MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2023

FY 2023 Required Corrective Action					
Standard	CMS Performance Measure	Recommendation (6)	Corrective Action Required (18)	Multi-Year Citation (12)	New Citation (6)
2.1	1 Findings	☒			
5.1	3 Findings		☒		☒
6.1	1 Finding	☒			
6.6	2 Findings		☒		☒
6.7			☒	☒	
7.1			☒	☒	
7.2			☒	☒	
7.7			☒	☒	
8.4	1 Finding	☒			
8.5	5 Findings		☒	☒	
8.9			☒	☒	
8.10	1 Finding	☒			
8.12	1 Finding	☒			
8.15	1 Finding				
9.5	1 Finding	☒			
9.6	4 Findings		☒	☒	
10.2			☒	☒	
10.3			☒		☒
11.1	1 Finding		☒		☒
11.2			☒	☒	
13.1	9 Findings		☒	☒	
13.2			☒		☒
14.3			☒		☒
14.4			☒	☒	
15.1	1 Finding				
15.2			☒	☒	

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Citations Requiring Corrective Action:

Citation:

5.1 Did the Supports Coordinator (SC) contact the participant/guardian prior to assessments, home visits and/or planning meetings to ensure the date(s), time(s) and location(s) were convenient for the participant/guardian? (Performance Measure 18) – NEW CITATION

Issues Cited:

- The record did not validate advanced notice was provided to the participant for Person-Centered Planning Meeting 09/26/23.
- The record did not validate advanced notice was provided to the participant for Re-Assessment conducted on 04/18/23.
- 1) Progress note 01/04/23 identified the participant chose to conduct the Re-assessment (RA) on 01/09/23. However, the RA was conducted on 01/10/23. 2) The record did not validate advanced notice was provided to the participant for Person-Centered Planning Meeting 07/07/23.

Root Cause Analysis:

- Supports Coordinator training and education.
- Current policy includes direction regarding documentation of prior contact, but procedures will be updated to include explicit direction for all forms of home visits, assessments, and planning meetings. Policy and Procedure updates are needed.

Staff Education Plan:

- Further education on follow up in regards to participant contact/scheduling will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 5.1 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

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Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.
- The Long-Term Care Quality Manager will be reviewing performance measures on a monthly basis. If a Supports Coordinator falls below acceptable standards the Director of LTC Programs will be notified and a one-on-one meeting with the Supports Coordinator will be scheduled.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Issues all pertained to progress notes lacking documentation of calls/contacts to schedule participant meetings/visits
- Initial assessment policy contains requirements for contact prior to scheduled visit to confirm date and time.
- Charting Examples policy contains language regarding documentation or contact prior to in-person meetings
- Will add additional language to Charting Examples under policy to cover requirement of documented contact prior to ANY home visit or meeting.

Citation:

6.6 Did the Supports Coordinator (SC) assess the participant for all risks including environmental and home-based risks, educate the participant/guardian on assessed/identified risks, offer modifications to promote safety and independence, and provide the participant/guardian the opportunity to manage risk throughout care planning and service delivery? (Performance Measure 18) – NEW CITATION

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Issues Cited:

- 1) Progress note 09/22/22 (Outside of The Review Period) identified the participant moved to a new apartment 09/25/22. However, the record identified an environmental assessment was conducted 10/06/22 (11 days). 2) Progress note 12/28/22 identified the participant's daughter requested an order for a manual wheelchair from the participant's doctor. However, to ensure the participant's safety, the record did not support the SC assisted the participant with obtaining a new wheelchair or ensured the participant's receipt of the wheelchair. Re-Assessment 01/27/23 identified the participant had a wheelchair. CQAR reviewed the rebuttal. Score Maintained.
- 1) Progress note 12/06/22 identified the participant's need for a two-wheeled walker. However, to ensure the participant's safety, the record did not support the SC assisted the participant with obtaining a new walker or ensured the participant's receipt of the walker. 2) Re-Assessment 02/10/23 identified the participant's need for a lightweight wheelchair. However, to ensure the participant's safety, the record did not support the SC assisted the participant with obtaining a new wheelchair or ensured the participant's receipt of the wheelchair. Participant dis-enrolled.

Root Cause Analysis:

- Supports Coordinator training and education.
- Current policy does not contain explicit direction re: documentation of follow up on DME or other purchased items or services not covered by the Waiver. Policy and procedure updates are needed.

Staff Education Plan:

- Further education on follow up in regards to risk management and restraints/seclusion will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 6.6 and 6.7 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.

- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Both citations received for this standard were related to follow up regarding Medicare/DME purchases.
- Service Arranging Policy was updated in December 2023 to include new language regarding non-Waiver services or community resources. Current policy does not contain explicit direction re: follow up on DME or other items purchased not covered by the Waiver
- Service Arranging Policy will be updated to include documentation of contact, Supports Coordinator assistance if needed, and follow up to ensure receipt of the requested item(s).
- Follow-up contact reminders should be added to COMPASS to ensure appropriate follow up and documentation or receipt.

Citation:

6.7 If the Supports Coordinator (SC) identified the use of restraints or seclusion, did the SC evaluate, address, and offer alternatives to the use of restraints or seclusion? MULTI-YEAR CITATION (2)

Issues Cited:

- The record identified the use of bed rails. However, documentation did not identify the purpose or the length of the bed rails.

Root Cause Analysis:

- Supports Coordinator training and education.
- Current policy contains procedures for assessing the use of restraints and seclusion, however, additional language is needed regarding further

documentation of the purpose and length of bed rails, if utilized. Policy and procedure updates are needed.

Staff Education Plan:

- Further education on follow up in regards to risk management and restraints/seclusion will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 6.6 and 6.7 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

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Additional Notes:

- Current policy contains procedure for addressing restraints in a residential setting.
- Participant Management of Risk Policy does match contract language from the Medicaid Provider Manual.
- NOTE: Medicaid Provider Manual does not specifically state the requirement to document the purpose or length of bed rails or bed canes. Policy states: "An exception to restraints or restrictive intervention is bed rails or bed canes. If bed rails or bed canes are used, this must be based upon assessed need for the participant and documented in the person-centered service plan. If the participant resides in a provider-controlled setting, there must be an order from a licensed medical professional, and this must be kept on file in the participant's case record at the waiver agency."
- Participant Management of Risk policy will be updated to include details of the bed rail or bed cane, including purpose, length, size, etc.
- Make sure you are accurately documenting the use of bed rail and bed cane – there is a difference between the two.

