CERTIFICATION REVIEW SAMPLE SIZE WORKSHEET (eff. 1-11-18)

Number of Individuals Receiving Services	Total Sample Size	Core Sample Size	Focused Sample Size	Number of Interviews/Observations	Staff Sample Size
1-2	100%	1	N/A if 1 person in services; 1 if 2 people in services	100% as relevant to focus sample	3
3-8*	50%	50%	50% of total sample	100% of Total Sample Size	3
9-49	4	2	2	100% of Total Sample Size	3
50-100**	10%	3	Remainder of total sample number	100% of core sample, focus sample as relevant (no observation required for a notice of costs for instance)	3
101 - 149 **	10%	4	Remainder of total sample number	Same as above	3
150+ **	10%	6	Remainder of total sample number	Same as above	3

*Round up to the nearest even number

** Calculate 10% and round to the nearest whole #, i.e. 10% of 64 people = 6.4 so sample size is 6; 10% of 65 people is 6.5 so sample size is 7

Agency/Area Program:	**Assigned Certification Lead:** **Sidekick(s):**
Core Sample Size: • At least 50% of the core sample must be full service, if both day and residential services are offered by the provider agency.	**Core Sample Name(s) and Key#(s): (Include Waiver Type & Services Received)** The sample should be representative of the services offered by the agency. The sample must include a file that is representative of any combination of continuous services, and a file that is representative of any combination of intermittent services, if both day and residential services are offered by the agency. 33% of the total sample (core or focus) need to have psychotropic medications taken by the person due to diagnosed mental illness per the 5-1-17 approved waiver. If fewer than 33% of persons in services use psych meds, include 100% of persons using those medications in the total sample size. **#1**

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Focus Sample Size: Select focus sample persons to reflect services offered after the core sample is chosen. If EFH service are offered, include evaluation of these services in the core or focus sample. Any service or regulation may be evaluated using the generic focus review form if there is not a focus review form for that area. If the provider does NOT have any EFH services, please document that on this form. Focus can be determined by previous certification reports or current observations.	**Focus Sample Name(s) and Key#(s): (Include Waiver Type & Services Received)** #

Staff Sample Names Key Letters: (chosen on site)

Hired since last cert visit* and employed at least 180 days:

Staff A:

Staff B:

Staff C:

*if there have not been 3 staff hired since the last visit, substitute other direct care staff to complete the sample

Certification Review Process Guide
TITLE 404 NAC

Division of Public Health – Licensure Unit
Community Based Specialized DD Services Team

July 3, 2019

Certification Review Preparation

Scheduling the On-Site review

The regulations allow for both unannounced and announced surveys.

The lead surveyor may call the provider up to two weeks in advance to confirm exact on-site dates as well as an expected time for the entrance and exit interviews. If a provider indicates they cannot be available or wish to schedule the review for a different time frame, the surveyor should consult with the manager to review the request and determine how to respond.
The lead Surveyor will send the Certification Notice Letter to the provider by email up to two weeks before the on-site review occurs.

Selecting the Core Sample

The lead Surveyor will select a sample of individuals served by the agency for inclusion in the on-site certification review using the "Cert Review Sample Size Worksheet".
The full sample for the survey will consist of:

- Core Sample: Individuals picked ahead of the survey.
- Focused Sample: Individuals chosen on-site based on observations and the need to fully round out the sample for the purpose of applying the regulations.

Surveyors will complete Cert Review Sample Size to guide the size of the sample, the instructions on how to choose the sample are on the guide. The form becomes part of the permanent survey document record.

These steps may be completed by the assigned surveyor prior to going on site:

1) Search and review GERs in Therap and APS reports in NFOCUS for individuals in the core sample for the previous 6 -12 months depending on the individual's particular situation. (I.E. if an individual had a rash of related incidents that spanned a time frame from 5-8 months prior to the review, that would be a relevant time frame to examine).
2) Information and data captured in Therap including the ISP, semi-annual review, and other team meeting notes from the previous year
3) Service Coordination monitoring forms, should be attached to SC case notes in Therap in the Service Coordination account.
4) The provider's recertification application (including updated policies and procedures) from the share drive if it has been submitted. (not due until 90 days prior to certification expiration) Lead surveyor
5) Any alternative compliance requests granted to a specific provider are located on the J drive (J:\DDD\4.2 Survey-Certification\Alternative Compliance) or the Provider Bulletins which would pertain to all providers are on the public website. (http://dhhs.ne.gov/developmental_disabilities/Pages/aDDPBulletins.aspx).

6) Citations issued during the last certification review including the Plan of Improvement (POI) and any POI follow up monitoring documented by the last survey team as well as complaint citations, POI, and POI monitoring since the last certification review.

Link to SharePoint Documents for certification:
(http://dhhsemployees/sites/DD/Community/CentralOffice/Forms/404%20NAC%20Survey%20Forms/Forms/Current%20Documents.aspx)

On-Site Review Activities

The opening meeting or entrance conference

This is an opportunity to meet provider staff who will be supporting activities of the review. The Surveyor will explain the purpose of the certification review and provide a brief overview of the activities, make specific requests for information and documentation, and schedule the administrative review and off-site visits such as residential settings and other work sites. The Surveyor's work space should be confirmed if not already specified.

- Introduce self, side-kick(s)
- Confirm core sample names, make changes if needed due to persons no longer in services, hospitalized, not on psychotropic medications, etc.
- Identify names and titles of those present and other staff you may need to request information from during the review from provider
- Determine what documentation the provider keeps on Therap, what is on paper
- Copier code wireless code
- Request list of staff hired since last cert review who are still with the organization with hire dates and indicate primary staff for individuals in the core sample
- Schedule administrative interview
- Schedule any off site vocational observations and residential visits for core sample
- Request files for complaints/grievances since last cert review from administrator
- Does provider use any subcontract services including EFHs?
- Get names and titles of key provider staff not present for obtaining
    - Financial info
    - HR/personnel/training files
    - Other?
- What time does building close at end of day, what time is someone present in the morning to let us in?
- Tour if needed (where are restrooms, copier)
- Notify SC and SC Supervisor of core sample names and exit date, time, and location.

On Day One, the emphasis should be on observations of those individuals in the core sample and general observations in the program and living areas. Observations will continue throughout the survey but should start shortly after the entrance as they are the first of three steps in surveying. The Surveyor will need to have time for either additional observations, as well as interview and record reviews in follow-up to the observations. The Surveyor should allow for enough time to get a good overview of the services and supports. At a minimum, the Surveyor should spend 30 minutes per observation.

Forms:

Observation/Interview Form for Provider Operated/Controlled Services or Observation/Interview Form for Supported Services.

General Observations:

The purpose of general observations are to see if the staff know the person and what to do to support the person; to determine if the services outlined in the ISP are being implemented, and whether individuals are given the opportunity to exercise choice and as much self-determination and independence as possible.

These observations should take place at both the individuals home and work or programming site based on services the individual receives from the provider being reviewed. They should span morning and evening including work, meals, leisure time and choices, formal and informal training sessions and use of adaptive equipment.

Focus Sample Selection:

Based on the initial general observations, the Surveyors should select the Focus Sample. The goal of adding additional individuals to the sample is to assure that a fair cross representation of the types of services provided is included. Since the sample serves as the means to measure how the provider meets the regulations, the additional Focus Sample members should be added, not as a full survey review, but to supplement the sample and focus on specific areas that are not well represented in the initial core sample. Use Focus Sample forms to guide these observations and to help the surveyor decide who to add to the sample for a focused review.

Observations of Sample Individuals:

Next, surveyors should focus on the individuals in the sample. The focus for these observations should be on implementation of the individuals' ISP.

Interviews:

The purpose of interviews is to determine how the individual/staff perceives the services and supports, clarify information gathered during observations, gather information that is not obtainable by other means and ask about priorities, preferences and perspective. Document your findings from the interviews.

The first interview to be conducted on-site is preferably with the person served. The Surveyor will rephrase interview questions as necessary in an effort to solicit a response that represents the view of the person being interviewed.

The remaining interviews may be scheduled with the direct support staff, service coordinator, day staff, and residential staff.

Guardians/family members should only be interviewed based on guidance from legal. (Chris Ferdico and cc'd to CJ Roberts) 3-1-16 and from CJ Roberts 3-2-16.
Legal guardian of a minor or adult-no release needed.
Per Susan's direction: you may interview legal guardians if helpful during a certification review or investigation after the proper releases are obtained. Also, "One caution on guardians of incapacitated adults, ask to see the letters of guardianship if you don't already have them on file. It's rare but not all guardianships for incapacitated adults include decision making authority for health care…most do but it's best practice to check." (Direction from legal) So if doing an interview with a guardian, actually look at the letter of guardianship.

When a person is their own guardian, you will need a release if you wish to interview advocates or family members.

The interactive administrative interview: (Ended here on 11-15-18)
The interview with the area administrator may involve whomever the area administrator deems is best suited to produce and explain processes and record formats used by the agency. This interview should normally be conducted on the second or third day of the survey, which will allow the lead Surveyor time to complete initial observations and review requested documentation.

The provider must supply documented records as evidence of the implementation of activities and processes discussed if requested by the surveyor. The Surveyors will review the documentation provided prior to the interview to support the responses given and identify additional questions; as documented on Administrative Review Form.

It may be necessary to schedule additional time to complete an administrative review at both the local level and the agency central office if administrative processes are completed locally and then resulting information is forwarded to the agency's central office. The Administrative Interview Form will guide this interview.

File review:
A file review (includes paper and electronic records) will be completed for each individual in the core sample. The purpose is to verify information obtained from observations and interviews, assess if needed revisions to objectives have been made, verify that needed health and safety supports are in place and verify who participates at team meetings. The record review may also include review of program information and financial information when appropriate. A key question to answer is whether

records are consistent with observations and interviews**.** For those individuals who are in the Focused Sample, a complete file review will not be needed. Only those components that are relevant to the focused review should be included.

Staff Sample Review (use survey sample size worksheet to pick staff for review)
For all certification reviews, lead Surveyor will select a staff sample consisting of 3 provider staff – 2 hired since the last certification visit, and 1 new hire employed at least 180 days. If the provider does not have 3 staff members, the sample will consist of all provider staff. If the provider has not hired any new staff in the designated time frames, then select 3 staff at random to complete the review. When possible, the staff selected will ideally be staff who work with someone in the core or focus sample if the above criteria are met.

Exit Conference

1. Prior to the exit conference, the lead surveyor will meet with other surveyors to prepare for the exit conference. Considerations may include the general findings, patterns and trends, any expected difficulties with the exit. The lead surveyor should ensure service coordinators & supervisors have been notified of the time and place of the exit.

2. The exit conference is conducted in person when possible but may include telephone or other distance technology when reasonable. Exit conferences are NOT to be recorded by any means. If a provider insists on recording an exit conference, the lead surveyor will end the review without conducting an exit conference and report the situation to the survey team manager or available administrator as soon as possible.
3. Exit conference attendees would normally include the surveyors involved in the review, service coordinators and/or supervisors, and provider representatives at the discretion and invitation of the provider.
4. The exit conference will be led and facilitated by the lead surveyor. It should be brief – 20-40 minutes which may depend upon the sample size and potential citations identified. General structure includes:
    - Introductions of the surveyors involved with the review
    - Impressions – final report may or may not reflect issues discussed today
    - Briefly review findings (issues which may result in citations, administrative, general comments)
    - Any questions that we can address while still on site? (once we leave, what we can share or consider as part of the review changes)
    - Next steps: certification report written, sent to provider within 10 business days; then 20 business days for the provider to submit POI which will be accepted or additional information requested followed by implementation and quarterly updates for POI. We may return to do an on-site follow up at any time.
    - Certification issued may be 1 or 2 year depending on final findings
    - Thank staff for cooperation
5. Normally the lead surveyor would begin and end the exit conference as well as speak to impressions related to the administrative and staff portions of the review, any trends or patterns noted, and information about core or focus sample findings for reviews the lead surveyor completed. The sidekick surveyor(s) would speak briefly to impressions related to their findings.
6. Although the exit reflects impressions of the certification and some areas of concern noted may not result in citations on the final report, the exit interview should at least address areas that may result in citations so that there are no “surprise” citations when the provider receives the written report.
7. The exit interview is a brief (20-40 minutes total) and preliminary overview of the certification review findings and does not need to go into great depth. It is acceptable to mention strengths and positive findings during the exit but the focus should be on issues of compliance with the regulations that are likely to be cited in the final report. Questions from the providers or SC as related to the review may be clarified but the exit should not be a “discussion” or “argument”.

Wrap Up Activities

The Surveyor may have some outstanding tasks to complete following the on-site review. These may include finishing any outstanding interviews, consulting together as a team to make final determinations regarding compliance with the regulations and providing an exit conference with the provider agency, either onsite of via a conference call, if this did not occur during the on-site review.

These tasks should be completed within one business week of the survey so that the report can be written and findings submitted.

Writing the certification review report

Within twenty (10) business days after the final date of the site visit, the lead Surveyor will coordinate completion of a report that contains the deficiency citations. Specific examples noted during the on-site review activities will be included to illustrate and support citations given. Templates for the cover letter and the certification report are available in the SharePoint library under Survey Forms.

The lead surveyor is responsible for creating the final citation document to accurately reflect the information collected by all surveyors who participated. Each surveyor will draft their citations including the regulation, deficiency statement, and evidence and submit the information to the lead surveyor. The lead surveyor will create the final document including correct formatting, grammar, and spelling as well as consistency so the document appears to have one author. Check the prevalence numbers (for 1 of 3 reviewed for example) to be sure the numbers match the number of situations reviewed for that regulation by all surveyors. Ensure the sources in the deficiency statement (document review, interview, observation, etc.) match the evidence presented. Ensure the regulations included in the citation match the deficiency statement and the evidence presented. Non-regulatory information such as the GER reference guide should NOT be included with the regulation but should be included in the evidence section if relevant.

When the final report is completed and has been proofread, the cert report cover letter, sample key, and certification report will be filed in the qdrive under Letters Pending Approval file, and then Ready for Manager file. The manager may consult with the lead surveyor and/or all surveyors who participated in the review to clarify questions or suggest revisions. The lead surveyor is responsible for the content of the final report and for ensuring the final document is consistent in format as a single document and it is not obvious that multiple people wrote separate sections.

Official correspondence including citation reports, POI acceptance letters, and Disciplinary Action documents are sent to the CEO/Executive Director or like position when a provider has multiple area programs. The area director is included on the cc list.

When the report is accepted and the cover letter is completed, the cover letter will be signed by the manager or administrator and distributed and filed by the support person or the surveyor if no support person is available.

The lead surveyor is responsible for monitoring the timing of the certification report and the POI process. If a new certificate based on an acceptable plan of improvement will not be delivered to the provider by the time the current certificate expires, the lead surveyor will consult with the manager to consider issuance of a certification extension.

Evaluation and Acceptance of the Plan of Improvement

See the Plan of Improvement Process Guide

Citation Guidance

These guidelines will not provide exact answers for every situation but do provide guidance that combined with knowledge and experience will help surveyors reach consistent conclusions about when to issue to citations for certification reviews or complaint investigations.

In order to issue a citation, the issue must meet all of the following criteria:

- Be out of compliance with minimum requirements (404 regulations GER reference guide, DD-Provider contract, billing guidelines, State Statute, etc.)
- [1]Be objective rather than subjective (not based on personal preference)
- Be supported by evidence that is specific from identified sources (observations, interviews, record reviews, P&P, etc.)
- Be clearly written so that someone reading it without other information would understand exactly why the citation was issued

Other considerations: (from surveyor meeting 8/31/15)

- Evaluate the progress/effectiveness of any POI(s) already in process
- Check the latest certification report and POI and/or complaint citation(s)/POI(s) for repeat offenses, patterns, trends, and failure to implement accepted POIs.
- Was an outcome for an individual impacted?
- Consider scope and severity or gravity of the situation
    1. Health and Safety
    2. Human and Legal Rights
    3. Impact to funding for services
    4. Optimum match between needs and services, progress in services
    5. Not already identified by the provider with steps taken to correct the issue prior to notification of the certification review or complaint investigation contact by the surveyor

Citation Structure

1st Paragraph: Regulation

Cite the specific regulation (reg numbers preceded by "Title 404 NAC" and heading in bold and underlined followed by italicized regulatory wording).

Example: **Title 404 NAC 4-004.04 Staff Training and Competency:**

Only include the specific sub parts of the regulation that is supported by evidence. At times we may group more than one reg for the same deficiency. (Waiting to enclose the regulation in a box until the very last step saves lots of frustration and formatting problems when editing).

2nd Paragraph: Deficiency Statement

The first sentence is the **Lead-in** and it should make it clear what the issue is, how wide-spread it is and what your sources are for saying this. Often people start off with their evidence...but they haven't told the reader what the issue was, so they get lost in the information provided, the evidence.

1) **State the Scope - how pervasive the issue is,** and identify the people or records you found the issue with:

Based on a review of records and administrative interviews, two of four individuals reviewed who had rights restrictions (Individual #2 and 4), ...
Based on a review of records and staff interviews, one of three staff whose personnel/training files were reviewed, (Staff #2), ...

2) Next, **state the Issue based on regulatory wording.**
...the provider did not maintain a separate record for each individual...
...the provider had not ensured that at least half of the rights review committee membership was individuals, family, or other interested persons who are not provider staff...
...there was no documentation that the individual was informed of his rights and responsibilities on an annual basis...

Then, **state your Sources.** Whatever sources you include in the lead-in should also be mentioned in the evidence statement that follows.
Choose the ones that apply, omit the ones that don't – to some extent, evidence found through observation is "better" than just seeing it written, or hearing it said. But observation by itself can also be subject to interpretation, so it's better when confirmed with an interview or documentation.

Example: Based on records reviewed and the administrative interview, for two of four individuals reviewed who had rights restrictions (Individuals #2 and #4), there was no documentation that the restrictions had been reviewed by the human rights committee.

3rd Paragraph: Evidence
State your evidence to back up the deficiency. Be concise but give enough specific information to clearly support the citation.

Example:
Specifically, no evidence was provided to demonstrate that the provider submitted copies of the subcontracted services to Developmental Disabilities Service Coordinator (DDSC) prior to utilization of services for the fiscal year (FY) 2014-2015 and 2015-2016. In an email correspondence with Individual #7's DDSC, the DDSC stated that she has not received copies of the current subcontractor agreement held between the provider and the Individual #7's Host Home provider. The DDSC stated that she had received a copy of the contract for the 2012-2013 FY; however, the DDSC had not received any others. The provider did submit evidence of a Therap SCOMM, dated 8/5/14, that demonstrates (Provider Name) administrative staff submitted the copy of the contract for FY 7/1/14 through 6/30/15 to the DDSC on this date; this is was not prior to the initiation of the contract on 7/1/14. Additionally, no further evidence was provided to demonstrate that the current subcontract for FY 2015-2016 was provided to the DDSC.

