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Secretary of State

John Thurston

500 Woodlane, Suite 026

Little Rock, Arkansas 72201-1094

(501) 682-5070

www.sos.arkansas.gov



For Office

Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Developmental Disabilities Services

Contact Mac E. Golden E-mail Mac.E.Golden@dhs.arkansas.gov Phone 501-563-7634

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: ADDT-1-20; SPA#2020-0020; Rules for DDS ADDT

Intended Effective Date
(Check One)

Emergency (ACA 25-15-204)

10 Days After Filing (ACA 25-15-204)

Other 01/01/2021
(Must be more than 10 days after filing date.)

Legal Notice Published

Final Date for Public Comment

Reviewed by Legislative Council

Adopted by State Agency

Date

09/30/2020

10/29/2020

12/18/2020

01/01/2021

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Jack Tiner jack.tiner@dhs.arkansas.gov

12/18/2020

Contact Person

E-mail Address

Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Signature

501-682-8662

Phone Number

melissa.stone@dhs.arkansas.gov

E-mail Address

Director

Title

December 18, 2020

Date

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised:

January 1, 2021

CATEGORICALLY NEEDY

9. Clinic Services

(1) Adult Developmental Day Treatment (ADDT) Services

Limited to comprehensive day treatment centers offering the following **core** services to beneficiaries age 18 and above:

- a. **Assessment and Treatment Plan Development, 2 units per year**
- b. Adult Day Habilitation Services, 5 units per day, 1 hour each
- c. Provision of noon meal

Optional Services available through ADDT in conjunction with core services are as follows:

- a. Physical therapy - Services must be prescribed by a physician and provided by or under the supervision of a qualified physical therapist.
- b. **Speech-language** therapy - Services must be referred by a physician and provided by or under the supervision of a qualified speech pathologist.
- c. Occupational therapy - Services must be prescribed by a physician and provided by or under the supervision of a qualified occupational therapist.

Occupational, Physical, and **Speech-Language** Therapy Services are provided in accordance with Items 3.1-A.4b(15), 3.1-A.11, 3.1-B.4b(15), and 3.1-B(11).

Extensions of the benefit limit for all ADDT services will be provided if medically necessary.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised:

January 1, 2021

MEDICALLY NEEDY

9. Clinic Services

(1) Adult Developmental Day Treatment (ADDT) Services

Limited to adult day treatment centers offering the following **core** services to beneficiaries age eighteen (18) and above:

- a. Assessment **and Treatment Plan Development, two (2)** units per year
- b. Adult Day Habilitation Services, five (5) units per day, one (1) hour each day
- c. Provision of noon meal

Optional Services available through Adult Developmental Day Treatment (ADDT) in conjunction with core services are as follows:

- a. Physical therapy—Services must be prescribed by a physician and provided by or under the supervision of a qualified physical therapist.
- b. Speech-**language** therapy—Services must be prescribed by a physician and provided by or under the supervision of a qualified Speech Pathologist.
- c. Occupational therapy—Services must be prescribed by a physician and provided by or under the supervision of a qualified Occupational therapist.

Occupational, Physical, and Speech-**Language** Therapy Services are provided in accordance with Items 3.1-A.4b(15), 3.1-A.11, 3.1-B.4b(15), and 3.1-B(11).

Extensions of the benefit limit for all ADDT services will be provided if medically necessary.

TOC required**201.000 Arkansas Medicaid Participation Requirements for Adult Developmental Day Treatment (ADDT) Providers 1-1-21**

A provider must meet the following participation requirements in order to qualify as an Adult Developmental Day Treatment (ADDT) provider under the Arkansas Medicaid Program:

- A. Complete the Provider Participation and enrollment requirements contained within section 140.000 of the Arkansas Medicaid provider manual.
- B. Obtain an Adult Developmental Day Treatment license issued by the Arkansas department of Human Services, Division of Provider Services and Quality Assurance (DPSQA).

ADDT providers may furnish and claim reimbursement for covered ADDT services subject to all requirements and restrictions set forth and referenced in the Arkansas Medicaid provider manual.

201.100 ADDT Providers in Arkansas and Bordering States 1-1-21

ADDT providers in Arkansas and within fifty (50) miles of the state line in the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as ADDT providers if they meet all Arkansas Medicaid Program participation requirements.

202.100 Documentation Requirements for All Medicaid Providers 1-1-21

See Section 141.000 of the Arkansas Medicaid provider manual for the documentation that is required for all Arkansas Medicaid Program providers.

202.200 ADDT Documentation Requirements 1-1-21

- A. ADDT providers must maintain medical records for each beneficiary that include sufficient, contemporaneous written documentation demonstrating the medical necessity of all ADDT services provided.
- B. Service documentation for each beneficiary must include the following items:
 1. The specific covered ADDT services furnished each day;
 2. The date and beginning and ending time for each of the covered ADDT services performed each day;
 3. Name(s) and credential(s) of the person(s) providing each covered ADDT service each day;
 4. The relationship of each day's covered ADDT services to the goals and objectives described in the beneficiary's Individual Treatment Plan; and,
 5. Weekly or more frequent progress notes, signed or initialed by the person(s) providing the covered ADDT service(s), describing each beneficiary's status with respect to his or her goals and objectives.

202.300 Electronic Signatures 1-1-21

The Arkansas Medicaid Program will accept electronic signatures in compliance with Arkansas Code § 25-31-103 et seq.

211.000 Introduction 1-1-21

The Arkansas Medicaid Program assists eligible individuals to obtain medical care in accordance with the guidelines specified in Section I of the Arkansas Medicaid provider manual. The

Arkansas Medicaid Program will reimburse enrolled providers for medically necessary covered ADDT services when such services are provided to an eligible beneficiary pursuant to an Individual Treatment Plan by a licensed ADDT meeting the requirements of the Arkansas Medicaid provider manual.

212.000 **Establishing Eligibility** **1-1-21**

212.100 **Age Requirement** **1-1-21**

A beneficiary must meet one of the following age criteria to be enrolled in an ADDT program and receive covered ADDT services through the Arkansas Medicaid Program:

- A. The beneficiary is at least twenty-one (21) years of age; or
- B. The beneficiary is between eighteen (18) and twenty-one (21) years of age and has a high school diploma or a certificate of completion.

212.200 **Prescription** **1-1-21**

The Arkansas Medicaid Program will reimburse enrolled providers for covered ADDT services only when the beneficiary's physician has determined that covered ADDT services are medically necessary.

- A. The physician must identify the beneficiary's medical needs that covered ADDT services can address.
- B. The physician must issue a written prescription for ADDT services dated and signed with his or her signature. The prescription for ADDT services is valid for one (1) year, unless a shorter period is specified. The prescription must be renewed at least once a year for ADDT services to continue.
- C. When prescribing ADDT services, the physician shall not make any self-referrals in violation of state or federal law.

212.300 **Qualifying Diagnosis** **1-1-21**

A beneficiary must have an intellectual or developmental disability diagnosis that originated before the age of twenty-two (22) and is expected to continue indefinitely in order to be eligible to enroll in an ADDT program and receive covered ADDT services.

- A. A qualifying intellectual or developmental disability diagnosis is any one or more of the following:
 - 1. A diagnosis of Cerebral Palsy established by the results of a medical examination performed by a licensed physician;
 - 2. A diagnosis of Spina Bifida established by the results of a medical examination performed by a licensed physician;
 - 3. A diagnosis of Down Syndrome established by the results of a medical examination performed by a licensed physician;
 - 4. A diagnosis of Epilepsy established by the results of a medical examination performed by a licensed physician;
 - 5. A diagnosis of Autism Spectrum Disorder established by the results of a team evaluation which must include a licensed physician, licensed psychologist, and licensed speech pathologist; or

6. A diagnosis of Intellectual disability or other similar condition found to be closely related to intellectual or developmental disability because it results in an impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual or developmental disability or requires treatment and services similar to that required for a person with an intellectual or developmental disability, based on the results of a team evaluation performed by a licensed physician and a licensed psychologist.
- B. The intellectual or developmental disability must constitute a substantial handicap to the beneficiary's ability to function without appropriate support services in areas such as daily living and social activities, medical services, physical therapy, speech-language therapy, occupational therapy, job training, and employment services.

213.000 Non-Covered Services

1-1-21

The Arkansas Medicaid Program will only reimburse for those ADDT services listed in Sections 214.000. Additionally, the Arkansas Medicaid Program will only reimburse for ADDT services when such services are provided to a Medicaid beneficiary meeting the eligibility requirements in Section 212.000 by an ADDT meeting the requirements of this Manual.

214.000 Covered ADDT Services

1-1-21

Covered ADDT services are either core services or optional services. It is presumed that no more than eight (8) combined hours of core and optional ADDT services per day is medically necessary.

214.100 ADDT Core Services

1-1-21

ADDT core services are those covered ADDT services that a provider must offer to its enrolled beneficiaries in order to be licensed as an ADDT.

214.110 ADDT Evaluation and Treatment Planning Services

1-1-21

An ADDT may be reimbursed by the Arkansas Medicaid Program for medically necessary ADDT evaluation and treatment planning services. ADDT evaluation and treatment planning services are a component of the process of determining a beneficiary's eligibility for ADDT services and developing the beneficiary's Individualized Treatment Plan (ITP).

Medical necessity for ADDT evaluation and treatment planning services is demonstrated by a developmental disability diagnosis by the beneficiary's physician that designates the need for ADDT evaluation and treatment planning services. Medically necessary ADDT evaluation and treatment planning services are covered once per calendar year and reimbursed on a per unit basis. The billable unit includes time spent administering an evaluation, scoring an evaluation, and writing an evaluation report along with time spent developing the ITP. [View or print the billable ADDT evaluation and treatment planning codes.](#)

214.120 Day Habilitative Services

1-1-21

- A. An ADDT may be reimbursed by the Arkansas Medicaid Program for medically necessary day habilitative services. Medical necessity for day habilitative services is established by a developmental disability diagnosis by the beneficiary's physician that designates the need for day habilitative services. ADDT day habilitative services include the following:
1. Instruction in areas of cognition, communication, social and emotional, motor or adaptive (including self-care) skills;
 2. Instruction to reinforce skills learned and practiced in occupational, physical, or speech-language therapy; or,
 3. Prevocational services that prepare a beneficiary for employment.
 - a. Prevocational services may not be used to provide job specific skill and task

instruction, or address explicit employment objectives, but may:

- i. Include habilitative goals such as compliance, attending, task completion, problem solving and, safety, and
 - ii. Be provided only to persons who are not expected to be able to join the general work force or to participate in a transitional sheltered workshop within one (1) year (excluding supported employment programs).
- b. A beneficiary's compensation for prevocational services must be less than fifty percent (50%) of the minimum wage for the training to qualify as prevocational services.
 - c. A beneficiary receiving prevocational services must have documentation in his or her file demonstrating such services are not available under a program funded under Section 110 of the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA) of 1997.
- B. ADDT day habilitative services are reimbursed on a per unit basis. No more than five (5) hours of ADDT day habilitative services may be billed per day without an extension of benefits. The unit of service calculation does not include time spent in transit from the beneficiary's place of residence to the ADDT facility and from the ADDT facility back to the beneficiary's place of residence. [View or print the billable day habilitative ADDT codes.](#)

214.200 ADDT Optional Services

ADDT optional services are those covered ADDT services that a provider may, but is not required to, offer to its enrolled beneficiaries in order to be licensed as an ADDT.

214.210 Occupational, Physical and Speech-Language Evaluation and Therapy Services

1-1-21

- A. An ADDT may be reimbursed for medically necessary occupational, physical, and speech-language evaluation and therapy services. Occupational, physical, and speech-language evaluation and therapy services must be medically necessary in accordance with the Medicaid Provider Manual for Occupational, Physical, and Speech-Language Therapy Services, Section II. A developmental disability diagnosis alone does not demonstrate the medical necessity of occupational, physical, or speech-language therapy.
- B. An ADDT may contract with or employ its qualified occupational, physical, and speech-language therapy practitioners. The ADDT must identify the qualified individual therapy practitioner as the performing provider on the claim when the ADDT bills the Arkansas Medicaid Program for the therapy service. The qualified therapy practitioner must be enrolled with the Arkansas Medicaid Program and the criteria for group providers of therapy services would apply (See Section 201.100 of the Occupational, Physical, and Speech-Language Therapy Services manual).
- C. All occupational, physical, and speech-language therapy services furnished by an ADDT must be provided and billed in accordance with the Arkansas Medicaid Provider Manual for Occupational, Physical, and Speech-Language Therapy Services, Section II. [View or print the billable occupational, physical, and speech-language therapy ADDT codes](#)

214.220 Nursing Services

1-1-21

- A. An ADDT may be reimbursed by the Arkansas Medicaid Program for medically necessary nursing services. Medical necessity for nursing services is established by a medical

- diagnosis and a comprehensive nursing evaluation approved by the physician that designates the need for ADDT services. The evaluation must specify the required nursing services, and the physician must prescribe the number of nursing service units per day.
- B. ADDT nursing services must be performed by a licensed Registered Nurse or Licensed Practical Nurse and must be within the nurse's scope of practice as set forth by the Arkansas State Board of Nursing.
 - C. For the purposes of this manual, ADDT nursing services are defined as the following, or similar, activities:
 - 1. Assisting ventilator-dependent beneficiaries;
 - 2. Tracheostomy suctioning and care;
 - 3. Feeding tube administration, care, and maintenance;
 - 4. Catheterizations;
 - 5. Breathing treatments;
 - 6. Monitoring of vital statistics, including diabetes sugar checks, insulin, blood draws, and pulse ox;
 - 7. Cecostomy or ileostomy tube administration, care, and maintenance; and
 - 8. Administration of medication; however, ADDT nursing services are not considered medically necessary if the administration of medication is the only nursing service needed by a beneficiary.
 - D. ADDT nursing services must be prior authorized and are reimbursed on a per unit basis. Time spent taking a beneficiary's temperature and performing other acts of standard first aid is not included in the units of ADDT nursing service calculation. [View or print the billable ADDT nursing codes.](#)

215.000 Individual Treatment Plan (ITP)

1-1-21

Each beneficiary enrolled in an ADDT, must have an individual treatment plan (ITP). This consists of a written, individualized plan to improve or maintain the beneficiary's condition based upon evaluation of the beneficiary. Each ITP must at a minimum contain:

- A. A written description of the beneficiary's treatment objectives;
- B. The beneficiary's treatment regimen, which includes the specific medical and remedial services, therapies, and activities that will be used to achieve the beneficiary's treatment objectives and how those services, therapies, and activities are designed to achieve the treatment objectives;
- C. Any evaluations or documentation that supports the medical necessity of the services, therapies, or activities specified in the treatment regimen;
- D. A schedule of service delivery that includes the frequency and duration of each type of service, therapy, activity session, or encounter;
- E. The job titles or credentials of the personnel that will furnish each service, therapy, or activity;
- F. A tentative schedule for completing re-evaluations of the beneficiary's condition and updating the ITP.

Prior authorization is required for the Arkansas Medicaid Program to reimburse for:

- A. Over five (5) hours of ADDT day habilitative services per day;
- B. Over ninety (90) minutes per week of occupational, physical, or speech-language therapy;
- C. All ADDT nursing services; and,
- D. Over eight (8) total hours of covered ADDT services in a day.

230.000 REIMBURSEMENT

231.000 Method of Reimbursement 1-1-21

ADDT services use “fee schedule” reimbursement methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge for the procedure or the maximum allowable reimbursement for the procedure under the Arkansas Medicaid Program. The maximum allowable reimbursement for a procedure is the same for all ADDT providers.

231.100 Fee Schedules 1-1-21

The Arkansas Medicaid Program provides fee schedules on the Arkansas Medicaid website. [View or print the ADDT fee schedule.](#)

Fee schedules do not address coverage limitations or special instructions applied by the Arkansas Medicaid Program before final payment is determined.

Fee schedules and procedure codes do not guarantee payment, coverage, or the reimbursement amount. Fee schedule and procedure code information may be changed or updated at any time to correct a discrepancy or error.

Rules for the Division of Developmental Disabilities

Adult Developmental Day Treatment



LAST UPDATED: January 1, 2021

Subchapter 1. General.

101. Authority.

- (a) These standards are promulgated under the authority of Ark. Code Ann. § 20-48-101 to -105, Ark. Code Ann. § 20-48-201 to -212, Ark. Code Ann. § 20-48-701 to -705, Ark. Code Ann. § 20-48-812, Ark. Code Ann. § 25-10-102, and Ark. Code Ann. § 25-15-217.
- (b) (1) The Division of Provider Services and Quality Assurance (DPSQA) shall perform all regulatory functions regarding the licensure and monitoring of Adult Developmental Day Treatment programs on behalf of the Division of Developmental Disabilities Services (DDS).
- (2) The Division of Developmental Disabilities Services (DDS) shall determine whether and to what an extent a county is underserved.

102. Purpose.

The purpose of these standards is to:

- (a) Serve as the minimum standards for adult developmental day treatment programs and facilities; and
- (b) Ensure that all beneficiaries receive all adult developmental day treatment services recommended by a physician for the maximum reduction of physical or mental disability and restoration of the beneficiary to the best functional level.

103. Definitions.

- (a) “ADDT” means an adult developmental day treatment program, which is a day treatment program prescribed by a physician that provides adult developmental day treatment services to adults with intellectual or developmental disabilities.
- (b) “ADDT license” means a non-transferable license issued by DPSQA to an ADDT for a specific location that meets these standards.
- (c) “Adult developmental day treatment services” means services that are available under the Adult Developmental Day Treatment program for Medicaid beneficiaries as defined in Section II of the Adult Developmental Day Treatment Medicaid Manual.
- (d) “Adverse regulatory action” means a denial of an ADDT license and any enforcement action taken by DPSQA pursuant to Section 803 to 807.

- (e) “Applicant” means an applicant for an ADDT license.
- (f) (1) “Change in ownership” means one (1) or more transactions within a twelve (12) month period that result in a change in greater than fifty percent (50%) of the financial interests, governing body, operational control, or other operational or ownership interests of the ADDT.
- (2) “Change in ownership” does not include a change of less than fifty percent (50%) in the membership of the ADDT’s board of directors, board of trustees, or other governing body.
- (g) “Directed in-service training plan” means a plan of action that:
 - (1) Provides training to assist an ADDT in complying with these standards and correcting deficiencies;
 - (2) Includes the topics covered in the training and materials used in the training;
 - (3) Specifies the length of the training;
 - (4) Specifies the employees required to attend the training; and
 - (5) Is approved by DPSQA.
- (h) (1) “Employee” means an employee, owner, independent contractor, or other agent of an ADDT and includes without limitation full-time employees, part-time employees, transportation contractors, and any other person who acts on behalf of an ADDT or has an ownership, financial, or voting interest in the ADDT.
- (2) “Employee” does not mean an independent contractor if:
 - (i) The independent contractor does not assist in the day-to-day operations of the ADDT; and
 - (ii) The independent contractor has no beneficiary contact.
- (i) “Irreconcilable conflict” means a conflict between two (2) standards where an ADDT cannot comply with both standards at the same time.
- (j) “ITP” means a beneficiary’s individual treatment plan, which is a written, individualized service plan for an ADDT beneficiary to improve the beneficiary’s condition.
- (k) (1) “Marketing” means the accurate and honest advertisement of an ADDT that does not also constitute solicitation.
- (2) “Marketing” includes without limitation:

- (A) Advertising using traditional media;
 - (B) Distributing brochures or other informational materials regarding the services offered by the ADDT;
 - (C) Conducting tours of the ADDT to interested beneficiaries and their families;
 - (D) Mentioning services offered by the ADDT in which the beneficiary or his or her family might have an interest; or
 - (E) Hosting informational gatherings during which the services offered by the ADDT are described.
- (l) “Medication error” means the loss of medication, unavailability of medication, falsification of medication logs, theft of medication, missed doses of medication, incorrect medications administered, incorrect doses of medication, incorrect time of administration, incorrect method of administration, and the discovery of an unlocked medication container that is always supposed to be locked.
- (m) “Plan of correction” means a plan of action that:
- (1) Provides the steps an ADDT must take to correct noncompliance with these standards;
 - (2) Sets a timeframe for each specific action provided in the plan; and
 - (3) Is approved by DPSQA.
- (n) “Residence” means the county where a beneficiary is listed as residing in the Arkansas Medicaid Management Information System.
- (o) “Serious injury” means any injury to a beneficiary that:
- (1) May cause death;
 - (2) May result in substantial permanent impairment;
 - (3) Requires the attention of an emergency medical technician, a paramedic, or a doctor; or
 - (4) Requires hospitalization.
- (p) (1) “Solicitation” means the initiation of contact with a beneficiary or his or her family by an ADDT when the beneficiary is currently receiving services from another provider and the ADDT is attempting to convince the beneficiary or his or her

family to switch to or otherwise use the services of the ADDT that initiated the contact.

- (2) “Solicitation” includes without limitation the following acts to induce a beneficiary or his or her family by:
 - (A) Contacting a beneficiary or the family of a beneficiary that is currently receiving services from another provider;
 - (B) Offering cash or gift incentives to a beneficiary or his or her family;
 - (C) Offering free goods or services not available to other similarly situated beneficiaries or their families;
 - (D) Making negative comments to a beneficiary or his or her family regarding the quality of services performed by another service provider;
 - (E) Promising to provide services in excess of those necessary;
 - (F) Giving a beneficiary or his or her family the false impression, directly or indirectly, that the ADDT is the only service provider that can perform the services desired by the beneficiary or his or her family; or
 - (G) Engaging in any activity that DPSQA reasonably determines to be “solicitation.”

- (q) “Underserved county” means a county that is underserved regarding adult developmental day treatment services in accordance with 20-48-105 of the Arkansas Code.

Subchapter 2. Licensing.

201. License Required.

- (a) (1) An ADDT must have an ADDT license issued by DPSQA pursuant to these standards for the location at which the ADDT will provide services.
- (2) An ADDT must comply with all requirements of these standards.
- (b) (1) An ADDT license is specific to a single location.
- (2) A separate ADDT license is required for each location even if the same person or entity has an ADDT at other locations.
- (3) A location may only have one (1) ADDT license attributed to it at any one time.

202. Licensure Application.

- (a) (1) To apply for an ADDT license, an applicant must submit a complete application to DPSQA.
- (2) A complete application includes:
 - (A) Documentation demonstrating the applicant's entire ownership, including without limitation all the applicant's financial, governing body, and business interests;
 - (B) Documentation of the applicant's management, including without limitation the management structure and members of the management team;
 - (C) Documentation of the applicant's current contractors and the contractors that the applicant intends to use as part of operating the ADDT;
 - (D) Documentation of all required state and national criminal background checks for employees and operators;
 - (E) Documentation of all required Child Maltreatment Registry checks and Adult Maltreatment Registry checks for employees and operators;
 - (F) Documentation demonstrating compliance with these standards; and
 - (G) All other documentation or other information requested by DPSQA.

- (b) To apply to change the ownership of an existing ADDT, the ADDT must submit a complete application described in Section 202(a)(2).

203. Licensure Process.

- (a) DPSQA may approve an application for an ADDT license and issue an ADDT license if:
 - (1) The applicant submits a complete application under Section 202(a);
 - (2) DPSQA determines that the applicant has successfully passed all required criminal background and maltreatment checks.
 - (3) DPSQA determines that the applicant satisfies these standards; and
 - (4) DPSQA determines that one (1) of the following conditions are met:
 - (A) DDS has determined that the county in which the new ADDT would be located is an underserved county;
 - (B) The applicant has one (1) or more ADDT licensed locations in the same county in which the new ADDT would be located; or
 - (C) The applicant has one (1) or more ADDT licensed locations in a county contiguous to the county in which the new ADDT would be located and the existing location serves at least twenty (20) individuals who are eligible, enrolled, and participating in the existing location, but reside in the county in which the ADDT would be located.
- (b) DPSQA may approve an application to change the ownership of an existing ADDT and change the ownership of an existing ADDT license if:
 - (1) The applicant submits a complete application under Section 202;
 - (2) DPSQA determines that all employees and operators have successfully passed all required criminal background and maltreatment checks; and
 - (3) DPSQA determines that the applicant satisfies these standards.
- (c) DPSQA shall issue new ADDT licenses in accordance with the order of priority required by section 20-48-105 of the Arkansas Code.
- (d) ADDT licenses do not expire until terminated under these standards.

204. Notice of Underserved Status.

DDS shall provide written notice of any underserved determination made under Section 203(a)(3)(i) as required in section 20-48-105 of the Arkansas Code.

Subchapter 3. Administration.

301. Organization and Ownership.

- (a) The ADDT must be authorized and in good standing to do business under the laws of the State of Arkansas.

- (b) (1) An ADDT must appoint a single manager as the point of contact for all DDS and DPSQA matters and provide DDS and DPSQA with updated contact information for that manager.

- (2) This manager must have authority over the ADDT, all ADDT employees, and is responsible for ensuring that DDS and DPSQA requests, concerns, inquiries, and enforcement actions are addressed and resolved to the satisfaction of DDS and DPSQA.

- (c) (1) An ADDT cannot transfer its ADDT license to any person or entity.

- (2) An ADDT cannot change its ownership unless DPSQA approves the application of the new ownership pursuant to Sections 202 and 203.

- (3) An ADDT cannot change its name or otherwise operate under a different name than the name listed on the ADDT license without prior written notice to DPSQA.

302. Employees and Staffing Requirements.

- (a) (1) An ADDT must appropriately supervise all beneficiaries based on each beneficiary's needs.

- (2) An ADDT must have enough employees on-site to supervise beneficiaries at the ADDT location.

- (b) (1) An ADDT must comply with all requirements applicable to employees under these standards, including without limitation criminal background checks and adult and child maltreatment checks.

- (2) An ADDT must verify an employee still meets all requirements under these standards upon the request of DPSQA or whenever the ADDT receives information after hiring that would create a reasonable belief that an employee no longer meets all requirements under the standards including without limitation requirements related to criminal background checks and adult and child maltreatment checks.

- (c) (1) An ADDT must conduct child maltreatment, adult maltreatment, and criminal background checks for all employees as required by law.

- (2) Except as provided in this section, all ADDT employees, contractors, sub-contractors, interns, volunteers, and trainees, as well as all other persons who have routine contact with beneficiaries within the ADDT or who provide services within the ADDT, must successfully pass all required criminal background checks and adult and child maltreatment checks.
- (d)
 - (1) Employees must be at least eighteen (18) years of age.
 - (2) A beneficiary's custodian or legal guardian is not required to have criminal background checks, child maltreatment checks, or adult maltreatment checks, if the custodian or legal guardian only volunteers on a field trip and is not left alone with any beneficiary.
- (e) An ADDT must maintain at least a 1:10 staff-to-beneficiary ratio at all times.
- (f)
 - (1) An ADDT must document all scheduled and actual employee staffing.
 - (2) The documentation required for of employee staffing includes without limitation employee names, job title or credential, shift role, shift days, and shift times.

303. Employee Training.

- (a) All employees involved in any way with services provided to beneficiaries or who have routine contact with beneficiaries must receive the following training before having contact with beneficiaries and no later than thirty (30) days after beginning employment:
 - (1) Basic health and safety practices;
 - (2) Infection control and infection control procedures;
 - (3) Identification and mitigation of unsafe environmental factors;
 - (4) Emergency and evacuation procedures required in Section 308;
 - (5) Identification and prevention of adult and child maltreatment;
 - (6) Mandated reporter requirements; and
 - (7) Reporting incidents and accidents as required in these standards.
- (b) Employees required to receive training prescribed in subdivision (a) must receive annual re-training on those topics at least once every twelve (12) months.

304. Employee Records.

- (a) An ADDT must maintain a personnel file for each employee that includes:
- (1) A detailed job description;
 - (2) All required criminal background checks;
 - (3) All required Child Maltreatment Registry checks;
 - (4) All required Adult Maltreatment Registry checks;
 - (5) All conducted drug screen results;
 - (6) Signed statement that employee will comply with the ADDT's drug screen and drug use policies;
 - (7) Copy of current state or federal identification;
 - (8) Copy of valid state-issued driver's license, if driving is required in the job description, and documentation of completion of any required driver safety courses;
 - (9) Documentation demonstrating that the employee received all training required in Section 303;
 - (10) Documentation demonstrating that the employee obtained and maintained in good standing all professional licensures, certifications, or credentials for the employee or the service the employee is performing that are required for the employee or the service the employee is performing; and
 - (11) Documentation demonstrating that the employee meets all continuing education, in-service, or other training requirements applicable to that employee under these standards and any professional licensures, certifications, or credentials held by that employee.
- (b) (1) An ADDT must ensure that each personnel record is kept confidential and available only to:
- (A) Employees who need to know the information contained in the personnel record;
 - (B) Persons or entities who need to know the information contained in the personnel record;
 - (C) DPSQA and any governmental entity with jurisdiction or other authority to access the personnel record;

- (D) The employee; and
 - (E) Any other individual authorized in writing by the employee.
- (2) (A) An ADDT must keep personnel records in a file cabinet or room that is always locked.
- (B) (i) An ADDT may use electronic records in addition to or in place of physical records to comply with these standards.
- (ii) An ADDT provider that uses electronic records must take reasonable steps to backup all electronic records and reconstruct a personnel record in the event of a breakdown in the ADDT's electronic records system.
- (c) An ADDT must retain all employee records for five (5) years from the date an employee is no longer an employee of the ADDT or, if longer, the final conclusion of all reviews, appeals, investigations, administrative actions, or judicial actions related to that employee that are pending at the end of the five-year period.