Citation:

7.1 Did the Medication Record include all prescribed medications? MULTI-YEAR CITATION (2)

Issues Cited:

- Documents provided included a physician office visit document dated 02/14/23 that included the participant's medication regimen. However, Medication and Allergy Report 02/27/23 contained the following discrepancies in prescribed medications when compared to the physician document: 1) The physician document listed the following prescribed medications. However, were not included on Medication and Allergy Report: albuterol sulfate, furosemide, lidocaine patch, and ProAir HFA. 2) The Medication and Allergy Report listed prescribed medication Senna. However, was not included on physician document.
- Documents provided for the review included the Skilled Home Health Care Plan of Care 11/28/22 - 01/24/23 which included the participant's medication list. However, the Medication and Allergy Report 02/10/23 contained the following discrepancies: 1) The Medication and Allergy Report identified the prescribed medication Lisinopril. However, the Home Health Plan of Care did not include this medication. 2) The Home Health Plan of Care identified Vitamin D3 80 mcg daily. However, the Medication and Allergy list identified Vitamin D3 800 IU daily. 3) The Home Health Plan of Care identified Folic Acid 1 mg daily. However, the Medication and Allergy List identified Folic Acid 800 mcg daily. Participant dis-enrolled.
- 1) Re-Assessment 12/01/22 Section M (Hearing and Vision) identified the participant was using over-the-counter drops to clear wax buildup from her ears. However, the Medication and Allergy Report did not include this medication. 2) Documents provided included the skilled nursing facility's Order Summary Report 01/24/23, including the participant's medication regimen. However, the Medication and Allergy Report 01/24/23 contained the following discrepancies: a) The Medication and Allergy Report 01/24/23 identified the prescribed medication Galantamine ER 8 mg daily. However, the Order Summary Report did not include this medication. b) The Order Summary Report identified Calmoseptine ointment twice daily. However, the Medication and Allergy Report identified Calmoseptine ointment daily. Additionally, the comment section of the Medication and Allergy Report identified Calmoseptine ointment as, "apply to buttocks every morning and at bedtime." c) The Order Summary Report identified Clotrimazole cream applied under the breast twice a day. However, the Medication and Allergy Report identified Clotrimazole cream applied to feet daily. d) The Order

Summary Report identified Diclofenac Sodium gel applied to the hand/wrist/elbow four times a day. However, the Medication and Allergy Report identified Diclofenac Sodium gel every four hours. 3) Progress note 05/19/23 identified the participant had a medication change which was updated in the re-assessment. However, the Medication and Allergy Report "Next" did not identify changes to the participant's medication regimen.

- Documents provided included Office Clinic Notes 03/09/23. The Medication Section was not congruent with the Medication and Allergy Report "Next." The Medication Section identified the participant was taking Mylanta and Vitamin C plus Zinc, 1 tab, oral, every other day. However, Medication and Allergy Report "Next" did not include these medications.
- Documents provided included the Home Health Certification and Plan of Care (485) dated 04/17/23. The Medication and Allergy Report 04/12/23 and "Next" were not congruent with the Home Health Certification and Plan of Care. The Home Health Certification and Plan of Care identified the following medications prescribed by the participant's physician, Clotrimazole Topical 1% and Lantus Solo Star Pen. However, the Medication and Allergy Report 04/12/23 and "Next" did not list these medications.

Root Cause Analysis:

- Supports Coordinator training and education.
- Current policy lacks explicit direction for contacting the physician when there is a discrepancy between the Medication and Allergy report and Home Health/Physician Office/Participant lists. Current policy includes the requirement of a review of medication discrepancies with the participant only. Policy and procedure updates are needed.
- It had already been determined through an internal review that there was a need for additional desk aides and resources for Supports Coordinators regarding documentation of medications, medication compliance, and appropriate follow-up procedures and policies. UPCAP created multiple guide documents and distributed them to Supports Coordination staff to assist with proper documentation of participant medications, ongoing follow-up and monitoring, minimizing participant risks, and medication reconciliation. Supports Coordinators received these guides toward the end of FY 2023 and it is to be noted that none of the issues that were identified within this citation occurred after Supports Coordinators were supplied with these guides.

Staff Education Plan:

- Further education and follow up in regards to management of participant risk with regards to medications, including documentation/medication lists, compliance with medications, and appropriate follow-up will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed and when the updated Medicaid Provider Manual is released, policies and procedures specific to citation 7.1, 7.2, and 7.7 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordination staff will be reminded to continue to utilize guide documents and resources provided to improve compliance with this standard.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if

needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
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- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Monitoring Contact Guide with direction re: updating COMPASS with changes to medication created and sent to Supports Coordinators in March 2023
- COMPASS Assessment Guide was completed and sent to Supports Coordinators in July 2023 – contains direction for consistent completion of the medication and allergy report within the iHC Compass Assessment.
- All noted issues within participant files were dated prior to the release of the COMPASS Assessment Guide
- Participant Medication Policy was updated in September 2023 which included more specific direction and policy regarding discrepancies with the medication list but it was specific to reviewing the list with the participant.
- Participant Medication Policy will be updated to be compliant with new Waiver application/contract language requiring reviewing discrepancies with the physician and documenting/monitoring the participant's medication regimen.
- New Waiver application language: "Most MI Choice participants live in their own homes, in which case the waiver agencies have ongoing responsibility for second line management and monitoring of participant medication regimens (first line management and monitoring is the responsibility of the

prescribing medical professional). As part of the assessment and reassessment (reassessments are conducted 90 days after the initial assessment, with a reassessment occurring annually thereafter, or upon a significant change in the participant's condition), supports coordinators collect complete information about the participant's medications, including what each medication is for, the frequency and dosage. An RN supports coordinator reviews the medication list for potential errors such as duplication, inappropriate dosing, or drug interactions. The RN supports coordinator is also responsible for contacting the physician(s) when there are questions or concerns regarding the participant's medication regimen. Regular supports coordinator monitoring of participants includes general monitoring of the effectiveness of the participant's medication regimens. These monitoring activities are conducted through case record review, face-to-face meetings with participants, and discussion with direct care and other staff as appropriate."

Citation:

7.2 Did the Medication Record include the name, prescribing physician name (as indicated on the prescription bottle), purpose, strength/dose, frequency, and route for all medications? MULTI-YEAR CITATION (3)

Issues Cited:

- Medication and Allergy Reports 11/29/22, 01/27/23, 04/26/23, and "Next" did not include the number of puffs for Breztri Aerosphere. Participant dis-enrolled.
- Medication and Allergy Report 01/19/23 and "Next" identified the dose for Ativan as "0.5".