Final formatting step: Enclose actual regulatory language in a box. (can do this by going to Insert then Table and making it a 1 row, 1 cell table – others may have another way.)

As edited at survey team meeting 11/9/15

Complaint Citation Guidelines
For DD Surveyors

Purpose: to provide guidance when determining if a complaint follow up assignment should result in citations(s) being issued.

Consideration	**Yes or No?**	
Is the situation regulated by 404, GER reference guide, DD contract or other DD requirement?		If yes, consider citation, if no, do not cite
Is the situation a result of action or inaction of the provider?		If yes, consider citation
Did the provider self-identify any issues prior to your contact and take actions to correct the issues?		If no, consider citation
From the information you have, was this a recurring situation? (may check prior cert review, complaint citations, GERs, NFOCUS intakes)		If yes, consider citation
Was there a negative result to an individual in services as a result?		If yes, consider citation
What guidance does the IPP/ISP provide if applicable?		Review IPP/ISP if applicable

As reviewed by survey team 2/17/2016

Complaint Intake Internal Process Guide

(created 1/8/18, rev 9/18)

Community-Based DD Surveyors

Division of Public Health – Licensure Unit

The last person who did intakes should have sent a scan via email of the DD intakes as they are listed in NFocus, with lines drawn through the ones they have entered/created. This will allow you to know where the previous person stopped doing intakes and where you will need to start. You will be expected to do the same at the end of your intake duties for the next person. Instructions on how to do this step are included at the end of this process. Sometimes intakes are listed "out of order" so you can't just assume everything has been entered prior to the last intake.

Complaints may also come from other sources such as phone calls, Ombudsman or elected officials, Service Coordination, and the physical "in box" that is located on the wall of Brian's cubicle where LU triage puts complaints they get that aren't theirs and may be ours. Use the processes below to check to see if those complaints are related to DD services not occurring in CDDs. (Center for the Developmentally Disabled).

Log in to NFocus
Second section down "Children and Family Services"
Blue "Intake" button with a blue telephone icon – click

On the right side, under the "Intake Count" button is a box titled, "Date Range"

Under "Date Range" box is another box. The first line in that box is "Intake Notification" and a drop-down arrow to the right. Click on the drop-down arrow and then click on "Developmental Disabilities"

Now go up to the "Date Range" box. The date range should have automatically populated with the current week. If you need to go back a week or more, click on "Prev" and the date range will go back one week each time the "Prev" button is clicked.

Once you are on the week you need, click the "Search" button on the bottom left of the screen. It may take a little bit for the information to pull up.

Once you have determined where the previous person left off, look to see if there are any intakes with a "1" entered in the 2nd column from the right titled, "P" for "Priority." A "1"-level priority intake should be addressed as soon as possible and before other intakes with a "2", "3", or no priority listed. If the status is listed as "OPEN", you will need to wait until CFS completes their process before creating a complaint. Check back later in the day or sometimes even the next day and create a complaint when the status is no longer "OPEN" to ensure complete and accurate information is available to enter into the complaint in SharePoint.

If there are no “Priority 1” intakes, it does not matter in what order the intakes are entered/created but entering them in order makes it easier to ensure they each have a complaint created in our system.

Make sure to look at the entire list, not just the very top names; sometimes one or more names are entered that appear below others that have been entered. Make sure to compare the list you have to what’s currently appearing. Because of the hotline processes, occasionally complaints show up several days later.

Double-click the intake you want to process.

Determine whether the individual is currently receiving DD services. This can be done several ways:

1. Double-click on their name in the “Persons/Allegations” box near the middle of the screen.

   Click on the button in the top row of the screen that looks like a yellow folder with a blue “M” on it. This is the “Go to Master Case” button.

   If you get a screen titled, “List for Master Case” double-click on the name you are looking into.

   The bottom box on the screen should be titled, “Program Cases.”

   There should be a program (column on the far left) called “DDSC” – Developmental Disabilities Service Coordination. If not, they most likely do not received DD services. If there is a “DDSC” listed in the left column, there should then be “AC” (Active) listed in the 5th column over to the right. If it is anything else (“PE” – pending, “CL” – closed” or “DE” – denied), then they most likely do not receive DD community-based services.

2. At the bottom of the screen titled “Detail Intake” there is a box titled, “Organizations.” If the person is being served by a certified provider, that provider will most likely be listed in this box if they are in any way involved with the allegation. Sometimes the provider is not listed if the allegation has nothing to do with their services (i.e. allegation is against an individual’s parent). If a person is receiving services from more than one provider, the provider listed here may not be the provider related to the complaint.

3. If the complaint is related to CDD services provided (Centers for the Developmentally Disabled which is different than the comprehensive waiver CDD), do not create a complaint per an agreement made 4/9/18 with Sheryl Mitchell and Becky Wisell. To determine if an address is a CDD, go to

http://dhhs.ne.gov/publichealth/Documents/CDD%20Facility%20Roster.pdf If a person lives in a CDD but the incident involves non-CDD services (example, day services) go ahead and create a complaint. If the incident appears to have occurred at a non-CDD address but under the supervision of CDD staff (example, grocery shopping), do not create a complaint.

4. If there is still a question regarding whether the individual is receiving DD services, you can go to Therap and do a search for the person in "Individual Data" or look for a current ISP in "Individual Support Plan."

If you are certain, using one or more of the above methods, that the individual is not receiving DD services, you do not need to create a complaint for the individual.

Once it has been established that the person is currently receiving DD services, the next step is to create a complaint in SharePoint.

1. From the DHHS intranet home page, click on "Developmental Disabilities" in the top middle of the screen.
2. On the far left, click on "Central Office" which is currently listed under "Archived CBS."
3. On the far left, click on "Public Health Surveys"
4. On the far left, click on "Complaints3"
5. At the top left of the screen click on "Files" tab and then "New Document"

It is very important to get the "CFS Intake Number" correct, so it is recommended that you copy/paste this number from NFocus. The number can be found on the "Detail Intake" screen, in the top right hand corner of the "Intake Information" box titled "Number."

The "Complaint Number" will auto-populate once you have submitted the form, so there is nothing to enter in that box.

Leave the "Complaint Status" on "Pending."

"Date Report Received" – enter the current date ("Date Report Received" applies to when the Public Health intake staff received the intake, not when the intake was initially received by APS).

"Initial Complaint Contact" – leave it on "NFocus" unless the source of the complaint was one of the others listed. If so, choose the most relevant option.

If it is an NFocus source, skip Section A and go to Section B

Almost always, click "Yes" on "Does the complaint share what occurred?" You would only click "No" if there is no narrative available in the NFocus intake or from the source of the complaint (see below on how to get to the narrative).

If there isn't a narrative then you may have to wait until the APS worker finishes doing the intake. If the status is not open and there is still no narrative, go ahead and create the complaint. You may wish to note in the comments box at the bottom of the first page that there is no narrative entered in NFOCUS.

To get to the narrative, click on the "Narrative" button, which is located on the top row of icons, about a third of the way on the left, and looks like a piece of paper and a pen. If you place your cursor on it, you should get a message on the bottom left of the screen that says, "Go to Narrative."

Click the button for "Select All" and then click the button on the bottom left titled, "Search."

If two or more items appear, make sure to open each one and copy/paste all relevant information from each into the complaint.

The information that you will need to copy/paste into the complaint is located in the large yellow box at the bottom. Scroll down until you get to "Situational Information" or "Imminent Danger/Maltreatment/Situational Information" or wherever it shows what actually occurred, not demographic information of the people involved.

Copy/paste everything that is in this section only. Stop when you get to the next section, which should be "Explain impact of caretaker services."

Paste the narrative into the complaint and make sure to bookend the actual narrative in quotation marks.

"Has complaint been reported to any other agency?" – will usually be yes. To find out what to enter here, look in two areas:

1. On the "Detail Intake" screen in NFocus, in the "Organizations" box at the bottom, enter any law enforcement entity that may be listed there. Do not list anything else from that box.
2. On the "Detail Intake" screen, click on the "Intake Notification" button which is second from the bottom along the far upper right side of the screen. You do not need to enter "Developmental "Disabilities" but make sure to enter anything else that may be highlighted in blue.

"Additional Comments/Details" is usually left blank unless there is additional information that is not appropriate in the intake summary section above.

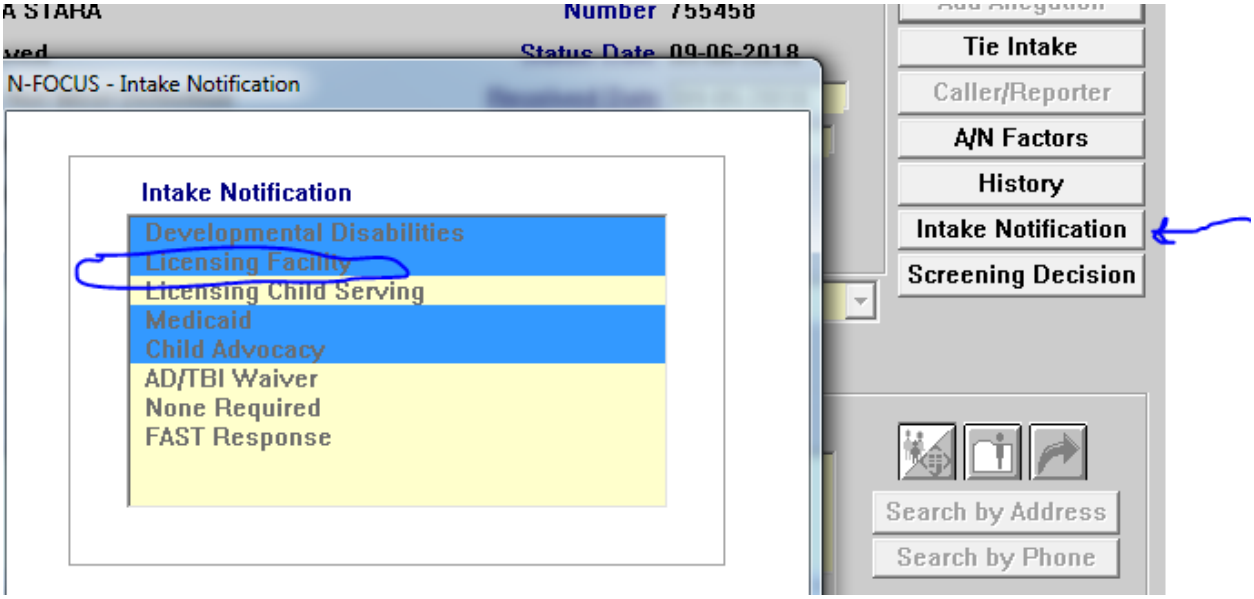
"Individual Information" – this is where you will list each person who is involved in the allegation. Enter the alleged victim first, followed by the alleged perpetrator, then anyone else listed. If the victim is not receiving DD services however, enter the person with DD services first. You will find these names and their roles on the "Detail Intake" screen in NFocus, in the "Persons/Allegations" box second from the bottom.

Make sure to enter the name of the person correctly.

- Click on the small blue drop-down arrow below “Last Name” to add another row for a second name or more.
- You will need to enter a last name and first name in order for the complaint to be submitted.
- You do not need to enter a middle name however middle initials may be helpful when there are multiple people with the same name in NFOCUS.
- Click the drop-down arrow to choose either “Victim” or “Perpetrator,” whichever is appropriate. If the person is neither the Victim nor the Perpetrator you can leave it as Select.
- For “Individual Type” click the drop-down arrow and choose the most appropriate option. Parents, relatives, friends and acquaintances should all be listed as “Other.” If “other” is chosen, then enter the relationship in the box below that.

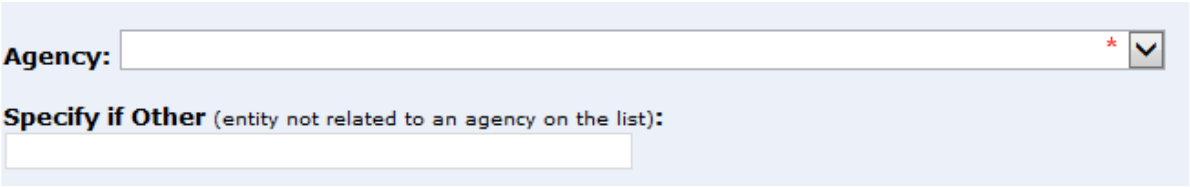
Occurrence Information:

- “Date of Occurrence” – if it is available, enter it. If not, leave it blank or the GER may have it.
- “Time of Occurrence” – same, if it is available, enter it. Otherwise, leave it blank or the GER may have it.
- “Location of Occurrence” – the narrative may include this information, or it may be listed above the narrative but still in the same box where the narrative is located or if there has been a GER completed, it should be there. If you can’t find a specific physical address, at least indicate the city.
- If the “location of occurrence” is one of the following:
    - Community Alternatives Nebraska, 2801 N 27TH STREET, Lincoln, NE (ADS license #ADS201104)
    - Goodwill Industries of Greater Nebraska, 3020 18th St., Suite 3, Columbus, NE (ADS license #ADS201702)
    - Goodwill Industries Day Services Program, 1808 South Eddy, Grand Island, NE (ADS license #58)
- Process the complaint as normal depending on whether or not any individual involved receives DD funded services but IF the person involved is NOT receiving DD funded services and if the “Intake Notification” does NOT indicate “Licensing Facility” was notified, email Susan and Pamela.Kerns@Nebraska.gov



Include the CFS intake number. You do not need to create a complaint in our SharePoint system. The email will ensure Licensure has been notified to conduct an investigation into the licensed Adult Day Services setting if needed.

- "Agency" – click on the drop-down arrow and choose the agency that is directly involved. Select "Other" for any entities not listed but DO NOT add anything else to the "other" selection in the "Agency" box. Doing so creates a new category for every single different entry and makes data management problematic. Make any clarifying comments about "other" in the "Specify if other" box below.



- If you have a new agency that is not on the drop down, notify Brian or Susan and they will submit a request to webapps to have it added. We realize "closed" providers such as Bridges and Elite are still listed but they cannot be deleted or our ability to pull those records from the past would be impacted.
- Select "SC Only" if the victim does not receive DD services but has an assigned, active SC. If an individual is receiving services from more than one agency, list the agency that is involved in the complaint situation. Make sure you check the agency list carefully, new agencies may not be alphabetical order.
- "Specify if Other" box to detail other involved parties.
- "Witness Name" – never enter anything here unless you have specific information appropriate to this section.
- "Preliminary Category of the Complaint" – choose any and all that apply.
- "Accepted by APS/CPS?" – there are several ways of determining whether the allegation was accepted by APS/CPS:
    - On the "List Intake" screen, if the column labelled "P" ("Priority") has a number 1, 2, or 3 in it, then it most likely has been accepted by APS/CPS.
    - On the "Detail Intake" screen, on the far middle right there is a button titled, "Screening Decision." Click on that button and below "Screening Detail" is "Initial"- and "Final Screening Decision." If "Do Not Accept" is listed in both areas, then APS/CPS did not accept the allegation. If "Final Screening Decision" is "Accept" then it has been accepted by APS/CPS. If it is greyed then APS/CPS did not accept the allegation.
    - It is recommended that you look in both areas above to confirm so this is accurately reflected on our complaint
    - Once you have determined whether APS/CPS has accepted the allegation, click on the drop-down arrow and choose the correct option.

Additional Comments – if the allegation is against the provider or if the provider has some follow-up they need to do, this is where you will copy/paste any relevant GER form ID from Therap.

GER copy/paste process:

1. Log on to Therap
2. Click on “Switch Provider” at the top middle of the screen.
3. Click on the provider that would be responsible for writing/submitting the GER
4. Click the “Search” option to the right of “General Event Reports (GER)” in the top middle of the screen
5. Type in the individual’s (most likely the victim) name and click on their name once it appears directly below
6. Click on “Search” at the bottom right of the screen.
7. If more than one GER appears, click on the GER that best matches the occurrence date. If there are more than one, you may have to open more than one to find the relevant GER, and there may be more than one that is relevant. Make sure to copy/paste all relevant GERs into the complaint.
8. At the top of the screen there is “General Event Reports (GER)” and then right next to that is the current status of the GER and next to that is a small “i” in a circle.
9. Click on the small “i” and copy/paste the entire Form ID # into the complaint. The Form ID # will always begin with “GER.”

You can also enter any additional information in the “Additional Comments” section that would be relevant to the triage/assigned surveyor. This could include mentioning that a GER was not present in Therap, any information regarding the context of the complaint not related in the narrative, or any information discovered along the way that might be useful/helpful to the triage/assigned surveyor.

“Complaint Entered By” – click on the drop-down arrow and select your name.

“Date” – use the calendar to enter the appropriate date that you entered the complaint.

Click on “Submit” and the complaint has now been created.

You will need to go to the “Complaints3” and check the complaint in.

- Click on the small box to the immediate left of the newly created complaint.
- At the top left of the screen click on “Check In”
- Make sure the “Retain your check out after checking in?” button is in the “No” position.
- If the complaint, per the “List Intake” screen, has a priority assigned to it (1, 2, or 3) then make a comment in the “Comments” section that there is a potential level (1, 2 or 3) intake that needs immediate attention.
- Click “OK”

If a complaint involves

a. A death of an individual that appears to suspicious or unexpected
b. Violent crimes involving individuals as victims or perpetrators
c. Serious occurrences of exploitation

d. Any situation with potential for media reporting

Notify the Triage surveyor and Program Manager immediately by email or phone. Include the intake # from NFocus, the complaint number, and a brief description of the situation so the Manager can determine if other notifications are required. It is also helpful to notify the triage surveyor so they can make this a priority for assignment and consult with the Manager if needed.

At the end of each day, print out the "List Intake" and cross off all the names that have been addressed so you will know where to start the next day. It is helpful to leave it on your desk easily accessible in case you are unexpectedly unable to come to work, it can be located and sent to whoever covers intake the next day.

- Click on "Action" at the top left of the "List Intake" screen.
- Click on "Prepare Report"
- Click on either the printer icon in the top left corner of the screen or click on "File" in the uppermost left-hand corner of the screen and click "Print…"
- Click on print at the bottom of the screen.

If someone else will be doing intakes the next day or week, print the "List Intake" and cross off all the names that have been addressed, then scan the document to yourself, then email it to the person who will be doing intakes next. If there are any names on the list that need explaining, do so in the email so the person knows what needs to be done.

Suggestion: Add "Complaints3" to your favorites for quicker/easier/more efficient access:

When on the "Complaints3" page, click on "Favorites" at the top left of the screen then click on "Add to Favorites…" Then later when you need to access the "complaints3" page all you need to do is go to the "Favorites" tab (top left) and "Complaints3 – Overview" will be listed.