305. Beneficiary Service Records.

- (a) (1) An ADDT must maintain a separate, updated, and complete service record for each beneficiary documenting the services provided to the beneficiary and all other documentation required under these standards.
- (2) Each beneficiary service record must be uniformly organized and readily available for review by DPSQA at the ADDT's location.
- (b) A beneficiary's service record must include a summary document at the front that includes:
- (1) The beneficiary's full name;
 - (2) The beneficiary's address and county of residence;
 - (3) The beneficiary's telephone number and email address;
 - (4) The beneficiary's date of birth;
 - (5) The beneficiary's primary language;
 - (6) The beneficiary's diagnoses;
 - (7) The beneficiary's medications, dosage, and frequency, if applicable;

- (8) The beneficiary's known allergies;
 - (9) The beneficiary's entry date into the ADDT;
 - (10) The beneficiary's exit date from the ADDT;
 - (11) The beneficiary's Medicaid Number;
 - (12) The beneficiary's commercial or private health insurance information or managed care organization information, if applicable;
 - (13) The name, address, phone number, email address, and relationship of the beneficiary's custodian or legal guardian; and
 - (14) The name, address, and phone number of the beneficiary's primary care physician.
- (c) A beneficiary's service record must include at least the following information and documentation:
- (1) The beneficiary's ITP;
 - (2) The beneficiary's behavioral management plan;
 - (3) The beneficiary's daily activity logs;
 - (4) The beneficiary's medication management plan and medication logs;
 - (5) Copies of any assessments or evaluations completed on the beneficiary; and
 - (6) Copies of any orders that place the beneficiary in the custody of another person or entity.
- (d) (1) An ADDT must ensure that each beneficiary service record is kept confidential and available only to:
- (A) Employees who need to know the information contained in the beneficiary's service record;
 - (B) Persons or entities who need to know the information contained in the beneficiary service record in order to provide services to the beneficiary;
 - (C) DPSQA and any governmental entity with jurisdiction or other authority to access the beneficiary's service record;
 - (D) The beneficiary's legal guardian or custodian; and

- (E) Any other individual authorized in writing by the legal guardian or custodian.
- (2) (A) An ADDT must keep beneficiary service records in a file cabinet or room that is always locked.
- (B) (i) An ADDT may use electronic records in addition to or in place of physical records to comply with these standards.
- (ii) An ADDT provider that uses electronic records must take reasonable steps to backup all electronic records and reconstruct a beneficiary's service record in the event of a breakdown in the ADDT's electronic records system.
- (e) An ADDT must retain all beneficiary service records for five (5) years from the date the beneficiary last exits from the ADDT or, if longer, the final conclusion of all reviews, appeals, investigations, administrative actions, or judicial actions related to beneficiary that are pending at the end of the five-year period.

306. Marketing and Solicitation.

- (a) An ADDT can market its services.
- (b) An ADDT cannot solicit a beneficiary or his or her family.

307. Third-party Service Agreements.

- (a) An ADDT may contract in writing with third-party vendors to provide services or otherwise satisfy requirements under these standards.
- (b) An ADDT must ensure that all third-party vendors comply with these standards and all other applicable laws, rules, and regulations.

308. Emergency Plans and Drills.

- (a) (1) An ADDT must have a written emergency plan.
- (2) (A) The written emergency plan must provide the procedures to follow in the event of emergencies to safeguard the health and safety of beneficiaries and ensure continuity of services to the extent possible.
- (B) A written emergency plan must address all foreseeable emergencies including without limitation fires, floods, tornados, utility disruptions,

bomb threats, active shooters, outbreaks of infectious disease, and public health emergencies.

- (3) An ADDT must evaluate all written emergency plans at least annually and update as needed.
- (b) The written emergency plan must include at least:
- (1) Designated relocation sites and evacuation routes;
 - (2) Procedures for notifying legal guardians and custodians of relocation;
 - (3) Procedures for ensuring each beneficiary's safe return to the ADDT or his or her residence;
 - (4) Procedures to address the special needs of each beneficiary;
 - (5) Procedures to address interruptions in the delivery of ADDT services;
 - (6) Procedures for reassigning employee duties in an emergency; and
 - (7) Procedures for annual training of employees regarding the emergency plan.
- (c)
- (1) An ADDT must conduct emergency fire drills and tornado drills at least once a month each and on separate days and at different times of day.
 - (2) An ADDT must document all emergency drills completed and include at least:
 - (A) The date of the emergency drill;
 - (B) The type of emergency drill;
 - (C) The time of day the emergency drill was conducted;
 - (D) The number of beneficiaries participating in the emergency drill;
 - (E) The length of time taken to complete the emergency drill; and
 - (F) Notes regarding any aspects of the emergency procedure or drill that need improvement based on the performance of the emergency drill.
- (d) An ADDT must have an emergency alarm system in place that will alert all employees and beneficiaries when there is an emergency.

309. Infection Control.

- (a)
 - (1) An ADDT must follow all applicable guidance and directives from the Arkansas Department of Health (ADH) related to infection control including without limitation guidance and directives on preventing the spread of infectious diseases, hand hygiene, handling potentially infectious material, use of personal protective equipment, tuberculosis, blood borne pathogens, and coronaviruses.
 - (2) An ADDT must provide personal protective equipment for all employees and beneficiaries as may be required in the circumstances.
 - (3) Employees and beneficiaries must wash their hands with soap before eating, after toileting, and as otherwise appropriate to prevent the spread of infectious diseases.
- (b)
 - (1) An ADDT cannot allow a beneficiary, employee, or any other person who has an infectious disease to enter an ADDT facility.
 - (2) A beneficiary who becomes ill while at an ADDT must be separated from other beneficiaries to the extent possible.
 - (3) The ADDT must notify a beneficiary's legal guardian or custodian if the beneficiary becomes ill while at an ADDT facility.

310. Compliance with State and Federal Laws, Rules, and Other Standards.

- (a) An ADDT must comply with all applicable state and federal laws and rules including without limitation:
 - (1) The Americans with Disabilities Act of 1990 (ADA);
 - (2) The Disability Rights Act of 1964;
 - (3) The Health Insurance Portability and Accounting Act (HIPPA);
 - (4) The Privacy Act of 1974; and
 - (5) All applicable laws and rules governing the protection of medical, social, personal, financial, and electronically stored records.
- (b) An ADDT facility must comply with all:
 - (1) Building codes and local ordinances;
 - (2) Fire and safety inspections and requirements of the State Fire Marshal or local authorities;

- (3) ADH requirements including without limitation requirements regarding water, plumbing, and sewage;
 - (4) Arkansas Department of Labor and Licensing requirements including without limitation requirements regarding water heaters and boilers; and
 - (5) Other federal, state, or local requirements applicable to the HCBS community service location, property, and structures.
- (c) An ADDT provider must maintain documentation of compliance with applicable state, local, and federal laws, rules, codes, and standards.
 - (d) A violation of any applicable state, local, or federal laws, rules, codes, or standards constitutes a violation of these standards.
 - (e)
 - (1) In the event of a conflict between these standards and other applicable state, local, or federal laws, rules, or standards, the stricter requirement shall apply.
 - (2) In the event of an irreconcilable conflict between these standards and other applicable state, local, or federal laws, rules, or standards these standards shall govern to the extent not governed by federal laws or rules or state law.

Subchapter 4. Facility Requirements.

401. General Requirements.

An ADDT facility must:

- (1) Have a minimum of forty (40) square feet of program training area per beneficiary;
- (2) Be heated, air-conditioned, well-lighted, well-ventilated, and well-maintained at a comfortable temperature;
- (3) Be safe, clean, maintained, in good repair, and sanitary, including without limitation as to the facility's exterior, surrounding property, and interior floors and ceilings;
- (4) Be free of offensive odors and potentially hazardous objects including without limitation explosives and broken equipment;
- (5) Have drinking water available to beneficiaries and employees;
- (6) Have an emergency alarm system throughout the facility to alert employees and beneficiaries when there is an emergency;
- (7) Have at least one (1) toilet and one (1) sink for every fifteen (15) beneficiaries, with running hot and cold water, toilet tissue, liquid soap, and paper towels or air dryers;
- (8) Have bathrooms that provide for individual privacy and are appropriate for all beneficiaries with regard to size and accessibility;
- (9) Have at least one (1) operable telephone on site that is available at all hours and reachable with a phone number for outside callers;
- (10) Have working smoke and carbon monoxide detectors in all areas used by beneficiaries or employees;
- (11) Have a first aid kit that includes at least the following:
 - (A) Adhesive band-aids of various sizes;
 - (B) Sterile gauze squares;
 - (C) Adhesive tape;
 - (D) Roll of gauze bandages;

- (E) Antiseptic;
 - (F) Thermometer;
 - (G) Scissors;
 - (H) Disposable gloves; and
 - (I) Tweezers;
- (12) Have enough fire extinguishers in number and location to satisfy all applicable laws and rules, but no fewer than two (2) fire extinguishers;
 - (13) Have hallways and corridors at least six (6) feet in width;
 - (14) Have screens for all windows and doors used for ventilation;
 - (15) Have screens or guards attached to the floor or wall to protect floor furnaces, heaters, hot radiators, exposed water heaters, air conditioners, and electric fans;
 - (16) Have no lead-based paint;
 - (17) Have lighted “exit” signs at all exit locations;
 - (18) Have written instructions and diagrams noting emergency evacuation routes and shelters to be used in case of fire, severe weather, or other emergency posted at least every twenty-five (25) feet, in all stairwells, in and by all elevators, and in each room used by beneficiaries;
 - (19) Have a copy of Title VI and VII of the Civil Rights Law of 1964 and all required legal notices prominently posted as required;
 - (20) Have an emergency power system to provide lighting and power to essential electrical devices throughout the ADDT, including without limitation power to exit lighting and fire detection, fire alarm, and fire extinguishing systems;
 - (21) Have chemicals, toxic substances, and flammable substances stored in locked storage cabinets or closets;
 - (22) Have the ADDT’s telephone, hours of operation, and hours of access, if applicable, posted at all public entrances;
 - (23) Prohibit the possession of firearms or other weapons except by authorized law enforcement personnel; and

- (24) Prohibit smoking, use of tobacco products, and the consumption of prescription medication without a prescription, alcohol, and illegal drugs.

Subchapter 5. Enrollments and Exits.

501. Enrollments.

- (a) An ADDT may enroll and provide services to a beneficiary who is eligible to receive ADDT services.
- (b) An ADDT must document the enrollment of all beneficiaries to the ADDT.

502. Exits.

- (a) An ADDT may exit a beneficiary from its program if the person becomes ineligible for ADDT services, chooses to enroll with another ADDT, or for any other lawful reason.
- (b) An ADDT must document the exit of all beneficiaries from its program.
- (c) An ADDT must provide reasonable assistance to all beneficiaries exiting its program including without limitation by:
 - (1) Assisting the beneficiary in transferring to another ADDT or other service provider; and
 - (2) Providing copies of the beneficiary's records to the beneficiary, the beneficiary's legal custodian or guardian, and the ADDT or other service provider to which the beneficiary transfers after exiting the program.

Subchapter 6. Program and Services.

601. Arrivals, Departures, and Transportation.

- (a) (1) An ADDT must ensure that beneficiaries safely arrive to and depart from an ADDT facility.
 - (2) (A) An ADDT must document the arrival and departure of each beneficiary to and from an ADDT facility.
 - (B) Documentation of arrivals to and departures from an ADDT must include without limitation the beneficiary's name, date of birth, date and time of arrival and departure, name of the person or entity that provided transportation, and method of transportation.
 - (3) (A) A manager or designee of an ADDT must:
 - (i) Review the beneficiary arrival and departure documentation each day and compare it with the ADDT's attendance record;
 - (ii) Sign and date the beneficiary arrival and departure documentation verifying that all beneficiaries for the day safely arrived to and departed from the ADDT facility.
 - (B) An ADDT must maintain beneficiary arrival and departure documentation for one (1) year from the date of transportation.
- (b) The requirements in subdivisions (c) through (f) apply only if an ADDT elects to provide transportation services.
- (1) Transportation to which these requirements apply includes without limitation transportation provided to a beneficiary by any person or entity on behalf of the ADDT and regardless of whether the person is an employee, or the transportation is a billed service; and
 - (2) Transportation to which these requirements apply also includes periodic transportation, including without limitation transportation provided at the request of a beneficiary's legal guardian or custodian to have a beneficiary occasionally dropped off or picked up due to a scheduling conflict with the legal guardian or custodian.
- (c) All employees transporting beneficiaries or present in vehicles during the transportation of beneficiaries shall meet the following requirements before transporting beneficiaries:

- (1) Be at least twenty-one (21) years of age or the minimum age required by the ADDT's commercial automobile insurance, whichever is higher;
 - (2) Hold a current valid driver's license or commercial driver's license as required by state law; and
 - (3) Successfully complete a driver safety training course.
- (d) (1) Each vehicle used to transport beneficiaries must:
- (A) Be licensed and maintained in proper working condition, including without limitation as to air conditioning and heating systems; and
 - (B) Have a seating space and a specific appropriate restraint system for each beneficiary transported.
- (2) (A) Any vehicle designed or used to transport more than seven (7) passengers and one (1) driver must have a safety alarm device.
- (B) The safety alarm device must:
- (i) Always be in working order and properly maintained;
 - (ii) Installed so that the driver is required to walk to the very back of the vehicle to reach the switch that deactivates the alarm;
 - (iii) Be installed in accordance with the device manufacturer's recommendations; and
 - (iv) Sound the alarm for at least one (1) minute after the activation of the safety alarm device.
- (3) (A) An ADDT must maintain commercial insurance coverage for any vehicle used to transport beneficiaries.
- (B) The commercial insurance coverage must include at least:
- (i) \$100,000 combined single limit;
 - (ii) \$100,000 for uninsured motorist;
 - (iii) \$100,000 for under-insured motorist; and
 - (iv) \$5,000 personal injury protection for each passenger based on the number of passengers the vehicle is manufactured to transport.

- (C) An ADDT must maintain documentation of all required commercial insurance coverage.
- (e) (1) An ADDT must maintain a roster of beneficiaries for each vehicle each day listing the driver, other persons, and name, age, date of birth, and emergency contact information for all beneficiaries that will be transported in that vehicle.
 - (A) The daily roster shall be used to check beneficiaries on and off the vehicle when they are picked up or dropped off at home, the ADDT, or other location.
 - (B) The employee who conducts the walk-through required by subdivision (f) must sign the vehicle roster once the employee confirms that all beneficiaries have exited the vehicle.
- (2) (A) A manager or designee of an ADDT must:
 - (i) Review the daily roster each day and compare it with the ADDT's attendance record;
 - (ii) Sign and date the daily roster verifying that all beneficiaries for the day safely arrived to and departed from home, the ADDT facility, or other location.
- (B) An ADDT must maintain the daily roster for one (1) year from the date of transportation.
- (f) (1) An employee must walk through a vehicle used to transport beneficiaries after each trip and physically inspect each seat after unloading to ensure that no beneficiaries are left on the vehicle.
- (2) The walk-through inspection for any vehicles designed or used to transport more than seven (7) passengers and one (1) driver must be conducted in one (1) of the following ways:
 - (A) (i) An employee unloads all beneficiaries from the vehicle, walks or otherwise moves through the interior of the vehicle to ensure that no beneficiaries remain on board, and deactivates the safety alarm device.
 - (ii) This option can only be used if all beneficiaries are able to unload from the vehicle in less than one (1) minute.
 - (B) (i) An employee supervises the beneficiaries during unloading and a second employee immediately walks or otherwise moves through

the interior of the vehicle to ensure that no beneficiaries remain on board and deactivates the safety alarm device.

- (ii) The employee who deactivated the safety alarm device will remain near the safety alarm device deactivation switch until all beneficiaries have unloaded to ensure that no beneficiary is left on board.
 - (iii) This option will require at least two (2) employees, one (1) to supervise the beneficiaries and one (1) to remain near the safety alarm device deactivation switch.
- (C)
- (i) An employee deactivates the safety alarm device and unloads all beneficiaries immediately upon arrival.
 - (ii) Immediately after unloading, an employee will start the vehicle and move it to a different location for final parking, which must reactivate the safety alarm device.
 - (iii) An employee deactivates the safety alarm device and walks or otherwise moves through the interior of the vehicle to ensure that no beneficiaries remain on board and deactivates the safety alarm device.

602. Medications.

- (a) (1) An ADDT must develop a medication management plan for all beneficiaries with prescribed medication that may be administered at the ADDT.
- (2) A medication management plan must include without limitation:
 - (A) The name of each medication;
 - (B) The name of the prescribing physician or other health care professional if the medication is by prescription;
 - (C) A description of each medication prescribed and any symptom or symptoms to be addressed by each medication;
 - (D) How each medication will be administered, including without limitation times of administration, doses, delivery, and persons who may lawfully administer each medication;
 - (E) How each medication will be charted;

- (F) A list of the potential side effects caused by each medication; and
 - (G) The consent to the administration of each medication by the beneficiary or, if the beneficiary lacks capacity, by the beneficiary's legal guardian or custodian.
- (b) (1) An ADDT must maintain a medication log detailing the administration of all medication to a beneficiary, including without limitation prescribed medication and over-the-counter medication.
- (2) Each medication log must be uniformly organized and document the following for each administration of a medication:
- (A) The name and dosage of medication administered;
 - (B) The symptom that the medication was used to address;
 - (C) The method by which the medication was administered;
 - (D) The date and time the medication was administered;
 - (E) The name of the employee who administered the medication or assisted in the administration of the medication;
 - (F) Any adverse reaction or other side effect from the medication;
 - (G) Any transfer of medication from its original container into individual dosage containers by the beneficiary's legal guardian or custodian;
 - (H) Any error in administering the medication and the name of the supervisor to whom the error was reported; and
 - (I) The prescription and the name of the prescribing physician or other health care professional if the medication was not previously listed in the medication management plan.
- (3) Medication errors must be:
- (A) Immediately reported to a supervisor;
 - (B) Documented in the medication log; and
 - (C) Reported as required under all applicable laws and rules including without limitation the laws and rules governing controlled substances.
- (c) All medications stored for a beneficiary by an ADDT must be:

- (1) Kept in the original medication container unless the beneficiary's custodian or legal guardian transfers the medication into individual dosage containers;
 - (2) Labeled with the beneficiary's name;
 - (3) Stored in an area, medication cart, or container that is always locked; and
 - (4) Returned to a beneficiary's custodian or legal guardian, or destroyed or otherwise disposed of in accordance with applicable laws and rules, if the medication is no longer to be administered to a beneficiary.
- (d) An ADDT must store all medications requiring cold storage in a separate refrigerator that is used only for the purpose of storing medications.

603. Behavior Management Plans.

- (a) An ADDT may implement a written behavior management plan for a beneficiary if a beneficiary exhibits challenging behaviors on a chronic basis.
- (b) A behavior management plan:
 - (1) Must involve the fewest and shortest interventions possible; and
 - (2) Cannot punish or use interventions that are physically or emotionally painful, frighten, or put the beneficiary at medical risk.
- (c)
 - (1) (A) An ADDT must reevaluate behavior management plans at least quarterly.
 - (B) An ADDT must refer the beneficiary to an appropriately licensed professional for re-evaluation if the behavior management plan is not achieving the desired results.
 - (2) An ADDT must regularly collect and review data regarding the use and effectiveness of all behavior management plans, including the use and effectiveness of restraints and other interventions.
 - (3) The collection and review of data regarding the use and effectiveness of behavior management plans must include at least:
 - (A) The date and time any intervention is used;
 - (B) The duration of each intervention;
 - (C) The employee or employees involved in each intervention; and

- (D) The event or circumstances that triggered the need for the intervention.

604. General Nutrition and Food Service Requirements.

- (a) An ADDT must ensure that a noon meal is available to each beneficiary who receives at least four (4) hours of adult developmental day treatment services in a day and who is unable to provide his or her own meal on that date of service.
 - (1) When a component of a beneficiary's ITP is the beneficiary providing his or her own meal, the ADDT may request the beneficiary furnish the meal.
 - (2) If a beneficiary who is responsible for providing his or her own meal fails to do so, the ADDT must furnish a meal for that beneficiary if he or she receives more than four (4) hours of adult developmental day treatment services that day.
 - (3) An ADDT may not charge a beneficiary for any meal provided by the ADDT, regardless of whether a component of the beneficiary's ITP is the beneficiary providing his or her own meal.
- (b)
 - (1) Each ADDT must ensure that any meals, snacks, or other food services provided to beneficiaries by the ADDT conform to U.S. Department of Agriculture guidelines including without limitation portion size, ADH requirements, and other applicable laws and rules.
 - (2) All food brought in from outside sources must be:
 - (A) From food service providers approved by ADH and transported per ADH requirements;
 - (B) In individual, commercially pre-packaged containers; or
 - (C) Individual meals or snacks brought from home by a beneficiary or a beneficiary's family.
 - (3)
 - (A) A violation of U.S. Department of Agriculture guidelines, ADH requirements, or other applicable laws or rules related to nutrition and food service constitutes a violation of these standards.
 - (B) In the event of a conflict between these standards and the requirements of U.S. Department of Agriculture guidelines, ADH requirements, or other applicable laws or rules related to nutrition and food service, the stricter requirement shall apply.

- (C) In the event of an irreconcilable conflict between these standards and the requirements of U.S. Department of Agriculture guidelines, ADH requirements, or other applicable laws or rules related to nutrition and food service, these standards shall govern to the extent not governed by federal or state laws or rules.
- (c)
 - (1) An ADDT must ensure that food provided to beneficiaries meets the specialized diet requirements of each beneficiary arising from medical conditions or other individualized needs including without limitation allergies, diabetes, and hypertension.
 - (2) An ADDT must ensure that all food prepared on-site is prepared, cooked, served, and stored in a manner that protects against contamination and spoilage.
 - (3) An ADDT must not use a perishable food item after its expiration date.
 - (4) An ADDT must keep all food service surfaces clean and in sanitary condition.
 - (5) An ADDT must serve all food on individual plates, bowls, or other dishes that can be sanitized or discarded.
 - (6) An ADDT must ensure that all food scraps are placed in garbage cans with airtight lids and bag liners that are emptied as necessary and no less than once every day.
 - (7) An ADDT must store all food separately from medications, medical items, or hazardous items.
 - (8)
 - (A) An ADDT provider must ensure that all refrigerators used for food storage are maintained at a temperature of forty-one (41) degrees Fahrenheit or below.
 - (B) An ADDT provider must ensure that all freezers used for food storage are maintained at a temperature of zero (0) degrees Fahrenheit or below.

Subchapter 7. Incident and Accident Reporting.

701. Incidents to be Reported.

- (a) An ADDT must report all alleged, suspected, observed, or reported occurrences of any of the following events:
- (1) Death of a beneficiary;
 - (2) Serious injury to a beneficiary;
 - (3) Adult or child maltreatment of a beneficiary;
 - (4) Any event where an employee threatens or strikes a beneficiary;
 - (5) Unauthorized use on a beneficiary of restrictive intervention, including seclusion or physical, chemical, or mechanical restraint;
 - (6) Any situation when the whereabouts of a beneficiary are unknown for more than two (2) hours;
 - (7) Any unanticipated situation when services to the beneficiary are interrupted for more than two (2) hours;
 - (8) Events involving a risk of death, serious physical or psychological injury, or serious illness to a beneficiary;
 - (9) Medication errors made by an employee that cause or have the potential to cause death, serious injury, or serious illness to a beneficiary;
 - (10) Any act or admission that jeopardizes the health, safety, or quality of life of a beneficiary;
 - (11) Motor vehicle accidents involving a beneficiary;
 - (12) A positive case of a beneficiary or a staff member for any infectious disease that is the subject of a public health emergency declared by the Governor, ADH, the President of the United States, or the United States Department of Health and Human Services; or
 - (13) Any event that requires notification of the police, fire department, or coroner.
- (b) Any ADDT may report any other occurrences impacting the health, safety, or quality of life of a beneficiary.

702. Reporting Requirements.

- (a) An ADDT must:
 - (1) Submit all reports of the following events within one (1) hour of the event:
 - (i.) Death of a beneficiary;
 - (ii.) Serious injury to a beneficiary; or
 - (iii.) Any incident that an ADDT should reasonably know might be of interest to the public or the media.
 - (2) Submit reports of all other incidents within forty-eight (48) hours of the event.
- (b) An ADDT must submit reports of all incidents to DPSQA as provided through DPSQA's website: <https://humanservices.arkansas.gov/about-dhs/dpsqa/>.
- (c) Reporting under these standards does not relieve an ADDT of complying with any other applicable reporting or disclosure requirements under state or federal laws, rules, or regulations.

703. Notification to Guardians and Legal Custodians.

- (a) An ADDT must notify the guardian or legal custodian of a beneficiary of any reportable incident involving a beneficiary, as well as any injury or accident involving a beneficiary even if the injury or accident is not otherwise required to be reported in this Section.
- (b) An ADDT should maintain documentation evidencing notification required in subdivision (a).

Subchapter 8. Enforcement.

801. Monitoring.

- (a) (1) DPSQA shall monitor an ADDT to ensure compliance with these standards.
- (2) (A) An ADDT must cooperate and comply with all monitoring, enforcement, and any other regulatory or law enforcement activities performed or requested by DPSQA or law enforcement.
- (B) Cooperation required under these standards includes without limitation cooperation and compliance with respect to investigations surveys, site visits, reviews, and other regulatory actions taken by DPSQA or any third-party contracted by DHS to monitor, enforce, or take other regulatory action on behalf of DHS, DPSQA, or DDS.
- (b) Monitoring includes without limitation:
 - (1) On-site surveys and other visits including without limitation complaint surveys and initial site visits;
 - (2) On-site or remote file reviews;
 - (3) Written requests for documentation and records required under these standards;
 - (4) Written requests for information; and
 - (5) Investigations related to complaints received.
- (c) DHS may contract with a third-party to monitor, enforce, or take other regulatory action on behalf of DHS, DPSQA, or DDS.

802. Written Notice of Enforcement Action.

- (a) DPSQA shall provide written notice to the ADDT of all enforcement actions taken against the ADDT.
- (b) DPSQA shall provide written notice to the ADDT by mailing the imposition of the enforcement action to the manager appointed by the ADDT pursuant to Section 301.

803. Remedies.

- (a) (1) DPSQA shall not impose any remedies imposed by an enforcement action unless:

- (A) The ADDT is given notice and an opportunity to be heard pursuant to this Section 802 and Subchapter 10; or
 - (B) DPSQA determines that public health, safety, or welfare imperatively requires emergency action;
- (2) If DPSQA imposes a remedy as an emergency action before the ADDT has notice and an opportunity to be heard pursuant to subdivision (a)(1), DPSQA shall:
 - (A) Provide immediate notice to the ADDT of the enforcement action; and
 - (B) Provide the ADDT with an opportunity to be heard pursuant to Subchapter 10.
- (b) DPSQA may impose on an ADDT any of the following enforcement actions for the ADDT's failure to comply with these standards:
 - (1) Plan of correction;
 - (2) Directed in-service training plan;
 - (3) Moratorium on new admissions;
 - (4) Transfer of beneficiaries;
 - (5) Monetary penalties;
 - (6) Suspension of ADDT license;
 - (7) Revocation of ADDT license; and
 - (8) Any remedy authorized by law or rule including without limitation section 25-15-217 of the Arkansas Code.
- (c) DPSQA shall determine the imposition and severity of these enforcement remedies on a case-by-case basis using the following factors:
 - (1) Frequency of non-compliance;
 - (2) Number of non-compliance issues;
 - (3) Impact of non-compliance on a beneficiary's health, safety, or well-being;
 - (4) Responsiveness in correcting non-compliance;

- (5) Repeated non-compliance in the same or similar areas;
 - (6) Non-compliance with previously or currently imposed enforcement remedies;
 - (7) Non-compliance involving intentional fraud or dishonesty; and
 - (8) Non-compliance involving violation of any law, rule, or other legal requirement.
- (d) (1) DPSQA shall report any noncompliance, action, or inaction by the ADDT to appropriate agencies for investigation and further action.
 - (2) DPSQA shall refer non-compliance involving Medicaid billing requirements to the Division of Medical Services and the Arkansas Attorney General's Medicaid Fraud Control Unit.
- (e) These enforcement remedies are not mutually exclusive and DPSQA may apply multiple remedies simultaneously to a failure to comply with these standards.
 - (f) The failure to comply with an enforcement remedy imposed by DPSQA constitutes a separate violation of these standards.

804. Moratorium.

- (a) DPSQA may prohibit an ADDT from accepting new beneficiaries.
- (b) An ADDT prohibited from accepting new admissions may continue to provide services to existing beneficiaries.

805. Transfer of Beneficiaries.

- (a) DPSQA may require an ADDT to transfer a beneficiary to another ADDT if DPSQA finds that the ADDT cannot adequately provide services to the beneficiary.
- (b) If directed by DPSQA, an ADDT must continue providing services until the beneficiary is transferred to his or her new service provider of choice.
- (c) A transfer of a beneficiary may be permanent or for a specific term depending on the circumstances.

806. Monetary Penalties.

- (a) DPSQA may impose on an ADDT a civil monetary penalty not to exceed five hundred dollars (\$500) for each violation of these standards.

- (b) (1) DPSQA may file suit to collect a civil monetary penalty assessed pursuant to these standards if the ADDT does not pay the civil monetary penalty within sixty (60) days from the date DPSQA provides written notice to the ADDT of the imposition of the civil monetary penalty.
- (2) DPSQA may file suit in Pulaski County Circuit Court or the circuit court of any county in which the ADDT is located.

807. Suspension and Revocation of ADDT License.

- (a) (1) DPSQA may temporarily suspend an ADDT license if the ADDT fails to comply with these standards.
- (2) If an ADDT's license is suspended, the ADDT must immediately stop providing ADDT services until DPSQA reinstates its license.
- (b) (1) DPSQA may permanently revoke an ADDT license if the ADDT fails to comply with these standards.
- (2) If an ADDT's license is revoked, the ADDT must immediately stop providing ADDT services and comply with the permanent closure requirements in Section 901(a).

Subchapter 9. Closure.

901. Closure.

- (a) (1) An ADDT license ends if an ADDT permanently closes, whether voluntarily or involuntarily, and is effective the date of the permanent closure as determined by DPSQA.
- (2) An ADDT that intends to permanently close, or does permanently close without warning, whether voluntarily or involuntarily, must immediately:
 - (A) Provide the custodian or legal guardian of each beneficiary with written notice of the closure;
 - (B) Provide the custodian or legal guardian of each beneficiary with written referrals to at least three (3) other appropriate service providers;
 - (C) Assist each beneficiary and his or her custodian or legal guardian in transferring services and copies of beneficiary records to any new service providers;
 - (D) Assist each beneficiary and his or her custodian or legal guardian in transitioning to new service providers; and
 - (E) Arrange for the storage of beneficiary service records to satisfy the requirements of Section 305.
- (b) (1) An ADDT that intends to voluntarily close temporarily due to natural disaster, pandemic, completion of needed repairs or renovations, or for similar circumstances may request to temporarily close its facility while maintaining its ADDT license for up to one (1) year from the date of the request.
- (2) An ADDT must comply with the requirements in subdivision (a)(2) for notice, referrals, assistance, and storage of beneficiary records if DPSQA grants an ADDT's request for a temporary closure.
- (3) (A) DPSQA may grant a temporary closure if the ADDT demonstrates that it is reasonably likely that it will be able to reopen after the temporary closure.
- (B) DPSQA shall end an ADDT's temporary closure and direct that the ADDT permanently close if the ADDT fails to demonstrate that it is reasonably likely that it will be able to reopen after the temporary closure.
- (4) (A) DPSQA may end an ADDT's temporary closure if the ADDT demonstrates that it is in full compliance with these standards.

- (B) DPSQA shall end an ADDT's temporary closure and direct that the ADDT permanently close if the ADDT fails to become fully compliant with these standards within one (1) year from the date of the request.

Subchapter 10. Appeals.

