving services licensed by DBHDS. The Office of Licensing is also tasked with monitoring providers' compliance with the Rules and Regulations for Licensing Providers. This involves monitoring the adequacy of individualized supports delivered by each provider. The Office of Licensing developed a crosswalk that ties the eight domains outlined in the Settlement Agreement to specific Licensing Regulations. All of the regulations listed in the checklist are checked during the annual inspection. In addition, the licensing specialist will be reviewing any regulations cited since the last annual inspection to ensure implementation of the corrective action plans in accordance with 12VAC35-105-170.G, 12VAC35-105-170.H and 12VAC35-105-620.C.4.

At each annual inspection, the licensing specialist reviews a sample of individual records to ensure individuals being served are receiving services consistent with their assessed needs and their agreed upon service plan. If a review uncovers a provider is not meeting an individual's needs, the appropriate regulation is cited. A provider is required to submit and implement a corrective action plan for each violation cited including a detailed description of the corrective actions to be taken to correct the specific deficiencies identified for individuals whose records were reviewed; that will minimize the possibility the violation will occur again and will correct any systemic deficiencies.

Included in this memo is a revised annual inspection chart for 2023 which incorporates feedback from providers as well as the Independent Reviewer. The chart outlines the minimum regulations that will be reviewed, the documents that will be viewed to determine compliance, and whether the documents will need to be submitted via the CONNECT provider portal or viewed onsite during the inspection. Please read this document carefully and provide all included information when requested by your licensing specialist.

As part of the annual inspection process, the specialist will conduct a brief 30-minute exit meeting with the provider. This meeting time will be scheduled at the beginning of the inspection to allow the provider ample time to make arrangements. The exit meeting should be attended by the person responsible for oversight of the implementation of the pledged corrective action. The specialist will outline the preliminary findings from the inspection including areas of non-compliance. The provider will be given the opportunity to ask questions and provide additional information, as appropriate. A provider may choose to decline an exit meeting. If a provider does not respond to a request for an exit meeting or declines the opportunity to participate in the meeting, the specialist will note this and proceed with closing out the inspection or issuing citations for any regulatory violations, if indicated.

In order to support providers in achieving and maintaining compliance with the Licensing Regulations, the Office of Licensing has offered training opportunities over the past few years as well as posted a significant number of power points, guidance documents and samples. Please take this opportunity to visit the Office of Licensing Webpage to review these materials if you have not already done so.

If you have any questions related to the content of this memorandum, please do not hesitate to reach out directly to your licensing specialist. For additional information related to the Settlement Agreement please visit the DBHDS DOJ Settlement Agreement webpage.

Regulation Number	Documents Used to Determine Compliance	Submit via CONNECT Or Review on-site
12VAC35-105-160.C	Last **two** quarterly reviews of all serious incidents including Level I, Level II and Level III incidents. • Must include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents If the provider does not have any Level I, II, or III serious incidents to review during the last two quarters, the provider must look back to 1/1/2021 to see if they had any serious incidents and provide the quarterly review for those.	Submit via CONNECT portal
12VAC35-105-160.D.2	Provider does not need to submit Level II or Level III serious incidents for review because the Licensing Specialist (LS) will review progress notes, quarterly reviews and ISPs and ensure anything that meets the criteria for a serious incident was reported. The LS will use the Death and Serious Incident by Type and Status report for a list of all reported incidents. Note: The Incident Management Unit (IMU) monitors reporting of serious incidents each business day. Please review Guidance for Serious Incident Reporting and the Guidance on Incident Reporting Requirements In addition, if, during an annual inspection or an investigation, the LS identifies serious incidents that should have been reported, but were not reported at all, or that were not reported within 24 hours of discovery and for which a licensing report has not already been issued, then the LS will issue a licensing report for late reporting.	LS will review on-site
12VAC35-105-160.E.1.a-c	Two most recent root cause analyses for Level II and Level III serious incidents that occurred during the provision of a service or on the provider's premises. Updated Crosswalk of DBHDS Approved Risk Management Training (August 2022)	LS will review on-site
12VAC35-105-160.E.2.a-d	Root cause analysis policy; and A root cause analysis completed as a result of a threshold being met, if applicable.	LS will review on-site
12VAC35-105-160.J	Serious incident management policy.	LS will review on-site
12VAC35-105-170.G	Evidence that any CAPs from past year were implemented.	LS will review on-site
12VAC35-105-170.H	Evidence that any CAPs from the past year were implemented in accordance with what is written in provider's QI Plan to monitor implementation and effectiveness of approved corrective action plans. Proof that CAP(s) were updated in accordance with 170.H.1 if the CAP was not effective; or	LS will review on-site