COMPLAINT TRIAGE PROCESS - Community Based DD Survey Team
Division of Public Health – Licensure Unit (Rev May 2019)

COMPLAINT INTAKE SOURCES

1. Hotline via NFOCUS;
2. Other External Sources (Phone Calls, Letters, and Ombudsman, Governor's office, legislator's office); and
3. Other Internal Sources DDSC (after going through DD chain of command).
4. Licensure interoffice referrals (box on Brian's cube wall)

COMPLAINT CREATED by Staff Assistant in SharePoint (see separate process guide), if the staff assistant is absent, the triage surveyor will handle complaint intake.
Notify the manager or designee of any egregious incidents and corresponding DD and CFS complaint numbers. Examples of these may include:

1. A death of an individual that appears to suspicious or unexpected
2. Violent crimes involving individuals as victims or perpetrators
3. Serious occurrences of exploitation
4. Any situation with potential for media reporting

COMPLAINT TRIAGE done on a rotation by surveyors

1. Filter out issues that need to be forwarded to other entities, and forward them to the applicable stakeholders; refer billing issues to DDD (Kim McFarland or Lelia Razey).
2. Identify and coordinate with manager to determine next steps for complaints that are received directly from other official complaint avenues (Ombudsman, Governor's office, State Legislator, etc.);
3. Complete the information on the **triage** tab
    a. Complaint Status – select appropriate actions, see #4 below for reasons to "close" a complaint without further assignment to a surveyor
    b. Surveyor Assigned (if any)
    c. Date Assigned (if any)
    d. Level of Severity: definitions included in drop down options
    e. Follow up: select appropriate box(es) to guide the assigned surveyor based on information you have at this point.
    f. Triaged by: enter your name
    g. Date of triage: self-explanatory
    h. Comments/Reasoning for Decision – briefly document your justification for the decision about whether to assign the complaint. Do not copy and paste information from the initial intake.

4. Common examples of closed or review complete, follow up not required (based on work surveyor completed) complaints may include:
    a) Peer to peer incidents with no/very minor injuries. (trends or patterns noted by the triage person should be assigned with a note to the surveyor about the issue that caused the complaint to be assigned)
    b) If services are not being delivered by a specialized provider, if the incident didn't occur within a specialized provider's culpability, or if the issue reported doesn't fall within the jurisdiction of Title 404 NAC related to certified providers. (may be family or school issues)
    c) Complaints including abuse/neglect allegations or suspicions may be closed out without further assignment IF
        - There is evidence that the provider is handling the situation according to regulatory requirements (Deleted requirement to assign complaint soley because APS accepted it)
            - the GER or other documentation indicates that the provider is doing an internal investigation, and
            - action was taken to protect individuals until the investigation is completed,
            - all notifications were made (hotline, SC, guardian if applicable)
            - there is evidence that the provider is handling the situation according to regulatory requirements and/or per their policy
            - the person does not receive DD services or if the allegation is not related to a provider. ~~Confirm SC is aware of the allegation and note the confirmation on the complaint form.~~ (3/4/19, to avoid exposing confidential information from intakes to SCs who no longer have intake access).
        - Document that provider is taking appropriate action in the "comments" box on the triage tab (It is not required to obtain a copy of the provider's internal investigation to close the complaint)
    d) all deaths reported to the survey team will be assigned to
        - a surveyor for review unless the triage person is able to determine and document that there was no provider culpability,
        - Notify Ellen Mohling by email,
        - and report to the team manager by phone or email

On the "Initial Intake Tab" you can update or add any additional information you become aware of during the triage process.

5. Submit and check in the document. Remember the system will not update or send notifications until you check the document in.
6. Complaints received from the public should be acknowledged (if contact information is provided, email providing the easiest way to respond with proof)

acknowledging that the complaint has been received and will be evaluated for further follow up but due to privacy constraints, no further information can be shared. The manage will be responsible for this step.

7. Complaints from sources including the Goveronor's office, Ombudsman, and elected officials should be entered and notification made to the manager immediately. If the manager is absent, the triage surveyor will contact the manager if possible or consult with the next available person up the chain of command (beginning with Becky Wisell) The manager or in their absence the administrator will communicate to the official within 1 business day to acknowledge receipt of the complaint. The manager will consult with the administrator or deputy director regarding next steps.

If the criteria above are met to close a complaint but you have other concerns, you can still assign the complaint for follow up. Document your justification in the "Comments/Reasoning for decision" box on the triage tab.

Use GERs when available as a resource to gather information to help evaluate the decision to assign or close a complaint. You may need to search for GERs on the "provider page".

<u>Assignment of Complaints (changed 7/2/18)</u>

1. Prior to assigning any complaints, in SharePoint go to "Complaints3 Overview" The sixth column from the left is titled, "Assignee."
   Starting with the first surveyor/assignee that's listed, write down the assignees in chronological order that they were assigned. The top assignee will be the most recent.
   Continue to write down the names of assignees until all current surveyors (including the triage surveyor) are listed. Do not list a surveyor twice; if their name has already been written down, skip them and go to the next person listed that has not been written down yet.
   Once all current surveyors have been listed, <u>start with the surveyor listed at the bottom of the list</u> (the surveyor who has gone the longest since being assigned a complaint). This surveyor will be assigned the next complaint that needs to be assigned out.
   When the second complaint that needs to be assigned comes in, it will be assigned to the surveyor who has gone the second-longest since their last assigned complaint. This should correspond to the name listed second from the bottom on the list.
   This process will repeat for each complaint that needs to be assigned. Once all surveyors on the list have been assigned a complaint, the triage surveyor will start over with the surveyor listed at the bottom and work their way back up the list a second (or more) time until their triage duties are done.

2. There will be some cases when the triage surveyor will assign a complaint to themselves; if that's the case, this will count as an "assigned" complaint and the triage surveyor will go to the end of the assignment line.
3. Do not consider complexity of the complaint when assigning. The assignments should be done strictly by chronological order.
4. No need to look at or consider the number of assignments a surveyor currently has "in progress." The assignments are done strictly by chronological order.
5. Do not consider whether a surveyor is out on a certification review, *unless the complaint is a high priority and needs to be addressed before the surveyor is due to return*. In that case, assign it to the next available person on the list. Assign complaints to Program Manager Susan Kotas in special circumstances; only after consulting with her.
6. If a surveyor is on leave, consider whether the complaint should be assigned to them or not. If the complaint can wait for them to return, go ahead and assign. If not, follow the same process as #4.
7. Exception to assigning complaints in this order- if a surveyor is already assigned a related complaint and it make sense to have the same surveyor handle the related complaints for the same situation, individual, or related issue.

<u>Determine and communicate severity:</u> When assigning in SharePoint, rate the severity level of the incident to communicate to the surveyor the timeline for follow up;

- Level 1: no imminent or potential harm- defined as any complaint not meeting the definition of a Level 2 or Level 3;
- Level 2: potential harm to person served- defined as police contacts, injuries of unknown origin where abuse or neglect is *not* suspected, injuries which require medical attention to individuals requiring treatment by physician or any injuries to individuals in services related to incidents involving planned or unplanned emergency safety interventions or discovery of injury of unknown origin.
- Level 3: imminent harm to person served- an allegation or suspicion of abuse or neglect or exploitation where no steps have been taken to mitigate risk; a death of an individual that appears to be suspicious or unexpected; physical harm (excluding peer to peer incidents unless it results in an injury requiring medical attention, which is a Level 2); and Loss of placement.

ASSIGNED SURVEYOR FOLLOW-UP TIMELINES

Timelines apply to initiating follow up but initial contact timelines do not apply if law enforcement, or APS/CPS have not given permission to proceed with our investigation as explained in "Assigned Surveyor considers the following when assigned a complaint" below.

Level 1 and Level 2: Initial contact must be made within 7 business days, IF CFS has accepted a complaint, the initial contact would be to CFS to get permission to proceed. NFOCUS includes information about when CFS has their contact scheduled (top, 2nd tab over "actions"). If we know or become aware of law enforcement investigation in progress, attempt to contact the assigned department to get permission to proceed.
Level 3- Initial contact must be made within 3 business days of the complaint being assigned, unless waiting for permission to proceed from APS or law enforcement

Types of Assignment (options on Triage tab)

1. Call DDSC to inquire about the issues present in the complaint (note that we do not have authority to share confidential information available to us through NFOCUS intakes not accessible to SCs)
2. Contact the provider to inquire about their follow up and actions taken in relation to the complaint;
3. Track and review findings from CFS investigation / work with CFS on investigation;
4. Desk review of provider policies and actions to determine culpability or preventative measures;
5. Onsite investigation (only after consulting with manager and at times, this will be coordinated with CFS); and
6. Follow up to previously assigned complaint.
7. No assignment/no follow up required (if this box is checked, the complaint should not be assigned to a surveyor for further review)

Assigned Surveyor considers the following when assigned a complaint:

1. Research of pertinent GERs in Therap;
2. NFOCUS information including intake narrative;
3. Research of prior like complaints entered in SharePoint;
4. Research of any relevant CFS history;
5. Research of recent citations (from certifications or complaints); and
6. E-Records & Therap documents (ISP, current programming, SC narratives/notes).
7. Law enforcement involvement; if you become aware of law enforcement involvement, obtain permission from the LE agency involved BEFORE making any contact with the provider. You may review records as above unless LE directs you not to do so pending their approval.
8. Complaints accepted by APS/CPS; obtain permission from the assigned investigator BEFORE making any contact with the provider. You may review records available to you without provider contact unless the investigator directs you not to do so pending their approval.

9. 4/9/18 CDD service complaints are only investigated by (Mark Luger's) team to avoid duplication and prior notification. "Prior notification" would violate CMS and DOJ guidelines and could result in action against the State. This is applicable only for issues that occurred at a CDD site or under CDD staff supervision (WalMart shopping trip, out to eat, etc.)

CITATIONS?

- If yes, complete a citation report (SharePoint template), put it in the "ready for manager folder" under 4.3, and send the manager an email noting there is a citation report ready to review.
- If citations were issued related to a CDD or Med Aide/Licensing Issue, cc the report to the correct unit(s) in Public Health
- Contract or billing issues? If yes, report to DD (Kim McFarland)

COMPLETED COMPLAINTS

After the surveyor has completed complaint process,

- Update the Complaint Status
- Select the radio button that indicates whether or not a citation was issued
- Check the complaint in to the SharePoint system

Please remember, after any changes, <u>you MUST "check in" complaints before updated information will be visible to others in SharePoint</u>. You can "check in" complaints but "retain" check out status to continue working but also ensure the most current status and information is reflected. When checking in, make a very brief note about the status of the complaint.

If citations are issued, update the complaint status to "Citations issued-awaiting POI/updates". Once you accept a POI, change the status to "Review complete-no follow up needed" but continue to monitor the POI quarterly updates per the normal process. (As discussed at 12-18-17 team meeting).

Contested Citations Internal Process Guide

If a provider has evidence that was made available to a surveyor during a review or information that the provider believes negates or alters the citation issued, the provider may contest that citation. If a provider disagrees with citations, you can say something like *"you may contest any citations you feel were incorrectly issued based on the information available during the certification review".*

Our goal is to respond to contested citations as soon as reasonable so the provider can continue with the POI process.

If a provider indicates they object to citations issued;

- The provider should submit the request to contest the citation in writing as soon as possible and the lead surveyor will consult with the manager and issue a decision to uphold the citations or issue a revised citation report. An email to the surveyor or the program manager is adequate.
- The lead surveyor consults with the program manager to review the citation and relevant evidence. The program manager will respond to the provider in writing if the citation is upheld. If citations are determined to be altered or eliminated, the lead surveyor will prepare a REVISED citation report reflecting the changes and labeled as a revised report. It is signed, sent, and filed like any citation report with the help of the staff assistant.

The provider will still need to submit a POI within specified timelines for all citations that are not being contested AND any citations that are upheld will still require a POI. For timelines, we will "freeze" the clock for the 20 days for POI submission for as long as it takes us to respond to any contested citations. For example, if they contested something and it took us 3 days to respond, give them 23 days to submit the POIs only for the contested citation(s).

Surveyors should be aware of the certification expiration date when setting timelines for requested revisions to POIs (when related to a certification review).

Reference:

Title 404 NAC 4-002.12 and 4-002.13 provides Informal Dispute Resolution (IDR) and Administrative Hearings for denial of certification and disciplinary actions as listed in 4-002.11. Citations issued are not considered disciplinary actions and thus are not subject to IDR or Administrative Hearing action.

July 3, 2019

Exit Conference Forms Process Guide (8/17/18)

“Exit Conference Issues Identified” form is used so the Community Based Provider’s Director or assignee acknowledges that they are aware of the issues identified in the exit discussion when the surveyors leave at the end of the certification review.

Just prior to the exit conference the lead surveyor will meet with the survey team to discuss the team’s findings during the certification review. The lead surveyor will document on the “Exit Conference Issues Identified” form by checking the box next to the heading of the regulation that that surveyor will discuss at the exit conference and write a brief explanation of what that issue is under the regulation heading.

Once the exit conference has been completed the lead surveyor and the director or assignee will sign and date the last page and ensure both parties have a copy.

Upon return from the review, the lead surveyor (?) will ensure the exit conference signature sheet and Issues Identified form are filed in the shared drive under (on-site documents?) Naming convention

How to use NFocus to run a list of Individuals an agency serves:

- Obtain the agency provider number. (Example: MOSAIC-Tri-Cities NE Agency-Hastings, Provider Number is 55911637)
- On the first page of NFocus, go the bottom left under "Services"
- Choose the "Organization" tab. (Looks like a red building) Click on it.
- On the next page, on the upper left hand side, under the first box under "ID", enter the provider ID number.
- On the next page, on the right hand side, click on the box that says "List Service Auth..."
- On the next page, on the bottom of the box, click on "Search"
- On the next page, on the top of the screen, click on "A to Z" (this will alphabetize the names for you)
- A box will pop up, select "Clients Last Name" and then "OK"
- On the next screen, go to the top of the screen and select "Actions" and then click "Prepare Report" (it may take a minute)
- Print the report-this will be your list of individuals the agency serves.
- **Note, they will be listed multiple times based on the number of services they receive. (Res/Workshop/Transportation/Supp Res)

On-Site Plan of Improvement Monitoring Process Guide (effective for POIs accepted after 10/12/18)

Purpose:
To monitor progress with Plan of Improvement (POI) implementation more closely than just the review of paper reports submitted by the provider.

Timelines:
Accepting the POI: Regulations do not provide a timeline for our response however we will hold ourselves to the same standard as the providers have to submit a POI which is 20 business days but make every effort to respond to POI submissions as soon as feasible.

On Site Monitoring: Go out within 45 calendar days of the provider's submission of the 1st POI implementation update

If no citations are issued or only minor citations that can be easily documented without an on-site review, no on site review needs to be conducted. If a surveyor isn't clear on whether an onsite is needed, consult with the manager. If no on site POI follow up is needed, review POI implementation updates submitted. Communicate in writing to the provider (SharePoint Template "POI follow-up letter" or email) documenting progress made, additional documentation requested, and, when appropriate, noting no further POI updates are required. The lead surveyor signs this letter and it is saved in the files (may send to Brian to label and save).

Process:
1. Advance notification regarding the POI follow up visit may be made to confirm someone will be present to provide access to records. The notification should not exceed one calendar week and may be less. Advance notification is not required by the regulations.
2. The lead surveyor will coordinate the POI follow up with a sidekick who may or may have not been the original sidekick based on availability. (Lead surveyor's choice, may take more than 1 sidekick if needed based on the information to be reviewed)
3. The sample will include both the individual(s)/situation(s) cited for non-compliance as well as at least one additional example to determine if systemic changes have occurred.
4. More than 1 on site POI visit may be necessary for providers under disciplinary actions or if the surveyors' initial visit or evidence submitted reveals continued non-compliance.

Documentation:
1. The surveyor will document evidence on the POI itself and surveyor notes if needed. Any other certification review forms may be used if helpful and should be saved with other supporting documents related to the review.
2. Copies of records used as evidence of non-compliance will be scanned into the subfolder with the letter to the provider. Label your notes and evidence but save them as separate documents.
3. A letter is sent to the provider with the findings described and directions regarding any further POI implementation reports required. (SharePoint Template "POI follow-up letter" and place in ready for manager folder)
4. If progress has not been made based on the POI timelines, the surveyor will consult with the team manager to evaluate need for further action such as discipline or termination.
5. Staff Assistant will assist with labeling and filing formal communication

Revised 1/25/19

Plan of Improvement for (Provider Name):
Date of Survey or Complaint Citation report:

4-002.10B Plan of Improvement: *The provider must submit an acceptable plan of improvement to continue certification. Within 20 days* of receipt of the Department's written results, the provider must submit an acceptable plan of improvement to address areas found to be out of compliance. The plan of improvement must:*

1. Be specific in identifying a planned action on how the areas found to be out of compliance have been or will be corrected, for the individual cases included in the review and system wide within the provider organization;
2. Include an expected date for completion of the plan of improvement that is timely, taking into consideration the nature of the violation;
3. Identify a means to prevent a recurrence;
4. Identify who is responsible for implementing the plan of improvement and ensuring all areas are corrected and maintained; and
5. Be signed and dated by the director of the entity or designee.
4-002.10C Upon receipt of an acceptable plan of improvement, the Department may conduct an on-site revisit or request information from the provider to follow-up on the plan of improvement.

*This will be considered to be 20 business days.
Do not include individual or staff names in the plan. All references to individuals or staff must correspond with the numbered sample key included with the citation report. Complete a separate section of the worksheet for each citation grouping in the report you were issued. Add additional sections as needed based on the citations you are addressing in this POI. Contact your certification lead for any questions about the process.

Once you are notified that the plan has been accepted, implementation progress reports including supporting documentation must be submitted to DHHS.CBSCert@Nebraska.gov according to timeframes specified in the citation document.

