Residential Habilitation - Standard

- iBudget Handbook -

Residential Habilitation service provides supervision and specific training activities that assist the person to acquire, maintain, or improve skills related to activities of daily living. The service focuses on personal hygiene skills, such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming, and laundry; and social and adaptive skills that enable the person to reside in the community.

This training is to be provided in accordance with a formal Implementation Plan, developed by the provider with direction from the person, and reflects the person's goals from the current Support Plan.

This service is provided primarily in a licensed residential facility. However, some activities associated with daily living that generally take place in the community (e.g., grocery shopping, banking, or working on social and adaptive skills) are included in the scope of service.

iBudget Handbook Effective Date: 6/10/18 (2-47)

Service Specific Record Review – Residential Habilitation (Standard)

#	Performance Measure/Standard	Protocol	Not Met Reasons

1	The provider maintains Daily Attendance Logs covering services provided and billed during the period under review.	CMS Assurance – Financial Accountability
		iBudget Handbook – June 2018
		Pages 1-5, A-4
		COMPLIANCE
		
		Review Daily Attendance Logs for the entire period of review.
		• Daily Attendance Logs must contain:
		  ○ Name of person receiving services
		  ○ Name of the service provider
		  ○ Dates of service
		
		Note: "Time period" is not a required component on Daily Attendance Logs for Residential Habilitation.
		
		Determine if Daily Attendance Logs match claims data to ensure accuracy in billing.
		• For each month claims data indicates provider billed a monthly rate:
		  ○ Monthly rate can only be used when the person is present 24 days or more.
		  ○ Review Daily Attendance Logs to determine the person was present for at least 24 days.
		  ○ Confirm monthly rate billed is correct
		• For each month claims data indicates provider billed a daily rate:
		  ○ Daily rate must be used when person is present 23 days or less in the month.
		  ○ Review Daily Attendance Logs to determine number of days the person was present each month the daily rate was billed.
		  ○ Refer to the current APD Rate Table to locate the correct daily rate based on the approved monthly rate.
		  ○ Service dates on the Daily Attendance Logs should
			1) Daily Attendance Logs were not present for some/all dates of service for which claims were submitted. (B)
			2) Daily Attendance Logs did not include the name of the person receiving services. (B)
			3) Daily Attendance Logs did not include the dates of service. (B)
			4) Provider documentation demonstrated the provider billed the monthly rate when less than 24 days of service were rendered. (B)
			5) Discrepancies were noted between units billed and services documented. (B)

#	Performance Measure/Standard	Protocol	Not Met Reasons

		match service dates in claims data. The provider may opt to bill the day rate multiplied by the total number of days present as one unit at the end of the month.
		• Exception to billing daily vs. monthly rate:
		  ○ Providers billing the RH live-in rate (Procedure Code H0043UCSC) bill by the day up to 365 days a year.
		  ○ The APD Regional Office can approve Residential Habilitation daily services for individuals residing in licensed foster or group homes with no more than three individuals living in the home.
		
		This standard is subject to identification of a potential billing discrepancy	

2	The Implementation Plan covering services provided and billed during the period under review is in the record.	CMS Assurance – Financial Accountability
		iBudget Handbook – June 2018
		Pages 1-7, A-4
		COMPLIANCE
		
		Review record to determine if there is an Implementation Plan present covering the entire period of review (this may require review of 2 Implementation Plans).
		• Implementation Plan must be developed, at a minimum, within 30 days of the initiation of the new service, or within 30 days of receipt of the support plan for continuation of services and annually thereafter.
		• Ask the provider to describe method of documenting receipt of Support Plans from WSCs.
		  ○ Determine date provider received the Support Plan from the WSC.
		  ○ Determine date Implementation Plan was developed.
		  ➢ **Provider is responsible for documenting the date the Support Plan was received from the WSC and/or efforts to obtain.**
			1) Implementation Plan was not in the record for some or all of the period of review. (B)
			2) Implementation Plan was not developed within 30 days following the initiation of the new service. (B)
			3) Implementation Plan was not developed within 30 days of receipt of the Support Plan from the WSC. (B)
			4) Provider documentation does not demonstrate date the support plan was received from WSC. (B)