Root Cause Analysis:

- Supports Coordinator training and education.
- Current policy lacks explicit direction for contacting the physician when there is a discrepancy between the Medication and Allergy report and Home Health/Physician Office/Participant lists. Current policy includes the requirement of a review of medication discrepancies with the participant only. Policy and procedure updates are needed.
- It had already been determined through an internal review that there was a need for additional desk aides and resources for Supports Coordinators regarding documentation of medications, medication compliance, and appropriate follow-up procedures and policies. UPCAP created multiple guide documents and distributed them to Supports Coordination staff to assist with proper documentation of participant medications, ongoing follow-up and monitoring, minimizing participant risks, and medication reconciliation. Supports Coordinators received these guides toward the end of FY 2023 and it is to be noted that none of the issues that were identified within this citation occurred after Supports Coordinators were supplied with these guides.

Staff Education Plan:

- Further education and follow up in regards to management of participant risk with regards to medications, including documentation/medication lists, compliance with medications, and appropriate follow-up will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.

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- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed and when the updated Medicaid Provider Manual is released, policies and procedures specific to citation 7.1, 7.2, and 7.7 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordination staff will be reminded to continue to utilize guide documents and resources provided to improve compliance with this standard.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
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- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- COMPASS Assessment Guide was completed and sent to Supports Coordinators in July 2023 – contains direction for consistent completion of the medication and allergy report within the iHC Compass Assessment.
- All noted issues within participant files were dated prior to the release of the COMPASS Assessment Guide and updates to UPCAP's Medication policy

- No updates required to policy at this time.

Citation:

7.7 Did the Supports Coordinator (SC) address issues the participant had with medication regimen compliance and take action to reduce the risk of medication mismanagement? MULTI-YEAR CITATION (2)

Issues Cited:

- Re-Assessment 10/13/22 Section R identified the participant was compliant with medications 80% of the time or more and noted the participant's friend "will check to make sure she has taken them." However, documentation did not validate the SC addressed the compliance issue(s) and took action to reduce the risk of medication mismanagement. Re-Assessment "Next" identified the participant is "always adherent" with Medications
- 1) Re-Assessment 01/19/23 Section R identified the participant was adherent with medications 80% of time and "PCP and DPOAs have stated that it is not a major concern if (participant) refuses her medications." Progress note 07/19/23 further identified the family is concerned about the participant not taking her medications and "having increased symptoms of dementia." (Daughter) will let this worker know Dr. Chandler's response." Progress note 08/07/23 identified the SC "made the Compass Medication Changes following (participant's) PCP appointment on 07/31/2023. (Participant's) PCP is attempting to address (participant's) pain and mood issues, per family's request." However, the record lacked further documentation to validate the SC followed-up to ensure the participant's medication compliance and reduce risk of medication mismanagement. 2) Progress note 07/19/23 identified the participant's daughter faxed the participant's physician a letter to address the participant's non-compliance and the SC "placed a copy in (participant's) UPCAP file, and attached a copy to (participant's) Compass file." However, documents submitted for review did not include physician communication related to medication non-compliance. Additional Documentation Request.

Root Cause Analysis:

- Supports Coordinator training and education.
- Current policy lacks explicit direction for contacting the physician when there is a discrepancy between the Medication and Allergy report and Home Health/Physician Office/Participant lists. Current policy includes the requirement of a review of medication discrepancies with the participant only. Policy and procedure updates are needed.
- It had already been determined through an internal review that there was a need for additional desk aides and resources for Supports Coordinators regarding documentation of medications, medication compliance, and appropriate follow-up procedures and policies. UPCAP created multiple guide documents and distributed them to Supports Coordination staff to assist with proper documentation of participant medications, ongoing follow-up and monitoring, minimizing participant risks, and medication reconciliation. Supports Coordinators received these guides toward the end of FY 2023 and it is to be noted that none of the issues that were identified within this citation occurred after Supports Coordinators were supplied with these guides.

Staff Education Plan:

- Further education and follow up in regards to management of participant risk with regards to medications, including documentation/medication lists, compliance with medications, and appropriate follow-up will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director,

Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.

- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed and when the updated Medicaid Provider Manual is released, policies and procedures specific to citation 7.1, 7.2, and 7.7 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordination staff will be reminded to continue to utilize guide documents and resources provided to improve compliance with this standard.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

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Additional Notes:

- COMPASS Assessment Guide was completed and sent to Supports Coordinators in July 2023 – contains direction for consistent completion of the medication and allergy report within the iHC Compass Assessment.
- Participant Medication Policy was updated in September 2023 which included more specific direction regarding assessing for risk with medication compliance. However, the policy language will be updated to be more explicit regarding requirement of documentation that the Supports Coordinator "took action to reduce the risk of medication mismanagement".

Citation:

8.5 Did the Person-Centered Service Plan (PCSP) include the process for minimizing risk factors, planning, and supporting the participant? (Performance Measure 17, 18) MULTI-YEAR CITATION (3)

Issues Cited:

- 1) PCSP 11/29/22 did not evidence interventions for Service Utilization Equipment/Other. PCSP documentation stated: "The following people and services will assist me in achieving my goals: To Be Determined." 2) The record identified the participant had a pacemaker managed by a cardiologist. However, this non-waiver service was not contained within the PCSP, Back-Up Plan, or Service Summary. Agency Follow-Up Not Required. Participant dis-enrolled.
- Initial Assessment 11/29/22 identified the participant received Supplemental Nutrition Assistance Program services and Re-Assessment 02/27/23 identified the participant was receiving psychiatry services. However, these non-waiver services were not contained within the PCSP, Back-Up Plan, or Service Summary.
- 1) PCSP 01/11/23 did not evidence intervention(s) for "Nutritional/Hydration Status and Service Utilization Treatments." The PCSP documentation stated: "The following people and services will assist me in achieving my goals: To Be Determined." Agency Follow-Up Not Required. PCSP 04/04/23 contained interventions for issues identified. 2) Initial Assessment 01/11/23 and/or Re-Assessment 04/04/23 identified the participant received Skilled Home Care (Physical Therapy) services, Community Mental Health services, and podiatry service (foot problems limit walking and wears foot/ankle brace). However, these non-waiver services were not contained within the PCSP, Back-Up Plan, or Service Summary.
- 1) Progress note 05/16/23 identified the participant's receipt of Dermatology and Neurology services. However, these non-waiver services were not contained within the PCSP, Back-Up Plan, or Service Summary. 2) Progress note 06/13/23 identified the participant's receipt of outpatient therapy (Physical Therapy). However, this non-waiver service was not contained within the PCSP, Back-Up Plan, or Service Summary. The Review Notes: The Desired Outcomes identified in the Person-Centered Service Plans 12/01/22, 01/24/23, 04/18/23, and "Next" did not contain the necessary actions that would help meet the goal. Please refer to the Person-Centered Service Plan training conducted on 12/12/19 for outcome evaluations and statement examples
- 1) Re-Assessment 12/06/22 identified the participant "is also being seen by a chiropractor every 2 weeks for a sciatic nerve pinch." However, this non-