The POI template is available in format you can edit at
http://dhhs.ne.gov/Licensure/Pages/DD-Certified-Provider-Certification-Review-Sample-Forms.aspx

Signature of Director (or designee): _____ Date:_____

Regulation Cited:			
Statement of Deficiencies:			
Requirements (see 4-002.10B for complete requirements)	**Provider plan:** *Be specific in identifying a planned action on how the areas found to be out of compliance have been or will be corrected, for the individual cases included in the review and system wide within the provider organization;*	**Date of Completion or Projected Completion & Title of Person Responsible for Completion**	**Surveyor review and approval (surveyor use only)**
Planned action on how deficiencies will be corrected for the individual:			
Planned action on how deficiencies will be corrected system wide within the provider organization:			

Signature of Director (or designee): _____ Date:_____

Means to prevent recurrence			

(Copy and paste additional sets of the table as needed based on the number of citations you are addressing in this POI)

Regulation Cited:			
Statement of Deficiencies:			
Requirements (see 4-002.10B for complete requirements)	**Provider plan:** *Be specific in identifying a planned action on how the areas found to be out of compliance have been or will be corrected, for the individual cases included in the review and system wide within the provider organization;*	**Date of Completion or Projected Completion & Title of Person Responsible for Completion**	**Surveyor review and approval (surveyor use only)**
Planned action on how deficiencies will be corrected for the individual:			

Signature of Director (or designee): _____ Date:_____

Planned action on how deficiencies will be corrected system wide within the provider organization:			
Means to prevent recurrence			

Signature of Director (or designee): _____ Date:_____

Department of Health and Human Services Community Based Certified Provider Certification Process Terms-in chronological order

1. Orientation (DDD-DPH jointly)
2. Application request (Kim responds)
3. Application Review (Kim completes)
4. DPH Initial Review of Submission (DPH)
    a. Application, sex offender and abuse & neglect check for owners, 11 core area policy and procedure review)
    b. Return to provider for revisions
5. 2nd Review of Submission (DPH)
6. Prospective Provider Interview (DPH)
7. Repeat cycle of submissions until 11 core areas and application materials are complete and compliant with regulations (DPH)
8. Provisional Certification (DPH, always 6 months, may issue 1 extension)
9. Maximus Enrollment Referral (DD)
10. Medicaid Number issued (MLTC)
11. Pre-Service Review (DPH – after an initial referral has been accepted by the provider but ***before service delivery begins,*** does not result in an actual certificate being issued, just a measure of how they are actually implementing the policies, procedures, and services)
12. Initial Certification Review (DPH-***after service delivery begins*** and before provisional certificate expires, always 1 year)
13. Home and Community Based Service Final Rule Assessment (DD-after services are offered)
14. Certification Review (DPH-recertification activities to evaluate services on an on-going basis, may be 1 or 2 years depending on citations)

Plans of improvement required for all citations as outlined in Title 404 NAC Chapter 4

SK: 2/4/2018

Document Request List for Prospective Providers

- Policies and procedures for all Title 404 NAC requirements (4-003.04)
- Consent forms (4-013)
- Notification of rights (4-007)- Ensure this notice includes all components as listed in the regulation and documentation that the notification was made to the individual in service and/or the legal representative, if applicable, at the time of entry and annually thereafter.
- Notice of costs (4-005.04) - Ensure this notice includes all components as listed in the regulation and documentation that the notification was made to the individual in service and the legal representative, if applicable, at the time of entry and if there are any changes.
- Notification of complaints and grievances (4-009)- Ensure this notice includes all components as listed in the regulation and documentation that the notification was made to the individual in service and the legal representative, if applicable, at the time of entry and annually thereafter.
- Assessments (4-005.01A)
- Training material and documented process for ensuring competency (4-004.04)
- Licensed Health Professional contract/job description (4-004.07/.08)
- Investigation form/format (4-010)
- Method of documenting RRC activities (4-011)
- Forms/methods of documenting QA/QI activities (4-014)
- Consent form for guardians/individuals for restrictive measures (6-004.01)

Prospective Provider Process

For Potential Community Based Developmental Disability Agency Providers

1. **Orientation:** Prospective provider registers for and attends Orientation. Orientation is completed by the DD Liaison and the DPH Surveyor Manager. It is conducted quarterly in Lincoln. A pilot to offer the orientation by webinar was discontinued in early 2019 after evaluation of distance learning success.
2. **Application Request:** Prospective provider requests Application Packet. DD Liaison sends the application packet.
3. **Application Review:** DD Liaison processes Application Packet, checking for completeness; if it isn't complete, DD Liaison returns to the prospective provider for corrections. Once the prospective provider has submited their application, P&P manual, P&P Worksheet, and any supplemental documentation, the DD Liaison will forward them to the DPH Surveyor Manager for assignment.
4. **DPH Initial Review:** DPH Surveyor Manager assigns the prospective provider to a surveyor via email and cc's the staff assistant so files can be set up. Complete within 20 business days.
    a. The provider name, location, contact name(s) for the provider, assignment date, and surveyor assigned, is recorded on the "Surveyor P&P review status tracking" spreadsheet and the "New Provider Overview" spreadsheet by the manager. The spreadsheets are located on the J drive (so DD Liaison can view it as well as surveyors) under DDD; 4.1 Technical Assistance; Prospective Providers.

    DPH Surveyor review steps

    b. Upon assignment, check all names on the application against the sex offender registry at https://sor.nebraska.gov/Registry/NameSearch ; check NFOCUS for any substantiated abuse or neglect for all applicants. Contact your supervisor immediately if any applicants appear on the registry or have substantiated allegations.
    c. Use the P&P worksheet, P&P manual, and any supplemental documentation submitted to complete a review of the 11 core areas (1. Entry to Services 2. Background Checks 3. Staff Training 4. Disaster Preparedness 5. Incident Reporting 6. Abuse and Neglect 7. Rights Review Committee 8. QA/QI, 9. Restrictions 10. Restraints, 11. Habilitation) of policies and procedures. Record notes and findings on the ProsProvP&P review 11 core areas worksheet for surveyors document. This review consists of checking for a policy, for a procedure, an assurance of implementation (forms, etc.), and compliance with regulations.
        - Verify that the page numbers recorded on the P&P worksheet actually match the corresponding P&P within the manual. If they do, proceed to the next step. If they do not, email the prospective provider requesting a resubmission of the P&P worksheet that includes accurate page numbers. Inform them that the P&P will not be reviewed until the page numbers match. CC the Program Manager & the DD Liaison.
        - Evaluate if there is a policy. A policy can be a mission statement, philosophical goal, or perhaps a reiteration of the regulations. An example policy for 4-010 Abuse and Neglect: "The provider will develop a system for handling allegations of abuse or neglect."
            - If there is not a policy, mark "no" and provide a description. For example: "There was no policy found for 4-010." If there is a policy, mark "yes" and proceed to the next step.
        - Evaluate if there is a procedure. A procedure describes *how* the provider will implement a policy. In other words, the procedure should describe "what it looks like." For example: "When an allegation of abuse or neglect is made, the provider will: _____."
            - If there is not a procedure, mark "no" and provide a description. Example of a comment for lack of procedure for 4-010 Abuse and neglect: "There were no

procedures describing how the provider will implement this policy." If there is a procedure, mark "yes" and proceed to the next step.

- If both a policy and a procedure are present, the surveyor needs to evaluate the prospective provider's "assurance of implementation." The prospective provider should submit forms and internal documents (investigation forms, training syllabus, etc.) used to implement any given policy or procedure, as required in the "Title 404 NAC Policy and Procedure Worksheet for Prospective Providers." For example: "Attachment 1 includes the internal, formal abuse and neglect investigation form."
    - If the provider does not provide an "assurance of implementation", does not provide all documents referred to in p&p, or if the surveyor evaluates the "assurance" to be insufficient, the surveyor marks "no" and documents the issue. If an "assurance of implementation" has been provided, mark "yes" on the worksheet and proceed to the next step.
- If above are complete, evaluate if the P&P and supplemental documentation are in compliance with the corresponding regulation(s) & statutes. When evaluating for compliance, surveyors are advised to use judgment similar to that used while conducting certification reviews.
    - If a policy, procedure, or supplemental document is not in compliance with regulations, mark "no" and provide a description. For example: "Definitions of abuse and neglect present in the P&P manual are in compliance with 404 NAC regulations, but they are not all inclusive. Specifically, there are no definitions of verbal or emotional abuse within the P&P." If there are no apparent concerns with compliance, mark "yes."
    - Be sure to record the date you completed the review on the first page of the worksheet.
- When the review is complete, save the P&P manual, the provider's P&P worksheet, supplemental documentation, and ProsProvP&P review 11 core areas Worksheet 11 for surveyors documents in the prospective provider's folder. Save these documents in the Q: CBS Surveyors drive/Prospective Providers/Name of Agency. Create a folder labeled "Submission 1" and save everything there including all email communication with the provider during the process.

5. **Notification of Initial Review Results:** Following the initial review of the 11 core areas *and* within 20 business days of the initial assignment, prepare the "ProsProv 1st submission letter" and "Title 404 NAC Policy and Procedure Review Worksheet", place them in the ready for manager folder and notify the manager it is ready to sign and send. Record the date you completed the review on the excel spreadsheets in DDD 4.1. Be sure you have recorded the date you completed the review on the 1st page of the worksheet. The manager will review and sign the letter when it is approved and forward the folder to the staff assistant to send and save in a folder labeled "1st Submission".
6. **2nd Submission Review:** The provider submits their corrected P&P documents. When reviewing the P&P a second time (or more), create a new folder in the agency's folder in the Q drive naming it the submission number it is (i.e. "Submission #2"). Save all documents and communication records (e-mails related to this submission, notes about phone calls) to the sub-folder that corresponds to the review submission. Review the 2nd submission and make notes in a different colored font regarding your findings based on the 2nd submission. Remember to record start and end dates on the first page of the worksheet and update the spreadsheets in the J drive for each step (receipt and return).
7. **DPH Interview:** conducted by 2 surveyors with the provider's representatives of choice at a date, time, and place coordinated by the lead surveyor. This may be provider's business space or State conference

area. You may consider distance options such as web ex for providers not close to Lincoln/Omaha. This will require preparation by the surveyor including being prepared to summarize issues identified during the P&P reviews as documented on the P&P review worksheet. When confirming the interview details, remind them to bring a copy of their most recent P&P submission and all supporting forms with them to use during the interview. Confirm date, time, location of the interview as well as the items you requested they bring by email (create template) so you have documentation of the preparation. The interview itself consists of:

a. Clarification of any questions from the application (if any)
b. Clarification of any issues identified in the P&P review (based on notes on P&P review worksheet a.k.a. 11 core areas)
c. Interview – use "ProsProv Interview after 2nd submission" form

Document results of the interview and any revised documents from the provider on the "ProsProv Interview Response letter". Put the documents in the ready for manager folder and notify the manger it is ready for review. Update the spreadsheets as needed. If no issues require correction, move to issue a provisional certification.

- Continue to review revised submissions and issue letters (template for ProsProv 3rd submission review can be edited to reflect infinite numbers) until the provider has met the requirements to be provisionally certified or until it appears they are not making adequpate progress and should be denied or have other steps considered. Consult with the program manager to make a recommendation for next steps.

8. **Provisional Certificate is issued to comply with the MLTC requirement that Medicaid provider numbers can only be issued to certified providers.** Once the provider has corrected all issues identified up to this point, the surveyor drafts a Provisional Certificate letter and saves that letter and the most recent version of the worksheet to the pending folder for DPH Surveyor Manager Review and signature. The Provisional Certificate and letter informs the provider they may begin working with DD to complete steps necessary to become a Medicaid provider. The DD Liaison is cc'd on that letter so they can coordinate MLTC enrollment.
9. **Maximus Enrollment Referral:** The DD Liaison works with the Prospective provider to complete Maximus Enrollment (Medicaid enrollment). Once completed, the DD Liaison contacts Therap, SC Staff, IS&T, DPH, and the provider that enrollment has been completed.
10. **Initial Referral:** When the prospective provider accepts a referral, the provider is required to notify DDD, DPH, and the lead surveyor within one business day of acceptance as specified in the "Provisional Certificate Letter".
    a. This does not mean the individual/family will ultimately choose the prospective provider for services. At this point, the DPH is only evaluating a provider's readiness to serve an individual.
    b. When the surveyor is notified by the provider that the provider has accepted a referral, the surveyor needs to ask the provider for the name of the referred individual.
    c. The surveyor needs to then contact the individual's SC (check NFOCUS) to ask the projected timeline for the transition, the probability and interest level of the individual/guardian in actually transitioning to this provider. The information from the SC will determine how quickly the surveyor needs to conduct the on-site pre-service review. The surveyor will consult with the manager to determine timelines for next steps based on the information from the SC.
11. **On-Site Pre-Service Review:** The surveyor will work with the DPH Survey Manager to schedule an on-site pre-service review; this review is used to determine whether or not DPH will approve service delivery to begin. Once a date has been established for the pre-service review, contact the prospective provider to arrange for the visit. A second surveyor should participate in the pre-service review to obtain another viewpoint, for safety reasons, and as a witness to the discussion. The pre-service

review is meant to evaluate the provider's "readiness" to serve an individual(s) in areas related to health and safety. The following must be completed on-site:

a. Review staff background checks to ensure they are completed in accordance with Title 404 NAC 4-004.03 A-F (use the Staff Review Form on SharePoint to document this review). This review must be completed for all direct care staff hired at this point; if there are more than three staff hired, a review is only required for three staff.
b. Review staff training requirements to ensure they are completed in accordance with Title 404 NAC 4-004.04 A-C and medication aide training, as applicable according to the service to be provided by that staff. For example, an EFH provider would inherently work alone so they would need all training prior to working alone. Also, in accordance with the provider's policies and procedures, some providers opt to have all 4-004.04 A-C training completed before they work alone with an individual. Your review will need to be tailored with those considerations in mind. The surveyor can document this review on the Staff Review Form as well. This review must be completed on any direct care staff hired at this point; if there are more than three staff hired, a review is only required for three staff.
c. Complete an interview with an employee in a senior management position, ideally, the Director (ProsProv Pre-service Interview form found in SharePoint).
d. During the pre-service review, evaluate the setting(s) for which services will be provided, if available. For example, if a provider will be serving an individual in a group home, the surveyor should visit the group home. Similar to observations conducted during a certification review, the surveyor should complete the Observation Interview form found on SharePoint, completing any items as applicable. If a setting has not yet been acquired by the prospective provider, this should be noted and considered when determining certification status.
e. Entry to Service Focus review form to evaluate preparation to serve individual identified? If not done during pre-service, the initial cert review should include at least 1 Entry to Service review
f. All non-compliance with regulations including any life, health, or safety concerns should be outlined in the Pre-Service review with issues letter to be signed by the DPH Surveyor Manager indicating that services can begin after identified issues are corrected. This letter should be cc'd to the SC and SC administrator for the person who had accepted the referral to this provider. The staff assistant will send and file this letter.

12. **Initial Certification Review after services begin:** Surveyor who conducted the P&P review will work with the manager to schedule and conduct an initial certification review to occur 30-60 calendar days after the first person started services to evaluate actual implementation of services, policies, and procedures. A second surveyor should participate. Include a review of the issues identified in the letter to the provider following the P&P review and the pre-service review in addition to the regular certification review issues. Note that 4-002.04 # says "unannounced on site review". As feasible, attempt to conduct the initial review without prior communication to the provider to with minimal notice if possible. Unsuccessful attempts to complete an announced review should be documented as part of the initial certification review report.
    a. Issue initial certification report within 30 calendar days (goal is 20) after the initial certification review is completed with the POI required to be submitted within 20 working days of receipt of the report (Lead Surveyor and Program Manager).
    b. Evaluate the Plan of Improvement (POI) and contact the provider to request clarification or additional information as needed. (Lead surveyor, consult manager if needed). (Reference 4-002.10B[4])

c. Issue the initial certification upon approval of the accepted POI. Initial certifications are normally issued for one year to allow additional evaluation of services prior to issuing a full 2 year certification. A six month extension of the provisional certification could also be issued. (Program Manager). (Reference 4-002.05C2[5])

13. **Home & Community Based Service Final Rule Assessment:** DD Liaison or designee completes HCBS rule assessment within X days of services beginning.
14. **Plan of Implementation Evaluation:**
    a. Conduct an on-site review of the progress the provider is making implementing the POI. The time frame for conducting the on-site POI progress review will be based on the length of the certification issued and whether any disciplinary actions were issued (Reference 4-002.11[6]). One year initial certifications may have the on-site POI progress visit conducted during the first 45 calendar days after receipt of the first POI progress update unless the specific situation makes another time frame appropriate.
    b. Monitor POI implementation reports

1 Generic form used w/ all Complaint investigations

Complaint Report Form
Department of Health and Human Services
Division of Public Health
Licensure Unit

Administrator

License Number:
Provider Number:
Investigation Number:
Complaint Number(s):

Allegation
****

The facility fails to ensure staff are providing services as agreed upon.

_____ _____

Signature of Administrator or Representative and Title Date

Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Department of Health and Human Services

Division of Public Health
Licensure Unit
P.O. Box 94986
Lincoln, NE 68509-4986

LICENSURE INSPECTION
Consent for Home Visit

Patient Name: _____

Address: _____

Name of Home Health Agency: _____

Date of Home Visit: _____

Name of Surveyor: _____

This consent statement permits the Department of Health and Human Services, Division of Public Health, Licensure Unit personnel to conduct a home visit to determine the Agency's compliance with the State Regulations governing the licensure of Home Health Agencies and to evaluate the quality of services provided to their patients.

I understand that consent for this visit is voluntary and the visit will only be performed with my permission.

_____ _____

Patient Signature Date

If you have any questions or concerns, contact the Licensure Unit at (402) 471-4967.

Distribution: White - Patient Pink - Licensure Unit Yellow - Provider Agency

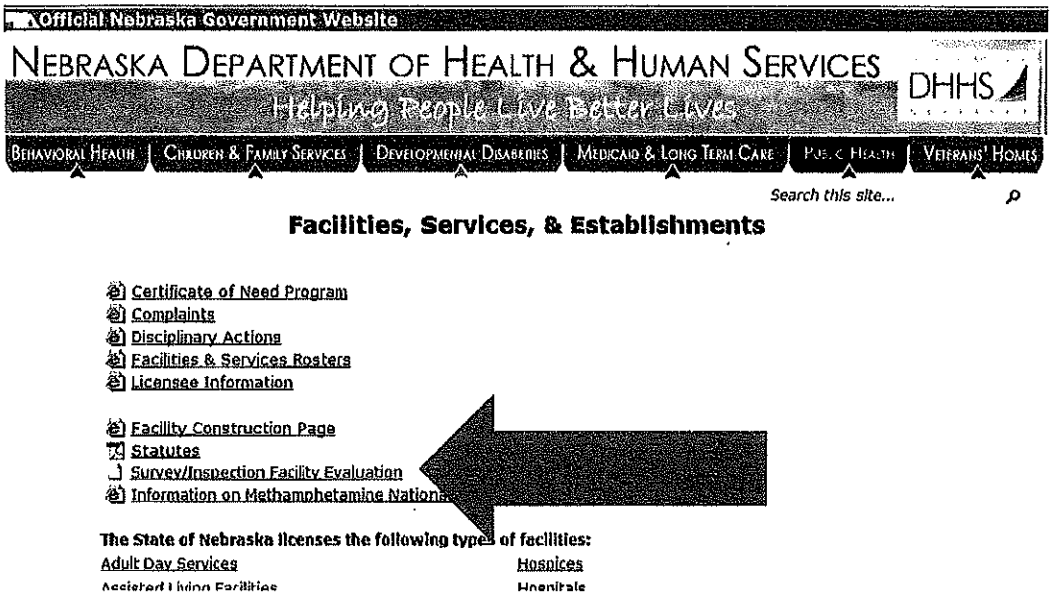
We Value Your Opinion!

Dear Administrator,
We depend on your feedback to help us know how to improve our survey process. If you have not already done so, will you please take a few minutes to tell us how we did on your recent survey? If you have already completed the evaluation form, please accept out thanks and disregard this notice.