1001. Reconsideration of Adverse Regulatory Actions.

- (a)
 - (1) An ADDT may ask for reconsideration of any adverse regulatory action taken by DPSQA by submitting a written request for reconsideration to: Division of Provider Services and Quality Assurance, Office of the Director: Requests for Reconsideration of Adverse Regulatory Actions, P.O. Box 1437, Slot 427, Little Rock, Arkansas 72203.
 - (2) The written request for reconsideration of an adverse regulatory action taken by DPSQA must be submitted by the ADDT and received by DPSQA within thirty (30) calendar days of the date the ADDT received written notice of the adverse regulatory action.
 - (3) The written request for reconsideration of an adverse regulatory action taken by DPSQA must include without limitation the specific adverse regulatory action taken, the date of the adverse regulatory action, the name of ADDT against whom the adverse regulatory action was taken, the address and contact information for the ADDT against whom the adverse regulatory action was taken, and the legal and factual basis for reconsideration of the adverse regulatory action.
- (b)
 - (1) DPSQA shall review each timely received written request for reconsideration and determine whether to affirm or reverse the adverse regulatory action taken based on these standards.
 - (2) DPSQA may request, at its discretion, additional information as needed to review the adverse regulatory action and determine whether the adverse regulatory action taken should be affirmed or reversed based on these standards.
- (c)
 - (1) DPSQA shall issue in writing its determination on reconsideration within thirty (30) days of receiving the written request for reconsideration or within thirty (30) days of receiving all information requested by DPSQA under subdivision (b)(2), whichever is later.
 - (2) DPSQA shall issue its determination to the ADDT using the address and contact information provided in the request for reconsideration.
- (d)
 - (1) An applicant may ask for reconsideration of a determination by DDS that a county is not underserved by submitting a written request for reconsideration pursuant to DDS Policy 1076.
 - (2) If a determination that a county is not underserved is reversed on reconsideration by DDS or on appeal by an agency or court with jurisdiction:

- (A) The applicant shall notify DPSQA of the reversal and submit a written request for reconsideration to DPSQA as provided in this section for any adverse regulatory action taken by DPSQA based on the initial determination; and
 - (B) DPSQA shall review the written request for reconsideration as provided in this section.
- (e) DPSQA may also decide to reconsider any adverse regulatory action on its own accord any time it determines, in its discretion, that an adverse regulatory action is not consistent with these standards.

1002. Appeal of Regulatory Actions.

- (a)
 - (1) An ADDT may administratively appeal any adverse regulatory action to the DHS Office of Appeals and Hearings (OAH) except for provider appeals related to the payment for Medicaid claims and services governed by the Medicaid Fairness Act, Ark. Code Ann. § 20-77-1701 to -1718, which shall be governed by that Act.
 - (2) OAH shall conduct administrative appeals of adverse regulatory actions pursuant to DHS Policy 1098 and other applicable laws and rules.
- (b) An ADDT may appeal any adverse regulatory action or other adverse agency action to circuit court as allowed by the Administrative Procedures Act, Ark. Code Ann. § 25-15-201 to -220.



**Arkansas Department
of Human Services**
**Division of Developmental Disabilities
Services**



**— DDS STANDARDS for
Certification, Investigation and
Monitoring**

**— FOR CENTER-BASED COMMUNITY
SERVICES**

~~DIVISION OF DEVELOPMENTAL DISABILITIES~~
~~SERVICES~~

~~PHILOSOPHY & MISSION STATEMENT~~

MARKY-UP

~~The Division of Developmental Disabilities Services (DDS), the DDS Board, and its providers are dedicated to the pursuit of the following goals:~~

MARKY-UP

- ~~Advocating for adequate funding, staffing, and services to address the needs of persons with developmental disabilities.~~
- ~~Encouraging an interdisciplinary service system to be utilized in the delivery of appropriate individualized and quality services.~~
- ~~Protecting the constitutional rights of individuals with disabilities and their rights to personal dignity, respect and freedom from harm.~~
- ~~Assuring that individuals with developmental disabilities who receive services from DDS are provided uninterrupted essential services until such time a person no longer needs to depend on these services.~~
- ~~Encouraging family, parent/guardian, individual, and public/community involvement in program development, delivery, and evaluation.~~
- ~~Engaging in statewide planning that ensures optimal and innovative growth of the Arkansas service system to meet the needs of persons with developmental disabilities and to assist such persons to achieve independence, productivity, and integration into the community.~~

-

To accomplish its mission, DDS, the DDS Board, and its providers are committed to the principle and practices of: normalization; least restrictive alternatives; affirmation of individuals' constitutional rights; provision of quality services; the interdisciplinary service delivery model; and the positive management of challenging behaviors.

TABLE OF CONTENTS

•INTRODUCTION

•DEFINITIONS

•SECTION 100 BOARD OF DIRECTORS

•SECTION 200 PERSONNEL PROCEDURES & RECORDS

•SECTION 300 STAFF TRAINING

•SECTION 400 INDIVIDUAL/PARENT/GUARDIAN RIGHTS

•SECTION 500 SERVICE PROVISION STANDARDS

•SECTION 600 FOOD SERVICES

•SECTION 700 TRANSPORTATION

•SECTION 800 PHYSICAL PLANT

INTRODUCTION

The licensing standards for DDS Community Programs have been developed to accomplish: normalization, least restrictive alternatives, affirmation of individuals' constitutional rights, provision of quality services, the interdisciplinary service delivery model, and the positive management of challenging behaviors.

These Standards shall apply to Early Intervention Day Treatment and Adult Developmental Day Treatment programs in Arkansas. The Department of Human Services and its Divisions and agents shall have the authority to enforce these regulations.

Individual program plans shall be developed with the participation of the individual (18 years and older), as appropriate, the family, and representatives of the services required. The team is responsible for assessing needs, developing a plan to meet them, and contributing to its implementation.

NOTE: It is imperative that all Medicaid providers be enrolled with the Division of Medical Services and meet all enrollment requirements for the specific Medicaid Program for which they are enrolling as an Arkansas Medicaid Provider.

All standards are applicable to all services provided, unless otherwise specified.

Administrative Rules and Regulation Sub-Committee of the Arkansas Legislative Council:

Effective Date: July 1, 2018

Implementation Date: July 1, 2018

Grandfathering Period: July 1, 2018 – June 30, 2019

100 GOVERNING BOARD/ORGANIZATION / LEADERSHIP

Guiding Principles: The Governing Board/organization/Leadership is that body of people who have been chosen by the corporation and vested with legal authority to be responsible for directing the business and affairs of the corporation. The responsibilities assured by each Board/organization member by their acceptance of membership are to provide effective and ethical governance leadership on behalf of its owners'/stakeholders' interest to ensure that the organization focuses on its purpose and outcomes for persons served, resulting in the organization's long-term success and stability.

The mission statement of the organization is based on the Board/organization's philosophical motivations, the services provided, and values of the members. The mission statement should identify the population to be served and the services to be provided. This description shall be nondiscriminatory by reason of sex, age, disability, creed, marital status, ethnic, or national membership.

NOTE: See Arkansas Code Ann. §§ 20-48-201—20-48-211 for examples of Board/organization responsibilities.

NOTE: All information regarding your organization shall be readily available to staff, consumers, referral and funding sources, and the interested public pursuant to the Freedom of Information Act.

101 The organization shall be legally incorporated under the appropriate federal, state or local statutes as defined by its official Articles of Incorporation and registered to do business in the State of Arkansas.

A. The governing body should periodically review the appropriateness of its governing documents. (Ark. Code Ann. §§ 20-48-201—20-48-211). This shall include the organizations mission statement as filed with the Secretary of State, and the Articles of Incorporation.

B. Any changes in the Articles of Incorporation must be filed with the Secretary of State. This includes name changes, amendments, or any reconstitution of the Governing Board/organization. The organization shall provide copies of any changes to DDS upon filing.

102 Bylaws shall be established which govern the internal affairs of the organization and will address each of the following areas as applicable:

A. Composition of Board

1. This shall include the number of Board members and the eligibility criteria (i.e. citizenship and residency).

2. Selection of Board/ members

a. Twenty percent (20%) consumer and advocate representation on the Board is required. (Note: defined as a consumer, immediate family member or guardian of a consumer receiving services or has received services at the organization or person in a qualified position that advocates on behalf of the population served)

- ~~B. Term of membership:~~
- ~~1. Number of years as dictated by the organization's Articles of Incorporation.
Note: It is recommended that membership on the governing body be rotated periodically.~~
- ~~C. Replacement/removal of directors:~~
- ~~1. Refers to written criteria for Board membership. Shall include any contingency to include but not be limited to resignation of Board/organization members and removal for non-attendance or other reasons.~~
- ~~D. Election of officers and directors:~~
- ~~1. Describe the election process~~
- ~~E. Duties and responsibilities of Board officers are described in writing~~
- ~~1. Must document each position's purpose, structure, responsibilities, authority, if any, and the relationship of the advisory committee of Board members to other entities involved with the organization.~~
- ~~F. Appointment of committees, if applicable;~~
- ~~1. Duties and functions of standing committees are described in writing, if applicable.~~
- ~~G. Meetings of the Board/organization and its committees. All meetings shall be planned, organized, and conducted in accordance with the organization's by-laws, policies, procedures, applicable statutes, or other appropriate regulations. In no event shall the full Board/organization meet less than four times per year.~~
- ~~Note: The Board/organization and its committees should meet with a frequency sufficient to discharge their responsibilities effectively.~~
- ~~H. The Board/organization shall adopt written procedures to guide the conduct of its meetings (i.e. Parliamentary Procedure, Robert's Rules of Order, etc.);~~
- ~~I. The Board/organization shall maintain minutes of all actions taken by the Board/organization for review by DDS. Minutes shall accurately document all members present and any action taken at the committee meetings to include any committee recommendations to the Board/organization:~~
- ~~1. Written minutes of previous Board/organization meetings should be made available by posting the adopted minutes in a location convenient to the staff and individuals served, and made available to members of the public upon request, as required under the Freedom of Information Act.~~
- ~~103 The Board/organization shall establish a procedural statement addressing nepotism as it relates to Board/organization and staff positions.~~
- ~~103.1 The Board shall establish a procedural statement addressing conflict of interest~~
- ~~Note: The intent of the standard does not rule out a business relationship, but does call for the governing body to decide in advance what relationships are in the best interest of the organization.~~
- ~~A. Paid employees may not serve as Board members. (Note: This DOES NOT include individuals receiving services.)~~
- ~~Note: Paid employees serving on the Board as of 11/01/07 may continue to serve for the remainder of their current term at which time they must rotate off the Board.~~

- ~~B. Directors of organizations may serve as non-voting ex officio Board members.~~
- ~~104 Board/organization meetings and public meetings as defined by Ark. Code Ann. §§ 25-19-106 shall be conducted at a time and place which make the meetings accessible to the public. Specifically, except as otherwise specifically provided by law, all meetings, formal or informal, special or regular, of the governing bodies of all municipalities, counties, townships, and school districts and all boards, bureaus, commissions, or organizations of the State of Arkansas, except grand juries, supported wholly or in part by public funds or expending public funds, shall be public meetings.~~
- ~~A. Board/organization meetings and Executive sessions shall be announced to be in compliance with Ark. Code Ann. §§ 25-19-101 – 25-19-107 “Freedom of Information Act”~~
- ~~B. All local media are to be notified one week in advance and a notice posted in a prominent place by the organization. Called meetings shall be announced to the local media and others who have requested notification at least two hours in advance of meeting. Documentation of Notification may include newspaper clippings, copy of item posted on bulletin Board/organization, radio contact forms, etc.~~
- ~~D. If the meetings are held each month at the same time and location, one notification and posting shall be sufficient.~~
- ~~105 The Board/organization of Directors shall adopt a mission statement to guide its activities and to establish goals for the organization. The plan shall show evidence of participation by stakeholders (evidence of open meeting, letters of input, survey, questionnaire, etc.).~~
- ~~105.1 The Board/organization of Directors shall review the mission statement annually and shall make changes as necessary to ensure the overall goals and objectives of the organization are reflected in its mission.~~
- ~~106 The Board/organization maintains a plan which shall identify annual and long range goals; the plan should address community needs and target populations and should be reviewed and updated annually.~~
- ~~A. Each Board/organization will develop and implement a long-range plan of action for that organization. Examples include, but are not limited to starting a new component, accessing individualized services in the community, etc.~~
- ~~B. Development and implementation of the plan shall include stakeholder input. The organization shall maintain evidence of this input (i.e., letters of input, minutes of open meetings, questionnaires, surveys, etc.)~~
- ~~C. The plan shall be reviewed annually and updated as needed. The Board/organization shall approve the initiation, expansion, or modification of the organization’s program based on the needs of the community and the capability of the organization to have an effect upon those needs within its established goals and objectives.~~
- ~~*Note: The Board/organization of Directors, at its discretion, may assign this responsibility to staff.*~~

~~107 The Board/organization shall demonstrate corporate social responsibility while maintaining overall accountability for the administration and direction of the organization, and shall delegate authority and responsibility to executive leadership as deemed appropriate by the organization.~~

~~A. The organization shall identify:~~

- ~~1. Its leadership structure.~~
- ~~2. The roles and responsibilities of each level of leadership.~~

~~B. The identified leadership shall guide the following:~~

- ~~1. Establishment of the mission and direction of the organization.~~
- ~~2. Promotion of value/achievement of outcomes in the programs and services offered.~~
- ~~3. Balancing the expectations of both the persons served and other stakeholders, as defined by the organization's policies.~~
- ~~4. Financial solvency.~~
- ~~5. Compliance with insurance and risk management requirements.~~
- ~~6. Ongoing performance improvement.~~
- ~~7. Development and implementation of corporate responsibilities.~~
- ~~8. Compliance with all legal and regulatory requirements.~~

~~C. The organization shall respond to the diversity of its stakeholders with respect to:~~

- ~~1. Culture.~~
- ~~2. Age.~~
- ~~3. Gender.~~
- ~~4. Sexual orientation.~~
- ~~5. Spiritual beliefs.~~
- ~~6. Socioeconomic status.~~
- ~~7. Language.~~

~~108 The Board/organization shall create a mechanism for monitoring the decisions and operations of the organization's programs which includes provisions for the periodic review and evaluation of its program in relation to the program goals. Documentation of the review must be maintained on file for review. Documentation may include but not be limited to Board/organization minutes, reports, etc.~~

Guiding Principle: ~~An organized training program for Board/organization Members prepares them for their responsibilities and assures that they are kept up-to-date on issues concerning services offered to individuals with a developmental disability.~~

~~109 The Board shall maintain a general plan for Board/organization training and will ensure that all items listed as required topics are covered in the required three-hour training.~~

~~A. Training shall be provided for all Board/organization members. Where the Board, because of its size, lacks sufficient resources to conduct a training program, it will make arrangements with another Board, organization, agency, appropriate community resource, or training organization to provide such training.~~

~~109.1 New Board Members must participate in a minimum of three hours of training.~~

- ~~A. The following topics shall be required during the first year of service~~
 - ~~1. Functions and Responsibilities of the Board~~
 - ~~2. Composition and Size of the Board~~

- ~~3. Legal Responsibilities~~
- ~~4. Funding Sources and Responsibilities;~~
- ~~5. Equal Employment Opportunity/Affirmative Action;~~
- ~~6. Due Process~~
- ~~7. Ark. Code Ann. §§ 25-19-101-25-19-107 "Freedom of Information Act of 1967"~~
- ~~8. U. S. C. § 12101 et. seq. "Title 42 THE PUBLIC HEALTH AND WELFARE CHAPTER 126 EQUAL OPPORTUNITY FOR INDIVIDUALS WITH DISABILITIES § 12101. Findings and purpose"~~
- ~~9. DDS Service Policy 3004 I Maltreatment Prevention, Reporting and Investigation;~~
- ~~10. DHS Policy 1090, Incident Reporting.~~
- ~~11. DDS Administrative Policy 1077~~
- ~~12. Chemical Right to Know~~
- ~~13. The Health Insurance Portability and Accountability Act (HIPAA)~~

~~NOTE: POSSIBLE TRAINING RESOURCES INCLUDE ASPEN PUBLICATIONS, WHICH HAS MATERIALS ON BOARD/ORGANIZATION AND ADMINISTRATOR TRAINING. (WWW.ASPENPUBLISHERS.COM) Resources or additional information should be obtained from DDS Licensure.~~

- ~~B. All new Board members as they begin service shall participate in training. Board members may disseminate training information to new Board members if they are unable to attend formal training sessions. Documentation of the information provided, date provided and the board member(s) involved must be maintained for review by DDS. (Note: Training may be documented in Board minutes or by Certificates of Attendance.)~~
- ~~109.2 All Board members shall complete a minimum of three hours annual training. Topics may be selected by the Board of Directors and must be germane to the annual plan and services provided. Training should be documented in Board minutes, by Certificates of Attendance or sign in sheets from approved training.~~
- ~~110 Board members shall visit service components of the organization during operating hours yearly.~~
- ~~A. All components of the organization must be observed annually. If on-site observations to each physical location are not feasible, at least 1 physical site from each program component must be observed during the calendar year. The sites must be rotated yearly. Committees or individual Board Members may be appointed to visit specific components and report back to the other Board members on observations. Documentation of reports in Board minutes shall be accepted as verification.~~
- ~~111 The Board/organization shall establish and approve policies and procedures which define Eligibility criteria, Readmission criteria, and transition/discharge/exit criteria~~
- ~~112 The Board/organization shall establish policy regarding financial oversight of the organization that addresses the following:~~
- ~~A. The organization's financial planning and management activities reflect strategic planning designed to meet:~~

- ~~_____ 1. Established outcomes for the persons served.~~
- ~~_____ 2. Organizational performance objectives.~~
- ~~_____ B. Budgets are prepared that:~~
 - ~~1. Include:~~
 - ~~a. Reasonable projections of revenues and expenditures.~~
 - ~~b. Input from various stakeholders, as required.~~
 - ~~c. Comparison to historical performance.~~
 - ~~2. Are disseminated to:~~
 - ~~a. Appropriate personnel.~~
 - ~~b. Other stakeholders, as appropriate.~~
 - ~~3. Are written.~~
- ~~_____ C. Actual financial results are:~~
 - ~~1. Compared to budget.~~
 - ~~2. Reported to:~~
 - ~~a. Appropriate personnel.~~
 - ~~b. Persons served, as appropriate.~~
 - ~~c. Other stakeholders, as required.~~
 - ~~3. Reviewed at least quarterly.~~
- ~~_____ D. The organization identifies and reviews, at a minimum:~~
 - ~~1. Revenues and expenses.~~
 - ~~2. Internal and external:~~
 - ~~a. Financial trends.~~
 - ~~b. Financial challenges.~~
 - ~~c. Financial opportunities.~~
 - ~~d. Business trends.~~
 - ~~e. Management information.~~
 - ~~3. Financial solvency, with the development and implementation of remediation plans, if appropriate.~~

~~113 For-profit organizations or organizations who receive less than \$10,000 in compensation for services under this program shall submit a compilation report that includes a balance sheet and statement of revenue and expense to DDS at the close of each financial period.~~

~~**Note: Sections 102 & 104 do not apply to organizations that are not governed by a Board of Directors**~~

~~200 PERSONNEL PROCEDURES & RECORDS~~

~~201 The organization shall maintain written personnel procedures that are approved by the Board and are reviewed annually and which conform to state and federal laws, rules and regulations.~~

~~NOTE: DDS SHALL NOT BECOME DIRECTLY INVOLVED IN PERSONNEL ISSUES UNLESS IT DIRECTLY IMPACTS CONSUMER CARE AND/OR SAFETY.~~

~~201.1 Personnel procedures shall be clearly stated and available in written form to employees as required by 42 U.S.C. § 2000a-6 “Title VI of the Civil Rights Act of 1964” and U.S.C. § 1201 et. Seq. Americans with Disabilities Act. These include but are not limited to:~~

- ~~A. Hiring and promotional procedures which are nondiscriminatory by reason of sex, age, disability, creed, marital status, ethnic, or national membership~~
- ~~B. A procedure for discipline, suspension and/or dismissal of staff which includes opportunities for appeal~~
- ~~C. An appeals procedure allowing for objective review of concerns and complaints~~

~~201.2 One copy of the organization’s Personnel procedures must be available in the personnel or administrator’s office. This copy must be readily accessible to each employee.~~

~~201.3 The organization shall develop and implement steps to voice grievances within the organization. All grievances are subject to review by the Governing Board and Court of Law (29 U.S.C. §§ 706(8), 794-794(b), the “Rehabilitation Act of 1973 Section 504; 20 U.S.C. § 1400 et. Seq. Section 615 “The Individual Disabilities Education Act”.~~

- ~~A. All steps in the Grievance Procedure should be time bound and documented, including initial filing of grievance.~~

~~201.4 The organization shall develop and implement policies regarding whether pre-employment and random drug testing will be required. If the organization chooses to do drug testing they must establish guidelines for actions to be taken when the drug test results are obtained, whether positive or negative.~~

~~Note: The organization may contact Arkansas Transit Association for further information on drug testing~~

~~202 Prior to employment, a completed job application must be submitted which includes the following documents.~~

- ~~A. The organization shall obtain and verify PRIOR to employment and maintain documentation of the following:
 - ~~1. The credentials required~~
 - ~~2. That required credentials remain current~~
 - ~~3. The applicant has completed a statement related to criminal convictions~~
 - ~~4. A criminal background check has been initiated. Refer to DDS Policy 1087.~~
 - ~~5. Declaration of truth of statement on job application.~~
 - ~~6. A release to complete reference checks is signed and reference checks have been completed~~~~

~~7. Results of pre-employment drug screen, if required by organization.~~

~~NOTE: THE ITEMS IN 202A.5 AND 202A.6 WILL NOT BE RATED FOR EMPLOYEES HIRED PRIOR TO JULY 1, 1986.~~

~~B. The organization shall obtain and verify within 30 days of employment and maintain documentation of the following:~~

~~1. Adult Maltreatment Central Registry Ark. Code Ann. §§ 5-28-201 has been completed and the response is filed, or a second request submitted~~

~~2. Arkansas Child Maltreatment Central Registry Ark. Code Ann. §§ 12-12-501-12-12-515 has been completed and the response is filed, or a second request submitted. This check will provide documentation that prospective employee's name do not appear on the statewide Central Registry.~~

~~a. The organization should adopt policy requiring subsequent criminal checks and registry checks. The organizations that provide licensed daycare services must adhere to Child Care Licensing regulations regarding Criminal background checks and central registry checks.~~

~~*Note: Staff holding professional licenses may be used in lieu of criminal background and adult and child maltreatment checks.*~~

~~3. TB skin test~~

~~a. Renewed yearly for ALL STAFF.~~

~~4. Hepatitis B series or signed declination~~

~~5. The results of criminal background check of the will be on file.~~

~~6. Employment reference verification and signed release~~

~~a. On file within thirty (30) days of hire date~~

~~C. The organization shall obtain and verify information in 202 A and B in response to information received (i.e., a complaint is received that a person's license has lapsed or a person has been convicted of a crime since they were hired).~~

~~203 The agency shall ensure sub-contractor's services meet all applicable standards and will assess performance on a regular basis.~~

~~A. The organization shall ensure that sub-contractors providing direct care services are in compliance with DDS policies and must have verification and documentation of all applicable items listed in 202A.~~

~~*Note: Staff holding professional licenses may be used in lieu of criminal background and adult and child maltreatment checks.*~~

~~B. The organization shall demonstrate:~~

~~1. Reviews of all contract personnel utilized by the organization that:~~

~~a. Assess performance of their contracts~~

~~b. Ensure all applicable policies and procedures of the organization are followed~~

~~c. Ensure they conform to DDS standards applicable to the services provided~~

~~d. Are performed annually~~

~~204 The organization shall develop, implement and monitor policies and procedures for staff recruitment and retention so that sufficient staff is maintained to ensure the health and safety of the individuals served, according to their plans of care.~~

~~A. The organization must ensure there are an adequate number of personnel to:~~

- ~~1. Meet the established outcomes of the persons served.~~
- ~~2. Ensure the safety of persons served.~~
- ~~3. Deal with unplanned absences of personnel.~~
- ~~4. Meet the performance expectations of the organization.~~

~~B. The organization shall demonstrate:~~

- ~~1. Recruitment efforts.~~
- ~~2. Retention efforts.~~
- ~~3. Identification of any trends in personnel turnover.~~

~~205 The organization shall develop and implement procedures governing access to staff members' personnel file.~~

~~A. An access sheet shall be kept in front of the file to be signed and dated by those who are examining contents, with stated reasons for examination.~~

~~B. The policy shall clearly state who, when, and what is available concerning access to personnel files and be in compliance with the Federal Privacy Act and Freedom of Information Act. At no time shall the policy allow access that violates the provisions of the Health Insurance Portability and Accountability Act (HIPAA).~~

~~206 The organization shall develop written job descriptions which describe the duties, responsibilities, and qualifications of each staff position.~~

~~A. The organization shall:~~

- ~~1. Identify the skills and characteristics needed by personnel to:
 - ~~a. Assist the persons served in the accomplishment of their established outcomes.~~
 - ~~b. Support the organization in the accomplishment of its mission and goals.~~~~
- ~~2. Assess the current knowledge and competencies of personnel at least annually.~~
- ~~3. Provide for the orientation and training needs of personnel.~~
- ~~4. Provide the resources to personnel for learning and growth.~~
- ~~5. Identify the supervisor of the position and the positions to be supervised.~~

~~B. Performance management shall include:~~

- ~~1. Job descriptions that are reviewed and/or updated annually.~~
- ~~2. Promotion guidelines.~~
- ~~3. Job posting guidelines.~~
- ~~4. Performance evaluations for all personnel directly employed by the organization shall be:
 - ~~a. Based on measurable objectives that tie back to specific duties as listed in the Job Description.~~
 - ~~b. Evident in personnel files.~~
 - ~~c. Conducted in collaboration with the direct supervisor with evidence of input from the personnel being evaluated.~~~~

- d. ~~Used to:~~
 - 1. ~~Assess performance related to objectives established in the last evaluation period.~~
 - 2. ~~Establish measurable performance objectives for the next year.~~
- e. ~~Performed annually.~~

~~207 The organization shall establish employment policies/practices for students, interns, volunteers and trainees utilized by the organization who have regular, routine contact with consumers.~~

- ~~A. The organization shall define who has and what constitutes regular, routine contact with consumers.~~
- ~~B. If students, interns, volunteers or trainees are used by the organization, the following shall be in place:~~
 - ~~1. A signed agreement.~~
 - ~~a. If professional services are provided, standards or qualifications applied to comparable positions must be met.~~
 - ~~2. Identification of:~~
 - ~~a. Duties.~~
 - ~~b. Scope of responsibility.~~
 - ~~c. Supervision.~~
 - ~~3. Orientation and training.~~
 - ~~4. Assessment of performance.~~
 - ~~5. Policies and written procedures for dismissal.~~
 - ~~6. Confidentiality policies.~~
 - ~~7. Background checks, when required.~~

300 STAFF TRAINING

Guiding Principle: Staff Training is an organized program which prepares new employees to perform their assigned duties competently and maintains and improves the competencies of all employees. Staff Training for the organization shall provide an on-going mechanism for the evaluation of the impact of the program on services provided to individuals with developmental disabilities. This should include service outcomes to individuals, meeting of the organization objectives and overall mission, compliance with regulatory and professional standards and positive changes in staff performance and attitudes. The needs of individuals with developmental disabilities require the efforts of competent personnel who continually seek to expand knowledge in their fields.

300.1 The organization shall establish a policy designating one or more employees to be responsible for coordinating in-service staff training.

A. The employee responsible for staff training should have broad knowledge of care and service needs of persons with developmental disabilities, and possess the necessary skills to organize and implement an in-service training program as evidenced in resume.

301 The organization shall establish a written training plan. This plan must show how the training will be provided and the areas covered. If training occurs during regularly scheduled service hours, documentation must be present that individual staff ratios were maintained.

301.1 ALL Personnel shall receive initial and annual competency based training to include, but not limited to:

A. Health and safety practices.

1. First Aid (review yearly, renew as required by American Heart Association, Red Cross, or Medic First Aid, applicable for ALL direct service personnel)

a. There is immediate access to:

(1) First aid expertise.

(2) First aid equipment and supplies.

(3) Emergency information on the:

(a) Persons served.

(b) Personnel.

b. Infection Control Plan

1. The organization shall implement an infection control plan that includes:

(a). Training regarding the prevention and control of infections and communicable diseases for:

(1). Persons served, when applicable.

(2). Personnel.

(b). The appropriate use of standard or universal precautions by all personnel.

(c). Procedures that specify that employees with infectious diseases shall be prohibited from contact with individuals until a physician's release has been provided to the organization director.