waiver service was not contained within the PCSP, Back-Up Plan or Service Summary. 2) Re-Assessment 12/06/22 identified the participant's receipt of Supplemental Nutrition Assistance Program (SNAP) benefits. However, this non-waiver service was not contained within the PCSP, Back-Up Plan or Service Summary.

Root Cause Analysis:

- Supports Coordinator training and education.
- Interpretation of Mi Choice Waiver Policy and person-centered planning. Staff were previously instructed to only include non-essential, non-Waiver services on the person-centered service plan or back-up plan when a participant requested. If a participant did not want to include an issue on the PCSP or back-up plan, Supports Coordinators did not add it. Policy and procedures will need to be updated to include this new focus and requirement of documenting all non-Waiver services, providers, and risk factors on the PCSP and back-up plan regardless of participant choice.
- Updates were recently made to UPCAP's Residential Services policy, including information regarding the HCBS Final Rule and process for those participants receiving residential services. Policy includes requirements for RCA on an annual basis. Updated policy was provided to Supports Coordination Staff at the beginning of FY2024.
- It had already been determined through an internal review that there was a need for additional desk aides and resources for Supports Coordinators regarding the development and documentation of the participant's Person-Centered Service Plan. UPCAP created multiple guide documents and distributed them to Supports Coordination staff to assist with proper documentation of participant goals and interventions, management of participant risk, follow-up/collaboration, and development of the participant's Person-Centered Service Plan and Back-up Plan. Supports Coordinators received these guides toward the end of FY 2023 and it is to be noted that none of the issues that were identified within this citation occurred after Supports Coordinators were supplied with these guides.

Staff Education Plan:

- Further education and follow up in regards to management of participant risk, follow up/collaboration, and person-centered service planning will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 8.5 and 8.9 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordination staff will be reminded to continue to utilize guide documents and resources provided to improve compliance with this standard.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.
- All Supports Coordination staff attended the Person-Centered Service Planning in HCBS: Requirements and Best Practices training on 1/10/2024. The

Director of LTC Programs will require Supports Coordination staff to attend other trainings specific to Person-Centered Service Planning and Management of Participant Risk Factors as they become available.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- UPCAP Interpretation of Mi Choice Waiver Policy and completion of PCSP or BUP
- Lack of training and consistency with person-centered service plan completion and requirements at the State level– did not include non-essential services on BUP
- COMPASS Assessment Guide was completed and sent to Supports Coordinators in July 2023
- COMPASS PCSP Guide was completed and sent to Supports Coordinators in August 2023
- Noted issues were all documented prior to the distribution of the COMPASS Assessment Guide and COMPASS PCSP Guide
- All Supports Coordination staff attended the Person-Centered Service Planning in HCBS: Requirements and Best Practices training on 1/10/2024
- Policy will not be updated at this time. However, Supports Coordinators will need to add any service or provider to the PCSP and BUP that is mentioned within the assessment and monitoring contacts.

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Citation:

8.9 Did the Supports Coordinator (SC) contact and collaborate in accordance with MDHHS policy and contract requirements? MULTI-YEAR CITATION (3)

Issues Cited:

- 1) Initial Assessment 01/11/23 identified the participant's receipt of Skilled Home Care service (Physical Therapy). However, the record lacked documentation to support the SC contacted the skilled agency for collaboration and service coordination. 2) Documents provided included the skilled Plan of Care identifying the participant was receiving skilled services in the home (05/25/23 - present). However, the record lacked documentation to support the SC contacted the skilled agency for collaboration and service coordination. Additionally, the record lacked documentation the SC reviewed the plan of care following the receipt of their plan of care.
- Documents provided included a Resident Care Agreement (RCA) or acceptable residency agreement 01/11/22. However, did not include an annual RCA or acceptable residency agreement. Additional Documentation Request.
- Re-Assessment 10/25/22 and progress notes 11/01/22 and 11/08/22 identified the participant's receipt of Skilled Home Care service (Physical Therapy, Occupational Therapy and Home Health Aide). However, the record identified contact with the skilled provider 01/20/23, evidencing a significant delay (73 days) for collaboration and service coordination. Agency Follow-Up Not Required. Skilled services terminated.
- 1) Progress note 02/24/23 identified the participant's receipt of Skilled Home Care services. However, the record lacked documentation to support the SC contacted the skilled agency for collaboration and service coordination. 2) Documents provided included the Home Health Care Certification and Plan of Care (485) identifying the participant skilled certification period 04/17/23 - 06/15/23. However, the record lacked documentation to support the SC contacted the skilled agency for collaboration and service coordination. Additionally, the record lacked documentation validating the SC reviewed the plan of care (485) following receipt of this document. Agency Follow-Up Not Required. Skilled terminated.

Root Cause Analysis:

- Supports Coordinator training and education.
- Interpretation of Mi Choice Waiver Policy and person-centered planning. Staff were previously instructed to only include non-essential, non-Waiver services on the person-centered service plan or back-up plan when a participant requested. If a participant did not want to include an issue on the PCSP or back-up plan, Supports Coordinators did not add it. Policy and procedures will need to be updated to include this new focus and requirement of documenting all non-Waiver services, providers, and risk factors on the PCSP and back-up plan regardless of participant choice.
- Updates were recently made to UPCAP's Residential Services policy, including information regarding the HCBS Final Rule and process for those participants receiving residential services. Policy includes requirements for RCA on an annual basis. Updated policy was provided to Supports Coordination Staff at the beginning of FY2024.
- It had already been determined through an internal review that there was a need for additional desk aides and resources for Supports Coordinators regarding the development and documentation of the participant's Person-Centered Service Plan. UPCAP created multiple guide documents and distributed them to Supports Coordination staff to assist with proper documentation of participant goals and interventions, management of participant

risk, follow-up/collaboration, and development of the participant's Person-Centered Service Plan and Back-up Plan. Supports Coordinators received these guides toward the end of FY 2023 and it is to be noted that none of the issues that were identified within this citation occurred after Supports Coordinators were supplied with these guides.