You can access the evaluation form directly at:

https://www.surveymonkey.com/r/CK38LWZ?sm=gm7Zn4csC71zAxfP6OgMyQ%3d%3d

Or you can access the evaluation form from our website at:



https://www.surveymonkey.com/r/CK38LWZ?sm=gm7Zn4csC71zAxfP6OgMyQ%3d%3d

Thank you for taking a moment to let us know what we are doing well and where we need to improve. Your responses are confidential and are used for data analysis and quality improvement purposes only. We appreciate your feedback!

PATIENT SAMPLE LIST

FACILITY NAME: _____
PROVIDER NUMBER: _____
SURVEYOR: _____
DATE OF SURVEY: _____

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____
16 _____
17 _____
18 _____
19 _____
20 _____
21 _____
22 _____
23 _____
24 _____
25 _____

LIST OF PERSONNEL

FACILITY NAME: _____

PROVIDER NUMBER: _____

SURVEYOR: _____

DATE OF SURVEY: _____

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

I. _____

J. _____

K. _____

L. _____

M. _____

N. _____

O. _____

P. _____

Q. _____

R. _____

S. _____

T. _____

U. _____

V. _____

W. _____

X. _____

Y. _____

Z. _____

EXIT CONFERENCE ATTENDEES

Facility Type: Hospice ADS HHA ESRD OPT CORF Respite X-ray HMO CDHS

Facility Name: _____

City: _____

CCN/ Lic Number: _____

Survey Date: _____

Surveyor(s) Name: _____

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

10 _____

11 _____

12 _____

13 _____

15 _____

Home Health Agency Licensure Patient Record Audit Form

Facility Name: _____ License #: _____ Surveyor: _____ Date: _____

Documentation of:	Pt. # & Name:	Pt. # & Name:	Pt. # & Name:	Pt. # & Name:	Pt. # & Name:	Pt. # & Name:	Pt. # & Name:	Pt. # & Name:	Pt. # & Name:	Pt. # & Name:
Plan of Care: Informed Consent form (signed)										
MD Name & Address										
MD Orders (signed/returned 30 days)										
Pertinent past/current Med. HX										
Medical Diagnosis										
Medication Orders										
Dietary Orders										
Treatment Orders										
Activity Orders										
Safety Orders										
Initial & Periodic Assessments & POC										
Admission/Observation/ Progress Notes (Clinical Notes)										
N. N. Follow Dr. orders										
Coordination of services (Case Conferences)										
Copy of 62 day Physician Summary Report										
POC review every 62 days										
Discharge Summary										
Home Health Aides: POC/Assignment Sheet										
Doc. POC done per assignment										
RN Supervisor Visits every 2 weeks										
Basic Therapeutic Supervisor Q 2 weeks										
Personal Cares Supervisor Q 62 days										
Observe Care & V.S. Q 6 months by RN										
Self Admin. of Meds. on Care Plan										
Code: (✔) if present; (-) if not applicable; (O) if not present										

HOME HEALTH AGENCY LICENSURE PATIENT RECORD AUDIT FORM

Date of review: _____ **Surveyor**_____

Agency: _____

Patient Name: _____ ID # _____

Home Visit: _____ Date & Time: _____ With: _____

Diagnosis: _____

Pertinent past/current medical history: _____

Plan of Care: Informed Consent form signed _____ Date: _____

Initial & Periodic Assessments & POC: _____

POC Reviewed every 62 days: _____

Admission/Observation/Progress Notes (clinical Notes) _____

Coordination of services: _____

Copy of 62 day Physician Summary Reports _____

MD Name & Address _____

MD Orders (Signed/returned W/I 30 days) _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medication Orders: _____

_____

_____

Self Administration of Medications addressed on Care Plan _____

Dietary orders: _____; Activity orders: _____

TreatmentOrders: _____

_____

_____

Home Health Aide POC/Assignment Sheet _____ Updated _____

HHA POC done per assignment; _____

RN Supervisory Visits every 2 weeks? _____

Basic Therapeutic Supervisory visit every 2 weeks? _____

Personal Cares Supervisory visit every 62 days? _____

Observation of HHA Performing cares and Vital signs every 6 months? _____

Discharge Summary (if applicable)? _____

Calendar Worksheet Patient: Orders for Disciplines:

Month

DISCIPLINES

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Month

DISCIPLINES

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Month

DISCIPLINES

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

See Surveyor Notes on reverse side

EMPLOYEE RECORD

FACILITY NAME:
SURVEYOR:

CCN/LIC:
DATE:

NAME/TITLE	DOH	JOB DESCRIPTION	LIC/CERT APPROVAL	BACKGROUND CHECKS	EVALS- 6 MO/ANNUAL	HEALTH SCREEN	ORG STRUCTURE	PATIENT RIGHTS	PT CARE POLICIES AND PROCEDURES	PERSONNEL POLICIES AND PROCEDURES	ABUSE REPORTING	INSERVICES	EP P&P TRAINING (F)	SPECIAL TRAINING

HOME HEALTH AIDE PERSONNEL FILES REVIEW WORKSHEET

Facility Name_____Provider #_____ Surveyor Name/Number _____

Name	DOH	Training Program	Competency Evaluation		Inservices			6mo SV by RN to Observe cares and vital signs	Evals
			Written	Skills	Date	Topic	Hours		

Revised 11/3/17 JF

HOME HEALTH AIDE PERSONNEL FILES REVIEW WORKSHEET

Facility Name_____Provider #_____ Surveyor Name/Number _____

Date of Inservice	Topic of Inservice	Facilitator	Hours

Revised 11/3/17 JF

Agency Name: _____

License #: _____

Home Health Care
Patient Rights

Surveyor: _____

Date Reviewed: _____

HHA F/S	Met	Not Met	Patient Rights
S			1. The right to choose an agency.
F/S			2. Notified in advance of the right to participate in the planning of their care, participate in the POC & planning of changes.
F/S			3. Receive instructions and education regarding plan of care prior to care being provided.
F/S			4. Is made aware of changes in the POC prior to the changes occurring.
S			5. Right to request information regarding diagnosis, prognosis, and treatment.
S			6. Right to be informed of alternatives to care and the risk involved.
S			7. Information is provided in plain language and is easily understood.
S			8. Right to refuse home health care and be informed of possible health consequences.
S			9. Care is given without discrimination.
S			10. Admitted only if the agency has the ability to provide the necessary care.
F/S			11. Right of confidentiality of all records, communications, and personal information.
S			12. Right to review all health records *unless the physician has documented otherwise in the medical record.
S			13. Right to receive BOTH oral and written explanation regarding termination of services.
S			14. Right to receive information regarding community services.
S			15. Right to receive two (2) week notice prior to termination of services.
F/S			16. Right to voice grievances/complaints and suggest changes in services or staff without fear of reprisal.
F/S			17. Complaints must be investigated.
F/S			18. The agency must document both existence and resolution of complaint/grievance.
S			19. Patient/designee informed of outcome/resolution of investigation of complaint/grievance.
F/S			20. Right to be fully informed of agency policies and charges for services.
F/S			21. Be free of abuse including injury of unknown origin, neglect & misappropriation of property & be treated with dignity.
F/S			22. Right to have property treated with respect.
F/S			23. Right to receive information on advance directives.
F/S			24. Are given verbal and written notice of rights and responsibilities prior to commencement of services.
F/S			25. The agency must maintain documentation that the patient received a copy of the Bill of Rights.
F			26. Patient and family or guardian may exercise the patient rights when the patient has been judged incompetent.
F			27. Right to be notified in advance of the disciplines that will furnish care.
F			28. Right to be notified in advance of the frequency of visits proposed to be furnished.
F			29. Right to be made aware of the agency's policy regarding disclosure of clinical records.

HHA F/S	Met	Not Met	Patient Rights
F			30. Right to be advised regarding payment before care is initiated; when change occurs/prior to next HHA visit.
			from Medicare or other sources
			extent to which payment may be required from the patient
F			31. Must be informed in writing of:
			* Extent of payment from Medicare, Medicaid, or other federally funded or aided program
			* Charges for services not covered by Medicare
			* Charge the individual will have to pay
F			32. Receive proper written notice in advance if agency believes service(s) may not be covered.
			* Notification in advance of HHA reducing or terminating on-going care
F			33. Right to be advised of the availability of the toll free HHA hotline in the state.
			* Must be advised in writing of: Phone number, hours of operation, and purpose of the hotline
F			34. Verbal notice in individual's preferred language.
F			35. Provided written notification of transfer/discharge policies at time of admission.
F			36. Contact information for administrator to file complaint/grievance. Administrator's name, business address, and phone number
F			37. Aware transfer or discharge is necessary for patient's welfare because HA & MD agree HA can no longer meet needs.
F			38. The HA must make efforts to resolve problem(s) presented by the patient's behavior or the behavior of other persons in the patient's home or situation and document the problem and efforts made to resolve in the clinical record.
F			39. Any HA staff must report potential abuse, neglect, misappropriation, or injuries of unknown origin immediately to HA and other appropriate authorities.
F			40. Patient has the right to receive all services as outlined in the plan of care.
F			41. Right to be informed regarding access auxiliary aides and language services and how to access these services.
F			42. The HHA must arrange a safe and appropriate transfer when the needs of the patient exceed the HHA's capabilities.
F			43. Be advised of names, addresses, and phone numbers of state & Fed funded entities serving area where patient resides.
F			44. Patient and representative provided with contact info for other agencies that may be able to provide care.
F			45. Action taken to prevent other violations including retaliation while complaint is being investigated.

HOME HEALTH AGENCY CERTIFICATION/LICENSURE SURVEY PACKET CHECKLIST

Agency Name: _____ City: _____

License or Provider Number: _____

Surveyor(s): _____

Survey Dates: _____

_____ CMS 670 Team Composition Workload Report ©

_____ CMS – 1513 Disclosure of Ownership (Complete for Medicaid only agencies)

_____ CMS 1572 Survey Report ©

_____ CMS 1515 Module E © Agency Care Summary

_____ CMS 1515 Modules #_____ © Includes: →

A= Copy of POC
B= Clinical Record Review
C= Home Visits
D= Patient Care Summary
Calendar Worksheet

_____ Home Visit Consent Forms # _____

_____ QBQM & QBQI – Presurvey & Sample Selection work sheet ©

_____ Patient Sample List
- Include review of patients across state lines

_____ List of Agency Personnel

_____ List of Exit Conference Attendees

_____ Deficiency Statements –
Recert Survey (CMS 2567) COPS: Yes – No
Deficiencies cited Yes No

Licensure Inspection Yes No
Licensure Deficiencies cited Yes No

Complaint w/survey _____
Submit Separate
CMS 670
Investigative Notes
Finding Statement

_____ Licensure Inspection Form – Initial – Compliance – Focused

_____ Licensure Patient Audit Form (Licensure Compliance Inspection Only)

_____ Copy of Patient Rights (Initial Cert or Licensure Only)

_____ Fiscal Year End _____ ©

_____ Exit Tape (<u>TAPE ALL EXITS</u>)

_____ Revisit: Yes – No PCV or Cert Visit Licensure revisit

_____ Paper or On Site

_____ Resurvey Date: _____

© = Certification only
Revised: 5/2011

INFORMATION NEEDED FOR INITIAL LICENSURE INSPECTION

Services:
List services agency is selecting to provide_____
List services provided directly by agency staff _____
List services provided by contracted staff_____
Does the agency utilize medication aides?_____

Geographic area:
List by county the area agency will serve_____

Branch offices:
List location of branch offices (if applicable)_____

Operations:
To complete the inspection the surveyor will need the following as appropriate for the services the agency will provide:

1. Written governing authority bylaws which govern the operation of the agency

2. Agency policies and procedures which address the following areas:
   a. Range of services to be provided
   b. Geographic area to be served
   c. Administration of the agency
   d. If there are branch offices, how the agency will supervise the branch, including onsite supervision
   e. Criteria for admission, discharge, and transfer of patients
   f. Patient care policies, including all services the agency will provide
   g. Coordination of services
   h. Availability of supervising nurse for skilled care and home health aide services
   i. Abuse and neglect reporting and investigation
   j. Personnel policies and procedures, including performance evaluations
   k. Patient rights
   l. Advance directives
   m. In-home assessments
   n. Patient consents
   o. Complaints/grievances
   p. Quality Assurance/improvement program policies
   q. Patient care and treatment policies and procedures, including the development and review of the plan of care
   r. Administration of medications
   s. Provision of direction and monitoring/supervision for home health aides and medication aides
   t. Verification of home health aide and medication aide qualifications
   u. Recordkeeping
   v. Infection control

3. Examples of patient record forms

4. Example of patient admission packet, must contain:
    a. Patients rights form
    b. Advance directive form
    c. Consent form

5. Job descriptions and duties for all employee positions

6. Written evidence to show employees are qualified for the positions they hold in the agency

7. Current employment records, which must include:
    a. Title of individual's position, qualifications, and description of the duties and functions assigned to that position;
    b. Evidence of licensure, certification, or approval, if required;
    c. Performance evaluations within six months of employment;
    d. Post hire/pre-employment health history screening.

8. Staff orientation and ongoing training program and planned listing of future inservice training

9. List of current employees. Please include:
    (a) All contracted personnel
    (b) The discipline of the employee
    (c) Licensure numbers, where applicable
    (d) Date of hire

10. Written contracts with individuals providing services for the agency

11. Home Health Aide competency evaluation/test

12. Medication Aide verification of competency

13. Patient Rights

14. Grievance/Complaint File

15. Quality Assurance/Improvement program and any reports the agency has completed to date

Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Department of Health and Human Services

Division of Public Health
Licensure Unit
P.O. Box 94986
Lincoln, NE 68509-4986

LICENSURE INSPECTION
Consent for Home Visit

Patient Name: _____

Address: _____

Name of Home Health Agency: _____

Date of Home Visit: _____

Name of Surveyor: _____

This consent statement permits the Department of Health and Human Services, Division of Public Health, Licensure Unit personnel to conduct a home visit to determine the Agency's compliance with the State Regulations governing the licensure of Home Health Agencies and to evaluate the quality of services provided to their patients.

I understand that consent for this visit is voluntary and the visit will only be performed with my permission.

_____ _____

Patient Signature Date

If you have any questions or concerns, contact the Licensure Unit at (402) 471-4967.

Distribution: White - Patient Pink - Licensure Unit Yellow - Provider Agency

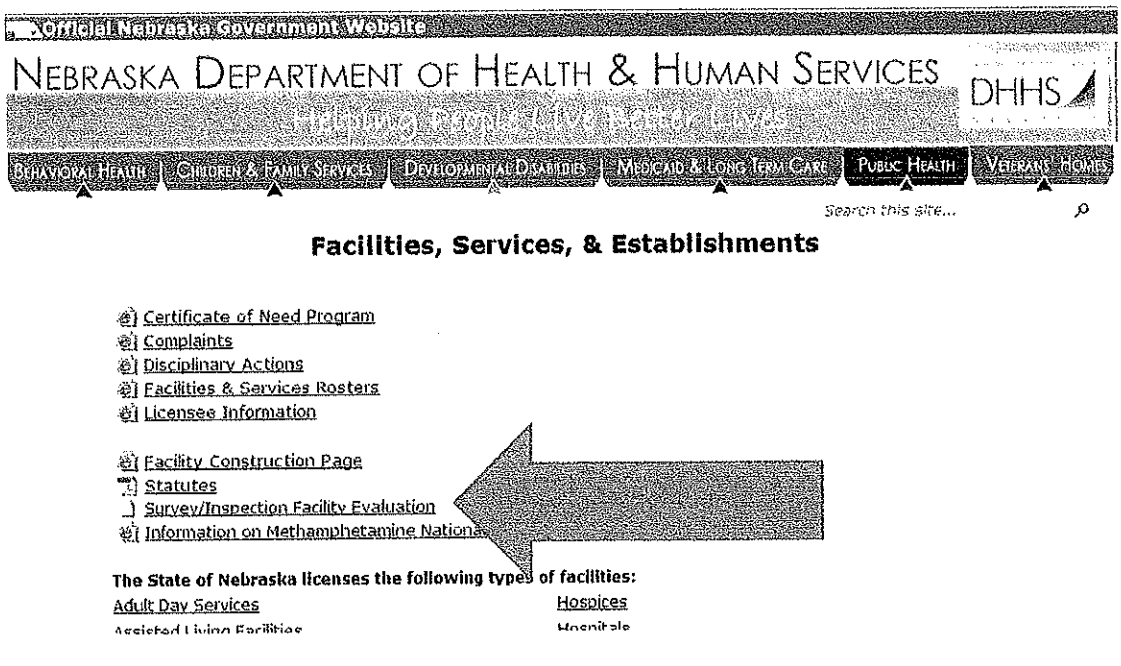
We Value Your Opinion!

Dear Administrator,
We depend on your feedback to help us know how to improve our survey process. If you have not already done so, will you please take a few minutes to tell us how we did on your recent survey? If you have already completed the evaluation form, please accept out thanks and disregard this notice.

You can access the evaluation form directly at:

https://www.surveymonkey.com/r/CK38LWZ?sm=gm7Zn4csC71zAxfP6OgMyQ%3d%3d

Or you can access the evaluation form from our website at:



https://www.surveymonkey.com/r/CK38LWZ?sm=gm7Zn4csC71zAxfP6OgMyQ%3d%3d

Thank you for taking a moment to let us know what we are doing well and where we need to improve. Your responses are confidential and are used for data analysis and quality improvement purposes only. We appreciate your feedback!