- ~~B. Identification of unsafe environmental factors:

 - ~~1. Issues Regarding Prevention of Acquired Immunodeficiency Syndrome (AIDS), Hepatitis B (HIV) and other Bloodborne Pathogens~~~~
- ~~C. Emergency procedures and Evacuation Procedures

 - ~~1. Emergency and Disaster Preparedness~~
 - ~~2. Fire and Tornado Drills, Violence in the Workplace, Bomb Threats, Earthquake~~~~
- ~~D. General Information

 - ~~1. Overview of Department of Human Services~~
 - ~~2. Overview of Developmental Disabilities Services~~
 - ~~3. Philosophy, Goals, Programs, Practices, Policies, and Procedures of Local Organization~~
 - ~~4. HIPPA policies and procedures~~
 - ~~5. Orientation to history of Developmental Disabilities~~
 - ~~6. Current Issues Affecting Individuals with Developmental Disabilities~~
 - ~~7. Introduction to Principles of Normalization~~
 - ~~8. Procedures for Incident Reporting~~
 - ~~9. Appeals Procedure for Individuals Served by the Program~~
 - ~~10. Introduction to Behavior Management~~
 - ~~11. Community Integration Training.~~~~
- ~~E. Legal

 - ~~1. Overview of Federal and State Laws related to serving individuals with a developmental disability (NOTE: Laws may change every 2 years)~~
 - ~~2. Legal Rights of Individuals with Developmental Disabilities~~
 - ~~3. Application of Federal Civil Rights Laws to Persons with AIDS or HIV related condition (or those who may be perceived to have AIDS or HIV related conditions).~~
 - ~~4. Ark. Code Ann. §§6-41-201 – 6-41-222 The Children With Disabilities Act of 1973~~
 - ~~5. Ark. Code Ann. §§20-48-201 – 20-48-211; – Arkansas Mental Retardation Act~~
 - ~~6. Ark. Code Ann. §§25-19-101 – 25-19-107 – Freedom of Information Act~~
 - ~~7. Ark. Code Ann. §§28-65-101 – 28-65-109; – Guardians Generally~~
 - ~~8. Ark. Code Ann. §§5-28-101 – 5-28-109; – Abuse of Adults~~
 - ~~9. Ark. Code Ann. §§12-12-501 – 12-12-515; – Arkansas Child Maltreatment Act~~
 - ~~10. Ark. Code Ann. §§25-2-104, 25-2-105, 25-2-107, Type 1, Type 2 and Type 4 Transfers~~
 - ~~11. Ark. Code Ann. §§25-10-102 – 25-10-116; Department of Health and Human Services General Provisions~~
 - ~~12. Ark. Code Ann. §§20-78-215 – Child sexual abuse – Federal funds~~
 - ~~13. U.S.C. § 12101 et. seq. – Americans with Disabilities Act of 1990 P. L. 101-336~~
 - ~~14. 20 U.S.C. §1400 et. seq. (Part B and Part C – P. L. 94-142 Individuals with Disability Education (IDEA) P.L. 99-457 Part C~~
 - ~~15. 42U.S.C. §2000a – 2000 h-6 – Title VI of the Civil Rights Act of 1964~~~~

~~16. 29 U.S.C. §§706 (8) Rehabilitation Act of 1973, 794 794(b) Section 504~~

~~17. 5 U.S.C. §552a Federal Privacy Act~~

~~18. 42 U.S.C. §6000 Developmentally Disabled Assistance & Bill of Rights Act of 1984~~

~~19. P.L. 109-171, Deficit Reduction Act, and 30 U.S.C. §3729 et.seq. False Claims Act~~

~~Note: Documentation of prior training of individual staff may be used for the required topics, if this situation is addressed in the organization's training plan.~~

~~301.2. Documentation of prior training of individual staff may be used for the required topics, if this situation is addressed in the organization's training plan.~~

~~301.3. Training Requirements for professional/administrative staff, as defined by the agencies policies~~

~~1. Twelve (12) hours minimum completed within ninety (90) days of employment (does not include First Aid and CPR training)~~

~~301.4. Training Requirements for direct care staff~~

~~1. Twelve (12) hours minimum completed within (30) days of employment (does not include First Aid and CPR training)~~

~~2. In addition to the training requirements specified Section 301.1, all direct care staff must receive the following training:~~

~~a. CPR (Initial Certification, renew as required by American Heart Association, Medic First Aid, or Red Cross).~~

~~1. ALL direct care staff members, including bus and van drivers, shall be trained and certified to provide CPR, unless they are deemed incapable of performing this task by a licensed medical professional, such as a nurse or doctor. Documentation must be maintained in the personnel file. Staff that are physically incapable of performing CPR must complete and have documentation of CPR training.~~

~~b. The organization shall develop and implement and monitor policy regarding timeframe for CPR certification after hire date. (Timeframe not to exceed 90 days.)~~

~~3. Medication Implications, Side Effects, Legality of Administering medication.~~

~~NOTE: IN ADDITION TO THOSE AREAS ADDRESSED IN THESE STANDARDS,~~

~~OTHER IDENTIFIED NEEDS BASED ON STAFF INPUT SHOULD BE~~

~~ADDRESSED.~~

~~NOTE: SEE APPENDIX B for Training Resources~~

~~301.5 In addition to the requirements in Section 301.1-301.4, all direct care staff shall receive annual in-service training and/or continuing education as follows:~~

~~A. Minimum of twelve (12) hours of training annually, including the required topics.~~

~~1. Topics must be applicable to the job and are to be chosen by the organization based on identified needs. Topics may be a combination of required and job specific training.~~

- ~~2. Behavior management techniques/programming~~
- ~~B. Documentation of the training shall be maintained in the staff's personnel file and shall be evidenced by the signatures of the trainer and the direct care staff, the date the training was provided and the specific information covered.~~
- ~~302 Annual in-service training and/or continuing education for Managerial Staff, as defined by the agencies policies:~~
- ~~A. Topics Chosen must be related to the job performed.~~
- ~~B. Minimum of twelve (12) hours of training required yearly, from the following list:~~
- ~~1. Issues Regarding Prevention of Acquired Immunodeficiency Syndrome (AIDS), Hepatitis B (HIV) and other Blood Borne Pathogens~~
 - ~~2. Application of Federal Civil Rights Laws to persons with AIDS or HIV related Conditions (or those who may be perceived to have AIDS or HIV Related conditions)~~
 - ~~3. Management of Non-Profit Organizations~~
 - ~~4. Procedures for Preventing and Reporting Alleged Maltreatment of Children and Adults~~
 - ~~5. Effective Supervision/Management Techniques~~
 - ~~6. Selection and Interviewing~~
 - ~~7. Fair Employment Principles~~
 - ~~8. Performance Evaluation~~
 - ~~9. Techniques for Working with the Board~~
 - ~~10. Overview of Federal and State Laws Related to Serving Individuals with a Developmental Disability (up dated every two (2) years)~~
 - ~~11. Federal and State Laws:~~
 - ~~a. Ark. Code Ann. §§6-41-201 - 6-41-222 The Children With Disabilities Act of 1973~~
 - ~~b. Ark. Code Ann. §§20-48-201 - 20-48-211 Arkansas Mental Retardation Act~~
 - ~~c. Ark. Code Ann. §§25-19-101 - 25-19-107 Freedom of Information Act~~
 - ~~d. Ark. Code Ann. §§28-65-101 - 28-65-109; Guardians Generally~~
 - ~~e. Ark. Code Ann. §§5-28-101 - 5-28-109; Abuse of Adults~~
 - ~~f. Ark. Code Ann. §§12-12-501 - 12-12-515; Arkansas Child Maltreatment Act~~
 - ~~g. Ark. Code Ann. §§25-2-104, 25-2-105, 25-2-107, Type 1, Type 2 and Type 4 Transfers~~
 - ~~h. Ark. Code Ann. §§25-10-102 - 25-10-116; Department of Health and Human Services General Provisions~~
 - ~~i. Ark. Code Ann. §§20-78-215 - Child sexual abuse - Federal funds~~
 - ~~j. U.S.C. § 12101 et. seq. - Americans with Disabilities Act of 1990 P. L. 101-336~~
 - ~~k. 20 U.S.C. §1400 et. seq. (Part B and Part C - P. L. 94-142 Individuals with Disability Education (IDEA) P.L. 99-457 Part C~~
 - ~~l. 42U.S.C. §2000a - 2000 h-6 - Title VI of the Civil Rights Act of 1964~~
 - ~~m. 29 U.S.C. §§706 (8) Rehabilitation Act of 1973, 794 - 794(b) Section 504~~

~~n. 5 U.S.C. §552a—Federal Privacy Act~~

~~o. 42 U.S.C. §6000—6083—Developmentally Disabled Assistance & Bill of Rights Act of 1984~~

~~C. Managerial Staff, as defined by the agencies policies, who have been with the agency for 2 or more years may select from the above list or choose from continuing education courses.~~

~~NOTE: SEE APPENDIX B FOR TRAINING RESOURCES~~

~~303 All employees who provide transportation services shall have the following training scheduled within thirty (30) days of employment and completed within seventy five (75) days of employment. This training shall be in addition to the required new employee training listed in Section 301~~

~~A. A course of instruction in consumer assistance and transfer techniques, lift operation and how to properly secure a wheelchair, if applicable, prior to transporting consumers; and~~

~~B. The provider must assure and document that each driver obtains the following:~~

~~1. A certificate of completion of an introductory defensive driving course;~~

~~2. A certification of completion of training addressing the transport of older persons and people with disabilities, and a refresher course every three years thereafter, both of which must include:~~

~~a. Sensitivity to aging training;~~

~~b. An overview of diseases and functional factors commonly affecting older adults;~~

~~c. Environmental considerations affecting passengers;~~

~~d. Instruction in consumer assistance and transfer techniques;~~

~~e. Training on the management of wheelchairs, and how to properly secure a wheelchair;~~

~~f. The inspection and operation of wheelchair lifts and other assistive equipment; and,~~

~~g. Emergency procedures.~~

~~C. D. Drivers are required to complete refresher courses every three years after the date the certificate(s) of completion was received.~~

~~Note: For all transportation workers employed prior to 11/01/07, documentation of the required training must be on file no later than 11/01/08.~~

~~304 Providers must assure:~~

~~A. Maintenance of a safety checklist completed prior to transporting consumer(s) and/or travel attendants. Checklist items shall include, but not be limited to, fire extinguisher; first aid kit,~~

~~B. Maintenance of service logs or trip sheets that include the date of service the consumer's name, the pick-up point and destination point for each trip, total mileage per trip, and the driver's signature.~~

- ~~C. Assistance in transfer of the consumer, as necessary, safely from the consumer's door to the vehicle and from the vehicle to the entrance of the destination point. The provider must perform the same transfer assist service when transporting the consumer back to the consumer's residence.~~

MARKY-UP

400—INDIVIDUAL/PARENT/GUARDIAN RIGHTS

Guiding Principle: ~~The organization shall implement a system of rights that nurtures and protects the dignity and respect of the persons served. The organization shall protect and promote the rights of the persons served. This commitment shall guide the delivery of services and ongoing interactions with the persons served.~~

- 401—~~The organization shall implement policies promoting the following rights of the persons served and ensures all information is transmitted to the person served and/or their parent or guardian in a manner and fashion that is clear and understandable:~~
- A. ~~Being free from physical or psychological abuse or neglect, retaliation, humiliation, and from financial exploitation.~~
 - B. ~~Having control over their own financial resources.~~
 - C. ~~Being able to receive, purchase, have and use their own personal property.~~
 - D. ~~Actively and meaningfully making decisions affecting their life.~~
 - E. ~~Access to information pertinent to the person served in sufficient time to facilitate his or her decision making.~~
 - F. ~~Having Privacy.~~
 - G. ~~Being able to associate and communicate publicly or privately with any person or group of people of the individual's choice.~~
 - H. ~~Being able to practice the religion of their choice.~~
 - I. ~~Being free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment, for the convenience of the provider or agent, in conflict with a physician's order or as a substitute for treatment, except when a physical restraint is in furtherance of the health and safety of the individual.~~
 - J. ~~Not being required to work without compensation, except when the individual is residing and being provided services outside of the home of a member of the individual's family, and then only for the purposes of the upkeep of their own living space and of common living area and grounds that the individual shares with others.~~
 - K. ~~Being treated with dignity and respect.~~
 - L. ~~Receiving due process.~~
 - M. ~~Having access to their own records, including information about how their funds are accessed and utilized and what services were billed for on the individual's behalf.~~
 - N. ~~Informed consent or refusal or expression of choice regarding:~~
 - 1. ~~Service delivery.~~
 - 2. ~~Release of information.~~
 - 3. ~~Concurrent services.~~
 - 4. ~~Composition of the service delivery team.~~
 - 5. ~~Involvement in research projects, if applicable.~~
 - O. ~~Access or referral to legal entities for appropriate representation.~~
 - P. ~~Access to self help and advocacy support services.~~
 - Q. ~~Adherence to research guidelines and ethics when persons served are involved, if applicable.~~
 - R. ~~Investigation and resolution of alleged infringement of rights.~~

~~1. The agency maintains documentation of all investigations of all alleged violations of individual's rights and actions taken to intervene in such situations.~~

~~The organization ensures that the individual has been notified of their right to appeal according to DDS Policy 1076.~~

~~R. Rights and responsibilities of citizenship~~

~~S. Other legal and constitutional rights~~

~~402 Records of persons served~~

~~A. The organization shall maintain complete records and treat all information related to persons served as confidential.~~

~~B. The organization shall create policy for the sharing of confidential billing, utilization, clinical and other administrative and service related information, and the operation of any Internet based services that may exist.~~

~~1. Information that is used for reporting or billing shall be shared according to confidentiality guidelines that recognize applicable regulatory requirements such as the Health Insurance Portability and Accountability Act (HIPAA).~~

~~C. The organization shall comply with its own service delivery design for the development of the record. Electronic records are acceptable. Electronic records must meet the following:~~

~~1. Format must meet DHS/ Office of Systems and Technology standards and be acceptable by the Department.~~

~~2. Files must be uniformly organized and easily accessible.~~

~~D. The location of the case record, and the information contained therein, shall be controlled from a central location as defined by the agency, shall be stored under lock and with protection against fire, water, and other hazards in an accessible location at each site. The organization shall establish and implement policies and procedures to ensure direct care staff have adequate access to the individual's current plan of care and other pertinent information necessary to ensure the individual's health and safety (i.e., name and telephone number of physician, emergency contact information, insurance information, etc.). If services are not provided at the central location, at a minimum the following information must be maintained at the service delivery site:~~

~~A. Access Sheet~~

~~B. Face Sheet to include emergency contact information and pertinent health information~~

~~C. Signed consent for emergency treatment~~

~~D. A copy of the consumer's current program plan~~

~~E. Copies of current progress reports~~

~~F. Documentation of service provision to include date, time in and time out, summary of activities, and signature of implementor for the period of the current program plan~~

~~E. Records maintained on computer shall be backed up at a minimum weekly and the duplicate copy shall be stored under lock and with protection against fire, water, and other hazards.~~

~~F. A list of the order of the file information shall either be present in each individual case file or provided to DDS Licensure staff upon request. The documents in active individual case records should be organized in a systematic fashion. An indexing and filing system shall be maintained for all case records.~~

- ~~G. — Each organization shall have written procedures to cover destruction of records. Procedures must comply with all state and federal regulations~~
 - ~~H. — Access sheets shall be located in the front of the file to maintain confidentiality according to 5 U.S.C. § 552a. If there is a signed release for a list of authorized persons to review the file, only those not listed will need to sign the access sheet with date, title, reason for reviewing, and signature. If there is not a signed release for authorized persons to review, all persons must sign the access sheet whenever the file is reviewed or any material is placed in the file.~~
- ~~402.1 — DDS staff shall have access upon demand to all individual case records as designated in Ark. Code Ann. §§ 20-48-201—20-48-211, DDS Policy 1090, Licensing Policy for Center Based Community Services.~~
- ~~402.2 — The organization shall ensure confidentiality of all case records is maintained. Access to case records shall be limited to Individual/Parent/Guardian, professional staff providing direct services to the person served, plus such other individuals as may be authorized administratively or by the consumer. All authorizations either those listed above or others shall be in writing.~~
- ~~A. — Access to individual files shall be limited to only those staff members who have a need to know information contained in the records of persons served.~~
 - ~~B. — Individual service records shall be maintained according to provisions of the Privacy Act.~~
 - ~~C. — Access to computer records shall be limited to those authorized to view records~~
 - ~~D. — The organization shall ensure the right of all persons served to access their own records.~~
 - ~~E. — The organization shall ensure that all persons served know how to access their records and the organization ensures that appropriate equipment is available.~~
 - ~~F. — An organization shall not prohibit the persons served from having access to their own records, unless a specific state law indicates otherwise. It is recognized that the organization must comply with HIPAA regulations as it relates to specific information that cannot be disclosed to persons served without authorization (i.e., psychotherapy notes).~~
- ~~402.2 — Adult individuals who are legally competent shall have the right to decide whether their family will be involved in planning and implementing the individual service plan. A signed release or document shall be present in individual case record giving permission for family to be involved.~~
- ~~402.3 — The Individual /Parent /Guardian shall be informed of their rights. The organization shall maintain documentation in the individual's file that the following information has been provided in writing: THE INFORMATION LISTED IN 402.3 A-I MUST BE PROVIDED UPON ADMISSION AND ANNUALLY THEREAFTER.~~
- ~~A. — All possible service options, including those not presently provided by the program.~~
 - ~~B. — A copy of the rules of conduct and mission statement of the organization.~~
 - ~~C. — Current list of Board members of the community program.~~
 - ~~D. — Summary of funding sources.~~
 - ~~E. — Copy of the appeal procedure for decisions made by the organization.~~
 - ~~F. — Solicitation Guidelines **See Solicitation under Definitions~~
 - ~~G. — All external advocacy services.~~
 - ~~H. — Right to appeal any service decision to DDS, under DDS Policy 1076~~
 - ~~I. — Name and phone number of the DDS Service Specialist for that area~~

Guiding Principle: ~~The organization identifies clear protocols related to formal complaints, including grievances and appeals. An organization may have separate policies and procedures for grievances and appeals, or may include these in a common policy and procedure covering complaints, grievances, and appeals. A review of formal complaints, grievances, and appeals gives the organization valuable information to facilitate change that results in better customer service and results for the persons served.~~

- ~~A. The organization shall identify clear protocols related to formal complaints, including grievances and appeals.~~
- ~~B. The organization shall:~~
- ~~1. Implement a policy by which persons served may formally complain to the organization.~~
 - ~~2. Implement a procedure concerning formal complaints that:~~
 - ~~a. Is written.~~
 - ~~b. Specifies:~~
 - ~~1. That the action will not result in retaliation or barriers to services.~~
 - ~~2. How efforts will be made to resolve the complaint.~~
 - ~~3. Levels of review, which includes availability of external review.~~
 - ~~4. Time frames that are adequate for prompt consideration and that result in timely decisions for the person served.~~
 - ~~5. Procedures for written notification regarding the actions to be taken to address the complaint.~~
 - ~~6. The rights and responsibilities of each party.~~
 - ~~7. The availability of advocates or other assistance.~~
 - ~~3. Make complaint procedures and, if applicable, forms:~~
 - ~~a. Readily available to the persons served.~~
 - ~~b. Understandable to the persons served and in compliance with 29 U. S. C. §§ 706 (8), 794—794(b).~~
- ~~C. These procedures shall be explained to personnel and persons served in a format that is easily understandable and meets their needs. This explanation may include, but not limited to a video or audiotape, a handbook, interpreters, etc.~~

~~403.1 The organization shall annually review all formal complaints filed.~~

- ~~A. A written review of formal complaints:~~
- ~~1. Determine:~~
 - ~~a. Trends.~~
 - ~~b. Areas needing performance improvement.~~
 - ~~c. Action plan or changes to be made to improve performance and to reduce complaints~~

~~403.2 The organization shall document a review of any action plan or changes made to determine if the plan/changes were effective in reducing complaints and shall make adjustments to the plan as deemed necessary to ensure quality services.~~

404 Health Related Issues

Guiding Principle: A successful health and safety program goes beyond compliance with regulatory requirements and strives to manage risk and to protect the health and safety of persons served, employees, and visitors. A successful health and safety program addresses both minimizing potential hazards and compliance activities.

- A. The organization shall implement policies/procedures to ensure the rights of individuals who have or who are perceived as having Acquired Immunodeficiency Syndrome (AIDS) or Human Immune Virus (HIV) related condition (or those who may be perceived as having AIDS or AIDS related conditions including Hepatitis B are not discriminated against in accordance with 29 U.S.C. §§ 706 (8), 794—794(b); U.S.C. § 12101 et. seq. A copy of the policies/procedures shall be provided to each Individual/Parent/Guardian(s).
- B. The organization shall implement policies/procedures concerning any person admitted for services or anyone proposed for admission to ensure confidentiality shall be maintained for all information related to HIV testing, positive HIV infection, any HIV associated condition, AIDS or Hepatitis B.
- C. Each organization will protect the confidentiality of records or computer data that is maintained which relates to HIV, AIDS or Hepatitis B.

405 Incident / Accident Reporting

A. The organization shall **report the following incidents to the DDS Licensing Unit** in accordance with DHS Policy 1090. This report shall contain: date, accident/injury, time, location, persons involved, action taken, follow-up, signature of person writing the report. The following are reportable incidents:

- 1. Use of seclusion or restraint.
- 2. Maltreatment or abuse as defined in statutes (See Ark. Code Ann. §§ 12-12-501—12-12-515 (503); Ark. Code Ann. §§ 5-28-101—5-28-109 (102))
- 3. Incidents involving injury:
 - a. Accident/injury reports shall be completed for each accident/injury that requires the attention of an EMT, Paramedic or Physician.
 - 1. Accident is defined as an event occurring by chance or arising from unknown causes.
 - 2. Injury is defined as an act that damages or hurts and results in outside medical attention.
 - 3. A copy of the report, redacted as required by the Freedom of Information Act must be sent to parent/guardian of all children (0-18), and to guardian of adults regardless of severity of injury.
 - 4. Other health related conditions resulting in Emergency treatment or hospitalization.
 - 4. Communicable disease
 - 5. Violence or aggression
 - 6. Sentinel events (i.e., an unexpected occurrence involving death or serious physical

- ~~_____ or psychological injury or the risk thereof)~~
- ~~_____ 7. Elopement and/or wandering defined as anytime the location of a person cannot
_____ be determined within 2 hours~~
- ~~_____ 8. Vehicular accidents _____~~
- ~~_____ 9. Biohazardous accidents _____~~
- ~~_____ 10. Use or possession of illicit substances or use or possession of licit substances in an
_____ unlawful or inappropriate manner (i.e., possession of prescription drugs by a person
_____ to whom the drugs have not been prescribed and who has no legitimate interest in
_____ possession of prescription drugs, such as a parent or guardian)~~
- ~~_____ 11. Arrests or convictions~~
- ~~_____ 12. Suicide or attempted suicide~~
- ~~_____ 13. Property destruction~~
- ~~_____ 14. Any condition or event that prevents the delivery of DHS services for more than 2
_____ hours~~
- ~~_____ 15. Behavioral incidents (incidents involving an individual's actions that are
_____ aggressive, disruptive and/or present a danger to the individual or to others)~~
- ~~_____ 16. Other areas, as required~~

~~_____ NOTE: FOR INDIVIDUALS 3-21 YEARS OF AGE, DESTRUCTION OF INCIDENT
_____ REPORTS MUST BE IN COMPLIANCE WITH DEPARTMENT OF
_____ EDUCATION.~~

- ~~B. The organization shall notify the parent/guardian of all children (0-18) or adults who have a
_____ guardian any time an incident/ injury report is submitted.~~
- ~~C. The organization shall develop and implement policies and procedures regarding follow-up of all
_____ incidents to include a time line for action, remediation and preventative measures that do not
_____ exceed DDS established timeframes, in accordance with DHS Policy 1090.~~

~~407 Behavioral Management _____~~

- ~~A. The organization shall develop policy and procedure that demonstrates a commitment to
_____ a system that nurtures personal growth and dignity, and supports the use of positive
_____ approaches and supports.~~
- ~~B. The organization's policy and procedure shall ensure that when behavior
_____ management approaches are used, positive behavior interventions are
_____ implemented prior to the use of restrictive procedures.~~
- ~~C. Written behavior management policy developed by the organization shall ensure the
_____ rights of individuals.~~
 - ~~1. The policy will be incorporated by the interdisciplinary team in programming,
_____ as appropriate.~~
 - ~~2. The plan must be reviewed quarterly or as dictated by the needs of the
_____ individual served.~~

- ~~3. This shall include all types of behavior management used i.e., time out, token economy, etc... This cannot include procedures that are punishing, physically painful, emotionally frightening, or deprivation, or that puts the individual served at medical risk which are used to modify behaviors~~
- ~~D. If restrictions are placed on the rights of a person served:~~
- ~~1. The organization shall follow its policies and procedures.~~
 - ~~2. The organization shall obtain informed consent from the individual/parent/guardian prior to implementation.~~
 - ~~3. The organization shall have methods to reinstate rights as soon as possible.~~
 - ~~4. Staff members are trained on proper implementation of all restrictions utilized by the organization.~~
- ~~E. The organization shall assure that maltreatment or corporal punishment of individuals will not be allowed.~~
- ~~1. Policies and Procedure must state that corporal punishment is prohibited.
 - ~~a. "Corporal punishment" refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.~~
 - ~~b. 20 U.S.C. § 1400 et. seq.; Maltreatment laws, Ark. Code Ann. §§ 12-12-501 12-12-515; Ark. Code Ann. §§ 5-28-101 5-28-109.~~~~
- ~~F. Individuals shall have the right to obtain and retain private property.~~
- ~~1. Personal possessions are regarded as the private property of the individuals and shall not be taken away unless danger to safety of the individual or to others is present.~~
- ~~G. Emergency Basis Procedure~~
- ~~An emergency safety situation is defined as unanticipated behavior that places the person served or others at serious threat of violence or risk of injury if no intervention occurs.~~
- ~~1. The organization shall establish policies/procedures for the use of restraint and/or emergency intervention procedures that must be used/undertaken in the event of a emergency circumstances for a consumer who has no behavior management plan in place. The policies/procedures must identify the circumstances under which emergency procedures will be used as a protective measure in a life or safety-threatening situation only when de-escalation has failed or is not possible.~~
 - ~~2. Emergency basis procedures may not be repeated more than three (3) times within six months without the interdisciplinary team meeting to revise the individual program plan. Each incident consists of: a behavior was exhibited, a procedure was used, the individual was no longer thought to be dangerous, the procedure was discontinued.~~
- ~~*Note: The number three (3) means three (3) distinct incidents. The three (3) distinct occurrences could take place in one (1) day.*~~

~~500 SERVICE PROVISION STANDARDS~~

~~501 The organization shall establish written policies and procedures for intake, evaluation, and diagnosis necessary to determine the eligibility of a person to receive services shall be documented.~~

~~501.1 The organization shall designate specific staff positions assigned with the responsibility for intake, evaluation, assessment, family contact, planning, updating, and alternate placement.~~

~~502 Face sheets shall be completed at intake and shall be updated as needed and at least annually as documented by date of signature of the person designated in organization's policy.~~

~~502.1 Every person receiving services shall have a service record face sheet that contains the information in 502.1 A-S and will be filed in a prominent location in the front of the file.~~

~~A. Full name of individual~~

~~B. Address, county of residence, telephone number and email address, if applicable~~

~~C. Marital status, if applicable~~

~~D. Race and gender~~

~~E. Birth date~~

~~F. Social Security number~~

~~G. Medicaid Number~~

~~H. Legal status~~

~~I. Parents or guardian's name and address and relationship, if applicable~~

~~J. Name, address, telephone number and relationship of person to contact in emergency, someone other than item H~~

~~K. Health insurance benefits and policy number~~

~~L. Primary language~~

~~M. Admission date~~

~~N. Statement of primary/secondary disability~~

~~O. Physician's name, address and telephone number~~

~~P. Current medications with dosage and frequency, if applicable~~

~~Q. All known allergies or indicate none, if applicable~~

~~R. The results of all independent, annual developmental screens conducted by the DHS third-party vendor, or authorized waiver of the developmental screen requirement.~~

~~502 A case manager/service coordinator/evaluator shall be designated in writing and shall organize the provision of services for every individual served. The case manager/service coordinator/evaluator shall provide the individual or parent/guardian with the name and contact information in writing.~~

~~A. For every individual served, the case manager /service coordinator/ evaluator shall:~~

~~1. Assume responsibility for intake, assessment, planning and services to the person~~

~~2. Coordinate the individual program plan~~

~~3. Cultivate the individual's participation in the services~~

~~4. Monitor and update services to assure that:~~

~~a. The person is adequately oriented~~

~~b. Services proceed in an orderly, purposeful, and timely manner~~

- e. ~~The transition and/or discharge decision and arrangements for follow-up are properly made.~~

~~503 Intake~~

- ~~A. A written intake procedure shall be available upon request, shall be understandable to the individual receiving the services, shall be presented to those requesting services, and shall be followed by the organization in the evaluation of a person to determine eligibility for services.~~
- ~~B. The organization shall implement policies and procedures for acceptance into services. Policies and procedures must:~~
 - ~~1. Establish the criteria for the order of acceptance of any person awaiting service.~~
 - ~~2. Identify the position or entity responsible for making acceptance decisions.~~
 - ~~3. Provide opportunities for persons to learn about the organization and its services.~~
 - ~~4. When a person is found ineligible:
 - ~~a. The person is informed of the reasons.~~
 - ~~b. The person is given information about potential alternative services.~~~~
 - ~~5. Ensure that all involved are aware of their responsibilities regarding services prior to the planning and delivery of services~~
 - ~~6. Ensure signed informed consent for services are obtained and retained as required by funding sources and for legal reasons~~
 - ~~7. Ensure persons served are given information about setting their individual service goals, when applicable, planning the services to be delivered and how progress on service goals will be communicated with them.~~

~~504 Information gathered prior to admission shall include the following information and shall be filed in the individual's record:~~

- ~~A. The results of the independent, annual developmental screen conducted by the DHS third-party vendor, or the authorized waiver of the developmental screen requirement.~~
- ~~B. Signed emergency medical release and all other necessary release forms (i.e., Publicity, field trip, fund raising, etc.). The emergency medical release form shall remain current (yearly) for the protection of the organization and the individual.
 - ~~1. Competent adults must always sign their releases~~
 - ~~2. Publicity releases shall be obtained on an as-needed basis (for each occurrence)~~
 - ~~3. Field trip releases shall be obtained on a per-occurrence basis unless that field trip is part of the regular program (i.e. bowling each week, swimming each week, etc.)~~
 - ~~4. Emergency medical releases must be taken on field trips or incorporated in the field trip release.~~~~
- ~~C. Statement of Legal (competency) status; See Ark. Code Ann. §§ 28-65-101-28-65-109 (see index)
 - ~~1. If the individual is under the age of 18, he/she is a minor. Organizations shall determine the who is the legal guardian of the child: Natural parent(s), ward of the state (DCFS/foster home, etc.) and shall ensure the legal guardian signs all appropriate documents.~~
 - ~~2. If the individual is age 18 or older, he/she is considered competent unless the court has appointed a legal guardian. Copies of guardianship orders must be maintained in the individual's record.~~~~

~~Note: An individual for whom a guardian has been appointed retains all legal and civil rights except those which have been expressly limited by court order or which have been specifically granted by order of the court to the guardian. 4.~~

~~505 Application for services~~

- ~~A. The organization shall develop and implement a written application to be made available upon request or presented to those requesting services. At a minimum, the application shall contain name, address and telephone number of individual/parent/guardian and a statement of the individual's needs. Applications shall be available in an alternate format and assistance to complete shall be offered to individual's that may require it~~

~~506 The organization shall complete a Financial Screen for all applicants for services as applicable.~~

- ~~A. The screen shall be completed prior to admission and is used by the program in the evaluation of a person's financial status~~
~~B. The organization shall include all information about benefits for Medicaid eligibility and, for individuals who may not be eligible for Medicaid, shall include information about Tax Equity Family Reform Act eligibility.~~

~~507 Medical prescription for services shall be obtained, if applicable~~

- ~~A. A current prescription for services (within twelve months), signed by qualified medical personnel, shall be on file prior to admission~~

~~508 The organization shall complete or obtain a full assessment at the time of the admission process. The assessment shall include the following items:~~

- ~~A. Social history~~
~~1. A social history shall be written or procured within thirty (30) days of admission. The social history must be comprehensive, in narrative form or a completed questionnaire. The social history must be updated annually as evidenced by dated signature.~~
~~B. Medical history and evaluation~~
~~1. A physical examination/assessment signed by qualified medical personnel shall be on file and current within 5 days but not longer than thirty (30) days after admission. In cases where a physical cannot be obtained within 5 days, documentation of a physical within 1 year will be accepted until a new physical can be obtained~~
~~2. Early Periodic Screening Diagnosis Treatment process for Medicaid eligible individuals (0-21)~~
~~a. All individuals 0-21 years of age eligible for Medicaid should have evidence in the file that they are participating in the EPSDT process~~

~~509 A psychological evaluation report shall be on file prior to admission for adults (age 18 and older) and for children (age 5-18) if applicable~~

- ~~A. Adults (age 18-up) transferring from a DDS Licensed provider may be admitted with a copy of the most current psychological evaluation~~

~~B. A new psychological evaluation may be conducted if an Interdisciplinary Team determines that it is reasonable and necessary based on significant life changes of the individual.~~

~~510 Therapy evaluations must be completed or procured within thirty (30) days after admission, when applicable or when prescribed by a physician or a therapist working under a physician's orders. Recommendations from therapy evaluations shall be incorporated into the individual's plan of care as appropriate.~~

~~511 When applicable, all psychiatric evaluation shall completed by a qualified person and must be on file within thirty (30) days after admission. Recommendations from psychiatric evaluations shall be incorporated into the individual's plan of care as appropriate.~~

~~512 The service needs assessment must be completed on every individual seeking services~~

~~NOTE: SEE SECTION 521 FOR FURTHER GUIDELINES
(CHILDREN'S SERVICES SECTION).~~

- ~~A. The person and/or family served and/or their legal representatives shall be involved in:~~
- ~~1. Assessments of potential risks to each person's health in the setting in which they receive services as well as in the community~~
 - ~~2. Assessments of potential risks to each person's safety in the setting in which they receive services as well as the community~~
 - ~~3. Decisions to accept or reject such risks~~
 - ~~4. Identification of actions to be taken to minimize risks~~
 - ~~5. Identification of individuals responsible for those actions~~

~~513 Personal Futures Planning~~

Guiding Principle: ~~Individual's with developmental disabilities and their families have competencies, capabilities and personal goals that shall be recognized, supported, encouraged, and any assistance to such individual's shall be provided in an individualized manner, consistent with the unique strengths, resources, priorities, concerns, abilities, and capabilities of such individuals. Any plan of service developed should significantly reflect the person for whom it is intended. Services/ supports are most effective when they are adapted to address individual outcomes~~

- ~~1. The organization shall prepare a written person-centered support plan for each individual that shall meet their individual needs. At a minimum, the plan shall:
 - ~~A. Be developed only after consultation with the individual/parent/guardian, and other individuals from the individual's support network as determined by the individual/parent/guardian;~~
 - ~~B. Contain a description of the individual's preferred lifestyle, including:
 - ~~1. The type of setting in which the individual wants to live or work;~~
 - ~~2. With whom the individual wants to socialize;~~
 - ~~3. The social, leisure, religious, or other activities in which the individuals wants to participate;~~
 - ~~4. Reflect the individual's / family's choice of services which are relevant to the individual's age, abilities, life goals/outcomes~~~~~~

5. Address areas such as the individual's / family's health, safety and challenging behaviors which may put the individual at risk
 6. Demonstrates the rights and dignity of individual/ family
 7. Incorporates the culture and value system of the individual/family
 8. Ensures the individual's/ family's orientation and integration to the community, its services and resources.
 9. The necessary activities, training, materials, equipment, assistive technology and services needed to assist the individual in achieving their preferred lifestyle;
 10. Describes how opportunities for individual choice will be provided;
 11. Be approved, in writing by the individual/parent/guardian.
2. The organization shall regularly review and revise the plan whenever necessary to reflect changes in the individual's preferred lifestyle; achievement of goals or skills outlined within the plan or the goal is no longer deemed appropriate for the individual

514 Every individual shall have a written Individualized Program Plan

NOTE: SEE INDIVIDUAL PROGRAM SECTIONS FOR SPECIFIC TIME FRAMES (CHILDREN'S SERVICES, SEE SECTION 521).