	Proof of submission of a revised corrective action plan submitted to LS if the CAP was not effective.	
12VAC35-105-280.A-J	Review of physical environment requirements	
12VAC35-105-410	Review of two employee records **and** the job description for the employee responsible for the risk management function; and Job Description for each employee with all required components outlines in A.1-A.4.	LS will review on-site
12VAC35-105-420. Qualifications of employees or contractors.	Proof of staff's education, training, and experience consistent with job description (transcript, resume, etc.); and Proof of DHP qualifications for staff, as appropriate.	LS will review on-site
12VAC35-105-430. Employee or contractor personnel records.	At least two employee records.	LS will review on-site
12VAC35-105-440	Evidence of orientation for new employees, contractors, volunteers, and students with the completion date.	LS will review on-site
12VAC35-105-450	For DSPs, the completed DMAS DSP Assurance form and a copy of the DSP orientation test. For supervisors, the completed DMAS Supervisor Assurance form and copy of the certificate of completion. Training policy; and Training records for employees being reviewed.	LS will review on-site
12VAC35-105-520.A Must be reviewed for all services **including** case management	Name of the person responsible for the risk management function. Job description for this employee must reflect that all or part their responsibilities include those of the risk management function. A completed (signed and dated) DBHDS Risk Management Attestation. Updated Risk Management Attestation Form (August 2022) For ALL topic areas listed in the chart, please select the name(s) of the completed DBHDS approved training(s) for each training topic area and document the date of completion for each training. Only training outlined in the DBHDS Crosswalk of Approved Training meets these requirements. Updated Crosswalk of DBHDS Approved Risk Management Training (August 2022)	Submit all via CONNECT Portal to include: Copy of Attestation and job description
12VAC35-105-520.B	Risk management plan. As required by 12VAC35-105-620, a provider's risk management plan may be a standalone risk management plan or it may be integrated into the provider's overall quality improvement plan. Risk management plans and overall risk management programs should reflect the size of the organization, the population served, and any unique risks associated with the provider's business model.	Submit via CONNECT Portal

12VAC35-105-520.C.1-5	**If a provider has not served any individuals, they would still need to complete this. Things to consider may be privacy (PHI), training for staff, emergency management protocols etc.** Annual Risk assessment review completed within the past 365 days. This review should include consideration of harms and risks identified and lessons learned from the provider's quarterly reviews of all serious incidents conducted pursuant to 12VAC35-105-160.C., including an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents. Any updates, as appropriate, made since the last review as a result of the provider identifying new risk areas that could result in the risk of harm to individuals receiving services. An example may be new risk areas identified as part of the quarterly review of serious incidents that were not already covered and how the provider plans to respond to serious incidents. SAMPLE Systemic Risk Assessment	Submit via CONNECT Portal
12VAC35-105-520.D	Proof the systemic risk assessment process incorporates uniform risk triggers and thresholds as defined by the department. As presented during trainings, DBHDS has defined risk triggers and thresholds as care concerns which are identified through the IMUs review of serious incident reporting. Therefore, if a provider has not had any care concerns, their systemic risk assessment review process would still need to outline how they would address care concerns if they were to occur. Providers will be able to generate CHRIS reports on incidents that have been identified as Care Concern Thresholds. Providers may access the *Provider Excel Individual Care Concern Threshold LSA notification* to see a list of individuals who have met the Care Concern Thresholds. Case Managers can run the *Excel-CM report Care Concern Threshold LSA notification* to see a report of any individual served by them regardless of provider. These reports are found in CHRIS under Individual Care Concern.	Submit via CONNECT Portal
12VAC35-105-520.E	Evidence of annual safety inspection of all licensed locations for this service; and Documentation of implementation of any annual safety inspection recommendations.	LS will review on-site
12VAC35-105-610	Proof of participation in community activities in accordance with the individual's ISP. This applies to residential and day support services. If providers have not had the opportunity to participate in community activities due to COVID, there must be documentation of alternatives provided to individuals based on individuals' preferences and identified needs	LS will review on-site
12VAC35-105-620.A	Current QI policies and procedures (that demonstrate provider has a program). A quality improvement (QI) program is the structure used to implement quality improvement efforts. The structure of the program shall be documented in the provider's policies.	Submit via CONNECT Portal