PATIENT SAMPLE LIST

FACILITY NAME: _____
PROVIDER NUMBER: _____
SURVEYOR: _____
DATE OF SURVEY: _____

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____
16 _____
17 _____
18 _____
19 _____
20 _____
21 _____
22 _____
23 _____
24 _____
25 _____

LIST OF PERSONNEL

FACILITY NAME: _____

PROVIDER NUMBER: _____

SURVEYOR: _____

DATE OF SURVEY: _____

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

I. _____

J. _____

K. _____

L. _____

M. _____

N. _____

O. _____

P. _____

Q. _____

R. _____

S. _____

T. _____

U. _____

V. _____

W. _____

X. _____

Y. _____

Z. _____

EXIT CONFERENCE ATTENDEES

Facility Type: Hospice ADS HHA ESRD OPT CORF Respite X-Ray HMO

Facility Name: _____

City: _____

License Number or Provider Number: _____

Date of Survery: _____

Surveyor(s) Name: _____

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

HOSPICE AIDE PERSONNEL FILES REVIEW WORKSHEET

Name	DOH	Training Program	Competency Evaluation		Inservices:			Annual SV by RN to observe cares and vital signs	Evals
			Written	Skills	Date	Topic	Hours		

Revised by TL 2/9/2011

EMPLOYEE RECORD
HOSPICE

FACILTY NAME: ______________________________ DATE: _____________

Name/Title	DOH	Job Description	Credentialing Lic Cert Approval	Background checks	Performance Evals	Health Screen	ORG Structure	PT Rights	PT Care policies/procedures	Personnel polices/procedures	Abuse Reporting	Inservices	Special Training.	Previous work experience

Agency Name: _____ **Hospice Patient Rights** Surveyor: _____

License #: _____ Date Reviewed: _____

Federal	State	Met	Not Met	Patient Rights
501	16-006.06			Promote and protect patient rights.
502	—			During initial assessment (before care) provide written and verbal notice of rights.
503	20			Must inform and distribute information regarding advance directives.
				State: Hospice must notify patient/representative if unable to comply with advance directives.
504	Footnote			Maintain documentation showing the patient was given notification of patient rights.
505 (i)	16-006.06			Right to exercise rights as a patient of hospice.
505 (ii)	18			Right to have person/property treated with respect.
505 (iii)	13			Right to voice grievances regarding care and treatment.
				State: Suggest changes in services or staff without fear of reprisal or discrimination and be informed of the resolution.
506	—			If patient adjudged incompetent then designee acts on patient's behalf.
507	—			If patient not adjudged incompetent then designee designated by patient may act on patient's behalf.
508	—			All alleged violations of mistreatment, neglect, abuse, injuries of unknown origin, & misappropriations are reported to administrator.
509	—			Immediately investigate all alleged violations of abuse, neglect, injuries of unknown origin, and misappropriations.
510	—			Take appropriate corrective action if alleged violation is verified.
511	—			Verified allegations must be reported within 5 working days.
512	16			Expect pain relief. Measures instituted to ensure comfort.
513	2			Involved in developing POC.
				State: Receive appropriate instruction and education regarding POC.
514	4			Right to refuse care or treatment.
				State: Informed of possible health consequences of this action.
516	9			Confidentiality of all records.
				State: Communication and personal information.
516	10			Review and receive a copy of all health records pertaining to them.
517 & 737	15			Be free of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown origin, and misappropriation of patient property.
				State: And be treated with dignity.
518	14			Receive information about the services covered under the hospice benefit.
				State: Be fully informed of hospice policies and charges for services, including eligibility for third-party reimbursement, prior to receiving care.
519	19			Receive information about the scope of services that the hospice will provide and specific limitations on these services.
				State: Informed in advance about the care to be furnished, and any changes in the care to be furnished.
	11 & 12			State: Oral and written explanation regarding discharge.

Agency Name: _____ **Hospice Patient Rights** **Surveyor:** _____

License #: _____ **Date Reviewed:** _____

Federal	State	Met	Not Met	Patient Rights
501	16-006.06			Promote and protect patient rights.
502	—			During initial assessment (before care) provide written and verbal notice of rights.
503	20			Must inform and distribute information regarding advance directives.
				State: Hospice must notify patient/representative if unable to comply with advance directives.
504	Footnote			Maintain documentation showing the patient was given notification of patient rights.
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505 (ii)	18			Right to have person/property treated with respect.
505 (iii)	13			Right to voice grievances regarding care and treatment.
				State: Suggest changes in services or staff without fear of reprisal or discrimination and be informed of the resolution.
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510	—			Take appropriate corrective action if alleged violation is verified.
511	—			Verified allegations must be reported within 5 working days.
512	16			Expect pain relief. Measures instituted to ensure comfort.
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				State: Receive appropriate instruction and education regarding POC.
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516	10			Review and receive a copy of all health records pertaining to them.
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				State: And be treated with dignity.
518	14			Receive information about the services covered under the hospice benefit.
				State: Be fully informed of hospice policies and charges for services, including eligibility for third-party reimbursement, prior to receiving care.
519	19			Receive information about the scope of services that the hospice will provide and specific limitations on those services.
				State: Informed in advance about the care to be furnished, and any changes in the care to be furnished.
	11 & 12			State: Oral and written explanation regarding discharge.

Federal	State	Met	Not Met	Patient Rights
737	21			Right to be free from restraint or seclusion of any form.
—	1			Choose care providers and communicate with those providers
—	3			Request information regarding diagnosis, prognosis, and treatment, including alternatives to care and risks.
—	5			Receive care without discrimination as to race, color, creed, sex, age, or national origin.
—	6			Exercise religious beliefs.
—	12			Patient may be discharged for cause based on an unsafe care environment in the patient's home, non-compliance, or failure to pay for services.
—	17			Expect all efforts will be made to ensure continuity and quality of care in the home and in the inpatient setting.

Hospice Clinical Record Review

Name:	Record #
Diagnosis:	
Location:	SOC:
Review Date:	
Plan of Care	**Record Content**
Initial POC developed by hospice RN or MD and attending MD plus 1 other IDG member prior to care.	Certification signed within 2 calendar days of cert period. (Initial 90 day period : if not able to get signature within 2 calendar days; must get oral cert within 2 calendar days and written cert within 8 calendar days after cert period begins)
POC reviewed & updated by attending MD and IDG at specified intervals	Consent
POC includes assessment of needs	Election of Benefit signed
POC identifies services provided	ID data
POC identifies scope and frequency of services	Initial and subsequent assessments
Care follows POC	Pertinent medical history
	Documentation of all events
Surveyor Notes:	

Hospice Patient Visit Tracking Form

Patient Name_______________________MR#____________ Comments______________________________

Payor_____________________________Case Mgr__________ ______________________________

SOC Date__________________________D/C Date__________ ______________________________

√ = Visit

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
RN																															
HHA																															
Aide Sup																															
MSW																															
Chaplin																															
Volunteer																															
IDG																															

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
RN																															
HHA																															
Aide Sup																															
MSW																															
Chaplin																															
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IDG																															

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
RN																															
HHA																															
Aide Sup																															
MSW																															
Chaplin																															
Volunteer																															
IDG																															

RN Frequency/Duration	HHA	Chaplin
	MSW	Volunteer

Hospice Agency Licensure Patient Record Audit Form

Facility Name:_____ **License #**_____

Surveyor_____ **Date:**_____

Documentation of:

	Pt # & Name	Pt # & Name	Pt # & Name	Pt # & Name	Pt # & Name
RN completes initial Assessment/RN Case Mngr Assigned					
Consent signed					
Bill of Rights provided					
Advance Directives					
Medical History					
Comp Care Plan W/I 5 calendar days Of initial assessment					
POC updated Q62days					
Assessment Update PRN & @least Q 15 days					
POC detailed re: scope & Frequency of services					
Coordination of Services					
Spiritual Counseling/ Bereavement Addressed In POC					
Aide CP by RN					
RN Supervisor Visits Every 2 weeks (W or Ø Aide)					
RN assessed Aide Services/POC review					
Homemaker Services Coordinated by IDT					
Volunteer Services					
Therapy Services					
Self Admin.of Meds. On POC					
Discharge Summary					
Transfer form					

HOSPICE CERTIFICATION/LICENSURE SURVEY PACKET CHECKLIST

Hospice Name: _____City:_____
Licensure or Provider Number: _____
Surveyor (s) _____Exit Date: _____

_____CMS 670 Team Composition Workload Report ©

_____ CMS 643 Survey Report ©

_____CMS 417 Request for Certification ©

_____ Home Visit Consent Forms #_____

_____Patient Sample List

_____Clinical Record Reviews #_____

_____List of Hospice Personnel

_____ List of Interdisciplinary Group Members

_____Volunteer Cost Saving Report

_____Exit Conference Attendees

_____Deficiency Statement/Compliance Statement ©

_____Licensure Inspection Form – Initial – Compliance – Focused

_____Licensure Patient Audit Form (Licensure Compliance Inspection Only)

_____Copy of Patient Rights (Initial Licensure Only)

_____Fiscal Year End _____©

_____Exit Tape

_____Revisit – Yes or No PCV or Cert Visit Licensure Revisit
Paper or On-Site Revisit

Revised October 2005
© = Certification Only

Hospice Licensure Only Survey

Information required for survey

Name of Agency: _____

Licensure number: _____

Dates of Survey: _____

Surveyor (s): _____

1. Weeks run _____
2. Director/ Administrator: _____
3. Medical Director: _____
4. Social Services: _____
5. Dietician: _____
6. Bereavement Director: _____
7. Volunteer Coordinator: _____
8. Spiritual Counselor: _____
9. Physical Therapist: _____
10. Occupational Therapist: _____
11. Speech/Language Pathologist: _____
12. Licensed Pharmacist: _____
13. Does the agency utilize Medication Aides? _____
14. IDG Members: _____
    _____
    _____
15. More than one IDG? _____
16. When does the IDG Meet? _____
17. Who is designated to act in the absence of the Administrator?
    _____
    _____
18. Where is this documented? _____
19. Who completes the initial assessment of patients when a referral is received?
    _____
    _____
20. Who are the members of the agency's Quality Assurance/Improvement Committee and how often does the QA/I meet?
    _____
    _____
21. Preventative Maintenance program for equipment?
    _____
    _____
22. How does the agency verify the competency of the Nursing Assistants/Medication Aides employed by the agency?
    _____
    _____
    _____
23. What agency staff is authorized to receive telephone and verbal, diagnostic and therapeutic and medication orders? _____

Hospice Licensure Inspection Information

Name of Agency: _____ Dates of Survey_____

Surveyor_____

To complete the survey the surveyor will need the following items:

1. List of:_____
   a.) All current patients
   b.) Include Services provided
   c.) Where the patient resides (Home, SNF/NF, or other facility)
   d.) List of Persons receiving Bereavement Counseling
2. Agency's Policy and Procedure Manual_____
3. Copy of the agency's by-laws outlining the responsibilities of the Governing Authority_____
4. List of all employees of the agency (include credentials license number, and Date of Hire) _____
5. Employee Personnel files for the following
   a.) Medical Director_____
   b.) Social Worker_____
   c.) Administrator_____
   d.) Dietician_____
   e.) Spiritual and Bereavement Counselors_____
   (Will need files of Home Health Aides and Medication Aides as chosen by the surveyor)
6. An Admission Packet_____
7. QA/QI Records_____
8. Volunteer Coordinator_____
   a.) List of Volunteers and titles of positions filed._____
   b.) Documentation of Recruitment and Retention of volunteers_____
   c.) Cost saving report. Include the following:
   *The identification of necessary positions which are occupied by volunteers;
   *The work time spent by volunteers occupying those positions; and
   *Estimates of the dollar costs which the hospice would have incurred if paid employees occupied the positions.
9. Agency's CLIA Number_____
10. List of Contracted Individuals with license numbers_____
11. List of members of the IDG and discipline _____
12. Grievance File _____
13. Orientation, In-service and Training Records for :
    a.) Employees_____
    b.) Contracted Individuals_____
    c.) Volunteers_____
    d.) Inpatient/Respite Staff_____
    e.) Nursing Homes_____
    f.) Home Health Aides_____
14. Preventive Maintenance logs for equipment owned by the Hospice used by patients
15. Does the Agency utilize Medication Aides? _____

We Value Your Opinion!

Dear Administrator,
We depend on your feedback to help us know how to improve our survey process. If you have not already done so, will you please take a few minutes to tell us how we did on your recent survey? If you have already completed the evaluation form, please accept out thanks and disregard this notice.

You can access the evaluation form directly at:

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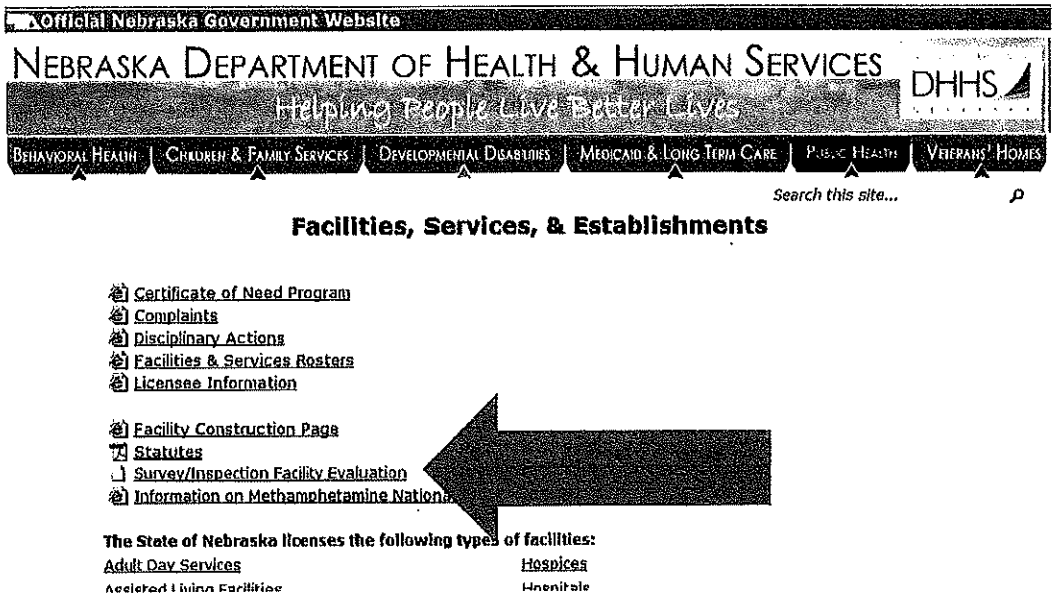

https://www.surveymonkey.com/r/CK38LWZ?sm=gm7Zn4csC71zAxfP6OgMyQ%3d%3d

Thank you for taking a moment to let us know what we are doing well and where we need to improve. Your responses are confidential and are used for data analysis and quality improvement purposes only. We appreciate your feedback!

Facility Name: _____

Dates of Survey: _____

Town: _____

Surveyor(s): _____

Sample Patient List

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

LIST OF PERSONNEL

FACILITY NAME: _____

PROVIDER NUMBER: _____

SURVEYOR: _____

DATE OF SURVEY: _____

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

I. _____

J. _____

K. _____

L. _____

M. _____

N. _____

O. _____

P. _____

Q. _____

R. _____

S. _____

T. _____

U. _____

V. _____

W. _____

X. _____

Y. _____

Z. _____

EXIT CONFERENCE ATTENDEES

Facility Type: Hospice ADS HHA ESRD OPT CORF Respite X-Ray HMO

Facility Name: _____

City: _____

License Number or Provider Number: _____

Date of Survery: _____

Surveyor(s) Name: _____

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

We Value Your Opinion!

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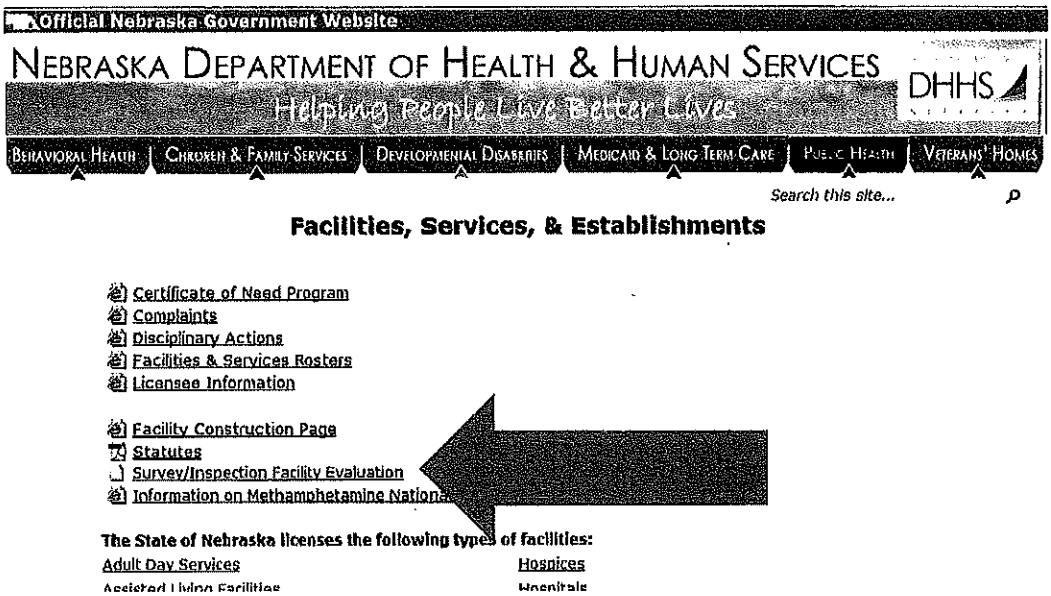

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Thank you for taking a moment to let us know what we are doing well and where we need to improve. Your responses are confidential and are used for data analysis and quality improvement purposes only. We appreciate your feedback!

Facility Name: _____

Dates of Survey: _____

Town: _____

Surveyor(s): _____

Sample Patient List

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

LIST OF PERSONNEL

FACILITY NAME: _____

PROVIDER NUMBER: _____

SURVEYOR: _____

DATE OF SURVEY: _____

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

I. _____

J. _____

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M. _____

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R. _____

S. _____

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U. _____

V. _____

W. _____

X. _____

Y. _____

Z. _____

EXIT CONFERENCE ATTENDEES

Facility Type: Hospice ADS HHA ESRD OPT CORF Respite X-Ray HMO

Facility Name: _____

City: _____

License Number or Provider Number: _____

Date of Survery: _____

Surveyor(s) Name: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Facility:_____

Regulation and Licensure
Credentialing Division ADS Compliance
Direct Care Staff Inspection

Date:_____
Time:_____

Staff Name/Title Hire Date	Criminal background checks	Nurse aide registry checked & findings	Adult Central Registry	Child Central Registry	Sex Offender Registry	Employed w/ criminal backgrnd or adverse registry findings	Profess. License OR Med Aide Registry checked & current	Health Screen prior to start of job	Job duties	Client rights	Client Service Agreements	Infection Control (hand washing, hygiene, disposal)	Info on physical, mental special needs	Medical / Health emergency procedures incl. Adv. Directives	Personnel policies	Client Policies	Abuse, Neglect, Misappropriation	Natural Disaster Preparedness	Ongoing Infec Control	Ongoing Emergency & Adv Dir	Ongoing Abuse, Neglect	Ongoing Disaster	Ongoing Client Rights
1																							
2																							
3																							
4																							
5																							
6																							
7																							
8																							
9																							
10																							

X=if information present
O=if information not present

Surveyor:_____

Revised: 8-7-09
ADS Compliance Insp Direct Care Staff.xls

ADS INSPECTION PACKET CHECKLIST

Facility Name: _____ **City:** _____

License Number: _____ Licensed Capacity: _____ **Census:** _____

Surveyor: _____ **Survey Dates:** _____

Type of inspection: Initial Compliance Focused Complaint (intake #_____)

_____ Inspection Checklist Provided on Entrance

_____ CMS 670 Team Composition Workload Report

_____ ADS Compliance Inspection Report

_____ ADS Compliance Inspection Protocols

_____ List of Clients

_____ Patient Sample Selection

_____ Direct Care Staff Form

_____ List of Employees

_____ Employee Sample Selection

_____ Number of Client Record Keeping Form

_____ Number of Client Interviews

Yes or No Licensure Deficiencies Cited

Yes or No Revisit On site:_____ or Paper:_____

_____ Surveyor Notes

_____ Copies requested from the ADS

_____ Exit CD on all surveys

_____ List of Exit Conference Attendees

_____ Pictures

Complaint w/survey: Yes or NO

Submit Separate:
- CMS 670
- Investigative Notes
- Finding Statement

Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Department of Health and Human Services

Division of Public Health
Licensure Unit
P.O. Box 94986
Lincoln, NE 68509-4986

LICENSURE INSPECTION
Consent for Home Visit

Patient Name: _____

Address: _____

Name of Home Health Agency: _____

Date of Home Visit: _____

Name of Surveyor: _____

This consent statement permits the Department of Health and Human Services, Division of Public Health, Licensure Unit personnel to conduct a home visit to determine the Agency's compliance with the State Regulations governing the licensure of Home Health Agencies and to evaluate the quality of services provided to their patients.