- A. The organization shall include the person served as an active participant giving direction in all aspects of the planning and revision processes
- B. Services shall be provided based on the choices of the individual/parent/guardian (as appropriate) and on the strengths and needs of the individuals to be served by the organization
- C. Individual choice shall be determined by personal futures planning as specified in Section 513 and a comprehensive assessment which addresses:
 1. Relevant medical history
 2. Relevant psychological information
 3. Relevant social information
 4. Information on previous direct services and supports
 5. Strengths
 6. Abilities
 7. Needs
 8. Preferences
 9. Desired outcomes
 10. Cultural background
 11. Other issues, as identified

514.1 The Individualized Program Plan:

- A. Shall be developed with the input of the person served and/or their legal guardian.
- B. Shall Identify:
 1. Least restrictive environment

- a. Documentation of discussion of least restrictive environment appropriate for individual strengths and needs
- b. The program must document the justification for specialized environments if they are to be used. Plans shall be made for return to normal environments as soon as possible.
 - 1. Individuals shall be in contact as much as possible with those who do not have disabilities
 - 2. Individual program plans will be reviewed for provisions of program services in the least restrictive environment appropriate to the ability of the individual. Document this item with a summary of the discussion by the entire team about the least restrictive alternatives
 - 3. If the person chooses community integration or a less restrictive environment, documentation of referral attempts for alternate placement shall be present

2. Barriers

- a. Describe the conditions or barriers that interfere with the achievement of the goal(s) or skills(s). Describe why a particular individual's needs cannot be met or what needs to be accomplished to meet the need.
 - b. Resources and/or environment changes, adaptations or modifications necessary to attain the goal or skill shall be listed. The person responsible for attempting to get the service must be identified.
Note: Example of barriers are: lack of contract work, lack of funds, lack of staff, individual absent due to illness, prosthetic devices, equipment space, etc. The responsible person may be staff member, individual, family, etc.
 - e. Documentation of efforts made to remove the identified barriers shall be noted in the individual's progress reports.
3. Long range goals (addressing a period of 3-5 years) and annual goals
- a. The plan shall incorporate the goals and objectives of the individual's person centered plan.
 - b. The planning process shall support the individual / family in decision making and choosing options by actively involving the individual/ family in the Individual Plan (IP) development

4. Specific measurable objectives.

514.2 Short term objectives (3-6 months' time frame) shall be developed, as needed, for each of the annual goals.

- A. Each objective must have criteria for success that states what the individual must do to complete the objective.
- B. Short term objectives must have methods/materials for implementation and give a simple statement describing the procedures to be used in individual training.
- C. The person responsible for implementation of each short term and service objective shall be specified.

Note: Utilization of title is recommended. This could be the individual or parent/guardian.

- ~~D. Short-term objectives shall have an initiation date, a target date, and, when completed, a completion date.~~
- ~~E. Target dates~~
 - ~~1. The target date shall be individualized and noted at the same time of the initiation date and the projected date when the individual can realistically be expected to achieve an objective.~~
 - ~~2. The target date shall be used as a prompt to see if expectations for the individual are realistic in relation to attainment and appropriateness of goals and objectives. If the starting or target dates need to be revised, the organization shall mark through, initial and put in a new date.~~
 - ~~3. The ending date shall be entered in as the person completes each objective.~~

~~514.3 Service Objectives~~

- ~~A. Shall be reviewed on a regular basis with respect to expected outcomes.~~
- ~~B. Shall be revised, as appropriate:~~
 - ~~1. Based on the satisfaction of the person served.~~
 - ~~2. To remain meaningful to the person served.~~
 - ~~3. Based on the changing needs of the person served.~~
- ~~C. Shall include a target date, which is a projected date when the team thinks the individual will no longer need the service or the service provision should be reviewed.~~

~~514.4 The following areas shall be assessed to determine needs in the plan and shall be documented:~~

- ~~A. Assistive technology.~~
- ~~B. Reasonable accommodations.~~
- ~~C. Identified health and safety risks~~

~~514.5 The individual program plan shall be communicated in a manner that is understandable:~~

- ~~A. To the person served and/or their guardian / advocate/ representative.~~
- ~~B. To the persons responsible for implementing the plan.~~

~~514.6 The organization shall ensure that persons involved or their legal guardian/advocate understand the plans and their own involvement in achieving the outcomes.~~

- ~~A. Active participation of the persons served, or their guardian or advocate in setting goals and planning services shall be documented. Documentation may be through interviews, records, checklists, etc. and shall be maintained in the individual's file~~
- ~~B. If a person served needs services that are not available through the organization, the organization shall make referrals to other providers as indicated. Documentation of the referral(s) shall be maintained in the individual's file.~~

~~NOTE: CONTACT DDS FOR A LIST OF PROVIDERS THAT PROVIDE THE REQUESTED SERVICE.~~

~~515 Every ninety (90) days of service delivery, the service provider shall complete a quarterly report on the goals/objectives of the IPP. If needed, modifications may be made with meeting of entire team. Quarterly reports must be specific to reflect the individual's performance concerning~~

- ~~implemented goals and short term objectives as specified in the individual program plan and shall be based on the case notes for the reporting period.~~
- ~~A. The quarterly notes shall establish goals or short term objectives which are:~~
- ~~1. Accomplished~~
 - ~~2. To be continued~~
 - ~~3. Modified or deleted (with statement of reason or barrier) and~~
 - ~~4. Will be worked on for the next three months or ninety (90) days~~
- ~~B. Data Collection/case notes shall be utilized in writing progress reports.~~
- ~~C. Quarterly reports shall be written, dated, and signed by persons responsible for case management. All persons responsible for implementation of services must contribute to the report.~~
- ~~D. Quarterly reports shall document referral to interdisciplinary team for modification of the annual goals as needed, in compliance with state and federal regulations~~
- ~~E. Documentation of communication of quarterly reports to the individual/parent/guardian (as appropriate) shall occur at least every three (3) months or ninety (90) days as in compliance with state and federal regulations.~~
- ~~F. Quarterly reports must include space for individual and/or parental/guardian evaluation of services. The organization shall document that the persons served and/or the parent/guardian has opportunity to evaluate the services received as in accordance with state and federal guidelines.~~

~~516 Updating~~

- ~~A. The organization shall have policies and procedures in place for updating individual program plans. Updates shall be done at least annually and more often if monitoring reports indicate a need or if federal regulations require more frequent updates.~~
- ~~B. The organization shall have policies and procedures in place for revising individual program plans when goals change.~~
- ~~C. Annually update financial, if applicable, social, medical, medical prescription for services, evaluations as applicable, IPP's, and service needs assessment;~~

~~517 Termination of services or alternate placement~~

~~NOTE: SEE THE SPECIFIC PROGRAMMING SECTION FOR MORE DETAILED INFORMATION (CHILDREN'S SERVICES 521).~~

- ~~A. An exit summary shall be prepared each time a person leaves a service, not just when the person is leaving the organization:~~
- ~~1. The report shall summarize the results of the services received by the person and makes recommendations for future services to continue the achievement of the person's life goals.~~
 - ~~2. The plan may suggest referrals to other services that are not available through the organization~~

~~518 Data Collection Requirements~~

- ~~A. Data collections shall provide specific information on annual goals and short term objectives and should be designed to measure and record the progress on each short term objective.~~

~~B. Data collection shall consist of sufficient written documentation to support each. Daily service documentation must, at a minimum, include:~~

- ~~• The specific services furnished;~~
- ~~• The date and actual beginning and ending time of day the services were performed;~~
- ~~• Name(s) and title(s) of the person(s) providing the service(s);~~
- ~~• The relationship of the services to the goals and objectives described in the person's individualized plan of care and~~

~~C. Data collection shall also consist of weekly or more frequent progress notes, signed or initialed by the person providing the service(s), describing each individual's status with respect to his or her goals and objectives.~~

~~D. Data Collection shall be filed in the individual's file at least monthly and shall be available for review upon request.~~

~~520 The organization shall establish and maintain each individual's daily schedule based upon the individual's program plan. The schedule shall indicate general activities throughout the day for each individual. As appropriate the schedule should reflect time segments for the individual to exercise choice in the selection of activities.~~

~~521 Children's Services Individual Program Planning~~

~~As a key element in establishing goals/objectives/ personal outcomes, the agency shall assess an individual's/family's preferences, desires, lifestyle choices, strengths, needs, skills, etc. through individual observations or interviews. Documentation of the assessment shall be maintained in the individual's file. At a minimum, the assessment must include:~~

~~A. Developmental Assessment~~

~~1. Initial evaluation shall include 2 developmental assessments; 1 standardized and 1 criterion based.~~

~~2. Documentation must include:~~

~~a. A written summary that includes standard deviation and/or percentage of delay as determined by the test protocols~~

~~b. An informed clinical opinion~~

~~3. Must be in a format that is understandable to the parent.~~

~~4. Must be signed by the evaluator.~~

~~B. An annual assessment must be conducted using a criterion based test.~~

~~C. A Social History must be completed, signed and dated on the approved form from DOE.~~

~~521.1 Children 3-5 The Individual Program Plan shall include a statement of the specific services necessary to meet the identified needs of the child/family.~~

~~A. At a minimum the IPP must include:~~

~~1. Frequency Number of days or sessions that a service will be provided~~

~~2. Intensity The length of time the service is provided during each session, and whether the service is provided on an individual or group basis~~

~~3. Location Location where the service is provided (e.g., in the child's home, early intervention center, or other setting) as appropriate to the age and needs of the child~~

- ~~4. Method—How a service is provided~~
- ~~5. Dates and duration—Projected dates of initiation of the services, a target date for completion and/or review and the anticipated duration of those services. If either of these dates needs to be revised, then simply mark through, initial and put in new date.~~
- ~~B. Completion of the IPP must meet all State and Federal requirements~~
- ~~C. In order to revise an individual's objectives, at least three (3) members of the team must be present. Parent(s) must be included.~~

~~521.2 Quarterly reviews must include a Family Rating which must be documented on the appropriate form as designated by DDS.~~

~~521.3 Children reaching 5 years of age must have a transition plan.~~

- ~~A. This plan must be developed 180 days prior to age 5 as per State and Federal guidelines.~~
- ~~B. The plan must be child specific and must include specific steps to ensure a smooth transition for the child and family, and must be in accordance with State and Federal Guidelines.~~
- ~~C. The plan must include a transition plan at kindergarten age. Children entering public schools must have a transition plan.~~
- ~~D. The individual program shall include the steps to be taken to support the transition of the child upon reaching kindergarten age.~~
- ~~E. The organization must document contact with the agency which will provide services following the transition, and must demonstrate an attempt to involve that agency in the transition planning. Documentation must be maintained in the individual's file.~~

~~521.4 If the organization is using the supervising teacher model, the organization must follow all State and Federal Guidelines and maintain appropriate documentation of supervision and direct contact with the child on file for review.~~

~~522 Vocational Maintenance & Monitoring~~

~~Vocational Maintenance & Monitoring~~

- ~~A. Case Notes~~
 - ~~1. Case notes shall document each contact with the individual the frequency of each contact will be determined by the team during the development of the IPP it should include date, time and summary of each contact.~~
 - ~~2. Service Objectives shall be listed in an outcome-oriented manner.~~
 - ~~A. Each service objective shall specify any environment modification necessary to facilitate the individual's accomplishment.~~
 - ~~B. Each service objective, including physical adaptations or modifications of the individual's environment, shall be stated as a single specific outcome.~~
 - ~~C. Service objectives shall provide opportunities in the social environment to support community integration and the enhancement of individual relationships.~~

~~D. Based on the individual's choice, and the needs assessment, plans shall include facilitation of the individual's participation in normal activities in normal settings of same age peers.~~

MARKY-UP

523 STAFF RATIOS

Ratios for Day Programming for Children 0-3 Years

1:4

Ratios for Day Programming for Children 3-5 Years

1:7 If non-integrated according to December 1st-child count

1:9 If integrated at the December 1st-child count, the center can send in documentation to DDS and use the alternative ratio of 1:9. Provider shall be required to assure DDS that the integrated status is maintained and it will be checked periodically during licensure visits.

523.3 Ratios for Adult Day Programming

The organization shall maintain a 1:10 ratio throughout the building using the following definition:

ONE DIRECT CARE STAFF PERSON THAT HAS VISUAL CONTACT WHILE **ACTIVELY ENGAGED** IN PROVIDING SUPPORT AND SUPERVISION TO CONSUMERS.

524 Square Footage

A minimum of forty (40) square feet of program training area per individual served shall be required. This is program training area only. This does not include halls, storage areas, or administrative offices.

~~600 FOOD SERVICES~~

~~A. This standards section shall be applied to all provider owned/leased/rented facilities. If the facility contracts for food services, the organization shall ensure compliance with DDS policies.~~

~~601 Written procedure shall be established that addresses how food services are provided to the individuals served by the facility:~~

~~A. Procedure shall include how meals are provided as well as staff responsible.~~

~~601.1 All Day services programs shall assure that organization provided meals are approved, adequate diets, which conform to the recommended dietary allowance.~~

~~601.2 Licensed Group Homes shall assure that three (3) meals a day are available for individuals served.~~

~~A. The organization shall keep on hand suitable food for preparing sack lunches, if appropriate.~~

~~B. All meals shall be part of an approved, adequate diet, which conforms to the recommended dietary allowance.~~

~~C. Facilities with apartment units shall have a mechanism for monitoring the resident's food-related skills.~~

~~602 The organization shall keep menus on file. Menu preparation should occur at least one week in advance in order to:~~

~~A. Allow adequate time to purchase foods to avoid too frequent menu substitutions. Meal planning shall occur so that identical meals are not served on the same day of consecutive weeks.~~

~~B. Serve as a reminder for scheduling advance preparation;~~

~~C. Allow menus to be available as a teaching tool for instruction of individuals, to include development of menus by individuals.~~

~~Menus shall be kept on file for a minimum of three (3) months.~~

~~603 Menus shall be prepared or approved by a registered dietitian/nutritionist. Organizations may contract with a dietitian/nutritionist.~~

~~A. Dietitian/nutritionist shall check for nutritional adequacy of menus and acceptable food safety and sanitation practices. This must be documented by a written report at least annually.~~

~~B. DDS shall accept Arkansas Nutrition Program approval, or site monitoring reports, as adequate approval for Centers that participate in the free/reduced lunch program.~~

~~604 The organization shall develop and implement written procedures that address provisions for special diets.~~

~~A. Special diets pertain to allergies, weight control, diabetes, religion, hypertension, and other medical conditions as documented in the consumers file.~~

~~605 Food items and toxic items shall not be stored together.~~

~~700~~ **TRANSPORTATION**

- ~~A.~~ The organization shall establish written procedures that address how transportation services are provided to individuals served by the program.
 - ~~B.~~ The procedures shall address transportation to the persons served, as well as staff responsible.
 - ~~C.~~ The organization shall ensure that all individuals receiving services are provided with a copy of the transportation policies and shall document receipt of this information in the individual's file.
- ~~701~~ The organization shall assure safety for all persons being transported. For all transportation services provided for the persons served by the organization, the organization shall ensure:
- ~~A.~~ For all vehicles owned or operated by the organization:
 - ~~1.~~ Compliance with all applicable federal, state, county, and city requirements:
 - ~~a.~~ All vehicles shall be properly licensed by the State of Arkansas.
 - ~~2.~~ Appropriate licensing of all drivers:
 - ~~a.~~ All drivers must be licensed according to state requirements for providers of public transportation.
 - ~~3.~~ Review of driving records of all drivers on an initial and annual basis.
 - ~~4.~~ Insurance requirements for vehicles and personnel:
 - ~~a.~~ The organization shall maintain insurance coverage providing a minimum of \$1,000,000 comprehensive, liability, and property damage.
 - ~~5.~~ Safety equipment / features in vehicle(s):
 - ~~a.~~ Fire extinguisher in every program vehicle used to transport consumers.
 - ~~b.~~ Each vehicle shall utilize seat belts or suitable restraints when in motion in accordance with Ark Code 27-37-702 "Seat Belt Use Required" and 27-34-101-107 "The Child Passenger Protection Act"
 - ~~c.~~ The organization shall establish policy and procedure to ensure Child Safety Alarms on every vehicle required under Ark Code 20-78-225 (all vehicles designed or used to transport more than 7 passengers and 1 bus driver)
 - ~~6.~~ Accessibility based on the individual's needs and reasonable requests.
 - ~~7.~~ Training of drivers in the organization's transportation requirements.
 - ~~8.~~ Written emergency procedures:
 - ~~a.~~ Each vehicle used in transporting clients shall have a documented emergency drill once every six months.
 - ~~9.~~ Availability of communication devices (i.e., cell phones 2-way radios, etc.).
 - ~~10.~~ Road warning/hazard equipment (i.e., safety cones, flairs, reflector signs, etc.)
 - ~~11.~~ First aid supplies:
 - ~~a.~~ Every program vehicle used to transport consumers shall maintain a First Aid kit.
 - ~~12.~~ Maintenance of vehicles owned or operated by the organization according to manufacturers' recommendations:
 - ~~a.~~ The organization shall establish/implement procedures that ensures a vehicle maintenance log is kept up to date for all vehicles used to transport consumers.

1. The procedure shall establish who is responsible for upkeep of vehicle and who is responsible for documentation and update of log.
- b. The maintenance log shall document the following:
 1. Oil changes
 2. Tires and brakes repair/inspection
 3. Head and tail lights and turn signals repair/inspection
 4. Windshield washer and wiper blades repair/inspection
 5. Air conditioner (if any), and defroster inspection/repair
 6. Hoses and fan belts inspection/replacement
 7. Fluid levels inspection and replacement
 8. Exhaust system inspection/repair
 9. Emergency warning system inspection/repair
 10. Steering assemblage inspection/repair
13. If services are contracted:
 - a. An annual review of the contract against elements 1-12 of this standard shall be performed by the organization.
 - b. Personnel or contractors shall provide transportation services for the persons served in a safe manner, with drivers having knowledge of unique needs of persons served, and consistent with the regulations of the local authorities.
 1. This standard shall apply when any vehicle, including a personal vehicle, is used to provide transportation for persons served.

702 The organization shall establish written policy and procedure to address apparent abandonment of consumer by family and/or guardian.

- A. The organization shall develop a procedure to be followed by transportation staff when unable to leave individuals at home or alternate sites as specified by family that ensure the safety of the individual at all times.

703 At least one responsible person, in addition to the driver, shall be present in the vehicle if any of the following conditions apply:

- A. Any person being transported has medical conditions as defined by the organization guidelines.
- B. Any person being transported has a severe disability as defined by the organization's guidelines.

NOTE: 'Responsible person' shall be defined by the organization's policy.

704 Organizations operating vehicles transporting children shall comply with the child:staff ratio specified by the Child Care Licensing Standards for Transportation

705 Organizations operating vehicles transporting adults shall establish/implement policies related to adult: staff ratios:

NOTE: DDS RECOMMENDS A 1 TO 10 RATIO AT ALL TIMES.

~~800 PHYSICAL PLANT, ACCESSIBILITY AND SAFETY~~

~~A. The organization shall provide a physical plant compatible with services provided and with the needs of the individuals and staff; provide an accessible and safe environment and be in compliance with U.S.C. § 12101 et. seq. “American with Disabilities Act of 1990” at all owned, leased, and/or rented program site(s).~~

~~801 The organization shall promote accessibility in all settings. The organization shall assess all physical sites to ensure accessibility for individuals and their families and shall establish time lines and actions to be taken for removal of identified barriers.~~

~~A. Organizations shall ensure that all physical sites address accessibility issues in order to:~~

- ~~1. Enhance the quality of life for those served in their programs and services.~~
- ~~2. Meet legal and regulatory requirements.~~
- ~~3. Meet the expectations of stakeholders in the area of accessibility.~~

~~801.1 Accessibility Requirements~~

~~A. The organization shall ensure architectural accessibility at each facility based on the individual’s needs.~~

- ~~1. Ramps, doors, corridors, toileting and bathing facilities, furnishings, and equipment are designed to meet the individual’s needs.~~

~~B. The organization shall ensure that all their facilities are in compliance with 29 U.S.C. §§ 706 (8), 794 – 794(b) “Disability Rights of 1964” and U.S.C. § 12101 et. seq. “American with Disabilities Act of 1990”. Compliance with the aforementioned laws is required to receive federal monies. Admissions criteria of who can be served shall identify any persons the facility or staff would be prevented from serving due to accessibility issues.~~

~~801.2 Accessibility Assessment and Planning~~

~~A. The organization shall assess all facilities. The assessment shall identify all barriers and shall develop a plan for removal of barriers in the following areas:~~

- ~~1. Architecture~~
 - ~~a. Architectural or physical barriers which may include steps that prevent access to a building for an individual who uses a wheelchair, narrow doorways that need to be widened, bathrooms that need to be made accessible, the absence of light alarms for individuals who have a hearing impairment, and the absence of signs in Braille for individuals who have visual impairments.~~
- ~~2. Environment~~
 - ~~a. Any location or characteristic of the setting that compromises, hinders, or impedes service delivery and the benefits to be gained.~~

~~802 Physical Plant Structure~~

~~802.1 Architecture~~

~~A. All water, food service, and sewage disposal systems must meet all local, state, and federal regulatory agencies, as applicable. The organization shall maintain documentation of all approved inspections for review by DDS.~~

1. Sewer inspections are not required if the site is on city water and sewage lines.
 2. Sites using a well and/or septic tank, shall obtain an inspection by the Division of Health documenting compliance with the DOH and local regulations.
- B. Floor furnaces, gas heaters, electric heaters, hot radiators, and exposed water heaters must be protected by screens or guards that are without sharp corners and are attached to floor or wall to prevent persons from falling against the guard and knocking it over.
- C. Enclosed gas heaters must be properly vented to the outside, and installed with permanent connection that includes a cut-off valve in the rigid part of the gas supply pipe.
Note: DDS recommends gas heaters with a pilot light and automatic cut-off valve which automatically cuts off gas to the main burner when the pilot light goes out.
- D. Restroom facilities used by individuals must provide for individual privacy and be appropriate for the individuals served regarding size and accessibility.

802.2 Environment

- A. Temperature of each facility must be maintained within a normal comfort range for the climate. Recognizing that there may be variances within a building, the organization shall make reasonable efforts to maintain a comfortable temperature range throughout the facility.
Note: The recommended standard for range of comfort is from 65 to 80 degrees F (U.S. Atmospheric Standards 29.1)
- B. All areas of the facility shall be sufficiently lighted to meet the needs of the individuals being served and the usage of the area.
- C. The organization shall maintain the interior and exterior of the building in a sanitary and repaired condition.
- D. The premises shall be free of offensive odors.
- E. The grounds and all buildings on the grounds shall be maintained in a clean and repaired condition.
1. Play and activity areas shall be free of dense undergrowth and refuse accumulations. All landscape plantings and the lawn shall be well groomed.
- F. The facility shall be maintained free of infestations of insects and rodents.
1. The organization shall maintain a contract for pest control that is administered by appropriately licensed professionals.
- G. The organization shall establish written procedures regarding smoking that is in accordance with The Clean Air Indoor Act (Act 8 of 2006).
1. For all congregate, day-hab settings, and licensed group homes, smoking will not be permitted in the following areas:
 - a. Common Work Areas
 - b. Auditoriums
 - c. Classrooms
 - d. Conference and Meeting Rooms
 - e. Private Offices
 - f. Elevators
 - g. Hallways
 - h. Health Care Facilities

- ~~_____ i. _____ Cafeterias~~
- ~~_____ j. _____ Employee Lounges~~
- ~~_____ k. _____ Stairs~~
- ~~_____ l. _____ Restrooms~~
- ~~_____ m. _____ All other enclosed areas.~~
- ~~_____ 2. _____ Approved Exemptions:~~
 - ~~_____ a. _____ Private residences or health care facility~~
 - ~~_____ b. _____ All workplaces of any employer with fewer than three (3) _____ employees. (Note: This exemption does not apply to any public place)~~
 - ~~_____ c. _____ Outdoor areas of places of employment or group homes~~
- ~~H. _____ All materials and equipment and supplies shall be stored and maintained in a safe _____ condition. Cleaning fluids and detergents must be stored in original containers with labels _____ describing contents.~~
 - ~~_____ 1. _____ The organization shall maintain an MSDS manual in a location that is accessible to _____ all employees. All MSDS sheets must be on file and current.~~

~~803 _____ Safety Inspections~~

~~803.1 _____ The organization shall ensure that annual safety inspections are completed by qualified individuals _____ to enhance and maintain the organization's health and safety practices. _____~~

- ~~_____ A. _____ All applicable inspections shall be maintained on file, and current within one year or as _____ specified by law/regulation (i.e., Annual Fire Department, Local Health Department, _____ Safety Engineer, OSHA, Safety Specialist, and Insurance Carrier).~~
- ~~_____ B. _____ A comprehensive inspection shall be conducted annually at all facilities where the _____ organization delivers services or provides administration on a regular and consistent basis. _____ Inspections shall be conducted by a qualified external authority(ies):~~
 - ~~_____ 1. _____ Results of each inspection shall contain written documentation that:~~
 - ~~_____ a. _____ Identifies the areas inspected.~~
 - ~~_____ b. _____ Identifies recommendations for areas needing improvement.~~
 - ~~_____ c. _____ Identifies actions taken to respond to the recommendation(s).~~
- ~~_____ C. _____ All applicable licenses, inspections, etc., shall be current. This shall include health _____ inspections for food service preparation, if applicable. Residential facilities with more than _____ ten (10) residents must have a Division of Health inspection.~~

~~803.2 _____ Regular self inspections shall be completed to assist personnel in internalizing current health and _____ safety requirements into everyday practices.~~

- ~~_____ A. _____ The organization may designate professional personnel (managers, supervisors, direct _____ service employees, maintenance personnel) or internal groups (safety committees, safety _____ circles, operation teams, consumers or advocates) within the organizational structure to _____ conduct self inspections. The organization shall ensure that all staff involved in self _____ inspections have received training in conducting inspections prior to participation.~~
- ~~_____ B. _____ The organization shall maintain a schedule of when self inspections will be conducted.~~
 - ~~_____ 1. _____ At a minimum, self inspections must be conducted:~~
 - ~~_____ a. _____ At least twice a year.~~
 - ~~_____ b. _____ At all facilities where the organization delivers services or provides _____ administration on a regular and consistent basis.~~
 - ~~_____ 2. _____ Results of self inspections shall contain written documentation that:~~

- ~~_____ a. _____ Identifies the areas inspected.~~
- ~~_____ b. _____ Identifies recommendations for areas needing improvement.~~
- ~~_____ c. _____ Identifies actions taken to respond to the recommendation(s).~~

~~804 _____ Emergency Procedures~~

~~804.1 _____ The organization shall establish emergency procedures that detail actions to be taken in the event of emergency and to promote safety for the individuals served.~~

- ~~_____ A. _____ Emergency procedures shall be in written form, and shall be available and communicated to all members of the staff and other supervisory personnel.~~
 - ~~_____ 1. _____ At a minimum, emergency procedures shall be implemented for:
 - ~~_____ a. _____ Fires.~~
 - ~~_____ b. _____ Bomb threats~~
 - ~~_____ c. _____ Natural disasters.~~
 - ~~_____ d. _____ Utility failures~~
 - ~~_____ e. _____ Medical emergencies~~
 - ~~_____ f. _____ Safety during violent or other threatening situations (i.e., intruders)~~~~
 - ~~_____ 2. _____ Written emergency procedures shall:
 - ~~_____ a. _____ Meet the requirements of all applicable authorities.~~
 - ~~_____ b. _____ Implement practices appropriate for the locale (i.e., Arkansas Chemical Stockpile Emergency Preparedness Program/CSEPP)~~~~
- ~~_____ B. _____ The organization shall maintain an emergency alarm system for each type of drill (fire and tornado).~~
- ~~_____ C. _____ The organization shall ensure that persons served, as appropriate, are be educated and trained about emergency and evacuation procedures.~~
- ~~_____ D. _____ The organization shall evaluate and consider modification of all emergency procedures during the following times:
 - ~~_____ a. _____ Training.~~
 - ~~_____ b. _____ After training drills.~~
 - ~~_____ c. _____ As risks increase.~~
 - ~~_____ d. _____ After actual emergencies.~~
 - ~~_____ e. _____ When responsibility is reassigned.~~
 - ~~_____ f. _____ When changes are made to the physical plant.~~
 - ~~_____ g. _____ When changes occur in the physical plant proximity.~~
 - ~~_____ h. _____ When a policy or procedure is revised.~~
 - ~~_____ i. _____ When briefing personnel on emergency plan changes.~~~~
- ~~_____ E. _____ The organization shall analyze tests of the emergency and evacuation procedures annually and shall use the results of the analysis to improve or to affirm satisfactory current practices.~~

~~804.2 _____ For all facilities where the organization delivers services or provides administration on a regular and consistent basis, the organizations shall establish/implement written procedures for evacuations:~~

- ~~_____ A. _____ Evacuation procedures shall address:
 - ~~_____ 1. _____ When evacuation is appropriate.~~
 - ~~_____ 2. _____ Complete evacuation from the physical facility.~~
 - ~~_____ 3. _____ The safety of evacuees.~~~~

4. Accounting for all persons involved.
 5. Temporary shelter, when applicable.
 6. Identification of essential services.
 7. Continuation of essential services.
 8. Emergency phone numbers.
 9. Notification of the appropriate emergency authorities.
- B. Evacuation routes must be posted in conspicuous places, except in residential settings and must be easily understandable to the individuals served.