#	Performance Measure/Standard	Protocol	Not Met Reasons
		Exception: When the support plan is received more than 30 days prior to the Support Plan effective date the following may apply -Implementation plan must be developed no later than 30 days prior to the SP effective date or within 30 days of receipt of the Support Plan, which ever date is later. Example: SP effective 10/1 • SP received 7/15 – develop IP no later than 9/1 (30 days prior to SP effective date) • SP received 8/15 – develop IP no later than 9/14 (within 30 days of receipt) • SP received 9/15 – develop IP no later than 10/15 (within 30 days of receipt). **This standard is subject to identification of a potential billing discrepancy**	
3	The current Implementation Plan covering services provided and billed during the period under review contains all required components.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Pages 1-7, A-4 COMPLIANCE NOTE: For the purposes of this standard, only the "current Implementation Plan" will be reviewed. This is defined as the Implementation Plan associated with the Support Plan in effect at the time of the record review. Review the current Support Plan to determine the goals/outcomes to be addressed by Residential Habilitation - Standard. Review the current Implementation Plan to determine minimum content is included: ○ Name of person receiving services	1) Current Implementation Plan was not in the record. 2) Current Implementation Plan did not include the name of the person served. 3) Current Implementation Plan did not include one or more. goal(s)/outcomes from the Support Plan the service will address. 4) Current Implementation Plan did not include the methods employed to assist the person in meeting the Support Plan goal(s)/outcomes. 5) The methods identified on the current Implementation Plan did not relate to the Support Plan goals/outcomes. 6) Current Implementation Plan did not identify the systems to be used for data

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		○ Goal(s)/outcomes from the current Support Plan the service will address ○ Methods employed to assist the person in meeting the support plan goal(s)/outcomes ○ The methods employed should vary based on the nature of the goal(s)/outcome(s), person's preferences and according to the person's learning style i.e. hand over hand, verbal prompt, simulations, role play, step by step instructions, demonstration, repetition. ○ System to be used for data collection and assessment of the person's progress in achieving the Support Plan goal(s)/outcomes ○ Data collection systems and assessment of progress toward Support Plan goals/outcomes should vary based on the nature of the goal(s)/outcome(s) and be consistent with methods. Examples may include but not be limited to data collection sheets, skill acquisition forms, progress notes. ○ Signature of the recipient Review current Implementation Plan to determine if changes or updates were completed prior to initiating.	collection and assessment of the person's progress in achieving the Support Plan goal(s)/outcomes. 7) Current Implementation Plan was not signed by the recipient/legal representative. 8) Current Implementation Plan was not updated prior to initiating identified changes.
4	Provider documentation demonstrates the Implementation Plan is being followed as written.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Pages 2-47, A-4 COMPLIANCE Review record for Implementation Plans covering the period of review. • Determine if provider documentation demonstrates identified methods employed to assist the person in	1) Implementation Plan was not in the record. 2) Provider documentation demonstrated one or more goal(s)/outcomes from the Support Plan were not being addressed. 3) Provider documentation did not demonstrate methods identified to assist the person to meet Support Plan goals/outcomes were being followed.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		meeting the Support Plan goal(s)/outcomes are being followed. ○ Refer back to Implementation Pan(s) for specific methods. • Determine if provider documentation demonstrates system to be used for data collection/assessment of progress is being followed. ○ Refer back to Implementation Plan for specific data collection/assessment systems. • Review documentation to determine if updates were made to the Implementation Plan during the Support Plan year. ○ If so, determine if ongoing service documentation demonstrates identified changes.	4) Provider documentation did not demonstrate systems to be used for data collection/assessment of progress were being followed. 5) Provider documentation did not demonstrate change when modifications were made to the implementation plan.
5	A copy of the Implementation Plan is provided to the person and when applicable, the legal representative, within required 30-day time frame.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Page A-4 COMPLIANCE NOTE: For the purposes of this standard, only the "current Implementation Plan" will be reviewed. This is defined as the Implementation Plan associated with the Support Plan in effect at the time of the record review. Ask the provider to describe method of documenting how and when the Implementation Plan has been provided to the person and when applicable, the legal representative. • Review record for documentation supporting stated method. • Determine the date a copy of the Implementation Plan was provided to the person and when applicable, the legal representative. • The Implementation Plan must be developed within 30 days of receipt of the Support Plan or initiation of a new	1) Provider documentation did not demonstrate a copy of the Implementation Plan was provided to the person. 2) Provider documentation did not demonstrate a copy of the Implementation Plan was provided to the legal representative. 3) Provider documentation demonstrated a copy of the Implementation Plan was provided to the person but not within the 30-day timeframe. 4) Provider documentation demonstrated a copy of the Implementation Plan was provided to the legal representative but not within the 30-day timeframe.