I understand that consent for this visit is voluntary and the visit will only be performed with my permission.

_____ _____

Patient Signature Date

If you have any questions or concerns, contact the Licensure Unit at (402) 471-4967.

Distribution: White - Patient Pink - Licensure Unit Yellow - Provider Agency

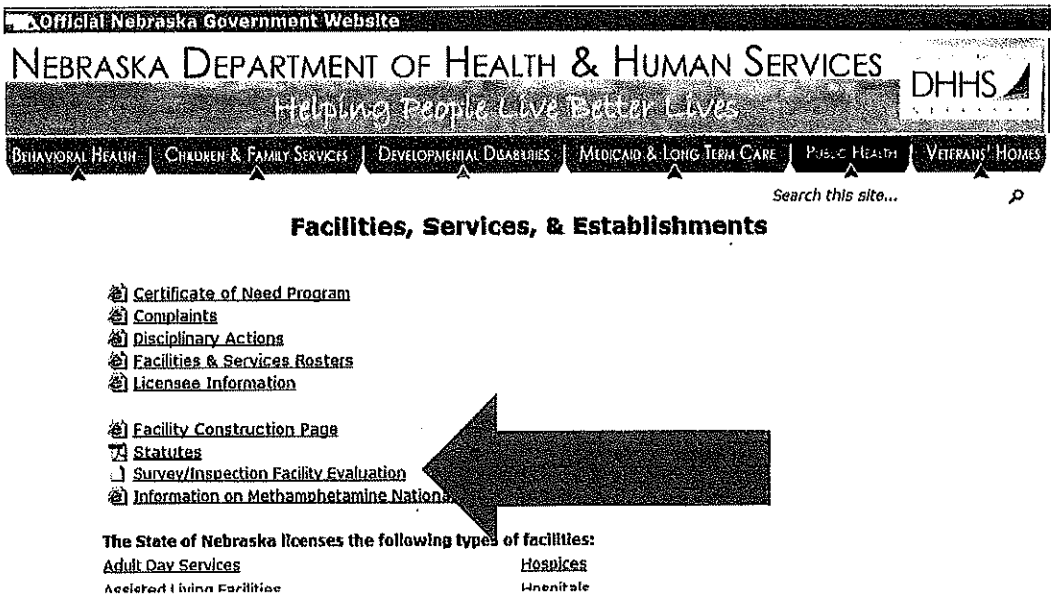
We Value Your Opinion!

Dear Administrator,
We depend on your feedback to help us know how to improve our survey process. If you have not already done so, will you please take a few minutes to tell us how we did on your recent survey? If you have already completed the evaluation form, please accept out thanks and disregard this notice.

You can access the evaluation form directly at:

https://www.surveymonkey.com/r/CK38LWZ?sm=gm7Zn4csC71zAxfP6OgMyQ%3d%3d

Or you can access the evaluation form from our website at:



https://www.surveymonkey.com/r/CK38LWZ?sm=gm7Zn4csC71zAxfP6OgMyQ%3d%3d

Thank you for taking a moment to let us know what we are doing well and where we need to improve. Your responses are confidential and are used for data analysis and quality improvement purposes only. We appreciate your feedback!

Facility Name: _____

Dates of Survey: _____

Town: _____

Surveyor(s): _____

Sample Patient List

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

LIST OF PERSONNEL

FACILITY NAME: _____

PROVIDER NUMBER: _____

SURVEYOR: _____

DATE OF SURVEY: _____

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

I. _____

J. _____

K. _____

L. _____

M. _____

N. _____

O. _____

P. _____

Q. _____

R. _____

S. _____

T. _____

U. _____

V. _____

W. _____

X. _____

Y. _____

Z. _____

EXIT CONFERENCE ATTENDEES

Facility Type: Hospice ADS HHA ESRD OPT CORF Respite X-Ray HMO

Facility Name: _____

City: _____

License Number or Provider Number: _____

Date of Survery: _____

Surveyor(s) Name: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Investigator Name: _____

Incident Number:

Onsite Investigation:

Start Date	Exit Date	PRE-SURVEY	12A - 8A	8A - 6P	6P - 12A	TRAVEL	OFFSITE

Phone Investigation:

Start Date	Exit Date	PRE-SURVEY	12A - 8A	8A - 6P	6P - 12A	OFFSITE

NURSE AIDE INVESTIGATION FORM

NURSE AIDE NAME
Nurse Aide address:
Nurse Aide City, State and zip:
Nurse Aide phone number:
Nurse Aide License #:
Nurse Aide Social Security #:

Nurse Aide Investigator:
Dates of investigation Onsite Dates: **TelephoneDates:**

Complaint Number: NE00090169

Administrator: Mr. David Williamson, Administrator
Facility Name: Eastern Nebraska Veterans Home
Facility Type: SNF-LIC

DATE/TIME OF INCIDENT

Incident was: Circle appropriate **Witnessed Admitted**

Resident's Name:

Condition, as it relates to general credibility and to the particular issue:(Condition, as it relates to general credibility and to the particular issue)

(1) ELEMENTS ***(Please check all that apply)***
[Definitions found at 471 NAC 12-001.04 or 42 CFR § 488.301]

_____ A. **ABUSE** *means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.*

Abuse

Willful infliction of	_____injury
	_____unreasonable confinement
	_____intimidation
	_____punishment
with resulting	_____physical harm
	_____pain
	_____mental anguish.

_____B. **NEGLECT** *means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.*

Neglect

Failure to provide _____goods
_____services

necessary to avoid _____physical harm
_____mental anguish
_____mental illness

Were there factors beyond the aides control?

_____ C. **Misappropriation** *of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.*

Misappropriation of resident property

Deliberate _____ misplacement
_____ exploitation
_____ wrongful use (temporary or permanent)

of a resident's _____ belongings
_____ money

without the resident's consent.

(2) EVIDENCE

(A) PEOPLE

Eye-witnesses (if any):

_____

_____

Interviewed: Yes_____ (Please locate/identify in the file.)

No_____ Why:_____

Staff/co-workers interviewed and location of information in file (any significant piece of information):

1.

2.

3.

4.

5.

For the following witnesses include phone number and synopsis of their interview:

Director of Nursing:

Nursing Home Administrator:

Charge Nurse on Date of Allegation:

(B) PAPER

A. Resident Issues
Care Plan/MDS _____
Nurses Notes _____

B. Facility Issues
   Floor Plan _____
   Schedules _____

C. NA Issues
   Orientation _____
   In-Service _____
   Personnel Records _____

D. Facility Investigation _____

(3) RECOMMENDATION (MAKE YOUR CASE!)

(4) Allegation (what is the Nurse Aide accused of): This is what will go on the certified letter--write as--While working at Facility you allegedly:

July 3, 2019

CERTIFIED MAIL

Dear

A representative from the Nebraska Department of Health and Human Services, Public Health Division, Licensure Unit is conducting an inquiry into an alleged incident of abuse, neglect and/or misappropriation that occurred during your employment Eastern Nebraska Veterans Home.

We are interested in hearing your version of what happened so that we may have an accurate account of the incident.

Should you choose not to respond to this letter, a decision will be made based on the information presently available. Please contact at to schedule a meeting or telephone conference by . Our telephones have voice messaging so please leave a message if you unable to reach one of us.

Sincerely,

,
Licensure Unit, Public Health Division

QUESTIONS FOR ADMINISTRATOR INTERVIEWS

Intake Number: NE00090169

Date_____Time_____Name_____Title_____
Yrs Employed_____ Address_____
Phone_____ Interview Site_____

Tell me about the incident on _____ between _____ and _____.

Tell me about your investigation.

Tell me about the staff member accused of abuse.

Describe the facility's orientation process for caregivers.

When was the last inservice on abuse? _____ When was the last inservice on care of cognitively impaired residents? _____

What is your policy on abuse?

Do you have a photograph of the accused staff member?

Do you have the phone number of the accused staff member?_____

Home address?_____

Is the accused staff member still employed here?

QUESTIONS FOR Medical Personal INTERVIEWS

Intake Number: NE00090169

Date_____Time_____Name_____Title_____
Yrs Employed_____ Address_____
Phone_____ Interview Site_____

Tell me about the incident on _____ between _____ and _____.

Do you confirm you still remember the incident?

Do you confirm the statement dated_____ and signed by _____ is correct?

Tell me about the resident?

Are you willing to testify?

QUESTIONS FOR RESIDENT INTERVIEWS

Intake Number: NE00090169

Date_____ Time_____ Name_____
Room_____ Interview Site_____

1. How do you feel about living here?
2. What do you do if you have a problem?
3. Do the nursing assistants know how to care for you?
4. How do the nursing assistants treat you?
5. Have you ever heard a nursing assistant speak harshly to a resident?
6. Have you ever seen a nursing assistant hurt a resident?
7. Do you have any concerns about your safety, health, or care here?

QUESTIONS FOR RESPONDENT INTERVIEW

Intake Number: NE00090169
Date_____ Time_____ Name_____ Title_____
Yrs Employed_____ Address_____
Phone_____ Interview Site_____

Tell me about the incident that occurred _____?
What happened?

(Clarify)

Who else was there?

What did they say?

What did they do?

When did this happen? Date? Time?

Do you have anything to add in respect to the allegations?

Who else can provide information about the situation?

Do you deny or agree with the allegation(s)?

Are you working now?

If so where:

QUESTIONS FOR STAFF INTERVIEWS

Intake Number: NE00090169

Date_____ Time_____ Name_____
Room_____ Interview Site_____

1. How long have you worked here?
2. How do you like working here?
3. How do you know what care each resident is to receive?
4. Are you able to perform the cares required for your assignment?
5. What is the call light policy?
6. What is included in a.m. and h.s. care?
7. What is the policy on abuse and neglect?
8. Have you ever heard a staff member speak harshly to a resident or seen a resident mistreated?
9. What concerns do you have for residents in this facility?
10. Confirm you still remember the incident?
11. Confirm the statement of the incident is correct?
12. Are you willing to testify?

July 3, 2019

Mr. David Williamson, Administrator
Eastern Nebraska Veterans Home
12505 South 40th Street
Bellevue, NE 68123

Dear: Mr. David Williamson, Administrator:

I am writing to request some additional information regarding an incident that occurred between resident and staff member around .

Please include this form when returning information. Any requested item already sent does not need to be resent – thank you.

You can mail this information to:
Health Facility Investigation
Attn:
PO BOX 94986
Lincoln, NE 68509

or you may fax it to us at 402-471-1679.

1. List of all residents with room numbers; Identify interviewable residents

2. Names of all employees with applicable titles; Indicate employees hired in the previous four months

3. Copy of nursing staff schedule **as worked** for
   Copy of nursing staff schedule for

4. Personnel file of
   a. back ground checks – copy of
   b. registry check – copy of
   c. disciplinary actions related to treatment of residents – copy of
   d. Previous 12 months of education. If not employed for year orientation record of abuse/neglect and resident's rights.
   e. Most recent address and phone number – _____ _____
   f. Dates of:
      Hire: _____ Suspension: _____ Termination: _____.
      Verify Birth: _____ SS# _____.
   g. Did you send a Nurse Aide Registry Form at time of hire and Nurse Aide Termination form at time of termination to the Nurse Aide Registry? The forms can be found at http://www.dhhs.ne.gov/crl/nursing/NA/na.htm and look under "facility forms".

5. Written policy and procedure for abuse.

6. In services the past year for Abuse, Residents' Rights, and Residents with Challenging Behaviors and attendance sheets since last survey.

7. Copies of medical record, nurses' notes, SS notes, behavior charting for related to incident **and** care plan, medication and treatment sheets for month of the incident, if not already sent.

8. Census _____ Capacity _____ at the time of the incident.

9. List nursing staff including home phone numbers who frequently worked with including any eye witness(s).

10. Please send a signed copy of the written statement by any witness(s), if not already sent.

Please have this information to us by . If you need additional assistance please feel free to give us a call at (402)471-0316.

Sincerely,

Health Facility Investigations
Licensure Unit
Public Health Division
Nebraska Department of Health and Human Services

July 3, 2019

ATTN:
, NE

Dear :

We are working on a case involving , Date of Birth from . We are needing a copy of record check and a copy of the report related to record number sent to us to help in our investigation for action against their certification.

This information can be fax to our investigations department at 402-471-1679 or mail to Health Facility Investigations Attn: Nurse Aide Investigations PO BOX 94986 Lincoln, NE 68509.

If you have any questions on this please feel free to give me at a call at 402-471-1719.

Sincerely,

Carrie Erickson
Staff Assistant II, Health Facility Investigations
Office of LTC Facilities
Licensure Unit
Public Health Division
Nebraska Department of Health and Human Services

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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

Mandatory Report of Licensed Health Professionals from Licensed Facilities

Licensed Health Facilities Reporting Licensed Health Professionals of adverse action to Division of Public Health-Investigations Unit.

STATE OF NEBRASKA *Name and address change eff 7/1/07 per LB296*
DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH
Office of PROFESSIONAL & OCCUPATIONAL INVESTIGATIONS
1033 O Street, Suite 500 Lincoln, Nebraska 68508
402-471-0175

PROFESSIONAL I AM REPORTING

Name	First:	Middle/MI:	Last:	Maiden:	Date of Birth:
Work Address:	Street:				
	City:		State:		Zip:
Home Address:	Street:				
	City:		State:		Zip:
Telephone	Home:		Work:		

LIST THE FIELD AND NUMBER FOR EACH NEBRASKA LICENSE, CERTIFICATE, OR REGISTRATION HELD

License Field	License Number

REPORTING PARTY

Name:

Title:

Organization:

Address:

Telephone Number:	Fax Number:

Email Address:

Relationship to Health Care Professional:

We are a:

☐ Health Care Facility ☐ Peer Review Organization ☐ Professional Association

We have (Health Care Facility Only):

☐ Made a payment due to adverse judgement, settlement, or award of a professional liability claim against the health care facility or health care professional.

☐ Taken actions adversely affecting the privileges, membership, or employment of a health care professional due to alleged:

- ☐ Incompetence
- ☐ Professional negligence
- ☐ Unprofessional conduct
- ☐ Physical, mental, or chemical impairment

We have (Peer Review Organizations or Professional Associations Only):

☐ Taken an action adversely affecting the privileges or membership of a health care professional due to alleged:

- ☐ Incompetence
- ☐ Professional negligence
- ☐ Unprofessional conduct
- ☐ Physical, mental, or chemical impairment

REPORTING AN ADVERSE ACTION

Date action was taken:	Effective Date:

Duration of the effect of the action:

Type of adverse action taken:

PATIENT OR CLIENT GIVING RISE TO THE ACTION TAKEN

Name:	Address:

Detailed description of act, omission, or conduct surrounding the reason of action taken:

Date of act, omission, or conduct:	Where did it occur?

List persons present at the end of the next page.

MALPRACTICE PAYMENT

Name of patient or client:	Address:
Name of Court:	Address
Date of judgement, settlement, or award:	Date of payment:

Amount of payment:

Description of the facts surrounding the reason of payment for the act or omission:

Date of occurrence:

Where did it occur?

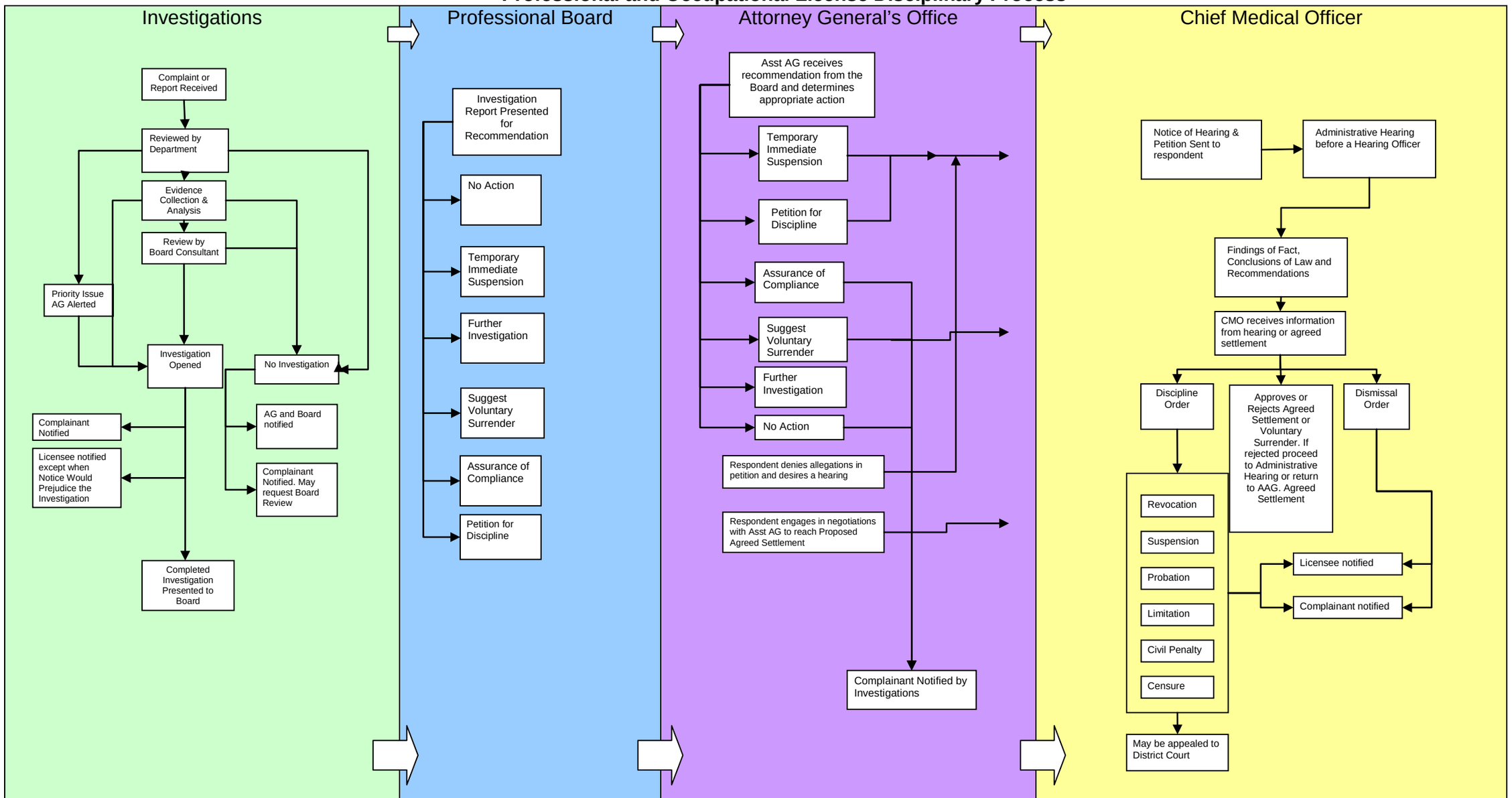
How did the act or omission occur?