804.3 As a part of an organization's performance improvement activities shall include emergency procedure testing.

A. A tornado drill must be held monthly.

1. Written reports telling date, hour of day, evacuation time, and other areas of concern shall be maintained.

B. A fire drill must be held monthly.

1. Written reports telling date, hour of day, evacuation time, and other areas of concern shall be maintained.

804.4 Detectors

Battery operated or electronic smoke detectors, heat sensors, carbon monoxide detectors and/or sprinklers shall be provided in all buildings where services are provided and shall meet life safety codes.

A. Fire Marshall's report shall be followed as to placement of these devices.

B. Equipment shall be tested at least quarterly or as recommended by the manufacturer/monitoring contractor.

804.5 Fire Extinguishers

Fire extinguishers shall be required to the extent specified by the State Fire Marshall or his designee and shall be checked annually.

A. The Fire Marshall uses Ark. Code Ann. §§12-13-101-12-13-116 "Fire Prevention Act" that follows the Life Safety Code 101 and additional National Fire Prevention Agency publications.

804.6 Emergency Lighting

The organization shall maintain emergency lighting, (i.e., flashlight or other battery operated lights) as required by the life safety codes.

804.7 First Aid

The organization shall maintain a first aid kit and current first aid manual at all sites where services are provided on a regular, consistent basis.

A. Antidote charts and the telephone numbers of poison control centers shall be readily accessible to staff and individuals served.

Note: This can be obtained through Poison Control Center at University of Arkansas Medical Science Center in Little Rock if you cannot get locally.

~~804.8 Water Temperatures~~

~~Provisions shall be made to control water temperature at facilities where services are provided on a regular, consistent basis.~~

- ~~A. To ensure the safety of individuals served, each organization shall develop/implement policy and procedure concerning water temperature adhering to current literature regarding water safety with a maximum temperature of 120 degrees. If the thermostat of the hot water heater is set above 120 degrees, a mixer must be to the lavatories and bathing facilities to maintain safety.~~

~~*Note: This standard shall apply only to service areas and where consumers are working.*~~

SUGGESTED BOARD/ORGANIZATION TRAINING TOPICS

Policy Development and Implementation

Planning and Evaluation
 Equal Employment Opportunity/Affirmative Action
 Employee Performance Evaluation
 Team Building
 Performance Management
 Effective meetings
 Due Process
 Freedom of Information

Overview of Department of Human Services
 Overview of Developmental Disabilities Services
 Philosophy and Goals
 Programs, Practices, Policies and procedures of Local Organizations
 Overview of Community Integration

History, Philosophy, Causes and Types, Functional Levels, Severity Levels, Prevention and Program Issues in Mental Retardation and Other Developmental Disabilities.

Introduction to Principles of Normalization
 Legal rights of Individuals with a Developmental Disability
 Interdisciplinary Approach Overview
 Age Appropriate Programming
 Medications—Implications, Side Effects, legality of Administering

Overview of Federal and State Laws related to serving people with Developmental Disabilities (see index):

U.S.C. S2000a—2000 h-6; Ark. Code Ann. SS 6-41-222; 20 U.S.C S 14000 et. seq. (Part B & Part H); 29 U.S.C SS 706(8), 794-794(b);
 5 U.S.C S 552a; 42 U.S.C SS 6000-6083; Ark. Code Ann. SS 20-48-201—20-48-211; Ark. Code Ann. SS 28-65-101—28-65-109; Ark. Code Ann. SS 5-28-101—5-28-109; Ark. Code Ann. SS 12-12-501—12-12-515; Ark. Code Ann. SS 25-2-104, 25-2-105, 25-2-107, Ark. Code Ann. SS 25-10-102—25-10-116; Ark. Code Ann. SS 20-18-215; U.S.C. S 12101 et. Seq.; DHS Administrative Policy 3002-I (Revised) and DDS Service Policy 3016, Prevention of Transmission of Disease Borne by Blood or other Body Fluids such as AIDS and Hepatitis B; DDS Administrative Policy 1077 Chemical Right to Know; DDS Service Policy 3004-I Maltreatment Prevention, Reporting and Investigation.

INDEX

ARKANSAS CODE ANNOTATIONS

ACTS

Ark. Code Ann. SS	6-41-201	102 of 1972
	6-41-222	Handicapped Children's Act
Ark. Code Ann. SS	20-48-201	265 of 1969
	20-48-211	AR Mental Retardation Act
Ark. Code Ann. SS	25-19-101	AR Freedom of Information Act
	25-19-515	
Ark. Code Ann. SS	12-12-501	397 of 1975
	12-12-515	Child Abuse and Neglect Act
Ark. Code Ann. SS	5-28-101	452 of 1983
	5-28-109,	Adult Abuse
	5-28-201	
	5-28-215,	
	5-28-301	
	5-28-305	
Ark. Code Ann. SS	28-65-101	940 of 1985
	28-65-109,	Guardianship Law
	28-65-201	
	28-65-220,	
	28-65-301	
	28-65-320,	
	28-65-401	
	28-65-403,	
	28-65-502,	
	28-65-601	
	28-65-602	
Ark. Code Ann. SS	25-10-102	348 of 1985
	25-10-116,	DHS Reorganization
	20-46-202,	
	20-46-310,	
	25-2-104,	
	25-2-105,	
	25-2-107	
Ark. Code Ann. SS	20-48-601	611 of 1987
	20-48-611	Location of Community Homes
Ark. Code Ann. SS	12-12-501 et. Seq.	Child Maltreatment
Ark. Code Ann. SS	27-34-101	Child Safety Seat Use
	27-34-107	
Ark. Code Ann. SS	20-78-215	1050 of 1985 Federal Funds for Child Sexual Abuse
Ark. Code Ann. SS	6-21-609	854 of 1987 Exposure to Smoke

UNITED STATES CITATIONS

ACTS

42 U.S.C. S2000a – 2000 h-6	Title VI of the Civil Rights Act of 1964
20 U.S.C. S14000 et. Seq.	P. L. 94-142 Individuals with Disability Education (IDEA) P.L. 99-457 Part H
29 U.S.C. SS 706(8), 794 – 794(b)	Rehabilitation Act of 1973 Section 504
42 U. S. C. S 552	Federal Freedom of Information Act
42 U.S.C. S 6000 – 6083	Developmentally Disabled Assistance and Bill of Rights Act of 1984 and Amendments of 1987
5 U.S.C. S 552a	Federal Privacy Act
42 U.S.C. S 12101 et. Seq.	Americans with Disabilities Act of 1990 P. L. 101-336
42 U. S. C. S 6000 – 6009 6021 – 6030 6041 – 6043 6061 – 6064 6081 – 6083	P. L. 98-527 Developmentally Disabled Assistance & Bill of Rights Act of 1984

~~ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY
DDS POLICY 1090
LICENSING POLICY FOR CENTER-BASED COMMUNITY SERVICES~~

1. ~~**Purpose.** This policy has been prepared to implement Ark. Code Ann. 20-48-201 et. seq.~~

2. ~~**Scope.** This policy is applicable to all Division of Developmental Disabilities Services (DDS) staff charged with implementation of licensure standards and to the nonprofit community programs and components of nonprofit community programs required to be licensed by DDS.~~

~~A. A nonprofit community program or program component that provides center-based, nonresidential services to individuals with developmental disabilities is required to be licensed by DDS.~~

~~B. Providers of Vocational Maintenance and Supported Employment Services must be currently licensed as a supported employment vendor by Arkansas Rehabilitation Services (ARS) and have certified Job Coaches. Continued licensure and job coach certification is a qualification requirement for the period the nonprofit community program is licensed to provide Vocational Maintenance and Supported Employment Services.~~

~~Further, if a Sheltered Workshop or other adult development service of a nonprofit community program or program component is paying a commensurate wage, the nonprofit community program or program component must maintain current wage and hour certification from the U.S. Department of Labor.~~

~~C. A nonprofit community program or program component that provides preschool must maintain current licensure in accordance with the Child Care Facility Licensing Act, Ark. Code Ann. 20-78-201 et. seq.~~

~~D. All educational services provided by a nonprofit community program or program component for school-age children must be approved by the Special Education Section of the Arkansas Department of Education and monitored and regulated by the applicable Local Education Agency in accordance with P.L. 94-142 and rules established by the Special Education Section of the Arkansas Department of Education.~~

3. License:

~~A. DDS shall license each qualified nonprofit community program or qualified program component.~~

~~B. A license is valid and effective only for the physical locations reviewed by DDS and the nonprofit community program or program component to which the license is issued.~~

~~C. A license is not transferable to another entity.~~

~~D. A copy of the license for a nonprofit community program and for each program component must be readily accessible and posted in a conspicuous place at the physical location of the nonprofit community program or program component to which the license is issued.~~

~~E. The validity of a license is contingent on continued substantial compliance with applicable licensure standards. A license is subject to corrective action or interim adverse action which may be imposed by DDS at any time upon a finding of substantial noncompliance.~~

~~F. A nonprofit community program or program component may not contract with a nonlicensed entity so that the nonlicensed entity may provide services under the authority of the programs's or program component's license unless:~~

~~1) The nonlicensed entity is directed by the same governing body that directs the nonprofit community program or program component holding the license in which case the nonlicensed entity is considered part of the nonprofit community program or program component and is subject to review by DDS, or~~

~~2) The nonlicensed entity is providing contract services for the nonprofit community program or program component over which the nonprofit community program or program component has direction. For example, a contract between nonprofit community program or program component for speech therapy services to be provided on behalf of the nonprofit community program or program component and for which the nonprofit community program or program component submits the billing; or~~

~~3) The contract between the nonprofit community program or program component and the entity providing services under the license was in existence on October 1, 2007 and is recognized by DDS.~~

~~G. Licensure Team Composition. DDS is responsible for evaluating a nonprofit community program's or program components' compliance with licensure standards. A DDS Licensure Team may include without limitation representatives of any relevant professional entities.~~

~~5. **Access.** DDS shall have access to the premises, staff, individuals served and their families, and all records of a licensed nonprofit community program or program component at all times for the purpose of conducting Abbreviated Reviews, Licensure Reviews, Service Concern Investigations, or Surveys concerning compliance with applicable licensure standards.~~

~~6. **Definitions.**~~

~~A. "Abbreviated Review" means a targeted on-site evaluation of an accredited nonprofit entity or nonprofit community program or program component for the purpose of determining compliance with specific licensure standards, providing technical assistance, or conducting brief unscheduled or unannounced visits to provide consultation and assistance in support of continued compliance with licensure standards.~~

~~B. "Licensure Review" means the on-site formal evaluation process of an accredited nonprofit entity or nonprofit community program or program component by DDS to ensure program quality and compliance with applicable licensure standards.~~

~~C. "Direct Care Staff" means staff employed by the certified organization who are responsible for implementing an individual's plan of care and providing day to day direct services in accordance with the plan of care and state and federal regulations.~~

~~D. "National Accrediting Organization" means a national accrediting organization with acknowledged expertise and experience in the field of developmental disabilities, such as the Commission for the Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA), recognized by DDS. In order to qualify a licensed provider as accredited for purposes of renewing a Regular License based on deemed status, the specific program standards of a National Accrediting Organization shall be consistent with the configuration of services to persons with developmental disabilities in Arkansas.~~

~~E. "Non-Profit Community Program" means a program that provides nonresidential services to persons with developmental disabilities or nonresidential and residential services to persons with developmental disabilities and is licensed by DDS.~~

~~F. "Accredited Non-Profit Entity" means a nonprofit entity that has successfully completed an ongoing accreditation process that is related to the delivery of services to persons with developmental disabilities offered by a national accrediting organization and satisfies the appropriate licensure criteria established by, and is positioned to provide nonresidential services to persons with developmental disabilities upon licensure by DDS because no existing nonprofit~~

- community provider is interested in providing the specific category of non-residential services to persons with developmental disabilities that has been identified by DDS as underserved.
- G. "Provisional License"—The status of a Regular License when DDS finds that a nonprofit community program or program component has failed to complete appropriate corrective action under the Regular License with Requirements and continues to be substantially out of compliance with applicable licensure standards or when warranted by the scope and severity level of noncompliance.
- H. "Regular License"—A license granted to an accredited nonprofit entity or renewed annually for a nonprofit community program or program component when the new provider or nonprofit community program or program component demonstrates compliance with applicable licensure standards.
- I. "Regular License with Requirements"—The status of a Regular License when DDS finds that a nonprofit community program or program component has been substantially out of compliance with applicable licensure standards for more than thirty (30) calendar days.
- J. "Service Concern Investigation" means a specific inspection of a nonprofit community program or program component by DDS with regard to a complaint or complaints.
- K. "Survey" means the on-site formal evaluation process of a nonprofit entity or nonprofit community program or program component by a national accrediting organization at regular intervals to ensure program quality and compliance with applicable policies and rules.
- L. "Temporary License"—A license granted for a term of ninety (90) calendar days with the possibility of one (1) ninety-day extension to allow time for the start-up of a new nonprofit community program or for an existing nonprofit community program to start-up a new program component.

7. Procedural Guidelines: Licensure Application Process.

- A. Temporary License. Applications for a Temporary License to serve as a nonprofit community provider are only accepted in the order of priority established under Ark. Code Ann. 20-48-201 as amended by Act 645 of 2007 and after DDS determines that a county is underserved under DDS Director's Office Policy #1089.
DDS does not consider an application submitted at any other time or under any other circumstances.

~~DDS considers only completed applications. If an application is incomplete, DDS promptly notifies the applicant that the application is incomplete and will not be considered. DDS identifies in the notice the items missing from the application.~~

~~1) Existing provider in underserved county:~~

~~a) Existing DDS-approved site for current service of existing nonprofit community provider. A nonprofit community program that is currently providing service at an existing DDS-approved site does not apply to DDS to expand the current services at the existing DDS-approved site.~~

~~b) New site for current service of existing nonprofit community provider. A nonprofit community program that is currently providing services in a county and wants to expand delivery of the current service to a new site is subject to DDS approval of the physical plant of the new site. The program or program component submits to DDS for review architectural drawings with dimensions of interior walls and identification of direct care areas in the facility to be used by the nonprofit community program for service delivery. DDS conducts an onsite visit and approves the site if it is in substantial compliance with Physical Plant, Accessibility, and Safety Section of the licensure standards.~~

~~2) Nonprofit community program that is not an existing provider in the underserved county:~~

~~a) Nonprofit community program provides services in the underserved county but is not providing the category of services for which the county has been declared underserved. If eligible under the established order of priority and DDS Director's Office Policy #1089, a nonprofit community program that is currently providing services in an underserved county but is not providing the service for which the county has been declared underserved may apply to DDS for a Temporary License to provide the service for which the county has been declared underserved at a new site in the county. The application includes:~~

- ~~• A description of how the program plans to address the applicable Service Provision Standards, and~~
- ~~• Architectural drawings with dimensions of interior walls and identification of direct care areas in the new facility to be used for service delivery.~~

~~DDS evaluates the completed application and all supporting documentation for compliance with licensure standards. If DDS determines that the application and supporting documentation satisfy licensure standards, a DDS Licensure Team conducts the following two (2) onsite Abbreviated Reviews:~~

- ~~An Abbreviated Review of the new facility to be used for service delivery for compliance with the Physical Plant, Accessibility, and Safety Section of the licensure standards.~~
- ~~An Abbreviated Review of program records pertaining to existing services for compliance with the Individual/Parent/Guardian Rights and Service Provision Sections of the licensure standards.~~

~~If the DDS Licensure Team determines that the new facility and existing records satisfy licensure standards, DDS issues a Temporary License to the nonprofit community program to provide the new services at the new site in the underserved county.~~

~~b) Nonprofit community program or program component does not provide any services in the underserved county. If eligible under the established order of priority and DDS Director's Office Policy #1089, a nonprofit community program or program component that is not currently providing any services in an underserved county may apply to DDS for a Temporary License to provide the service for which the county has been declared underserved. The application includes:~~

- ~~A description of how the program will address the applicable service provision standards, and~~
- ~~Architectural drawings with dimensions of interior walls and identification of direct care areas in the new facility to be used for service delivery.~~

~~DDS evaluates the completed application and all supporting documentation for compliance with licensure standards. If DDS determines that the application and supporting documentation satisfy licensure standards, a DDS Licensure Team conducts the following two (2) onsite Abbreviated Reviews:~~

- ~~An Abbreviated Review of the new facility to be used for service delivery for compliance with the Physical Plant, Accessibility, and Safety Section of the licensure standards.~~
- ~~An Abbreviated Review of program records pertaining to existing services for compliance with the Individual/Parent/Guardian Rights and Service Provision Sections of the licensure standards.~~

~~If the DDS Licensure Team determines that the new facility and existing records satisfy licensure standards, DDS issues a Temporary License to the nonprofit community program to provide the new services at the new site in the underserved county.~~

~~3) Accredited nonprofit entity. If eligible under the established order of priority and DDS Director's Office Policy #1089, an accredited nonprofit entity may apply to DDS for a Temporary License to provide the service for which the county has been declared underserved. The application includes:~~

- documentation of required qualifications;
- copies of written policies and procedures for implementation of the DDS Licensure Standards concerning Board of Directors, Personnel Procedures and Records, Staff Training and Individual/Parent/Guardian Rights;
- a description of how the program or program component will address the DDS Licensure Standards concerning Service Provision, Food Services, Transportation and Physical Plant, Accessibility, and Safety; and
- architectural drawings with dimensions of interior walls and identification of direct care areas in the facility to be used for service delivery.

DDS evaluates the completed application and all supporting documentation for compliance with the DDS Licensure Standards for Center-Based Community Programs. If DDS determines that the application and supporting documentation satisfy licensure standards, a DDS Licensure Team conducts an onsite Abbreviated Review of the facility to be used for service delivery for compliance with the Physical Plant, Accessibility, and Safety Section of the licensure standards. If the DDS Licensure Team determines that the premises of the accredited nonprofit entity satisfy the Physical Plant, Accessibility, and Safety Section of the licensure standards, DDS issues a Temporary License as a nonprofit community program to the accredited nonprofit entity.

B. Licensure Review under Temporary Licensure.

During the term of a Temporary License, a DDS Licensure Team conducts a Licensure Review in accordance with Section 8 of this policy. If the DDS Licensure Team determines that the nonprofit community program or program component is in substantial compliance with applicable Licensure Standards, DDS issues a Regular License. If the DDS Licensure Team determines that the nonprofit community program or program component is not in substantial compliance with applicable licensure standards, DDS imposes corrective actions or sanctions or both in accordance with Section 9 of this policy.

If the nonprofit community program or program component is unable to achieve substantial compliance with applicable Licensure Standards during the term of the Temporary License, DDS denies issuance of a Regular License to the nonprofit community program or program component.

C. Regular License.

1) Regular License Renewal based on Licensure Review.

A nonprofit community program or program component applies annually to DDS to renew a Regular License which requires a Licensure Review by a DDS Licensure Review Team in accordance with Section 8 of this policy. If the DDS Licensure Review Team determines after conducting a Licensure Review that the program or program component is in substantial compliance with applicable

~~Licensure Standards, DDS renews the program's or program component's Regular License. If the DDS Licensure Review Team determines after conducting a Licensure Review that the program or program component is not in substantial compliance with applicable licensure standards, DDS imposes corrective actions or sanctions or both in accordance with Section 9 of this policy.~~

~~2) Regular License Renewal based on Deemed Status.~~

~~a) Deemed Status. A nonprofit community program or program component may apply for renewal of a Regular License based on current accreditation from a National Accrediting Organization by providing DDS with a copy of the most recent complete report issued by the national accrediting organization concerning the program or program component and the official accreditation certificate.~~

~~(i) If already accredited prior to the nonprofit community program's or program component's Licensure Review month, the program or program component shall submit the report and certificate to DDS at least ninety (90) calendar days prior to the beginning of the program's or program component's Licensure Review month.~~

~~(ii) If a nonprofit community program or program component is requesting Regular Licensure Based on Deemed Status to begin with the issuance or renewal of the program or program component's most recent Regular License and the program or program component receives national accreditation within eight (8) months after completion of its most recent Licensure Review, the program or program component shall submit the report and certificate to DDS within fourteen (14) calendar days of program's or program component's receipt of the report and certificate.~~

~~If the current accreditation indicates that that the nonprofit community program or program component is in substantial compliance with licensure standards and a review of other pertinent information does not indicate a pattern of noncompliance or pervasive noncompliance at Level 2 or above, DDS renews the Regular License of the program or program component without any further formal review. Pertinent information may include consumer satisfaction surveys, incident reports and results of service concern investigations.~~

~~b) Required communications with DDS.~~

~~(i) A nonprofit community program or program component shall notify DDS immediately after receipt of notification of a change in accreditation status.~~

~~(ii) A nonprofit community program or program component shall notify DDS within fourteen (14) calendar days of the program's or program~~

~~component's receipt of notice of a pending Survey by the National Accrediting Organization~~

~~(iii) A nonprofit community program or program component shall submit contemporaneously to DDS its quality improvement plan and any other document submitted to its National Accrediting Organization.~~

~~(iv) A nonprofit community program or program component shall authorize its National Accrediting Organization to release information to DDS upon DDS's request.~~

~~e) *DDS Access:*~~

~~(i) Nothing in this section shall affect the right of an authorized representative of DDS to have access to the premises, staff, individuals served and their families, and all records of a nonprofit community program or program component at all times for the purpose of conducting Abbreviated Reviews, Licensure Reviews, Service Concern Investigations, or Surveys concerning compliance with applicable Licensure Standards.~~

~~(ii) DDS reports findings of Abbreviated Reviews, Licensure Reviews, Service Concern Investigations, or Surveys and actions taken to the National Accrediting Organization of the nonprofit community program or program component.~~

~~(iii) A DDS staff member may participate in the entrance conference and exit conference during any survey conducted by the National Accrediting Organization of the nonprofit community program or program component.~~

~~ei) *Withdrawal of Regular License Based on Deemed Status:* DDS may withdraw a Regular Licensure Based on Deemed Status under the following circumstances:~~

~~(i) When a complaint concerning substantial noncompliance, as designated in Levels 3 and 4 of the Sanctions Matrix, with a health or safety standard is founded;~~

~~(ii) When an Abbreviated Review, Licensure Review, Service Concern Investigation, or Survey find instances of noncompliance with DDS licensure standards; or~~

~~(iii) When the national accreditation status of the nonprofit community program or program component has expired, is downgraded, or withdrawn by the National Accrediting Organization.~~

~~eii) *National Accreditation Not Required:* DDS does not require any nonprofit community program or program component to seek or submit to accreditation by a National Accrediting Organization.~~

When a nonprofit community program or program component is not accredited by a national accrediting organization, DDS conducts a Licensure Review of the program or program component as required by this rule.

8. Procedural Guidelines: Licensure Review Process:

A. Notice of Licensure Review:

~~Within ninety (90) calendar days before a Licensure Review, DDS sends notice of the Licensure Review to the Director or Executive Officer and Board President of the nonprofit community program and identifies any information that DDS requires the nonprofit community program or program component to submit prior to the Licensure Review. For example, DDS may request a letter of assurances signed by the Director or Executive Office of the nonprofit community program or designee and the President of the Board of Directors of the nonprofit community program or designee stating that the program's or program component's written policies and procedures are in compliance with the applicable licensure standards.~~

~~After receipt of notice of a Licensure Review, the director nonprofit community program or program component shall post a sign announcing in advance the approximate date range during which DDS expects to perform a Licensure Review of the program or program component. The notice should be posted in areas easily observable by individuals served and their families and should include DDS contact information.~~

B. Offsite Preparation:

~~The objective of offsite preparation is to analyze various sources of information available about the nonprofit community program or program component to identify any potential areas of concern, to ascertain any special features of the program or program component, and to focus the efforts of the DDS Licensure Review Team during the onsite tour and with regard to onsite information gathering.~~

~~The DDS Licensure Review Team Leader or designee is responsible for obtaining all available sources of information about the program or program component for review by the Team including without limitation:~~

- ~~• Documentation from the program or program component requested in advance,~~
- ~~• The prior year's Licensure Review report,~~
- ~~• Incident reports submitted during the prior year, and~~
- ~~• The results of any complaint investigations during the prior year.~~

~~The Team Leader is responsible for presenting the information obtained to the Team for review at an offsite team meeting prior to the Licensure Review. At this meeting, the Team Leader should establish preliminary review assignments, and the Team should identify potential areas of concern and note any special features of the program or program component.~~

C. Entrance Conference:

The Team Leader or designee conducts the entrance conference with the director of the nonprofit community program or program component and any program staff designated by the director. During the entrance conference, the Team Leader or designee:

- Introduces team members;
- Explains the Licensure Review process;
- Informs program staff that the team will be communicating with them through the Licensure Review and will ask for assistance when needed;
- Advises program staff that they will have the opportunity to provide the Team with any information that would clarify an issue brought to their attention; and
- Answers any questions from program staff.

It is recommended that after their introduction to director of the program or program component, the other team members proceed to the initial tour and make general observations of the nonprofit community program or program component.

D. Onsite Preparation:

The Team Leader asks director of the nonprofit community program or program component to provide access to information determined by the Team as necessary to complete the Licensure Review.

In areas easily observable by individuals served and their families, the Team Leader or designee shall post a sign or arrange for the director of the program or program component to post a sign announcing that DDS is performing a Licensure Review and that DDS team members are available to meet in private with individuals served or their families or both.

Throughout the Licensure Review process, the Team should discuss among themselves, on a daily basis, observations made and information obtained in order to focus on the concerns of each team member, to facilitate information gathering and to facilitate decision making at the completion of the Licensure Review.

E. Initial Tour:

The initial tour is designed to provide team members with an initial assessment of the nonprofit community program or program component, the individuals served and their families, and program staff. During the initial tour, team members should:

- Make an initial evaluation of the environment of the program or program component;
- Identify areas of concern to be investigated during the Licensure Review;

- Confirm or invalidate pre-review information about potential areas of concern, and
- Document their findings.

F. Onsite Information Gathering:

The DDS Licensure Review Team gathers information for the Licensure Review from three (3) primary sources: review of records, interviews, and observations. Each team member should verify information and observations in terms of credibility and reliability. All findings must be documented. The Team should maintain an open and ongoing dialogue the program staff throughout the Licensure Review process.

The Team should meet on a daily basis to share information, such as findings to date, areas of concern, any changes needed in the focus of the Licensure Review. These meetings include discussions of concerns observed, possible requirements to which those concerns relate, and strategies for gathering additional information to determine whether the program or program component is meeting licensure standards.

Immediate jeopardy. At any time during the Licensure Review, if one or more team members identify possible immediate jeopardy, the Team should meet immediately to confer. The team must determine whether there is immediate jeopardy during the information gathering task.

Immediate jeopardy is defined as a situation in which the program's or program component's failure to meet one or more licensure standards has caused, or is likely to cause, serious injury, harm, impairment, or death of an individual served. The guiding principles for determining the scope and severity of noncompliance make it clear that immediate jeopardy can be related to mental or psychosocial well-being as well as physical well-being and that the situation in question need not be a widespread problem.

If the team concurs that there is immediate jeopardy, the team leader immediately consults his or her supervisor. If the supervisor concurs, that the situation constitutes immediate jeopardy, the team lead informs the director of the program or program component or designee that DDS is invoking the immediate jeopardy license revocation procedures. The team leader explains the nature of the immediate jeopardy to the director of the program or program component or designee who must submit a statement while the team is on-site asserting that the immediate jeopardy has been removed and including a plan of sufficient detail to demonstrate how and when the immediate jeopardy was removed.

The Team will provide the director of the program or program component with a written report concerning the nature of the immediate jeopardy within ten (10) days of the date of the exit conference.