Service Specific Record Review – Residential Habilitation (Standard)

#	Performance Measure/Standard	Protocol	Not Met Reasons
		service. (See "Exception" in protocol on standard #2) • A copy of the Implementation Plan, signed by the person, must be furnished to the person and when applicable the person's legal representative at the end of this 30-day period	

6	A Quarterly Summary covering services provided and billed during the period under review is in the record.	CMS Assurance – Financial Accountability
		iBudget Handbook – June 2018
		Pages 1-9, A-2, A-4
		COMPLIANCE
		
		The quarterly time period begins on the effective date of the Support Plan.
		
		Refer to Support Plan to determine the goals/outcomes addressed by RH-Standard
		
		Determine Support Plan effective date to determine Quarterly Summary timeframes.
		• Determine if provider completes Monthly rather than Quarterly Summaries.
		  ○ Monthly Summaries in lieu of Quarterly Summaries are acceptable.
		• Review each Quarterly (Monthly) Summary within the review period to ensure minimum content is included.
		  ○ Description of the person's progress, or lack thereof, toward achieving each of the goals/outcomes identified on the Support Plan specific to RH-Standard.
		  ○ Description of the activities that took place during each quarter (month) of the Support Plan year that services were rendered.
		
		*Description of activities that took place during each quarter (month) of the Support Plan year for Residential Habilitation -
			1) Quarterly/Monthly Summaries were not in the record.
			2) One or more Quarterly/Monthly Summaries were not in the record.
			3) Quarterly/Monthly Summaries were present but were not reflective of progress toward one or more Support Plan goals/outcomes.
			4) Quarterly/Monthly Summaries were present but did not include a description of activities that took place during each quarter/month.
			5) Quarterly Summaries were completed but were not aligned with the Support Plan effective date.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		Standard will vary by person and could include but not be limited to social activities, special events, medical appointments, hospitalizations, medication changes, Support Plan meetings, Implementation Plan meetings, family activities/visits, celebrating achievement of a significant milestone, updates on any unresolved issues reported on a previous quarterly, etc. If the provider was not providing services at the time the last Quarterly (Monthly) Summary was due, score as N/A.	

7	The Annual Report covering services provided and billed during the period under review is in the record.	CMS Assurance – Financial Accountability
		iBudget Handbook – June 2018
		Pages 1-3, A-4
		COMPLIANCE
		
		Review record to determine if there is an Annual Report present covering the entire period of review (this may require review of 2 Annual Reports).
		
		Review record to determine Support Plan effective date.
		• Determine if the Annual Report is a component of the Third Quarterly Summary, Ninth Monthly Summary (for those completing Monthly Summaries) or a separate document (which is acceptable).
		  ○ The Third Quarterly Summary or Ninth Monthly Summary may serve as the Annual Report when a summary of the previous three quarters (nine months) is included.
		• Determine date Annual Report was completed and provided to the Support Coordinator.
		  ○ Annual Report must be completed and provided to the Support Coordinator at least 60 days prior to
			1) Annual Report was not in the record. (B)
			2) Annual Report was completed, but not at least 60 days prior to the Support Plan effective date. (B)
			3) Annual Report was present but did not indicate a date of completion. (B)