Staff Education Plan:

- Further education and follow up in regards to management of participant risk, follow up/collaboration, and person-centered service planning will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 8.5 and 8.9 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordination staff will be reminded to continue to utilize guide documents and resources provided to improve compliance with this standard.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.
- All Supports Coordination staff attended the Person-Centered Service Planning in HCBS: Requirements and Best Practices training on 1/10/2024. The Director of LTC Programs will require Supports Coordination staff to attend other trainings specific to Person-Centered Service Planning and Management of Participant Risk Factors as they become available.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

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Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Current policy contains direction for follow up and requirements for contact with skilled providers in the Care Transitions policy
- Current policy contains direction re: RCA
- Significant changes to the Residential Services policy were recently made, including information regarding the HCBS Final Rule and process for those participants receiving residential services. Policy includes requirement for RCA on an annual basis

Citation:

9.6 Did the authorized MI Choice Program services meet service standard requirements? (Performance Measure 15, 18) **MULTI-YEAR CITATION (4)**

Issues Cited:

- The Service Summary identified the implementation of a ramp 07/31/23. However, documentation did not support the SC validated within 10 working days/14 calendar days of completion: 1) the work was complete and correct; and 2) the work satisfied applicable building codes.
- The Service Summary identified the authorization of MI Choice Liquid Nutritional Supplements (LNS) 05/24/23. Documents submitted included an invalid physician order dated 03/31/23. Agency Follow-Up Not Required. LNS has been terminated.
- Documents submitted for review included Liquid Nutritional Supplement prescriptions 07/28/22 and 11/13/23. However, did not include a valid prescription for 01/25/23 - 09/30/23. Additional Documentation Request.
- The Service Summary identified the Waiver Agent authorized ramp installation 12/09/22. Progress note 12/09/22 further identified "Received an email with pictures from (vendor) confirming the completion of the ramp." However, the record did not validate the local building inspector verified the work to ensure applicable building codes in accordance with MDHHS policy and contract requirements were met.

Root Cause Analysis:

- Supports Coordinator training and education.
- Current policy contains procedures for authorizing and arranging for home modifications and environmental adaptations, however, additional language

is needed regarding further documentation of permits and building codes. Policy and procedure updates are needed.

Staff Education Plan:

- Further education and follow up in regards to MI Choice program service standards and requirements will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 9.6 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.
- The Long-Term Care Quality Manager will be reviewing performance measures on a monthly basis. If a Supports Coordinator falls below acceptable standards the Director of LTC Programs will be notified and a one-on-one meeting with the Supports Coordinator will be scheduled.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC

Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:
- Current home modification policy does not include direction/requirement for ensuring that the local building inspector verified the work to ensure building codes were followed.
- Service Arranging policy explicitly states the requirement for physician orders every 180 days for LNS – reminder of importance of getting script and updating the file. Update the due dates in the Participant Case File.
- Home Modification Policy does not require update at time as it contains the appropriate timeframe requirements for follow up after completion
- Provider Bid form will be updated to include the question, "Does this project require permit or inspection?"
- Provide contracts will be updated to ensure requirement of licensed provider to ensure permits and inspections are completed as necessary based on local building codes.

Citation:

10.2 Did the Supports Coordinator (SC) assess the presence of, or the need for, non-waiver services, and then, as preferred by the participant, provide the participant/guardian with information and/or assistance linking to non-waiver services or resources, and/or provide ongoing coordination and monitoring?
MULTI-YEAR CITATION (4)

Issues Cited:
- Progress note 01/23/23, 02/24/23, and 05/01/23 identified the participant requested assistance with accessing skilled nursing service to assist with in-home catheter care. However, the record lacked documentation validating the SC provided follow-up, as indicated. Agency Follow-Up Not Required. Progress note 08/04/23 validated the participant was receiving Skilled Home Care Nursing service.
- Progress note 07/12/23 identified the participant's daughter requested information regarding programs that provide assistance with heating costs. However, the record lacked documentation validating that the participant was provided this information.

Root Cause Analysis:
- Supports Coordinator training and education
- Additional language was recently added to the Service Arranging policy to include process for follow up and documentation for non-waiver and community-based referrals/resources/services, etc. and provided to staff on 12/21/2023.

Staff Education Plan:
- Further education on follow up in regards to participant service arranging, including non-waiver services, will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements

for each one.

- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 10.2 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analying all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Additional language was recently added to the Service Arranging policy to include process for follow up and documentation for non-waiver and community-based referrals/resources/services, etc. and provided to staff on 12/21/2023

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Citation:

10.3 If the participant/guardian experienced difficulty in securing a non-waiver/arranged service(s), did the Supports Coordinator (SC) continue to assist as warranted? NEW CITATION

Issues Cited:

- Progress note 08/28/23 identified the participant reported difficulties with obtaining increased J&B Medical supplies and not receiving her products as requested. Additionally, the progress note identified the SC contacted the participant's physician to request a prescription for increased supplies. However, the record lacked documentation validating follow-up by the SC for resolution.

Root Cause Analysis:

- Supports Coordinator training and education.
- Additional language was recently added to the Service Arranging policy to include process for follow up and documentation for non-waiver and community-based referrals/resources/services, etc. and provided to staff on 12/21/2023.

Staff Education Plan:

- Further education on follow up in regards to participant service arranging, including non-waiver services, will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 10.3 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which

improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Additional language was recently added to the Service Arranging policy to include process for follow up and documentation for non-waiver and community-based referrals/resources/services, etc. and provided to staff on 12/21/2023

Citation Home Interview:

10.8 Did your Supports Coordinator help you to access resources when requested, including calling to coordinator or arrange care with your doctor(s), skilled services, etc. as applicable? **NEW CITATION**

Issues Cited:

- The participant reports the SC did not provide timely and efficient assistance with providing information and/or linking/coordinating non-waiver services (assistance with home heating cost). The participant's daughter-in-law reports that they have discussed this request with the SC (noted in the record review progress note 07/12/2023).

Root Cause Analysis:

- Supports Coordinator training and education.
- Additional language was recently added to the Service Arranging policy to include process for follow up and documentation for non-waiver and community-based referrals/resources/services, etc. and provided to staff on 12/21/2023.