~~*Substandard Quality of Care.* At any time during the Licensure Review, if a team member identifies possible substandard quality of care, the team member should notify other members of the team as soon as possible. The team may make a finding of substandard quality of care during the information gathering task or the information analysis and decision-making task.~~

~~If there is a deficiency(ies) related to noncompliance with Licensure Standards concerning Individual/Parent/Guardian Rights or Service Provision and the team member classifies the deficiency as an isolated incidence of severity level 3 or as a pattern of severity level 2, the team member determines if there is sufficient evidence to support a decision that there is substandard quality of care. If the evidence is not sufficient to confirm or refute a finding of substandard quality of care, the team member may expand the Licensure Review to include additional evaluation of the program or program component's compliance with the licensure standard at issue. To determine whether or not there is substandard quality of care, the Team should assess additional information related to the licensure standard at issue, such as written policies and procedures, staff qualifications and functional responsibilities, and specific agreements and contracts that may have contributed to the outcome. It may also be appropriate to conduct a more detailed review of related service delivery.~~

~~If the determination of substandard quality of care is made prior to the exit conference, the Team will provide the director of the program or program component with information concerning the nature of the substandard quality of care.~~

~~If the determination of substandard quality of care is made after the exit conference, the Team will provide the director of the program or program component with a written report concerning the nature of the substandard quality of care within fifteen (15) days of the date of the completion of the review.~~

~~G. Information Analysis and Decision-Making.~~

~~The objective of information analysis for deficiency determination is to review and analyze all information collected and to determine whether or not the nonprofit community program or program component has failed to meet one or more of the applicable licensure standards. Information analysis and decision making builds on discussions of the DDS Licensure Review Team during daily meetings, which should include discussions of observed problems, area of concern, and possible failure to meet licensure standards. The team leader or designee collates all information and records the substance of the decision-making discussions on the Licensure Review report.~~

~~*Deficiency Criteria:* The Team bases all deficiency determinations on documented observations, statements by individuals served, statement by the~~

families of individual served, statements by program staff, and available written documents.

Evidence Evaluation: The Team evaluates the evidence documented during the Licensure Review to determine if a deficiency exists due to a failure to meet a licensure standard and if there are any negative outcomes for individuals served due to the failure. The Team should evaluate all evidence in terms of credibility and reliability.

F. Exit Conference:

The DDS Licensure Review Team will conduct an exit conference with nonprofit community program or program component staff immediately following the completion of the Licensure Review. The general objective of the exit conference is to inform the program or program component of the Team's observations and preliminary findings.

During the exit conference, the Team describes the deficiencies that have been identified and the findings that substantiate these deficiencies. The Team provides the program staff with an opportunity to discuss and supply additional information that the program staff believe is pertinent to the identified findings.

G. Writing the Report:

The report of the Licensure Review should be written in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the licensure standard(s) that is (are) not met. The report should identify the specific licensure standards not met and reflect the content of each licensure standard identified. The report should include a summary of the evidence and supporting observations for each deficiency. The report shall identify the sources of evidence (e.g., interview, observation, or records review) and identify the impact or potential impact of the noncompliance on the individual served, and how it prevents the individual served from reaching his or her highest practicable physical, mental or psychosocial well-being. The levels of severity and scope of deficiencies should be clearly identifiable.

In order to select the appropriate remedy(ies) for noncompliance, the seriousness of the deficiency(ies) is first assessed because specific levels of seriousness correlate with specific remedies. The assessment factors described below are also presented on the matrix in Appendix A:

Guidance on Severity Levels: There are four (4) severity levels:

- Level 1—No actual harm with potential for minimal harm—is a deficiency that has the potential for causing no more than a minor negative impact of the individual served.
- Level 2—No actual harm with potential for more than minimal harm that is not immediate jeopardy—is a noncompliance that results in minimal

physical, mental or psychosocial discomfort to the individual served or has the potential to compromise the individual served's ability to maintain or reach his or her highest practicable physical, mental or psychosocial well-being as defined by a plan of care and provision of services.

- Level 3—actual harm that is not immediate jeopardy—is noncompliance that results in a negative outcome that has compromised the individual served's ability to maintain or reach his or her highest practicable physical, mental or psychosocial well-being as defined by an accurate and comprehensive assessment, plan of care, and provision of services. This *does not include* a deficient practice that only has limited consequence for the individual served and would be included in Level 2 or Level 1.
- Level 4—immediate jeopardy to the health or safety of an individual served—is a situation in which immediate corrective action is necessary because the program's or program component's noncompliance with one or more licensure standards has caused, or is likely to cause, serious injury, harm, impairment, or death to an individual served.

Guidance on Scope Levels: There are three (3) scope levels:

- Isolated—when one or a very limited number of individuals served are affected, when one or a very limited number of staff are involved, or when the situation has occurred only occasionally or in a very limited number of locations.
- Pattern—when more than a very limited number of individuals served are affected, when more than a very limited number of staff are involved, when the situation has occurred in several locations, or when the same individual served has been affected by reported occurrences of the same deficient practice. A pattern of deficient practices is not found to be pervasive through the program or program component. If the program or program component has a system or policy in place but the system or policy is being inadequately implemented in certain instances or if there is inadequate system with the potential to impact only a subset of individuals served, then the deficient practice is likely a pattern.
- Pervasive—when the problems causing the deficiencies are pervasive in the program or program component or represent systemic failure that affected or has the potential to affect a large portion or all of the individuals served by the program or program component. If the program or program component lacks a system or policy or has an inadequate system or policy to meet the licensure standard and this failure has the potential to affect a large number of individuals served, then the deficient practice is likely widespread.

H. Issuing the Report

DDS provides the nonprofit community program or program component with a written report documenting the findings made during the Licensure Review within thirty (30) calendar days of the date of the exit conference.

DDS DIRECTOR'S OFFICE POLICY MANUAL

DDS Policy 1090, Licensure Policy for Center-Based Community Services

Effective November 1, 2007

Page 15 of 28

~~If the Licensure Review Report contains a deficiency that is classified as substandard quality of care, DDS provides the program or program component with a written report concerning the nature of the substandard quality of care within fifteen (15) days of the date of the exit conference.~~

~~If the Licensure Review Report contains a deficiency that is classified as immediate jeopardy, DDS provides the program or program component with a written report concerning the nature of the immediate jeopardy within ten (10) days of the date of the exit conference.~~

I. Plan of Correction

~~*In General.* A plan of correction is a plan that the nonprofit community program develops in order to achieve compliance with licensure standards after a finding of substantial noncompliance. Substantial noncompliance refers to a deficiency(ies) that is (are) categorized as no actual harm with potential for more than minimal harm that is (are) not immediate jeopardy and is (are) not substandard quality of care.~~

~~In order for a plan of correction to be acceptable, it must:~~

- ~~• Contain elements detailing how the nonprofit community program or program component will correct the deficiency as it relates to the individual served;~~
- ~~• Indicate how the program or program component will act to protect individual service in similar situations;~~
- ~~• Include the measures the program or program component will take or the systems it will alter to ensure that the problem does not recur;~~
- ~~• Indicate how is plans to monitor its performance to make sure that solutions are sustained; and~~
- ~~• Provide dates when corrective action will be completed. Completion dates will be determined in conjunction with DDS.~~

~~DDS approves the plan of correction if it satisfies the elements described above. If DDS does not approve the plan of correction, DDS shall provide the nonprofit program or program component with a written explanation stating the reasons the plan of correction does not satisfy the elements described above. The program or program component shall revise the plan of correction until it is approved by DDS. All revisions must be completed within the time frame designated below for submission of the plan of correction.~~

~~*Substantial compliance:* Substantial compliance means a level of compliance with Licensure Standards such that any identified deficiencies pose no greater risk to the health or safety of individuals served than the potential for causing minimal harm. Substantial compliance constitutes compliance with Licensure Standards.~~

~~When DDS finds that a nonprofit community program or program component is in substantial compliance but has deficiencies that are isolated with no actual harm and potential for only minimal harm, a plan of correction is not required but the program or program component is expected to correct all deficiencies.~~

~~When DDS finds that a nonprofit community program or program component is in substantial compliance but has deficiencies that constitute a pattern or widespread with no actual harm and potential for only minimal harm, a plan of correction is required. While a program or program component is expected to correct deficiencies at this level, these deficiencies are within the substantial compliance range and do not need to be reviewed for correction during subsequent follow-up reviews within the same Licensure Review cycle.~~

~~*Not in substantial compliance:* Within fifteen (15) calendar days of receipt of a licensure report with deficiencies that are categorized as no actual harm with potential for more than minimal harm that is not immediate jeopardy and are not substandard quality of care, the nonprofit community program or program component develops and submits to DDS a written plan of correction.~~

~~*Not in substantial compliance with substandard quality of care or actual harm that is not immediate jeopardy.* Within ten calendar (10) days of receipt of a licensure report with deficiencies that are categorized as substandard quality of care or actual harm that is not immediate jeopardy, the nonprofit community program or program component develops and submits to DDS a written plan of correction.~~

~~*Not in substantial compliance with immediate jeopardy.* Within two calendar (2) days of receipt of a licensure report with deficiencies that categorized as immediate jeopardy, the nonprofit community program or program component develops and submits to DDS a written plan of correction.~~

J. Post Licensure Review Revisits.

~~DDS conducts a follow-up Abbreviated Review to confirm that the nonprofit program or program component is in compliance with licensure standards and has the ability to remain in compliance with licensure standards. The purpose of the follow-up Abbreviated Review is to re-evaluate the specific care and services that were cited as noncompliant during the Licensure Review, Service Concern Investigation, or other onsite Survey.~~

~~If DDS accepts program's or program component's plan of correction, DDS conducts a follow-up Abbreviated Review within thirty (30) calendar days of acceptance of the plan of correction but not before the latest date of corrective action proposed by the program or program component. At the follow-up Abbreviated Review, the Team should focus on the actions taken by the program or program component since the correction dates listed on the plan of correction.~~

~~Within fifteen (15) calendar days of the follow-up Abbreviated Review, DDS sends a written report documenting the findings made during the follow-up Abbreviated Review.~~

9. Enforcement Remedies:

~~DDS may impose any of the Enforcement Remedies described below alone or in combination with any other Enforcement Remedy or Remedies to encourage quick compliance with licensure standards:~~

A. License downgrade

~~1) *Regular License with Requirements:* If a nonprofit community program or program component is not in substantial compliance with applicable licensure standards within thirty (30) calendar days after receiving notice of noncompliance in a Licensure Review Report, the status of the program's or program component's Regular License will be downgraded to a Regular License with Requirements. In order to achieve restoration of its Regular License, the program or program component must correct all identified deficiencies and demonstrate substantial compliance with licensure standards within sixty (60) calendar days of being downgraded to a Regular License with Requirement. DDS may pass over Regular License with Requirements and immediately impose a Provisional License when warranted by the scope and severity level of the noncompliance.~~

~~2) *Provisional License:* If a nonprofit community program or program component continues to be out of compliance with applicable licensure standards at the end of the period allowed for a Regular License with Requirements or when warranted by the scope and severity level of the noncompliance, the program's or program component's license is downgraded to a Provisional License for a maximum term of one hundred and eighty calendar days (180) and Moratorium on New Admissions is imposed. During the term of a Provisional License, the program or program component submits weekly progress reports regarding compliance efforts until all deficiencies have been corrected. The failure of a program or program component to substantially comply with licensure standards after sixty (60) calendar days of Provisional Licensure results in the imposition of a Moratorium on Expansion and an underserved determination in accordance with DDS Director's Office Policy #1089.~~

~~B. *Directed Plan of Correction:* A directed plan of correction is an Enforcement Remedy in which DDS develops a plan to require a nonprofit community program or program component to take action within a specified timeframe. Achieving substantial compliance is the responsibility of the program or program component whether or not a directed plan of correction is followed. If a program or program component fails to achieve substantial compliance after complying with a directed~~

~~plan of correction, DDS may impose another Enforcement Remedy until the program or program component achieves substantial compliance or loses its license.~~

~~DDS may impose a directed plan of correction fifteen (15) calendar days after the program or program component receives notice in non-immediate jeopardy situations and two (2) calendar days after the program or program component receives notice in immediate jeopardy situations.~~

~~The date a directed plan of correction is imposed does not mean that all corrections must be completed by that date.~~

- ~~C. Directed In-Service Training: Directed in-service training is an Enforcement Remedy that DDS imposes when it believes that education is likely to correct the deficiencies and help the nonprofit community program or program component achieve substantial compliance. This remedy requires program staff to attend an in-service training program.~~

~~DDS may provide special consultative services for obtaining this type of training. At a minimum, DDS should compile a list of resources that can provide directed in-service training and make this list available to programs and program components and other interested parties.~~

~~The program or program component bears the expense of directed in-service training.~~

~~If a program or program component fails to achieve substantial compliance after completing directed in-service training, DDS may impose another Enforcement Remedy until the program or program component achieves substantial compliance or loses its license.~~

- ~~D. Referral to Audit for Investigation. Referral to Audit for Investigation is an Enforcement Remedy that DDS imposes in response to identifying specific information that a nonprofit community program or program component has received inappropriate payment for services.~~

~~If an audit reveals that a program or program component has not complied with billing requirements in a reckless or intentional manner, DDS may impose additional Enforcement Remedies, including without limitation, license revocation, exclusion and debarment.~~

- ~~E. State Monitoring: State Monitoring is an Enforcement Remedy that DDS impose when DDS determines that oversight of the nonprofit community program's or program component's efforts to correct cited deficiencies is necessary as a~~

safeguard against further harm to individuals served when harm or a situation with the potential for harm has occurred.

A State Monitor is an appropriate professional who:

- Is an employee or contractor of DDS;
- Is not an employee or contractor of the monitored program or program component;
- Does not have an immediate family member who is served by the monitored program or program component, and
- Does not have any other conflict of interest with the monitored program or program component.

When State Monitoring is imposed, DDS selects the State Monitor. Monitoring may occur anytime in a program or program component. State Monitors have complete access to the premises, staff, individuals served and their families, and all records of the program or program component at all times and in all instances for performance of the monitoring task.

Some situations in which State Monitoring may be appropriate include without limitation:

- Poor compliance history, i.e. a pattern of poor quality of care, many complaints;
- DDS concern that the situation has the potential to significantly worsen, or
- Substandard quality of care or immediate jeopardy exists and the program or program component seems unable or unwilling to take corrective action.

The Enforcement Remedy of State Monitoring is discontinued when the program or program component demonstrates that it is in substantial compliance with licensure standards and that it will remain in substantial compliance. A program or program component can demonstrate continued compliance by adherence to a plan of correction that delineates what systemic changes will be made to ensure that the deficient practice will not recur and how the program or program component will monitor its corrective actions to ensure it does not recur.

- F. Moratorium on New Admissions. Moratorium on New Admissions is an Enforcement Remedy that DDS may impose any time DDS finds a nonprofit community program or program component to be out of substantial compliance as long as the program or program component is given written notice at least two (2) calendar days before the effective date in immediate jeopardy cases and at least fifteen calendar (15) days before the effective date in non-immediate jeopardy cases.

DDS imposes a Moratorium New Admissions when DDS finds that the program or program component is not in substantial compliance ninety (90) calendar days after the last day of the Licensure Review identifying the deficiency, or when a

~~program or program component has been found to have furnished substandard quality of care during its last three (3) consecutive Licensure Reviews.~~

~~An individual admitted to a program or program component on or after the effective date of the remedy is considered a new admission. An individual admitted to a program or program component on or after the effective date of the remedy who is discharged from the program or program component or takes a temporary leave from the program or program component is still considered new admission upon readmission or return.~~

~~An individual admitted to a program or program component before and discharged on or after the effective date of the remedy is not considered a new admission if the individual is subsequently readmitted to the program or program component. An individual admitted to a program or program component before the effective date of the remedy who takes temporary leave before or after the effective date is not consider a new admission upon return.~~

~~Generally, if the program or program component achieves substantial compliance and it is verified through a follow-up Abbreviated Review or credible written evidence, DDS lifts the Moratorium on New Admissions. However, when a Moratorium on New Admissions is imposed for repeated instances of substandard quality of care, DDS may impose the remedy until the program or program component is in substantial compliance and DDS believes the program or program component will remain in substantial compliance.~~

~~G. Moratorium on Expansion. Moratorium on Expansion is an Enforcement Remedy that DDS may impose when DDS finds a nonprofit community program or program component to be out of substantial compliance with licensure standards after sixty (60) calendar days of Provisional Licensure. A Moratorium on Expansion may include expanding capacity for current service delivery in existing service areas and expanding to offer current or new services in new service areas.~~

~~The failure of a program or program component to substantially comply with licensure standards after sixty calendar (60) days of Provisional Licensure indicates that the program or program component is unable or unwilling to take necessary corrective action and that individuals with developmental disabilities are in danger of losing services. A Moratorium on Expansion continues until the nonprofit community program or program component is in substantial compliance with applicable licensure standards, and DDS believes the program or program component is willing and able to remain in substantial compliance.~~

~~If the nonprofit community program or program component has made considerable progress toward substantial compliance with applicable licensure standards during the period of Provisional Licensure, the DDS Director or designee may grant an extension before a Moratorium on Expansion is imposed.~~

~~H. License Revocation. When considering whether to revoke the license of a nonprofit community program or program component, DDS considers many factors, particularly the program's or program component's noncompliance history (e.g., it is consistently in and out of noncompliance), the effectiveness of alternative Enforcement Remedies when previously imposed, and whether the program or program component has failed to follow through on an alternative Enforcement Remedy (e.g. directed plan of correction or directed in-service training). These considerations are not all inclusive but factors to consider when determining whether License Revocation is appropriate in a given case.~~

~~*Provisional Licensure.* If the license of a nonprofit a nonprofit community program or program component is downgraded to Provisional License more than one (1) time in a three-year period, the program or program component is subject to License Revocation.~~

~~*Immediate Jeopardy.* When there is immediate jeopardy to the health or safety of an individual served, DDS revokes the license of a nonprofit community program or program component to be effective within thirty (30) calendar days of the last day of the Licensure Review that found the immediate jeopardy if the immediate jeopardy is not removed before then. If the program or program component provides a written and timely credible allegation that the immediate jeopardy has been removed, DDS will conduct a follow-up Abbreviated Survey prior to revocation if possible. In order for a License Revocation to be reversed, the immediate jeopardy must be removed even if the underlying deficiencies have not been fully corrected.~~

~~*No Immediate Jeopardy.* License Revocation is always an option that may be imposed for the noncompliance of any nonprofit community program or program component regardless of whether or not immediate jeopardy is present. When there is not immediate jeopardy, DDS revokes the Regular License of a nonprofit community program or program component if the program or program component fails to achieve substantial compliance after one hundred and eighty (180) calendar days of Provisional Licensure.~~

~~I. Voluntary Surrender of License. If a nonprofit community program or program component intends to voluntarily surrender its license, the director of the program or program component notifies DDS immediately. As a condition of licensure, the program or program component agrees to assist DDS with transitioning consumers~~

~~J. Transitioning Consumers. DDS has the ultimate responsibility for transitioning consumers when a license is revoked or surrendered. In some instances, the program or program component may assume responsibility for the safe and orderly transition of consumers. However, this does not relieve DDS of its~~

~~ultimate responsibility to transition consumers. The goal of transitioning consumers is to minimize disruption in service and the period of time during which consumers receive less than adequate care.~~

~~K. Exclusion. Exclusion from contracting with all DHHS divisions and enrolling in the Arkansas Medicaid Program for a specific term is an Enforcement Remedy that may be imposed upon recommendation of DDS and approval by the DHHS Director.~~

~~L. Debarment. Recommendation to appropriate federal regulatory agency for Permanent Debarment is an Enforcement Remedy that may be imposed upon recommendation of DDS and approval by the DHHS Director.~~

~~10. Solicitation.~~

~~A. "Solicitation" means an attempt to unduly influence an individual served by a nonprofit community program or program component or his or her family to transfer from one program to another program. Solicitation is prohibited by the all of the following:~~

- ~~1) A nonprofit community program and any program component or any individual acting on behalf of the program or program component,~~
- ~~2) Any staff member of a nonprofit community program or program component or any individual acting on behalf of the staff member, and~~
- ~~3) Any individual who provides or has provided professional or direct care services for a nonprofit community program or program component or any individual acting on his or her behalf.~~

~~B. The following methods of solicitation are prohibited and will compel a DDS investigation:~~

~~1) Hiring an individual who has been previously employed by or contracted with another nonprofit community program or program component who subsequently contacts consumers on the individual's caseload with the previous program or program component with the intent of inducing the consumer to transfer to the nonprofit community program or program component with which the individual is currently employed or contracted.~~

~~a) Protected Health Information (PHI), such as consumer addresses and telephone numbers, are considered confidential and the property of the nonprofit community program or program component with which the individual was employed or contracted. An individual formerly employed or contracted with a nonprofit community program or program component may not disclose PHI without a signed release from the consumer according to HPPA regulations.~~

~~b) When a consumer transitions between two (2) nonprofit community programs or program components, the receiving program or program component shall indicate on the transition plan if the receiving program or~~

~~program component has hired or contracted with an individual who previously served the transferring individual through the sending nonprofit community program or program component.~~

~~c) If five (5) or more individuals transfer under the circumstances described immediately above, DDS contacts the individuals or their family members or guardians to determine if solicitation occurred;~~

- ~~2) Offering cash or gift incentives to an individual served or his or family or guardian to induce the individual served or his or her family or guardian to change programs;~~
- ~~3) Offering an individual served or his or her family or guardian free goods or services that are not available to other similarly stationed consumers to induce the individual served or his or her family or guardian to change programs;~~
- ~~4) Refusing to provide an individual served access to entitlement services for which the individual is eligible if the individual served or his or her family or guardian selects another nonprofit community program or program component to provide waiver services to the individual;~~
- ~~5) Making negative comments to a potential individual served, his or her family or guardian, or an advocate regarding the quality of services provided by another nonprofit community program or program component other than for the purpose of monitoring or official advocacy;~~
- ~~6) Promise to provide services in excess of those necessary to induce an individual served or his or her family or guardian to change programs, and~~
- ~~7) Directly or indirectly giving an individual served or his or her family or guardian the impression that the nonprofit community program or program component is the only agency that can provide the services desired by the individual served or his or her family.~~

~~C: Only an authorized DDS representative may offer an individual or his or her family provider choice.~~

~~D: Enforcement Remedies for solicitation may include Regular Licensure with Requirements, Provisional Licensure, Moratorium on New Admissions, Moratorium on Expansion, and if a pattern of solicitation occurs, Licensure Revocation.~~

~~E: Marketing is distinguishable from solicitation and is considered an allowable practice. Examples of acceptable marketing practices include without limitation:~~

- ~~1) General advertisement using typical media;~~
- ~~2) Distribution of brochures and other informational materials regarding the services provided by a nonprofit community program or program component if the brochures and materials are factual and honestly presented;~~
- ~~3) Providing tours of a nonprofit community program or program component to interested individuals;~~
- ~~4) Mentioning other services provided by the nonprofit community program or program component in which a consumer might have an interest, and~~

5) Hosting informational gatherings during which the services provided by a nonprofit community program or program component are honestly described.

11. Procedural Guidelines: Change in Director.

- A. A nonprofit community program or program component shall provide DDS with written notification of a change in the director of the nonprofit community program or program component immediately upon resignation, discharge, or death of the director.
- B. Within ninety (90) calendar days after the effective date of a change in the director of a nonprofit community program or program component, DDS staff will conduct an Abbreviated Review of the nonprofit community program or program component to provide onsite technical assistance.

12. Procedural Guidelines: Change in Location of Physical Plant.

- A. A nonprofit community program or program component shall provide DDS with written notification of a relocation of any part of the program's or program component's physical plant at least sixty (60) calendar days prior to the proposed relocation.
- B. If the relocation is the result of new construction, the nonprofit community program or program component shall provide DDS with copies of architectural drawings that include dimensions of interior walls and identification of direct care areas in the new facility and information regarding any changes made during the course of construction that deviate from the architectural drawings as soon as practicable but in no event later than sixty (60) calendar days prior to the proposed relocation.
- C. Before the nonprofit community program or program component provides services at a new site or moves individuals to a new site, DDS conducts an Abbreviated Review of the new physical plant location for compliance with the Physical Plant, Accessibility, and Safety Section of the licensure standards.
If the relocation is the result of an act of God or violence, DDS staff will be onsite as soon as possible to provide technical assistance with temporary relocation and licensure standards regarding Physical Plant, Accessibility, and Safety.

13. **Codes.** A nonprofit community program is responsible for compliance with all applicable building codes, ordinances, rules, statutes and similar regulations that are required by city, county, state, or federal jurisdictions. Where such codes are not in effect, it is the responsibility of the nonprofit community program or program component to consult one of the national building codes generally used in the area for all components of the building type being used or constructed.

~~Nothing in this policy relieves a nonprofit community program or program component of these responsibilities.~~

- ~~14. **Appeals.** An appeal of any decision made under this policy may be filed according to procedures outlined in DDS Director's Office Policy #1076.~~

MARK-UP

**DDS Licensure
Sanctions Matrix
Appendix A**

Severity of Noncompliance	Scope of Noncompliance		
	Isolated	Pattern	Pervasive
Level 4	“J”	“K”	“L”
	<i>*Substandard Quality of Care</i>	<i>*Substandard Quality of Care</i>	<i>*Substandard Quality of Care</i>
	Plan of Correction	Plan of Correction	Plan of Correction
	Directed Plan of Correction	Directed Plan of Correction	Directed Plan of Correction
Level 3	“G”	“H”	“I”
	<i>*Substandard Quality of Care</i>	<i>*Substandard Quality of Care</i>	<i>*Substandard Quality of Care</i>
	Plan of Correction	Plan of Correction	Plan of Correction
	Directed Plan of Correction	Directed Plan of Correction	Directed Plan of Correction
Level 2	“D”	“E”	“F”
	<i>*Substandard Quality of Care</i>	<i>*Substandard Quality of Care</i>	<i>*Substandard Quality of Care</i>
	Plan of Correction	Plan of Correction	Plan of Correction
	Directed Plan of Correction	Directed Plan of Correction	Directed Plan of Correction
Level 1	“A”	“B”	“C”
	No Plan of Correction	Plan of Correction	Plan of Correction
	No Remedies		
	Commitment to Correct		

The DDS Licensure Sanctions Matrix is used to promote consistent practices in imposing Enforcement Remedies. Deviations based on particular circumstances are appropriate and expected.

*Substandard Quality of Care:

Substandard Quality of Care is any noncompliance with Individual/Parent/Guardian Rights and Service Provision Standards that constitutes immediate jeopardy to the health or safety of an individual served, or a pattern of or widespread actual harm that is not immediate jeopardy, or a widespread potential for more than minimal harm that is not immediate jeopardy with no actual harm.

State Monitoring is imposed when a nonprofit community program or program component has been found to have provided substandard quality of care on three (3) consecutive Licensure Reviews.

Factors Considered When Selecting Enforcement Remedies: In order to select the appropriate Enforcement Remedy(ies) for noncompliance, the seriousness of the deficiency(ies) is first assessed because specific levels of seriousness correlate with specific remedies. These factors are listed below. They relate to whether the deficiencies constitute:

- No actual harm with a potential for minimal harm;
- No actual harm with a potential for more than minimal harm but not immediate jeopardy;
- Actual Harm that is not immediate jeopardy, or
- Immediate jeopardy to the health or safety of an individual served;

AND whether deficiencies

- Are Isolated
- Constitute a pattern, or
- Are Widespread.

Additional Factors that may be considered in selecting Enforcement Remedy(ies) include without limitation:

- The relationship of one deficiency to other deficiencies;
- The nonprofit community program's or program component's prior history of noncompliance in general, and specifically with reference to the cited deficiency(ies); and
- The likelihood that the selected remedy(ies) will achieve correction and continued compliance.