#	Performance Measure/Standard	Protocol	Not Met Reasons
		the Support Plan effective date. If the provider rendered services to the person for less than 12 months, the Annual Report would cover all months since services were initiated. If provider was not providing services to the person at the time the last Annual Report was due, score as N/A. **This standard is subject to identification of a potential billing discrepancy**	
8	The Annual Report covering services provided and billed during the period under review contains all required components.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Pages 1-3, A-4 COMPLIANCE Refer to Support Plan to determine the goals/outcomes addressed by RH-Standard Review record to determine Support Plan effective date. • Determine if the Annual Report is a component of the Third Quarterly Summary, Ninth Monthly Summary (for those completing Monthly Summaries) or a separate document (which is acceptable). ○ The Third Quarterly Summary or Ninth Monthly Summary may serve as the Annual Report when a summary of the previous three quarters (nine months) is included. • Review Annual Report for a summary of the first three quarters (or nine months) of the Support Plan year which must include: ○ Description of the person's progress, or lack thereof, towards achieving personally determined	1) Current Annual Report was not in the record. 2) Current Annual Report did not include a summary of the previous three quarters (nine months) of the Support Plan year. 3) Current Annual Report did not contain a summary of the person's progress toward achieving one or more personally determined goals/outcomes on the Support Plan. 4) Current Annual Report did not contain any pertinent information about significant events that occurred in the person's life during the previous year.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		goals/outcomes identified on the Support Plan specific to the service rendered. ○ Any pertinent information about significant events that occurred in the person's life during the previous year. *Examples of "any pertinent information about significant events that occurred in the person's life during the previous year" will vary by person and could include but not be limited to major milestone achieved, significant event in the person's personal or social life that may have influenced daily activities positive or negatively, significant health event (hospitalization, surgery, injury or improvement in health), change in residence/roommate, etc. If a provider has rendered services to the person for less than 12 months, the Annual Report, would cover all months since services were initiated If the provider was not providing services to the person at the time the last Annual Report was due, score as N/A.	
9	The provider maintains Service Authorization(s) covering services provided and billed during the period under review.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Pages 1-10, 3-4, 3-5 COMPLIANCE Service Authorizations are provided quarterly or more frequently as changes dictate. Review the Service Authorizations for Residential Habilitation (Standard) and ensure: ○ The Service Authorizations are available to cover all services provided and billed during the period under review;	1) Service Authorizations were not present in the record. 2) One or more Service Authorizations were not present in the record. 3) One or more Service Authorizations were not in approved status. 4) One or more Service Authorizations did not indicate the correct rate.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		○ The Service Authorizations are in approved status; ○ The Service Authorizations indicate the correct rate (Correct RH-Standard rate, geographic, non-geographic, Monroe County rates) (agency vs. solo, ratio for RH live-In only). ❖ Refer to the current APD Provider Rate Table as needed. WSCs **and** service providers must verify the Service Authorizations are correct based on the amount, duration, frequency, intensity and scope authorized for the service in the iBudget system. If corrections are needed the service provider should immediately contact the WSC for resolution. ○ Consider provider's documented due diligence in securing corrected Service Authorizations when incorrect Service Authorizations are received or updates are in process.	
10	The provider is in compliance with billing procedures and the Medicaid Waiver Services Agreement.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Current APD Provider rate table Pages 2-47, 2-48, 2-49 COMPLIANCE Determine if services are being provided in accordance with the Handbook. Provider bills the appropriate rate: • Non-Geographical, Geographical, Monroe Co. rates • Correct RH-Standard Rate (Level) • Solo vs. Agency (Applies to Daily Live-in rate only) • An agency or group provider for rate purposes is a provider that has two or more employees to carry out the enrolled service(s). A provider that hires only	1) Provider documentation demonstrated the provider is a solo but billed the agency rate. (B) 2) Provider documentation demonstrated the provider is not considered an agency for rate purposes but billed the agency rate. (B) 3) Provider documentation demonstrated provider billed the geographic rate for services rendered in a non-geographic area. (B) 4) Provider documentation demonstrated provider billed the Monroe County rate for services not rendered in Monroe County. (B) 5) Provider documentation demonstrated

#	Performance Measure/Standard	Protocol	Not Met Reasons
		subcontractors to perform waiver services is not considered an agency provider for rate purposes. ○ Determine if provider has at least two employees to carry out the enrolled service(s). If necessary, ask to see the W9 or W4 forms. Review Claims data to determine rate billed ❖ Refer to the current APD Provider rate table as needed. • Compare Service Authorizations with claims data to determine if provider bills at the proper rate and limits. • Determine through record review and staff/person interview if person is in the process of transitioning to Supported Living and working with a Supported Living Coach. ➢ If so, review the person's claims for SLC services billed to determine if in excess of 90 days. ➢ Review claims data using the person's Medicaid number, not the agency provider ID, as the SLC chosen might be a different agency/provider. • Review provider records for Service Authorizations, Daily Attendance Logs, Implementation Plans, Quarterly/Monthly Summaries, Annual Report and/or other provider documentation to assist in determining if the provider is in compliance with billing procedures and the Medicaid Waiver Services Agreement. **This standard is subject to identification of a potential billing discrepancy**	receipt of Residential Habilitation and Supported Living Coaching beyond 90 days. (B) 6) Service is not being rendered and/or billed in accordance with the Handbook. (B)
11	Provider bills for services only after services are rendered.	CMS Assurance – Financial Accountability iBudget Handbook – June 2018 Pages 2-49, 3-2	1) Provider billed the monthly rate prior to the person being present 24 days. 2) Provider billed the day rate prior to