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Staff Education Plan:

- Further education on follow up in regards to participant service arranging, including non-waiver services, will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 10.3 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Additional language was recently added to the Service Arranging policy to include process for follow up and documentation for non-waiver and

community-based referrals/resources/services, etc. and provided to staff on 12/21/2023

- Service Arranging Policy will be updated to include more explicit language regarding assistance, coordination, arranging, and follow up for all documented needs for non-Waiver services or items.

Citation:

11.1 Did the Supports Coordinator (SC) contact the newly-enrolled participant/guardian to ensure service delivery in accordance with MDHHS policy and contract requirements? (Performance Measure 20) **NEW CITATION**

Issues Cited:

- The Service Summary identified the initial implementation of a Personal Emergency Response System on 12/05/22 and the SC did not ensure service delivery within 14 days (12/05/22 - 12/28/22; 23 days).

Root Cause Analysis:

- Supports Coordinator training and education.
- It had already been determined through an internal review that there was a need for additional desk aides and resources for Supports Coordinators regarding proper follow-up and monitoring. UPCAP created multiple guide documents and distributed them to Supports Coordination staff to assist with proper documentation of monitoring contacts, two-week follow up calls, and ongoing monitoring. Supports Coordinators received these guides toward the end of FY 2023 and it is to be noted that none of the issues that were identified within this citation occurred after Supports Coordinators were supplied with these guides.

Staff Education Plan:

- Further education in regards to follow up, will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 11.1 & 11.2 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

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Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Long-Term Care Quality Manager will be reviewing performance measures on a monthly basis. If a Supports Coordinator falls below acceptable standards the Director of LTC Programs will be notified and a one-on-one meeting with the Supports Coordinator will be scheduled.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Current policy contains requirements for two-week follow-up calls and documentation in participant record.
- No update to policy needed at this time.

Citation:

11.2 Did the Supports Coordinator (SC) contact the participant/guardian/designated person for follow-up and monitoring as specified in the Person-Centered Service Plan (PCSP) in accordance with MDHHS policy and contract requirements? **MULTI-YEAR CITATION (12)**

Issues Cited:

- Documents provided included "Other Healthcare Correspondence 2" and contained the medical records of a person other than the participant.
- Progress note 01/11/23 and 08/10/23 entered 01/24/23 and 09/25/23 were not completed according to MDHHS policy when making a late entry or an amendment to the record.
- 1) Progress note 12/12/22 and 08/01/23 was not completed according to policy when making a late entry or an amendment to the record. 2) The PCSP identified the participant preferred monitoring contacts every 30 days. 08/28/23 - 10/10/23 (43 days). The Review Notes: Progress note 04/07/23

indicated: Do you have any concerns or needs that we can help you with at this time? Yes. However, the comment section did not address the issue.

- The PCSP identified the participant preferred monitoring contacts every 30 days. 11/21/22 - 12/22/22 (31 days). The Review Notes: Monthly contact 07/17/23 indicated: Are your caregivers prompt and do they treat you with respect and dignity? No. However, the comment section did not explain this identified issue.

Root Cause Analysis:

- Supports Coordinator training and policy.
- It had already been determined through an internal review that there was a need for additional desk aides and resources for Supports Coordinators regarding proper follow-up and monitoring. UPCAP created multiple guide documents and distributed them to Supports Coordination staff to assist with proper documentation of monitoring contacts, two-week follow up calls, and ongoing monitoring. Supports Coordinators received these guides toward the end of FY 2023 and it is to be noted that none of the issues that were identified within this citation occurred after Supports Coordinators were supplied with these guides.

Staff Education Plan:

- Further education in regards to follow up will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 11.1 and 11.2 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out the contact due report to all Supports Coordinators on a monthly basis as an additional reminder, besides their dashboard.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have

additional charts monitored if needed.

- The Long-Term Care Quality Manager will be reviewing performance measures on a monthly basis. If a Supports Coordinator falls below acceptable standards the Director of LTC Programs will be notified and a one-on-one meeting with the Supports Coordinator will be scheduled.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Started running progress note reports monthly to track late entries & record amendments to ensure proper documentation and timeliness of data entry – added this to SC performance reports and reviews
- Recently updated Follow-Up and Monitoring policy to include more explicit language re: documentation for late entries and record amendments – provided to SCs in a MEMO on 12/21/2023 so there is no longer a lack of clarity regarding late entries and amendments.
- This is a 12 year citation and could result in monetary sanctions against UPCAP.

Citation:

13.1 Did the record contain a complete and up-to-date contingency plan in accordance with MDHHS policy and contract requirements? (Performance Measure 30) **MULTI-YEAR CITATION (3)**

Issues Cited:

- 1) The contingency plan 11/04/22 contained the acronym (w/c). Therefore, not understandable or written in plain language. 2) The contingency plan 11/04/22 identified "I do not use medical equipment that relies on power." However, the contingency plan identified the participant would use a "power lift platform in garage." 3) The contingency plan 11/04/22 identified the participant's Service Need Level as 2A Urgent-Informal Supports None. However, My Back-Up Plan For Care identified: In the event that the service provider is unable to find a replacement aide then the participant will contact informal supports to assist.
- 1) The contingency plan 11/29/22 did not identify the participant's oxygen provider. 2) The contingency plans 11/29/22, 01/27/23, and 04/26/23 did not identify the participant's cardiologist. 3) The contingency plans 11/29/22, 01/27/23, and 04/26/23 did not identify the correct Service Need Level. 2A

was identified, however, documentation validated the participant had informal support available. Agency Follow-Up Not Required. Participant dis-enrolled.

- The contingency plan provided to the participant was incomplete. Initial Assessment 11/29/22 identified the participant received Supplemental Nutrition Assistance Program services and Re-Assessment 02/27/23 identified the participant was receiving psychiatry services. However, the contingency plan did not list these non-waiver service providers or contact information.
- The contingency plan provided to the participant was incomplete. Initial Assessment 01/11/23 and/or Re-Assessment 04/04/23 identified the participant received Skilled Home Care (Physical Therapy) services, incontinent supplies through J&B Medical, Community Mental Health services, and podiatry service (foot problems limit walking and wears foot/ankle brace). However, the contingency plan did not list these non-waiver service providers or contact information.
- Progress note 05/16/23 identified the participant's receipt of ongoing dermatology (skin biopsy) and neurology (immunotherapy) services. However, the contingency plan "Next" did not identify these providers.
- The contingency plan identified the participant's Service Need Level as 1B. However, the record identified the participant resided in a Supervised Residential Setting.
- 1) The record identified the participant's receipt of chiropractic care every two weeks. However, this critical service and support was not identified on the contingency plan. 2) The record identified the participant's receipt of Supplemental Nutrition Assistance Program (SNAP) benefits.
- The contingency plan 10/14/22, 01/10/23 and "Next" indicated: No primary care physician on record. However, the Medication and Allergy Report identified a prescribing physician. Additionally, an order was obtained for Liquid Nutritional Supplements, including a physician name and contact information.
- The contingency plan provided to the participant was incomplete. Re-Assessments 10/25/22 and 01/18/23 identified the participant utilized continuous oxygen. However, the participant's oxygen provider, including contact information was not included on the contingency plan.