Describe the nature of any injury, illness, damage, or other loss upon which the claim was based:

PERSONS PRESENT AT TIME OF ACT OR OMISSION OR WITH FIRST HAND KNOWLEDGE

Name	Title
Address	Telephone
Name	Title
Address	Telephone
Name	Title
Address	Telephone

Department of Health and Human Services
Professional and Occupational License Disciplinary Process



Nebraska Department of Health and Human Services

MANDATORY REPORT OF INSURERS REPORTING LICENSED HEALTH PROFESSIONALS

Insurers Reporting Licensed Health Professionals for adverse judgment or settlement as a result of a suit, claim or violation of insurance coverage, to Division of Public Health Investigations Unit.

STATE OF NEBRASKA *Name and address change eff 7/1/07 per LB296*
DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH
Office of PROFESSIONAL & OCCUPATIONAL INVESTIGATIONS
1033 O Street, Suite 500 Lincoln, Nebraska 68508
402-471-0175

PROFESSIONAL I AM REPORTING

Name:	First:	Middle/MI:	Last:	Maiden:	Date of Birth:
Work Address:	Street:				
	City:		State:		Zip:
Home Address	Street:				
	City:		State:		Zip:
Telephone	Home:		Work:		

LIST THE FIELD AND NUMBER FOR EACH NEBRASKA LICENSE, CERTIFICATE OR REGISTRATION HELD

License Field	License Number

Reporting Party

Name:	
Title:	
Organization:	
Address:	
Telephone No.	FAX No.
E-mail Address:	
Relationship to Health Care Professional:	

☐ 1. We have made a payment resulting from a professional liability claim.

☐ 2. We have taken an adverse action that affects the coverage provided by the insurer due to alleged:
- ☐ Incompetence
- ☐ Negligence
- ☐ Unethical
- ☐ Unprofessional conduct
- ☐ Physical, mental or chemical impairment

Type of action taken
- ☐ Denial of coverage
- ☐ Refusal to renew coverage
- ☐ Coverage terminated or cancelled
- ☐ Coverage limited, reduced or modified
- ☐ Premium or rate increase
- ☐ Other

Date adverse action was taken:_____
- ☐ Person is subject to National Practitioner Data Bank requirements and Data Bank Supplement form completed.
- ☐ Person not subject to National Practitioner Data Bank and next page completed.

☐ 3. The insurer has reasonable grounds to believe that the practitioner has committed a violation of the regulatory provisions governing the profession or practitioner.

☐ 4. The Department has requested the insurer to provide information.

Patient or Client

Name:	Date of Birth:
Address:	

Location of act, omission or conduct being reported

Name:

Address:

Date of Occurrence:_____

Describe in detail the acts, omissions or conduct being reported

MALPRACTICE PAYMENT

Name of patient or client:

Address:

Name of court:

Address:

Date of judgement, settlement or award:

Date of payment:

Amount of payment:

Description of the facts surrounding the reason for the payment for the act or omission:

Date of occurrence:_____
Where did it occur?

How did the act or omission occur?

The nature of any injury, illness, damage or other loss upon which the claim was based:

Persons present at time of act or omission or with first hand knowledge:

Name	Title
Address	Telephone
Name	Title
Address	Telephone
Name	Title
Address	Telephone

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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

Mandatory Licensed Health Professional Reporting Another Licensed Health Professional

Licensed Health Facilities Reporting Licensed Health Professionals of adverse action to Division of Public Health-Investigations Unit.

STATE OF NEBRASKA *Name and address change eff 7/1/07 per LB296*
DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH
Office of PROFESSIONAL & OCCUPATIONAL INVESTIGATIONS
1033 O Street, Suite 500 Lincoln, Nebraska 68508
402-471-0175

IDENTIFYING INFORMATION FOR PERSON I AM REPORTING

Name	First:	Middle/MI:	Last:	Maiden:	Date of Birth:
Work Address:	Street:				
	City:		State:		Zip:
Home Address:	Street:				
	City:		State:		Zip:
Telephone	Home:		Work:		
Field of License:			Nebraska License Number:		

A. I AM IN THE SAME PROFESSION AND IT IS NECESSARY FOR ME TO REPORT

- ☐ A pattern of negligent conduct
- ☐ Unprofessional conduct
- ☐ Other violations of laws or regulations governing the practice of the profession
- ☐ Gross incompetence
- ☐ Practicing while his/her ability to practice is impaired by:
  - ☐ Controlled substances
  - ☐ Alcohol
  - ☐ Narcotic drugs
  - ☐ Physical disability
  - ☐ Mental disability
  - ☐ Emotional disability

B. I AM IN A DIFFERENT PROFESSION AND IT IS NECESSARY FOR ME TO REPORT

- ☐ Gross incompetence
- ☐ Practicing while impaired **(Check boxes in A above under Practicing while impaired)**

Name	First:	Middle/MI:	Last:	Maiden:	Date of Birth:
Work Address:	Street:				
	City:		State:		Zip:
Home Address:	Street:				
	City:		State:		Zip:
Telephone	Home:		Work:		
Email:			Preferred Contact Number:		

INFORMATION TO REPORT

Act, omission, or conduct being reported:

Date of occurrence:

Statute, or regulation believed to have been violated, if known:

Where did it occur?

Description of the facts surrounding it:

Description of the nature of any injury, damage, detriment, or loss that resulted from the conduct, act, or omission:

Names, addresses, and telephone numbers of all persons present:

Your relationship to the person you are reporting:

Additional information:

172 NAC 5 – Regulations Governing Mandatory Reporting by Health Care Professionals, Facilities, Peer and Professional Organizations and Insurers

Summary of Mandatory Reporting Requirements

- Reports must be submitted in writing within 30 days of occurrence/action
- Reporting partners, except for self-reporting are immune from criminal or civil liability
- Must have first hand knowledge

WHAT TO REPORT	WHO MUST REPORT
1. Practice without License	All Professionals
2. Gross Incompetence 3. Pattern of Negligent Conduct 4. Unprofessional Conduct 5. Practice while Impaired by Alcohol/Drugs or Physical, Mental, or Emotional Disability 6. Violations of Other Regulatory Provisions of the Profession	All Professionals Report Others of the SAME Profession*
7. Gross Incompetence 8. Practice while Impaired by Alcohol/Drugs or Physical, Mental, or Emotional Disability	All Professionals Report Others of a DIFFERENT Profession*
9. Loss of or Voluntary Limitation of Privileges 10. Resignation from Staff 11. Loss of Employment 12. Licensure Denial 13. Loss of Membership in Professional Organization 14. Adverse Action pertaining to Professional Liability Coverage 15. Licensure Discipline/Settlement/Voluntary Surrender/Limitation in any State or Jurisdiction 16. Conviction of Felony or Misdemeanor in any State or Jurisdiction	Due to Alleged Incompetence, Negligence, Unethical or Unprofessional Conduct, or Physical, Mental, or Chemical Impairment. *** All Professionals—Self-Reporting
17. Payment made due to Adverse Judgment, Settlement, or Award 18. Adverse Action affecting Privileges or Membership***See above	Health Facilities, Peer Review Organizations, and Professional Associations
19. Violation of Regulatory Provisions Governing a given Profession** 20. Payments made due to Adverse Judgment, Settlement, or Award 21. Adverse Action affecting Coverage	Insurers
22. Convictions of Felony or Misdemeanor involving Use, Sale, Distribution, Administration, or Dispensing Controlled Substances, Alcohol or Chemical Impairment, or Substance Abuse. 23. Judgments from Claims of Professional Liability	Clerk of County or District Court

*Exceptions to reporting are: 1) If you are a spouse of the practitioner; 2) If you are providing treatment which means information is protected by a practitioner-patient relationship (unless a danger to the public); 3) When a chemically impaired professional enters the Licensee Assistance Program 4) When serving as a committee member or witness for a peer review activity; 5) Convictions that were dismissed by diversion, pardoned, set aside; or expunged.

**Unless knowledge is based on confidential medical records.

(Revised 3/2007)

Send Written Report To:
DHHS Division of Public Health
Investigations Unit
1033 O Street, Suite 500
Lincoln NE 68508

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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
COMPLAINT FORM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
OFFICE OF PROFESSIONAL & OCCUPATIONAL INVESTIGATIONS
1033 O Street, Suite 500 Lincoln, Nebraska 68508 402-471-0175

PUBLIC COMPLAINT FORM TO REPORT ADVERSE ACTION OF LICENSED OR UNLICENSED HEALTH PROFESSIONAL

Non licensed general public form used to report adverse actions about Licensed or Unlicensed Practice of Professionals and or Facilities to Division of Public Health Investigations Unit

INSTRUCTIONS: (Please type or print legibly.)
Please furnish all identifying information for the complainant, the patient and all practitioners and facilities involved in the complaint. Additional pages may be added if necessary

Person Making Complaint

(1) Name: First | Middle/MI | Last | Maiden or other Name Used

Address: Street

Address: City | State | Zip

Home Telephone | Work Telephone

May we contact you at your place of employment? ☐ Yes ☐ No

This Complaint is Being Filed Against

(1) Name: First | Middle/MI | Last | Maiden

Address: Street

Address: City | State | Zip

Date of Birth | Work Phone | Home Phone

(2) Name: First | Middle/MI | Last | Maiden

Office Address: Street

Office Address: City | State | Zip

Please check your response to the below statements and then sign the form. Please remember to also fill out and sign the Release of Information Authorization form.

I agree to testify in any licensure hearings that may arise as a result of my complaint ☐ Yes ☐ No

I grant my permission for the Division of Public Health - Investigations to provide a copy of my narrative to the subject of my complaint ☐ Yes ☐ No

The statements I have made are true and correct to the best of my knowledge ☐ Yes ☐ No

Date_____ Signed_____

NARRATIVE (Please type or print legibly)

Please describe in detail all allegations against the practitioner(s). Describe each incident with specific dates and list any witnesses. Attach copies of any documents you have concerning the allegations. Use additional sheets if necessary.

Release of Information Authorization

I authorize any person, including, but not limited to, hospitals, institutions, health care providers, mental health providers, clinics, employers (past and present), laboratories, attorneys, insurance companies, government agencies, or other public or private agencies to release to the Nebraska Health and Human Services and the Nebraska Attorney General's Office, their representatives, agents or employees, any and all information about me, including documents, reports, records, files, testimony or any other documents regardless of form or content.

Date of Incident:	Patient/Client's Name:

HIPAA: Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required. 45CFR 164.512 (d) Standard: Uses and disclosures for Health Oversight Activities. (1) Permitted disclosures. A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions.

A copy of this authorization shall be as valid as the original.

Name (Print or Type)	Date of Birth
Signature	Date
(or) Parent or legal guardian (if applicable)	Relationship

DO NOT WRITE BELOW THIS LINE

To:

Address:

Please submit copies of all records indicated below regarding the above release of information authorization. Thank you.

❑ Facesheet	❑ History and Physical	❑ Pathology Reports	❑ Consultant	❑ Progress Notes
❑ EKG Tracings	❑ Nurses Notes	❑ Discharge Summary	❑ Laboratory Reports	❑ Imaging Reports
❑ Operative Reports	❑ Physician Orders	❑ Emergency Dept. Record		

Other:

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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

Mandatory Licensed Health Professional Self Reporting

Licensed Health Facilities Reporting Licensed Health Professionals of adverse action to Division of Public Health-Investigations Unit.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
Office of PROFESSIONAL & OCCUPATIONAL INVESTIGATIONS
1033 O Street, Suite 500 Lincoln, Nebraska 68508
402-471-0175

INDICATE THE TYPE OF SITUATION YOU ARE REPORTING

☐ Loss or Voluntary Limitation of Privileges ☐ Resignation from Staff ☐ Loss of Employment
☐ Professional Liability ☐ Credential Denied or Disciplined ☐ Membership Lost ☐ Court Conviction

IDENTIFYING INFORMATION - COMPLETE ALL ITEMS

Name	First:	Middle/MI:	Last:	Maiden
Work Address	Street/PO/Route:			
	City:		State:	Zip:
Home Address	Street/PO/Route:			
	City:		State:	Zip:

Home Phone Number (Optional):	Work Phone Number (Optional):
Cell Phone Number (Optional):	Email Address Number (Optional):

LIST THE FIELD AND NUMBER FOR EACH NEBRASKA LICENSE, CERTIFICATE, OR REGISTRATION HELD

License Field	License Number

PATIENT OR CLIENT NAME ASSOCIATED WITH THIS REPORT

Name	First:	Middle/MI:	Last:	Maiden
Address	Street:			
	City:		State:	Zip:

Date of Birth:

FACILITY, BOARD, ASSOCIATION, JURISDICTION, EMPLOYER, OR HOSPITAL ASSOCIATED WITH THIS REPORT

Name:

Address:	Street:		
	City:	State:	Zip:

LOSS OR VOLUNTARY LIMITATION OF PRIVILEGES OR RESIGNATION FROM STAFF OR LOSS OF EMPLOYMENT REPORT

1. ☐ I lost my privileges in a hospital or other health care facility due to alleged:
   - ☐ Incompetence
   - ☐ Negligence
   - ☐ Unethical or unprofessional conduct
   - ☐ Physical, mental, or chemical impairment

2. ☐ I voluntarily limit my privileges or resigned from the staff of a health care facility while under the formal or informal investigation or evaluation by the facility or a committee of the facility for issues of:
   - ☐ Clinical incompetence
   - ☐ Unprofessional conduct
   - ☐ Physical, mental, or chemical impairment

3. ☐ I lost my employment due to alleged:
   - ☐ Incompetence
   - ☐ Negligence
   - ☐ Unethical or unprofessional conduct
   - ☐ Physical, mental, or chemical impairment

Date the above action occurred:	Date of Incident that led to 1, 2, or 3 above:

Name of person investigating or acting on privileges or employment:

Name of facility:

Address:	Street:		
	City:	State:	Zip:

Phone Number:

Facility Name Incident occurred at if different:

Facility Address Incident occurred at if different:

DESCRIBE THE CONDUCT, OMISSION, OR OTHER REASON THAT CAUSED YOUR LOSS OF EMPLOYMENT OR AFFECTED YOUR PRIVILEGES

PROFESSIONAL LIABILITY REPORT

1. ☐ I had a professional liability claim that resulted in an adverse judgement, settlement, or award, including settlements made prior to suit; OR

2. ☐ My professional liability insurance coverage has been canceled, limited, or otherwise modified due to a professional liability claim; OR

3. ☐ I have been refused professional liability insurance coverage on an initial or renewal basis due to professional liability claim.

Date(s) on which the act(s) or omission(s) which gave rise to the action or claim occurred:

Date of ☐ judgement ☐ settlement or ☐ award:	Day:	Month:	Year:
Date of payment:	Amount:		

Case Number:

Name of court or adjudicative body:

Address:	Street:		
	City:	State:	Zip:

Name of insurer, employer, other person, or entity making payment of the claim:

Address:	Street:		
	City:	State:	Zip:

Contact Person:

Name of patient, client, or other person to whom or for whose behalf payment was made:

Address:	Street:		
	City:	State:	Zip:

Name of location or where act(s) or omission(s) occurred:

Address:	Street:		
	City:	State:	Zip:

Description of the act(s) or omission(s) upon which the action was based:

CREDENTIAL DENIED OR DISCIPLINED, MEMBERSHIP LOST, OR COURT CONVICTION REPORT

1. ☐ I was denied a credential or other form of authorization to practice by a state, territory, or other jurisdiction, including any military or federal jurisdiction, due to alleged:
   - ☐ Incompetence
   - ☐ Negligence
   - ☐ Unethical or unprofessional conduct
   - ☐ Physical, mental, or chemical impairment

2. ☐ I had disciplinary action taken against a credential or other form of permit by another state, territory, or jurisdiction, including any federal or military jurisdiction, or I had a settlement of such action, or I voluntarily surrendered or had a limitation placed on my credential or other form of permit.

3. ☐ I lost my membership in a professional organization due to alleged:
   - ☐ Incompetence
   - ☐ Negligence
   - ☐ Unethical or unprofessional conduct
   - ☐ Physical, mental, or chemical impairment

Name of board, association, organization, or jurisdiction taking action:

Name:	Phone Number:	
City:	State:	Zip:
Date Action Takes:	Date Action Effective:	Duration of Action:

Nature of the action and description of any terms and conditions:

4. ☐ I was convicted of a misdemeanor or felony in Nebraska or another state, territory, or jurisdiction, including any federal or military jurisdiction. (Do not report speeding or parking tickets.) Include copy of conviction.

Name:

City:	State:	Zip:
Date of Conviction:	Case Number	☐ Under Appeal? To: (Court)

Name of crime for which convicted:

Sentence imposed, including duration and any terms and conditions:

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health – Investigations Unit
1033 "O" Street, Suite 500
Lincoln NE 68508
402-471-0175

Report of Investigation
Board of «LongBoardNamesDrop»
«InvFirstName» «INV_ASSIG», «InvestigatorTitle», Investigator

RESPONDENT

«PermRespFirst» «PermRespLast», «PermRespLicType»
«PermRespBusiness»
«PermRespStreet»«PermRespPOBox»
«PermRespCity», «PermRespState» «PermRespZip»
«RespInfoHomePhone»

DATE OF REPORT

CASE NUMBER
«COMPLAINT»

"Reports…complaints and investigational records of the department shall not be public records, shall not be subject to subpoena or discovery, and shall be inadmissible in evidence in any legal proceeding of any kind or character except a contested case before the department…No person, including, but not limited to, department employees and members of a board, having access to such reports, complaints or investigational records shall disclose such information in violation of this section…Violation of this subsection is a Class I misdemeanor." Neb. Rev. Stat. § 38-1, 106(1)

BACKGROUND

EDUCATION

LICENSE INFORMATION

EMPLOYMENT HISTORY

PREVIOUS DHHS LICENSE ACTION

ACTIONS TAKEN BY ANOTHER JURISDICTION OR AGENCY

NEBRASKA CRIMINAL HISTORY

MANDATORY REPORTING

INVESTIGATIVE SUMMARY

ATTACHMENTS