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		COMPLIANCE
		
		Provider is not to bill for services prior to rendering.
		• Review Claims data to determine if provider billed a monthly or daily rate for services rendered.
		• Compare Daily Attendance Logs for each day/month in the review period against date billed in claims data.
		  ○ If provider billed the monthly rate:
		  – Review Daily Attendance Logs to determine the person was present for at least 24 days
		  – Determine the date of the 24th day the person was present.
		  – Compare that date to date billed in claims to determine if the provider billed prior to the person being present at least 24 days.
		  ○ If provider billed the daily rate, confirm each date was not billed until after the service was rendered.
			rendering services on one or more dates during the period under review.

12	The provider documents ongoing efforts to address the person's choices and preferences.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Pages 2-8, F.A.C. 65G-2 COMPLIANCE Ask the provider to describe method of soliciting and documenting the person's choices and preferences related to implementing this service on an ongoing basis. • Review record for documentation supporting stated method of soliciting and addressing person's choices and preferences on an ongoing basis. • Review Quarterly/Monthly Summaries, Implementation Plans, Annual Report and/or other provider documentation to assist in determining if the person's choices and preferences are being identified and match provider	1) Provider documentation did not demonstrate efforts to learn about the person's choices and preferences. 2) Provider documentation did not demonstrate ongoing efforts to address the person's identified choices and preferences.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		activities on an ongoing basis. • If available, refer to the Support Plan as a reference document to determine if person's choices and preferences are identified and match provider activities.	
13	The provider documents ongoing efforts to assist the person to increase community participation and involvement based on his/her interests.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Pages 2-47, 2-48, F.A.C. 65G-2 PERSON CENTERED PRACTICE Ask the provider to describe method of soliciting and documenting the person's interests regarding community participation and involvement on an ongoing basis. • Review record for documentation supporting method of soliciting and addressing person's interests regarding community participation and involvement on an ongoing basis. • Review Daily Attendance Logs, Implementation Plans, Quarterly/Monthly Summaries, Annual Report and other available provider documentation to assist in determining: o If interests in community participation and involvement are solicited on an ongoing basis. o Identified interests are being addressed. o If available, refer to the Support Plan as a reference document to determine if person's community interests are identified and match provider activities.	1) Provider documentation did not demonstrate efforts to learn about the person's interest related to community participation and involvement. 2) Provider documentation did not demonstrate ongoing efforts to increase the person's community participation and involvement.
14	The provider documents ongoing efforts to assist the person/legal representative to know about rights.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Pages B-7, F.A.C. 65G-2, Chapter 393 Florida Statute PERSON CENTERED PRACTICE Ask the provider to describe method of assisting person and when applicable the legal representatives to know about their rights and responsibilities as related to this service on an	1) Provider documentation did not demonstrate efforts to assist the person/legal representative to know about rights. 2) Provider documentation demonstrated efforts to assist the person/legal representative to know about rights but