Root Cause Analysis:

- Supports Coordinator training and education.
- It had already been determined through an internal review that there was a need for additional desk aides and resources for Supports Coordinators regarding contingency plan requirements. UPCAP created multiple guide documents and distributed them to Supports Coordination staff to assist with proper documentation of participant goals and interventions, management of participant risk, follow-up/collaboration, and development of the participant’s Person-Centered Service Plan and Back-up Plan. Supports Coordinators received these guides toward the end of FY 2023 and it is to be noted that none of the issues that were identified within this citation occurred after Supports Coordinators were supplied with these guides.

Staff Education Plan:

- Further education regarding contingency plan requirements will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a

weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 13.1 & 13.2 will be updated and submitted to MDHHS/CQAR for review.

- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.
- All Supports Coordination staff attended the Person-Centered Service Planning in HCBS: Requirements and Best Practices training on 1/10/2024.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- UPCAP Interpretation of Mi Choice Waiver Policy and completion of PCSP or BUP
- Lack of training and consistency with person-centered service plan completion and requirements at the State level– did not include non-essential services on BUP
- COMPASS Assessment Guide was completed and sent to Supports Coordinators in July 2023
- COMPASS PCSP Guide was completed and sent to Supports Coordinators in August 2023
- Noted issues were all documented prior to the distribution of the COMPASS Assessment Guide and COMPASS PCSP Guide
- All Supports Coordination staff attended the Person-Centered Service Planning in HCBS: Requirements and Best Practices training on 1/10/2024

- Policy will not be updated at this time. However, Supports Coordinators will need to add any service or provider to the PCSP and BUP that is mentioned within the assessment and monitoring contacts.

Citation:

13.2 Did the participant/guardian receive a copy of the contingency plan in accordance with MDHHS policy and contract requirements? If no, were they offered a copy and declined? NEW CITATION

Issues Cited:

- The record did not validate the participant received a copy of their initial contingency plan or that the participant declined a copy of the initial contingency plan when offered. Additionally, progress note 08/24/23 identified the Supports Coordinator was to provide a copy of the contingency plan to the participant during a scheduled home visit on 08/30/23. However, documentation did not validate a copy was provided to the participant during the visit.
- The record did not validate the participant received a copy of their contingency plan or that the participant declined a copy of the contingency plan, when offered.
- The record did not validate the participant received a copy of the contingency plan or that the participant declined a copy of the contingency plan, when offered
- The record did not validate the participant received a copy of their contingency plan or that the participant declined a copy of the initial contingency plan when offered

Root Cause Analysis:

- Supports Coordinator training and education.
- It had already been determined through an internal review that there was a need for additional desk aides and resources for Supports Coordinators regarding contingency plan requirements. UPCAP created multiple guide documents and distributed them to Supports Coordination staff to assist with proper documentation of participant goals and interventions, management of participant risk, follow-up/collaboration, and development of the participant's Person-Centered Service Plan and Back-up Plan. Supports Coordinators received these guides toward the end of FY 2023 and it is to be noted that none of the issues that were identified within this citation occurred after Supports Coordinators were supplied with these guides.
- Review and updated policy to include language on proper documentation related to when a participant declines a copy of their contingency plan. Policy and procedure updates are needed.

Staff Education Plan:

- Further education in regards to ensuring the contingency plan is sent as required, as well as documentation if the participant wishes not to receive a copy, will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one. On a quarterly basis the LTC Quality Improvement Manager will also utilize a software

(Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.

- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 13.1 & 13.2 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out the contact due report to all Supports Coordinators on a monthly basis as an additional reminder, besides their dashboard.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Participant Management of Risk policy contains requirements for providing and documenting receipt of contingency plan. However, language will be updated to include documentation when a participant declines having the plan sent. This must be documented each time – having in the Supports Coordination Intervention in the PCSP is not sufficient.

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2023

Citation:

14.3 Did the Supports Coordinator (SC) take appropriate action and discuss methods to prevent further occurrence with the participant/guardian? NEW CITATION

Issues Cited:

- Progress note 11/09/22 identified the SC "Met face to face with R. from Hearthside for monthly monitoring. R. mentioned (participant's) recent elopement, which daughter (name) is aware." However, the record lacked documentation evidencing the SC discussed methods to prevent further occurrences.

Root Cause Analysis:

- Supports Coordinator training and education.

Staff Education Plan:

- Further education will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one. On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 14.3 & 14.4 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

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Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- No updates needed to policy at this time.

Citation:

14.4 Did the Waiver Agent (WA) enter, report, and provide updates to the critical incident portal in accordance with MDHHS policy and contract requirements? MULTI-YEAR CITATION (2)

Issues Cited:

- Progress note 11/09/22 identified the SC "Met face to face with R. from Hearthside for monthly monitoring. R. mentioned (participant's) recent elopement, which daughter (name) is aware." However, the record did not evidence the critical incident was reported and entered into the MDHHS Critical Incident Management System.

Root Cause Analysis:

- Supports Coordinator training and education.
- Unclear guidance on what constitutes a critical incident and appropriate reporting. Supports Coordinators received training on critical incidents from CMS as well as MDHHS, which identified discrepancies in what is considered a critical incident, specifically falls. Updates were made to the critical incident policy with Cheryl Decker on 08/03/2023.

Staff Education Plan:

- Further education on critical incident reporting will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one. On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.

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- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 14.1 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Lack of clarity on what constitutes a critical incident
- All Supports Coordination staff attended the Critical Incident training provided by MDHHS
- Updates made to Critical Incident Policy in conjunction with Cheryl Decker on 8/03/2023
- No policy updates needed at this time.