12VAC35-105-620.B	Current QI policies and procedures (that demonstrate provider has a program); and Evidence of the utilization of quality improvement tools, ex. completed root cause analysis (RCA), Plan Do Check Act (PDCA).	Submit via CONNECT Portal
12VAC35-105-620.C.1 - 5	Current quality improvement plan. 12VAC35-105-20 defines a quality improvement plan as "a detailed work plan developed by provider that defines steps the provider will take to review the quality of services it provides and to manage initiatives to improve quality. A quality improvement plan consists of systematic and continuous actions that lead to measurable improvement in the services, supports, and health status of the individuals receiving services." When assessing compliance, the licensing specialist will review the QI plan to ensure that it contains each of the elements specified in C.1 -C.5; and that the provider has evidence of implementing each element. This may include: Documentation of - the annual review; - specification of measurable goals and objectives, including evidence of regular monitoring of goals and actions taken when goals have not been met; - inclusion of reporting on statewide reporting measures (memo from the Office of Developmental Services regarding specific expectations and time frame for implementation will be sent separately) - evidence of monitoring the implementation and effectiveness of corrective actions (if applicable)	Submit via CONNECT Portal
12VAC35-105-620.D 1-3	QI policies and procedures responsive to regulatory requirements. Please review December 2021 training on Quality Improvement, Risk Management, and Root Cause Analysis: RM-QI-RCA Compliance Webinar December 2021 Providers need to explain when they will establish or update goals/objectives. For example, when a goal has been met, when the goal has been assessed as not effective to meet the needs etc.	Submit via CONNECT Portal
12VAC35-105-620.E	QI Plan; and Proof that input was requested from individuals/AR and documentation of implemented improvements made as a result of analysis.	LS will review on-site
12VAC35-105-645.B.1-5	Last two completed screening forms completed by providers regardless of whether or not the individuals were admitted.	LS will review on-site
12VAC35-105-660.D (all of it)	Informed choice form for annual ISP development; ISP meeting notes with essential components discussed in D.1.a-c; For changes made to the ISP (part V) there should **be documentation at the provider level that regulatory requirements for D.3 were met (notes, attached to ISP etc.); and** Signature sheet for ISP.	LS will review on-site
12VAC35-105-665.A.6	Parts I-V of ISP including safety plan and falls risk plan.	LS will review on-site

12VAC35-105-665.A.7	If individual is open to REACH, provide a copy of the crisis, education and prevention plan, which should also be included in the ISP (part V); and If CM service, then provide the most recent Crisis Risk Assessment (CAT) with recommendation.	LS will review on-site
12VAC35-105-665.D	Most recent proof of DD competency completed; and Proof staff trained on individual's ISP, including health and safety protocols, for those individuals reviewed.	LS will review on-site
12VAC35-105-675.A	Last annual reassessment dated within past year; and Re-assessments completed as a result of changes in status.	LS will review on-site
12VAC35-105-675.B	Any changes to ISP as a result of assessments.	LS will review on-site
12VAC35-105-675.C	Most recent ISP; and ISP updates within past year based on assessments or change in status.	LS will review on-site
12VAC35-105-675.D (all of it)	Last 2 quarterlies signed or noted that consent was given (due to COVID).	LS will review on-site
12VAC35-105-680	Past three months of progress notes or other documentation for the individuals being reviewed.	LS will review on-site
12VAC35-105-693.C	Last discharge summary with official discharge date from service; and Proof of referrals made prior to discharge date.	LS will review on-site
12VAC35-105-780.5	Documentation that medication errors have been reviewed quarterly (last two quarters); If there are medication errors, provide QI Plan that demonstrates how this is being addressed; and Data (meeting minutes) that shows provider is reviewing trends or looking at effectiveness of QI initiative if there is one.	LS will review on-site
12VAC35-105-810	Behavior plan; Assessment the plan was based on; Name/qualifications of person responsible for developing, implementing and monitoring plan; Proof of OHR approval for any restrictions; Proof of monitoring of plan (data); and Documentation that shows who is monitoring the plan and their qualifications.	LS will review on-site
12VAC35-105-1240.1	Community integration goals should be identified in ISP; and Documentation of provision of the opportunities and individual's response.	LS will review on-site
12VAC35-105-1240.2	Last 3 months of case management notes; and Documentation of contacts made to significant others.	LS will review on-site

12VAC35-105-1240.4	Last three months of case management notes; Documentation showing individual linked to supports consistent with the ISP; and Documentation that the case manager located, developed, or obtained needed services.	LS will review on-site
12VAC35-105-1240.5	Documentation showing the individual was assisted with locating, developing or obtaining needed services and/or public benefits.	LS will review on-site
12VAC35-105-1240.6	Documentation of coordination with other agencies and providers in accordance with ISP.	LS will review on-site
12VAC35-105-1240.7	Last three months of case management notes; Proof that individual received case management every 90 days in person for TCM; or Proof individual received ECM every 30 days (10 day grace period) for ECM and every other month must be in the home.	LS will review on-site
12VAC35-105-1240.11	Last three months of case management notes showing monitoring of individual's conditions and medication and accessing medical services.	LS will review on-site
12VAC35-105-1240.12	the Virginia Informed Choice form, does it reflect that the services offered align with individual's needs and preferences	LS will review on-site
12VAC35-105-1245	Clear documentation that at each face to face meeting the CM is documenting that all expectations are being completed; and Clear documentation of how this regulation is being met during COVID.	LS will review on-site
12VAC35-105-1255	Written policy describing how individuals are assigned case managers and how they can request a change of their assigned case manager.	LS will review on-site