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		ongoing basis. • Review provider documentation supporting stated methods for provider efforts to assist the person/legal representative to know about rights on an ongoing basis. • Review available Daily Attendance Logs, Quarterly/Monthly Summaries, Annual Report, Implementation Plan and/or other provider documentation demonstrating efforts to support the person, and when applicable the legal representative to know about rights. *Examples of efforts to assist the person/legal representative to know about rights will vary per person and frequency of service. Information could include, but not be limited to identification of rights most important to the person, access to personal possessions, fair wages, voting, freedom from discrimination, specific rights restrictions identified on a behavior plan, education on Informed Consent, confidentiality, voting, privacy, religion, freedom from harm, self-determination, etc.	not on an ongoing basis.
15	The provider documents ongoing efforts to ensure the person's behavioral/emotional health needs are addressed.	CMS Assurance – Health and Welfare iBudget Handbook – June 2018 Pages 2-7, 2-10, 2-45, 2-56 PERSON CENTERED PRACTICE Ask the provider to describe method used to gain and document knowledge of person's behavioral/emotional health information relevant to the service provided. • Ask the provider how information related to behavioral/emotional health is maintained and updated on an ongoing basis. • Review record for documentation supporting stated method. • Supporting documentation may be found in Daily	1) Provider documentation did not demonstrate efforts to gather information about the person's behavioral/emotional health needs. 2) Provider documentation demonstrated knowledge of the person's behavioral/emotional health needs but not ongoing efforts to address identified needs. 3) Key and critical behavioral/emotional health information was absent from the record.

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		Attendance Logs, Quarterly/Monthly Summaries, Annual Report, Implementation Plans, intake forms, stand-alone forms, and other available provider documentation. • Based on review of the current Support Plan and provider documentation, there are no behavioral/emotional health concerns indicated, score N/A. *Key/critical behavioral/emotional health information will vary by person and could include, but not be limited to diagnosis, certain environmental factors, medication and related information, Behavior Plans, Baker Acts, Police involvement, Safety Plans, emotional well-being (stress, anxiety, depression, grief, other emotional issues, or diagnosis) and any other information critical to the behavioral/emotional health of the person relevant to the service being provided.	
16	The provider documents ongoing efforts to ensure the person's health and health care needs are addressed.	CMS Assurance – Health and Welfare iBudget Handbook – June 2018 Pages 2-7, 2-10, 2-45 PERSON CENTERED PRACTICE Health and health care needs could include but not be limited to, medical conditions, medications (prescription and over-the-counter), preventive healthcare, wellness exams, therapeutic intervention, medical device/apparatus. Ask the provider to describe method used to gather and document knowledge of person's health and health care needs. • Ask the provider how this information is maintained and updated on an ongoing basis. • Review record for documentation supporting stated method. • Review record for documentation supporting provider	1) Provider documentation did not demonstrate efforts to gather information about the person's health and health care needs. 2) Provider documentation demonstrated knowledge of the person's health and health care needs but not ongoing efforts to address identified needs. 3) Key and critical health and/or healthcare needs have not been addressed.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		efforts to learn about and solicit information regarding the person's health and health care needs; steps taken to address the person's needs. ○ For example scheduled medical appointments, provided education, and procured medical services/devices. • Review the record for documentation related to routine and preventive medical and dental care. • Review Daily Attendance Logs, Implementation Plans, Quarterly/Monthly Summaries, Annual Report and any other available provider documentation for evidence the provider identifies and addresses the person's health and healthcare needs on a routine basis. *Key/Critical health and health care information will vary by person, and could include, but not be limited to diagnosis, certain environmental factors, medications and related information, required follow-up with specialists, food allergies, dietary needs, specialized equipment needs, medical/physical/emotional conditions, and any other information critical to the health and healthcare needs of the person and relevant to the service being provided.	
17	The provider documents ongoing efforts to ensure the person's safety needs are addressed.	CMS Assurance – Health and Welfare iBudget Handbook – June 2018 Pages 2-7, 2-10, 2-45 PERSON CENTERED PRACTICE Ask the provider to describe the method used to gather and document knowledge related to the safety needs of the person. • Ask the provider how this information is maintained and updated on an ongoing basis. • Review record for documentation supporting provider	1) Provider documentation did not demonstrate efforts to assess the person's safety needs. 2) Provider documentation demonstrated knowledge of the person's safety needs but not ongoing efforts to address identified needs. 3) Key and Critical safety needs have not been addressed.