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2023

Citation:

15.2 Was the Adverse (Advance) Action Notice (AAN) and/or Adverse Benefit Determination (ABD) complete, and accurate? MULTI-YEAR CITATION (2)

Issues Cited:

- The ABD with a mailing date 11/21/22 identified a written appeal request from the participant must be received by 12 calendar days to maintain services. However, Waiver Agents must maintain the MI Choice service(s) during an appeal or an adverse benefit determination if the participant files the appeal within 10 days. The Review Notes: ABD with a mailing date of 11/21/22 did not include the contact information for the Ombudsman Program. CQAR reviewed the rebuttal. Score Maintained.
- The ABDs 11/09/22, 12/30/22, and 01/10/23 identified a written appeal request from the participant must be received by 12 calendar days to maintain services. However, Waiver Agents must maintain the MI Choice service(s) during an appeal or an adverse benefit determination if the participant files the appeal within 10 days. The Review Notes: ABDs 11/09/22, 12/30/22, and 01/10/23 did not include the contact information for the Ombudsman Program. CQAR reviewed the rebuttal. Score Maintained
- The ABD(s) with a mailing date 11/08/22 identified a written appeal request from the participant must be received by 12 calendar days to maintain services. However, Waiver Agents must maintain the MI Choice service(s) during an appeal or an adverse benefit determination if the participant files the appeal within 10 days. The Review Notes: ABD(s) with a mailing date of 11/08/22 did not include the contact information for the Ombudsman Program. CQAR reviewed the rebuttal. Score Maintained.
- The ABD(s) provided for the review identified a written appeal request from the participant must be received by 12 calendar days to maintain services. However, Waiver Agents must maintain the MI Choice service(s) during an appeal or an adverse benefit determination if the participant files the appeal within 10 days. The Review Notes: ABD(s) provided for the review did not include the contact information for the Ombudsman Program. CQAR reviewed the rebuttal. Score Maintained.
- The ABD mailing date 11/23/22 and 01/27/23 identified a written appeal request from the participant must be received by 12 calendar days to maintain services. However, Waiver Agents must maintain the MI Choice service(s) during an appeal or an adverse benefit determination if the participant files the appeal within 10 days. The Review Notes: ABD mailing date 11/23/22 and 01/27/23 did not include the contact information for the Ombudsman Program. CQAR reviewed the rebuttal. Score Maintained.

Root Cause Analysis:

- Supports Coordinator training and education.
- UPCAP identified the issue related to this citation during the FY2022 review. The ANN, ABD and related policies were updated to reflect the appropriate timeframe requirements. These updates were provided to staff in March 2023 at which time Supports Coordinators began utilizing the updated forms. Please note that none of the issues that were identified within this citation occurred after Supports Coordinators were supplied with these updates.

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Staff Education Plan:

- Further education regarding accurate AAN's and ABD's will be provided at the all staff meeting scheduled for February 14, 2024. Leadership (Director, Supervisor and Quality Manager) will specifically address every citation and review requirements for each one. On a quarterly basis the LTC Quality Improvement Manager will also utilize a software (Question Pro) to create a quiz for all Supports Coordinators on policies and procedures, including specifics on citations received in the FY2023 review.
- Policies and procedures will be reviewed to ensure contents are accurate and meeting required standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff and trainings conducted. If needed, policies and procedures specific to citation 15.2 will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed and one-on-one education/training provided if warranted.
- The Director of LTC Programs will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials as well as recognition for improved performance.

Who/What will be Monitored:

- In order to ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed on a monthly basis. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The results of peer reviews and supervisory reviews are analyzed by the Compliance Manager to track performance trends and identify areas in which improvement is needed. Supports Coordinators that are not meeting requirements on monthly peer reviews or supervisory reviews will also have additional charts monitored if needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly quiz and reporting results to the Director of LTC Programs. Supports Coordinators will be responsible for conducting no less than one peer review on a monthly basis. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The Compliance Manager will be responsible for analyzing all data from the peer and supervisory reviews and report findings to the Director of LTC Programs.
- The Director of LTC Programs will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- All documented issues were prior to the changes made to UPCAP's ABD form and accompanying paperwork

- Adverse Benefit Determination was updated to reflect 10-day advance notice period and ombudsman information on 1/11/2023
- Action Notices and Appeals Policy was updated to reflect 10-day advance notice period on 1/12/2023
- No policy updates needed at this time.

Compliance plan to evaluate effectiveness of CAP when compliance not demonstrate:

If compliance has not been met within three months, further education will be provided to Supports Coordinators. If the compliance issues are specific to a particular Supports Coordinator one-on-one training will be provided and ongoing monitoring will occur with no less than 10% of their caseload.

Recommendations (Not Resulting in Citation):

Recommendation:

2.1: Is there a valid Freedom of Choice (FOC) form in the record for the review period?

Issue Cited:

- FOCs 05/26/21 and 11/29/22 were signed by the participant's representative. However, the "Representative (if any)" field was incomplete.

Recommendation:

6.1: Did the Waiver Agency (WA) complete the Initial Assessment (IA) and/or Re-Assessments (RA) in accordance with MDHHS policy and contract requirements?

Issue Cited:

- Person-Centered Service Plan 01/11/23 and 04/04/23 identified the participant requested a RA every 90 days: RA 04/04/23 – due 07/03/23 and not conducted.

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Recommendation:

8.4: Did the Person-Centered Service Plan (PCSP) identify the participant's health and welfare issues, needs, and risks as preferred by the participant and as needed for continued monitoring by the Supports Coordinator (SC)?

Issue Cited:

- Progress note 11/09/22 identified the participant's recent elopement. Progress note 08/30/23 identified the participant "continues to try to elope." However, the record lacked documentation validating the Supports Coordinator assisted with creating safeguards and support mechanisms to minimize or mitigate the risks related to the participant's elopement.

Recommendation:

8.10: Did the Person-Centered Service Plan (PCSP) include outcome evaluations for each goal in accordance with MDHHS policy and contract requirements?

Issue Cited:

- The PCSP did not evidence outcome evaluations completed every 180 days (01/18/23 - 11/07/23; 293 days).

Recommendation:

8.12: Is the person responsible for monitoring the Person-Centered Service Plan (PCSP) identified in the plan?

Issue Cited:

- The PCSP 01/19/23 and "Next" did not identify the person responsible for monitoring the plan.

Recommendation:

9.5: Did the Supports Coordinator (SC) authorize a change in a MI Choice Program service(s) in accordance with MDHHS policy and contract requirements, or provide the participant/guardian with appropriate alternatives?

Issue Cited:

- Progress note 06/13/23 identified the participant requested a change in the Home Delivered Meal service provider. The record did not support the Supports Coordinator honored this request in a timely manner.