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		efforts to assess the person's safety needs including steps taken to address the person's needs. ○ For example, evaluation/training in areas such as community awareness/safety, home safety, education related to extreme weather events, etc. • Supporting documentation may be found in the Daily Attendance Logs, Implementation Plans, Quarterly/Monthly Summaries, Annual Report and/or any other documented systems used by the provider demonstrating efforts to identify, assess and address safety needs of the person. • If available, refer to the current Support Plan and if applicable Behavior Plan as an additional resource. Key/Critical safety information will vary by person, and could include, but not be limited to needed safety skills, adaptive equipment/needed repairs, environmental modification needs, situational or environmental factors related to safety in the home and community, disaster preparedness planning and preparation, or other items critical to the safety needs of the person and relevant to the service being provided.	
18	Provider documents ongoing efforts to assist the person to define abuse, neglect, and exploitation including how the person would report any incidents.	CMS Assurance - Health and Welfare iBudget Handbook – June 2018 Pages 1-11, 1-12, B-7, 393 F.S PERSON CENTERED PRACTICE Ask the Provider to describe method used to gather and document efforts to assist the person to define abuse, neglect and exploitation. • Review the record for documentation demonstrating **individualized efforts** to support the person to recognize and know how to report abuse, neglect and/or exploitation (Call Abuse Hotline, tell WSC, Police, Family, etc.) on an	1) Provider documentation did not demonstrate individualized efforts to provide education to the person in the area of abuse, neglect, and exploitation 2) Provider documentation demonstrated individualized efforts to provide education to the person in the area of abuse, neglect, and exploitation but not on an ongoing basis. 3) Provider documentation did not demonstrate individualized efforts to assist the person to define abuse,

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		ongoing basis. • Supporting documentation may include intake forms, Implementation Plan, Quarterly/Monthly Summaries, Annual Reports, evidence of customized training techniques used to support people with different learning styles and levels of understanding, documentation training sessions (individual or group) indicating specific scenarios reviewed and feedback received or other available documented systems used by the provider demonstrating efforts to assist the person to define and report abuse, neglect and exploitation	neglect, and/or exploitation. 4) Provider documentation demonstrated individualized efforts to assist the person to define abuse, neglect, and/or exploitation but not on an ongoing basis. 5) Provider documentation did not demonstrate how the person would report any incidents of abuse, neglect, and exploitation.
19	The provider submits documents to the Waiver Support Coordinator as required.	CMS Assurance - Service Plan iBudget Handbook – June 2018 Pages A-2, A-4 COMPLIANCE Ask the provider to describe method used to submit documents to the Waiver Support Coordinator (WSC). • Review available provider documentation for proof of submission to the WSC. • Examples could include fax transmittal reports with cover sheet indicating descriptions of what was faxed, submission tracking logs, date stamps, or indication of date of submission and method sent on the documentation. Items below must be provided to the WSC prior to billing or within 10 days of billing at the latest unless otherwise indicated. ○ If billing more than once a month, information with an asterisk (*) and indicated as "(sent monthly)*" may be submitted to the WSC at the time of the last billing in	1) Provider did not have documented evidence of submitting copies of Daily Attendance Logs. 2) Provider had documented evidence of submitting copies of some but not all Daily Attendance Logs 3) Provider had documented evidence of submitting copies of Daily Attendance Logs but not within 10 days of billing each month. 4) Provider had documented evidence of submitting copies of some but not all Daily Attendance Logs within 10 days of billing each month. 5) Provider did not have documented evidence of submitting a copy of the Implementation Plan. 6) Provider had documented evidence of submitting a copy of Implementation Plan but not within 30 days following receipt of the Support Plan from the WSC 7) Provider had documented evidence of

Service Specific Record Review – Residential Habilitation (Standard)

#	Performance Measure/Standard	Protocol	Not Met Reasons
		the month. The following documentation is required to be provided to the WSC within the timeframes indicated: • Daily Attendance Logs* ○ Monthly within 10 days of billing for the month • Implementation Plan ○ Within 30 days following receipt of the Support Plan from the WSC or initiation of new service. • Quarterly/Monthly Summaries ○ Within 10 days of billing • Annual Report ○ At least 60 days prior to the effective date of the Support Plan.	submitting a copy of the Implementation Plan but not within 30 days following initiation of new service. 8) Provider did not have documented evidence of submitting Quarterly/Monthly Summaries. 9) Provider had documented evidence of submitting some but not all Quarterly/Monthly Summaries. 10) Provider had documented evidence of submitting Quarterly/Monthly Summaries but not within 10 days of billing. 11) Provider had documented evidence of submitting some but not all Quarterly/Monthly Summaries within 10 days of billing. 12) Provider did not have documented evidence of submitting the Annual Report. 13) Provider had documented evidence of submitting the Annual Report but not at least 60 days prior to the Support Plan effective date.