~~ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY
DDS POLICY 1091
CERTIFICATION POLICY FOR NON-CENTERBASED SERVICES~~

1. ~~**Purpose.** This policy has been prepared to implement Ark. Code Ann. 20-48-201 et. seq.~~

2. ~~**Scope.** This policy is applicable to all Division of Developmental Disabilities Services (DDS) staff charged with implementation of certification standards and to individuals and organizations that are required to be certified by DDS in order to provide services designated in this policy to individuals with developmental disabilities.~~
 - A. ~~An individual or organization that provides any of the following Early Intervention Services is required to be certified by DDS:~~
 - 1) ~~Service Coordination;~~
 - 2) ~~Developmental Therapy/Therapy Assistant Services;~~
 - 3) ~~Speech Therapy Services;~~
 - 4) ~~Physical Therapy Services;~~
 - 5) ~~Occupational Therapy Services;~~
 - 6) ~~Consultation Services; and~~
 - 7) ~~Assistive Technology/Adaptive Equipment.~~

 - B. ~~An individual or organization that provides any of the following services under the Alternative Community Services (ACS) Waiver is required to be certified by DDS:~~
 - 1) ~~Case Management Services;~~
 - 2) ~~Supportive Living Services;~~
 - 3) ~~Community Experiences;~~
 - 4) ~~Respite Care;~~
 - 5) ~~Non-Medical Transportation;~~
 - 6) ~~Supported Employment Services;~~
 - 7) ~~Crisis Intervention Services;~~
 - 8) ~~Crisis Center Services;~~
 - 9) ~~Consultation;~~
 - 10) ~~Specialized Medical Services;~~
 - 11) ~~Adaptive Equipment; and~~
 - 12) ~~Environmental Modifications.~~

 - C. ~~A certified provider that offers Supported Employment Services must maintain a current license as a vendor with the Arkansas Rehabilitation Services of the Department of Workforce Education and staff who are certified Job Coaches.~~

~~D. Any individual or organization certified to provide Supportive Living Services or Case Management Services under the ACS Waiver may request DDS for approval to serve as an Organized Health Care Delivery System (OHCDS).~~

3. Certification.

~~A. DDS shall certify each qualified individual or organization that applies to provide a service designated in this policy.~~

~~B. A certification is valid and effective only for the individual or organization to which the certification is issued.~~

~~C. A certification is not transferable to another entity.~~

~~D. A copy of the certification for each service offered must be readily accessible by the individual or organization to which the certification is issued.~~

~~E. The validity of a certification is contingent on continued substantial compliance with applicable certification standards. A certification is subject to corrective action or interim adverse action which may be imposed by DDS at any time upon a finding of substantial noncompliance.~~

4. Certification Team Composition. ~~DDS is responsible for evaluating a certified provider's compliance with certification standards. A DDS Certification Team may include without limitation representatives of any relevant professional entities.~~

5. Access. ~~DDS shall have access to the premises, staff, individuals served and their families, and all records of a certified provider at all times for the purpose of conducting Abbreviated Reviews, Certification Reviews, Service Concern Investigations, or Surveys concerning compliance with applicable Certification Standards.~~

6. Certification Definitions.

~~A. "Abbreviated Review" means a targeted onsite evaluation of a new provider or certified provider for the purpose of determining compliance with specific certification standards, providing technical assistance, or conducting brief unscheduled or unannounced visits to provide consultation and assistance in support of continued compliance with certification standards.~~

~~B. "Certification Review" means an onsite formal evaluation of a new provider or certified provider by DDS to ensure program quality and compliance with applicable certification standards.~~

- ~~C. "Death Investigation" means an onsite review of an unexpected death that occurs accidentally, or as a result of an undiagnosed condition while the client is receiving services in accordance with DHS Policy 1106.~~
- ~~D. "Focused Review" means an onsite targeted evaluation of a certified Early Intervention provider due to non-compliance with state and/or federal regulations based on data submitted to DDS.~~
- ~~E. "Direct Care Staff" means staff employed by the certified organization who are responsible for implementing an individual's plan of care and providing day to day direct services in accordance with the plan of care and state and federal regulations.~~
- ~~F. "National Accrediting Organization" means a national accrediting organization with acknowledged expertise and experience in the field of developmental disabilities, such as the Commission for the Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA), recognized by DDS. In order to qualify a certified provider as accredited for purposes of renewing a Regular Certification based on deemed status, the specific program standards of a National Accrediting Organization shall be consistent with the configuration of services to persons with developmental disabilities in Arkansas.~~
- ~~G. "Provisional Certification" means the status of a Regular Certification when DDS finds that a certified provider has failed to complete appropriate corrective action under the Regular Certification with Requirements and continues to be substantially out of compliance with applicable certification standards or when warranted by the scope and severity level of noncompliance.~~
- ~~H. "Regular Certification" means a certification granted to a new provider or renewed annually for a certified provider when the new provider or certified provider demonstrates compliance with applicable certification standards.~~
- ~~I. "Regular Certification with Requirements" means the status of a Regular Certification when DDS finds that a certified provider has been substantially out of compliance with applicable Certification Standards for more than thirty (30) days.~~
- ~~J. "Service Concern Investigation" means a specific inspection of a certified provider by DDS with regard to a complaint or complaints.~~
- ~~K. "Survey" means an onsite formal evaluation of a new provider or certified provider by a national accrediting organization to ensure program quality and compliance with specific program standards.~~

~~L. “Temporary Certification” means a certification granted for a term of ninety (90) days with the possibility of one (1) ninety-day extension to allow time for the start-up of a new provider or a new service for an existing certified provider.~~

~~7. **Procedural Guidelines: Certification Application Process.**~~

~~A. Temporary Certification. In order to deliver any of the services designated under this policy, an applicant first applies for Temporary Certification with DDS on forms provided for that purpose. DDS considers only completed applications. If an application is incomplete, DDS promptly notifies the provider that the application is incomplete and will not be considered and identifies the items missing from the application.~~

~~1) Early Intervention Services.~~

~~a) Applicant is an Organization. If an applicant to provide Early Intervention Services is an organization, the application includes documentation of required qualifications, copies of written policies and procedures for implementation of the DDS Certification Standards concerning Board of Directors, Personnel Procedures and Records and Individual/Parent/Guardian Rights, a description of the applicant’s plan to address applicable Service Provision Standards, and any other documentation requested by DDS to accompany the application.~~

~~b) Applicant is an Individual. If an applicant to provide Early Intervention Services is an individual, the application includes documentation of required qualification, documentation related to the DDS Certification Standard concerning Certification of Individuals, a description of the applicant’s plan to address Service Provision Standards, and any other documentation requested by DDS to accompany the application.~~

~~e) Temporary Certification for Early Intervention Services. DDS evaluates the completed application and all supporting documentation for compliance with the DDS Certification Standards for Early Intervention Services. If DDS determines that the application and supporting documentation satisfy certification standards, DDS issues a Temporary Certification to the applicant in order to initiate services. After services are initiated, DDS will conduct an on-site review or in person interview to determine the provider’s compliance with certification standards concerning Service Provision, Individual/Parent/Guardian Rights, and Record Keeping.~~

~~2) ACS Waiver Services.~~

~~a) Applicant is an Organization. If an applicant to provide an ACS Waiver Service is an organization, the application includes documentation of required qualifications, copies of written policies and procedures for implementation of~~

~~the DDS Certification Standards concerning Board of Directors, Personnel Procedures and Records, Staff Training and Individual/Parent/Guardian Rights, a description of the applicant's plan intends to address the applicable Service Provision Standards, and any other documentation requested by DDS to accompany the application.~~

~~b) *Application is an Individual.* If provider applies to provide an ACS Waiver Service and the provider is an individual, the application shall include documentation of required qualifications, copies of written policies and procedures related to implementation of the DDS Certification Standards concerning Personnel Procedures and Records, Staff Training and Individual/Parent/Guardian Rights, a description of the applicant's plan to address the applicable Service Provision Standards, and any other documentation requested by DDS to accompany the application.~~

~~e) *Temporary Certification for ACS Waiver Services.* DDS evaluates the completed application and all supporting documentation for compliance with the applicable DDS Certification Standards for ACS Waiver Services. If the Temporary Certification is for Respite Care, Supportive Living Services in a community or congregate setting, or Crisis Center Services, DDS also conducts an onsite Abbreviated Review of the premises for compliance with Certification Standards concerning Physical Plant, Accessibility, and Safety. If DDS determines that the application, supporting documentation, and if applicable, the Abbreviated Review of the premises satisfy certification standards, DDS issues a Temporary Certification to the applicant in order to initiate services. After services are initiated, DDS will conduct an on-site review or in person interview to determine the provider's compliance with certification standards concerning Service Provision, Individual/Parent/Guardian Rights, and Record Keeping.~~

~~3) *Request for Approval as an Organized Health Care Delivery System.* Any individual or organization certified to provide Supportive Living Services or Case Management Services under the ACS Waiver may request DDS for approval to serve as an Organized Health Care Delivery System (OHCDS).~~

~~B. *Certification Review under Temporary Certification.* During the term of the Temporary Certification, DDS conducts a Certification Review in accordance with Section 8 of this policy. If DDS determines that the provider is in substantial compliance with applicable Certification Standards, DDS issues a Regular Certification. If DDS determines that the provider is not in substantial compliance with applicable certification standards, DDS imposes corrective actions or sanctions or both in accordance with Section 9 of this policy.~~

~~If the provider is unable to achieve substantial compliance with applicable Certification Standards during the term of the Temporary Certification, DDS may~~

~~extend the term of the Temporary Certification or deny the issuance of a Regular Certification.~~

~~C. Regular Certification.~~

~~1) Regular Certification Based on Certification Review.~~

~~DDS conducts periodic reviews of certified providers to ensure continued compliance with Certification Standards. A periodic review may be an Abbreviated Review or a Certification Review. If DDS determines after conducting a review that the certified provider is in substantial compliance with applicable Certification Standards, DDS renews the certified provider's Regular Certification. If DDS determines after conducting a review that the certified provider is not in substantial compliance with applicable Certification Standards, DDS imposes corrective actions or sanctions or both in accordance with Section 8 of this policy.~~

~~2) Regular Certification Based on Deemed Status.~~

~~a) Deemed Status. A certified provider may apply for renewal of a Regular Certification based on current accreditation from a National Accrediting Organization by providing DDS with a copy of the most recent complete report issued by the National Accrediting Organization concerning the provider and the official accreditation certificate.~~

~~(i) If already accredited prior to the provider's Certification Review month, the provider submits the report and certificate to DDS at least thirty (30) days prior to the beginning of the provider's Certification Review month.~~

~~(ii) If a provider is requesting Regular Certification Based on Deemed Status to begin with the prior year's certification and the provider receives national accreditation within eight (8) months of completion of the prior year's certification process, the provider submits the report and certificate to DDS within thirty (30) days of provider's receipt of the report and certificate.~~

~~If the current accreditation indicates that the provider is in substantial compliance with certification standards, DDS issues a Regular Certification to the provider without any further Certification Review.~~

~~If the current accreditation indicates that that the certified provider is in substantial compliance with licensure standards and a review of other pertinent information does not indicate a pattern of noncompliance or pervasive noncompliance at Level 2 or above, DDS renews the Regular Certification of the certified provider without any further Certification Review. Pertinent~~

~~information may include consumer satisfaction surveys, incident reports and results of service concern investigations.~~

~~b) Required Communications.~~

~~(i) A certified provider notifies DDS immediately after receipt of notification of a change in accreditation status.~~

~~(ii) A certified provider notifies DDS within fourteen (14) calendar days of the provider's receipt of notice of a pending Survey by the National Accrediting Organization~~

~~(iii) A certified provider submits contemporaneously to DDS its quality improvement plan and any other document submitted to its National Accrediting Organization.~~

~~(iv) A certified provider authorizes its National Accrediting Organization to release information to DDS upon DDS's request.~~

~~e) DDS Access.~~

~~(i) Nothing in this section affects the right of DDS to have access to the premises, staff, individuals served and their families, and all records of a certified provider at all times for the purpose of conducting Abbreviated Reviews, Certification Reviews, Service Concern Investigations, or Surveys concerning compliance with applicable Certification Standards.~~

~~(ii) DDS reports findings of Abbreviated Reviews, Certification Reviews, Service Concern Investigations, or Surveys and actions taken to the National Accrediting Organization of the certified provider.~~

~~(iii) A DDS staff member may participate in the entrance conference and exit conference during any survey conducted by the National Accrediting Organization of the certified provider.~~

~~d) Withdrawal of Regular Certification Based on Deemed Status. DDS may withdraw a Regular Certification Based on Deemed Status under the following circumstances:~~

~~(i) When a complaint concerning substantial noncompliance, as designated in Levels 3 and 4 of the Sanctions Matrix, with a health or safety standard is founded;~~

~~(ii) When an Abbreviated Review, Certification Review, Service Concern Investigation, or Survey find instances of noncompliance with DDS Certification Standards, or~~

~~(iii) When the national accreditation status of the certified provider has expired, is downgraded, or withdrawn by the National Accrediting Organization.~~

~~e) National Accreditation Not Required. DDS does not require any provider to seek or submit to accreditation by a National Accrediting Organization.~~

~~When a certified provider is not accredited by a national accrediting organization, DDS conducts a review of the provider as specified in this section.~~

8. ~~Procedural Guidelines: Certification Review Process.~~

A. ~~Notice of Certification Review.~~

~~Within ninety (90) days before a Certification Review, DDS sends notice of the Certification Review to the Director and Board President, if applicable, of the certified provider and identifies any information that DDS requires certified provider to submit prior to the Certification Review. For example, DDS may request a letter of assurances signed by the Director of the certified provider or designee and the President of the Board of Directors of the certified provider or designee stating that the certified provider's written policies and procedures are in compliance with the applicable certification standards.~~

~~After receipt of notice of a Certification Review, the director of the certified provider shall distribute a notice announcing in advance the approximate date range during which DDS expects to perform a Certification Review of the certified provider. The notice should be made available to all individuals served and their families and should include DDS contact information.~~

B. ~~Offsite Preparation.~~

~~The objective of offsite preparation is to analyze various sources of information available about the certified provider to identify any potential areas of concern, to ascertain any special features of the provider, and to focus the efforts of the DDS Certification Review Team during the onsite tour and with regard to onsite information gathering.~~

~~The DDS Certification Review Team Leader or designee is responsible for obtaining all available sources of information about the certified provider for review by the Team including without limitation:~~

- ~~• Documentation from the provider requested in advance,~~
- ~~• The prior year's Certification Review report,~~

- Incident reports submitted during the prior year, and
- The results of any complaint investigations during the prior year.

The Team Leader is responsible for presenting the information obtained to the Team for review at an offsite team meeting prior to the Certification Review. At this meeting, the Team Leader should establish preliminary review assignments, and the Team should identify potential areas of concern and note any special features of the certified provider.

C. Entrance Conference.

The Team Leader or designee conducts the entrance conference with the director of the certified provider and any staff designated by the director. During the entrance conference, the Team Leader or designee:

- Introduces team members,
- Explains the Certification Review process,
- Informs the director and any staff that the Team will be communicating with them through the Certification Review and will ask for assistance when needed,
- Advises the director and any staff that they will have the opportunity to provide the Team with any information that would clarify an issue brought to their attention, and
- Answers any questions from the director or any staff.

If services are provided on-site, it is recommended that after their introduction to director of the certified provider, the other team members proceed to the initial tour and make general observations of the certified provider.

D. Onsite Preparation.

The Team Leader asks director of the certified provider to provide access to information determined by the Team as necessary to complete the Certification Review.

If applicable, the Team Leader shall post a sign or arrange for the director of the certified provider to post a sign in areas easily observable by individuals served and their families announcing that DDS is performing a Certification Review and that DDS team members are available to meet in private with individuals served or their families or both.

Throughout the Certification Review process, the Team should discuss among themselves, on a daily basis, observations made and information obtained in order to focus on the concerns of each team member, to facilitate information gathering and to facilitate decision making at the completion of the Certification Review.

E. Initial Tour.

The initial tour of the provider's administrative facility(ies) and agency owned/operated/controlled sites is designed to provide team members with an initial assessment of the certified provider, the individuals served and their families, and any staff. During the initial tour, team members should:

- Make an initial evaluation of the environment of the certified provider,
- Identify areas of concern to be investigated during the Certification Review,
- Confirm or invalidate pre-review information about potential areas of concern, and
- Document their findings.

F. Onsite Information Gathering.

The DDS Certification Review Team gathers information for the Certification Review from three (3) primary sources: review of records, interviews, and observations. Each team member should verify information and observations in terms of credibility and reliability. All findings must be documented. The Team should maintain an open and ongoing dialogue with the director and any staff throughout the Certification Review process.

The Team should meet on a daily basis to share information, such as findings to date, areas of concern, any changes needed in the focus of the Certification Review. These meetings include discussions of concerns observed, possible requirements to which those concerns relate, and strategies for gathering additional information to determine whether the certified provider is meeting certification standards.

Immediate jeopardy: Immediate jeopardy is defined as a situation in which the certified provider's failure to meet one or more certification standards has caused, or is likely to cause, serious injury, harm, impairment, or death of an individual served. The guiding principles for determining the scope and severity of noncompliance make it clear that immediate jeopardy can be related to mental or psychosocial well-being as well as physical well-being and that the situation in question need not be a widespread problem.

NOTE: See Section 8.I and the Certification Sanctions Matrix in Appendix A to this policy for more information on classifying the scope and severity of deficient practices.

At any time during the Certification Review, if one or more team members identify possible immediate jeopardy, the Team should meet immediately to confer. The team must determine whether there is immediate jeopardy during the information gathering task. If the team concurs that there is immediate jeopardy, the team

leader immediately consults his or her supervisor. If the supervisor concurs, that the situation constitutes immediate jeopardy, the team lead informs the director of the certified provider or designee that DDS is invoking the immediate jeopardy certification revocation procedures. The team leader explains the nature of the immediate jeopardy to the director of the certified provider or designee who must submit a statement while the team is on-site asserting that the immediate jeopardy has been removed and including a plan of sufficient detail to demonstrate how and when the immediate jeopardy was removed.

The Team will provide the director of the certified provider with a written report concerning the nature of the immediate jeopardy within ten (10) days of the date of the exit conference.

Substandard Quality of Care: Substandard quality of care is defined as a deficient practice related to Certification Standards concerning Individual/Parent/Guardian Rights or Service Provision classified as an isolated incident at severity level 3 or as a pattern of deficient practices at severity level 2.

NOTE: See Section 8.1 and the Certification Sanctions Matrix in Appendix A to this policy for more information on classifying the scope and severity of deficient practices.

At any time during the Certification Review, if a team member identifies possible substandard quality of care, the team member should notify other members of the team as soon as possible. The team may make a finding of substandard quality of care during the information gathering task or the information analysis and decision-making task.

If there is a deficiency(ies) related to noncompliance with Certification Standards concerning Individual/Parent/Guardian Rights or Service Provision and the team member classifies the deficiency as an isolated incidence of severity level 3 or as a pattern of severity level 2, the team member determines if there is sufficient evidence to support a decision that there is substandard quality of care. If the evidence is not sufficient to confirm or refute a finding of substandard quality of care, the team member may expand the Certification Review to include additional evaluation of the certified provider's compliance with the licensure standard at issue. To determine whether or not there is substandard quality of care, the Team should assess additional information related to the Certification Standard at issue, such as written policies and procedures, staff qualifications and functional responsibilities, and specific agreements and contracts that may have contributed to the outcome. It may also be appropriate to conduct a more detailed review of related service delivery.

~~If the determination of substandard quality of care is made prior to the exit conference, the Team will provide the director of the certified provider with information concerning the nature of the substandard quality of care.~~

~~If the determination of substandard quality of care is made after the exit conference, the Team will provide the director of the certified provider with a written report concerning the nature of the substandard quality of care within fifteen (15) days of the date of the completion of the review.~~

~~G. Information Analysis for Deficiency Determination.~~

~~The objective of information analysis for deficiency determination is to review and analyze all information collected and to determine whether or not the certified provider has failed to meet one or more of the applicable certification standards. Information analysis and decision making builds on discussions of the DDS Certification Review Team during daily meetings, which should include discussions of observed problems, area of concern, and possible failure to meet certification standards. The team leader or designee collates all information and records the substance of the decision-making discussions on the Certification Review report.~~

~~*Deficiency Criteria:* The Team bases all deficiency determinations on documented observations, statements by individuals served, statement by the families of individual serviced, statements by the director and staff, and available written documents.~~

~~*Evidence Evaluation:* The Team evaluates the evidence documented during the Certification Review to determine if a deficiency exists due to a failure to meet a certification standard and if there are any negative outcomes for individuals served due to the failure. The Team should evaluate all evidence in terms of credibility and reliability.~~

~~H. Exit Conference.~~

~~The DDS Certification Review Team will conduct an exit conference with the certified provider immediately following the completion of the Certification Review. The general objective of the exit conference is to inform the certified provider of the Team's observations and preliminary findings.~~

~~During the exit conference, the Team describes the deficiencies that have been identified and the findings that substantiate these deficiencies. The Team provides the director and any staff with an opportunity to discuss and supply additional information that he or she believes is pertinent to the identified findings.~~

~~I. Writing the Report.~~

The report of the Certification Review should be written in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the certification standard(s) that is (are) not met. The report should identify the specific certification standards not met and reflect the content of each certification standard identified. The report should include a summary of the evidence and supporting observations for each deficiency. The report shall identify the sources of evidence (e.g., interview, observation, or records review) and identify the impact or potential impact of the noncompliance on the individual served, and how it prevents the individual served from reaching his or her highest practicable physical, mental or psychosocial well-being. The levels of severity and scope of deficiencies should be clearly identifiable.

Guidance on Severity Levels—There are four (4) severity levels:

- Level 1—No actual harm with potential for minimal harm is a deficiency that has the potential for causing no more than a minor negative impact of the individual served.
- Level 2—No actual harm with potential for more than minimal harm that is not immediate jeopardy is a noncompliance that results in minimal physical, mental or psychosocial discomfort to the individual served or has the potential to compromise the individual served's ability to maintain or reach his or her highest practicable physical, mental or psychosocial well-being as defined by a plan of care and provision of services.
- Level 3—Actual harm that is not immediate jeopardy is noncompliance that results in a negative outcome that has compromised the individual served's ability to maintain or reach his or her highest practicable physical, mental or psychosocial well-being as defined by an accurate and comprehensive assessment, plan of care, and provision of services. This *does not include* a deficient practice that only has limited consequence for the individual served and would be included in Level 2 or Level 1.
- Level 4—Immediate jeopardy to the health or safety of an individual served is a situation in which immediate corrective action is necessary because the certified provider's noncompliance with one or more certification standards has caused, or is likely to cause, serious injury, harm, impairment, or death to an individual served.

Guidance on Scope Levels—There are three (3) scope levels:

- Isolated—When one or a very limited number of individuals served are affected, when one or a very limited number of staff are involved, or when the situation has occurred only occasionally or in a very limited number of locations.
- Pattern—When more than a very limited number of individuals served are affected, when more than a very limited number of staff are involved, when the situation has occurred in several locations, or when the same individual

~~served has been affected by reported occurrences of the same deficient practice. A pattern of deficient practices is not found to be pervasive throughout the operations of the certified provider. If the certified provider has a system or policy in place but the system or policy is being inadequately implemented in certain instances or if there is inadequate system with the potential to impact only a subset of individuals served, then the deficient practice is likely a pattern.~~

- ~~• Pervasive—When the problems causing the deficiencies are pervasive in the operations of the certified provider or represent systemic failure that affected or has the potential to affect a large portion or all of the individuals served by the certified provider. If the certified provider lacks a system or policy or has an inadequate system or policy to meet the certification standard and this failure has the potential to affect a large number of individuals served, then the deficient practice is likely widespread.~~

~~J. Issuing the Report.~~

~~DDS provides the certified provider with a written report documenting the findings made during the Certification Review within thirty (30) calendar days of the date of the exit conference.~~

~~If the Certification Review Report contains a deficiency that is classified as substandard quality of care, DDS provides the certified provider with a written report concerning the nature of the substandard quality of care within fifteen (15) days of the date of the exit conference.~~

~~If the Certification Review Report contains a deficiency that is classified as immediate jeopardy, DDS provides the certified provider with a written report concerning the nature of the immediate jeopardy within ten (10) days of the date of the exit conference.~~

~~K. Plan of Correction.~~

~~*In General.* A plan of correction (POC) is a written statement developed by a certified provider to guide its efforts in achieving substantial compliance with certification standards after a finding of substantial noncompliance. Substantial noncompliance refers to a deficiency(ies) that is (are) categorized as no actual harm with potential for more than minimal harm that is (are) not immediate jeopardy and is (are) not substandard quality of care.~~

~~In order for a plan of correction to be acceptable, it must:~~

- ~~• Contain elements detailing how the certified provider will correct the deficiency as it relates to the individual served;~~

- Indicate how the certified provider will act to protect individual service in similar situations;
- Include the measures the certified provider will take or the systems it will alter to ensure that the problem does not recur;
- Indicate how the certified provider plans to monitor its performance to make sure that solutions are sustained; and
- Provide dates when corrective action will be completed. Completion dates will be determined in conjunction with DDS.

DDS approves the plan of correction if it satisfies the elements described above. If DDS does not approve the plan of correction, DDS shall provide the certified provider with a written explanation stating the reasons the plan of correction does not satisfy the elements described above. The certified provider shall revise the plan of correction until it is approved by DDS. All revisions must be completed within the time frame designated below for submission of the plan of correction.

POC when there is substantial compliance: Substantial compliance means a level of compliance with Certification Standards such that any identified deficiencies pose no greater risk to the health or safety of individuals served than the potential for causing minimal harm. Substantial compliance constitutes compliance with Certification Standards.

When DDS finds that a certified provider is in substantial compliance but has deficiencies that are isolated with no actual harm and potential for only minimal harm, a plan of correction is not required but the certified provider is expected to correct all deficiencies.

When DDS finds that a certified provider is in substantial compliance but has deficiencies that constitute a pattern or widespread with no actual harm and potential for only minimal harm, a plan of correction is required. While a certified provider is expected to correct deficiencies at this level, these deficiencies are within the substantial compliance range and do not need to be reviewed for correction during subsequent follow-up reviews within the same Certification Review cycle.

POC when there is not substantial compliance: Within fifteen (15) days of receipt of a certification report with deficiencies that are categorized as no actual harm with potential for more than minimal harm that is not immediate jeopardy and are not substandard quality of care, the certified provider develops and submits to DDS a written plan of correction.

POC when there is not substantial compliance and there is also substandard quality of care or actual harm that is not immediate jeopardy: Within ten (10) days of receipt of a certification report with deficiencies that are categorized as

~~substandard quality of care or actual harm that is not immediate jeopardy, the certified provider develops and submits to DDS a written plan of correction.~~

~~*POC when there is not substantial compliance and there is also with immediate jeopardy:* Within two (2) days of receipt of a certification report with deficiencies that categorized as immediate jeopardy, the certified provider develops and submits to DDS a written plan of correction.~~

L. Post Certification Review Revisits.

~~DDS conducts a follow-up Abbreviated Review to confirm that the certified provider is in compliance with certification standards and has the ability to remain in compliance with certification standards. The purpose of the follow-up Abbreviated Review is to re-evaluate the specific care and services that were cited as noncompliant during the Certification Review, Service Concern Investigation, or other onsite Survey.~~

~~If DDS accepts the certified provider's plan of correction, DDS conducts a follow-up Abbreviated Review within thirty (30) calendar days of acceptance of the plan of correction but not before the latest date of corrective action proposed by the certified provider. At the follow-up Abbreviated Review, the Team should focus on the actions taken by the certified provider since the correction dates listed on the plan of correction.~~

~~Within fifteen (15) calendar days of the follow-up Abbreviated Review, DDS sends a written report documenting the findings made during the follow-up Abbreviated Review.~~

9. Enforcement Remedies.

~~DDS may impose any of the Enforcement Remedies described below alone or in combination with any other Enforcement Remedy or Remedies to encourage quick compliance with certification standards.~~

A. Certification downgrade.

~~*↳ Regular Certification with Requirements.* If a certified provider is not in substantial compliance with applicable certification standards within thirty (30) calendar days after receiving notice of noncompliance in a Certification Review Report, the status of the certified provider's Regular Certification will be downgraded to a Regular Certification with Requirements. In order to achieve restoration of its Regular Certification, the certified provider corrects all identified deficiencies and demonstrates substantial compliance with certification standards within sixty (60) calendar days of being downgraded to a Regular Certification with Requirements. DDS may pass over Regular Certification with Requirements~~

~~and immediately impose Provisional Certification when warranted by the scope and severity level of the noncompliance.~~

~~2) Provisional Certification. When a certified provider continues to be out of compliance with applicable certification standards at the end of the period allowed for a Regular Certification with Requirements or when warranted by the scope and severity level of the noncompliance, the certified provider's certification is downgraded to a Provisional Certification for a maximum term of one hundred and eighty calendar days (180) and Moratorium on New Admissions is imposed. During the term of a Provisional Certification, the certified provider submits weekly progress reports regarding compliance efforts until all deficiencies have been corrected. The failure of a certified provider to substantially comply with certification standards after sixty (60) calendar days of Provisional Certification results in the imposition of a Moratorium on Expansion.~~

~~B. Directed Plan of Correction.~~

~~A directed plan of correction is an Enforcement Remedy in which DDS develops a plan to require a certified provider to take action within a specified timeframe. Achieving substantial compliance is the responsibility of the certified provider whether or not a directed plan of correction is followed. If a certified provider fails to achieve substantial compliance after complying with a directed plan of correction, DDS may impose another Enforcement Remedy until the certified provider achieves substantial compliance or loses its certification.~~

~~DDS may impose a directed plan of correction fifteen (15) calendar days after the certified provider receives notice in non-immediate jeopardy situations and two (2) calendar days after the certified provider receives notice in immediate jeopardy situations.~~

~~The date a directed plan of correction is imposed does not mean that all corrections must be completed by that date.~~

~~C. Directed In-Service Training.~~

~~Directed in-service training is an Enforcement Remedy that DDS imposes when it believes that education is likely to correct the deficiencies and help the certified provider achieve substantial compliance. This remedy requires provider staff to attend an in-service training program.~~

~~DDS may provide special consultative services for obtaining this type of training. At a minimum, DDS should compile a list of resources that can provide directed in-service training and make this list available to certified providers and other interested parties.~~

~~The certified provider bears the expense of directed in-service training.~~

~~If a certified provider fails to achieve substantial compliance after completing directed in-service training, DDS may impose another Enforcement Remedy until the certified provider achieves substantial compliance or loses its certification.~~

~~D. Referral to Medicaid Audit for Investigation.~~

~~Referral to Medicaid Audit for Investigation is an Enforcement Remedy that DDS imposes in response to identifying specific information that a certified provider has received inappropriate payment for services.~~

~~If an audit reveals that a certified provider has not complied with billing requirements in a reckless or intentional manner, DDS may impose additional Enforcement Remedies, including without limitation, certification revocation, exclusion and debarment.~~

~~E. State Monitoring.~~

~~State Monitoring is an Enforcement Remedy that DDS impose when DDS determines that oversight of the certified provider's efforts to correct cited deficiencies is necessary as a safeguard against further harm to individuals served when harm or a situation with the potential for harm has occurred.~~

~~A State Monitor is an appropriate professional who:~~

- ~~• Is an employee or contractor of DDS,~~
- ~~• Is not an employee or contractor of the monitored provider,~~
- ~~• Does not have an immediate family member who is served by the monitored provider, and~~
- ~~• Does not have any other conflict of interest with the monitored provider.~~

~~When State Monitoring is imposed, DDS selects the State Monitor. Monitoring may occur anytime in a program or program component. State Monitors have complete access to the premises, staff, individuals served and their families, and all records of the certified provider at all times and in all instances for performance of the monitoring task.~~

~~Some situations in which State Monitoring may be appropriate include without limitation:~~

- ~~• Poor compliance history, i.e. a pattern of poor quality of care, many complaints,~~
- ~~• DDS concern that the situation has the potential to significantly worsen, or~~
- ~~• Substandard quality of care or immediate jeopardy exists and the certified provider seems unable or unwilling to take corrective action.~~

~~The Enforcement Remedy of State Monitoring is discontinued when the certified provider demonstrates that it is in substantial compliance with certification standards and that it will remain in substantial compliance. A certified provider can demonstrate continued compliance by adherence to a plan of correction that delineates what systemic changes will be made to ensure that the deficient practice will not recur and how the certified provider will monitor its corrective actions to ensure it does not recur.~~

~~F. Moratorium on New Admissions.~~

~~Moratorium on New Admissions is an Enforcement Remedy that DDS may impose any time DDS finds a certified provider to be out of substantial compliance as long as the program or program component is given written notice at least two (2) calendar days before the effective date in immediate jeopardy cases and at least fifteen (15) calendar days before the effective date in non-immediate jeopardy cases.~~

~~DDS imposes a Moratorium New Admissions when DDS finds that a certified provider is not in substantial compliance ninety (90) calendar days after the last day of the Certification Review identifying the deficiency, or when a program or program component has been found to have furnished substandard quality of care during its last three (3) consecutive Certification Reviews.~~

~~An individual admitted to a certified provider's service on or after the effective date of the remedy is considered a new admission. An individual admitted to a certified provider's service on or after the effective date of the remedy who is discharged from the service component or takes a temporary leave from the service is still considered new admission upon readmission or return.~~

~~An individual admitted to a certified provider's service before and discharged on or after the effective date of the remedy is not considered a new admission if the individual is subsequently readmitted to the service. An individual admitted to a certified provider's service before the effective date of the remedy who takes temporary leave before or after the effective date is not consider a new admission upon return.~~

~~Generally, if the certified provider achieves substantial compliance and it is verified through a follow-up Abbreviated Review or credible written evidence, DDS lifts the Moratorium on New Admissions. However, when a Moratorium on New Admissions is imposed for repeated instances of substandard quality of care, DDS may impose the remedy until the certified provider is in substantial compliance and DDS believes the certified provider will remain in substantial compliance.~~

~~G. Moratorium on Expansion.~~

~~Moratorium on Expansion is an Enforcement Remedy that DDS may impose when DDS finds a certified provider to be out of substantial compliance with certification standards after sixty (60) calendar days of Provisional Certification. A Moratorium on Expansion may include expanding capacity for current service delivery in existing service areas and expanding to offer current or new services in new service areas.~~

~~The failure of a certified provider to substantially comply with certification standards after sixty (60) calendar days of Provisional Certification indicates that the certified provider is unable or unwilling to take necessary corrective action and that individuals with developmental disabilities are in danger of losing services. A Moratorium on Expansion continues until the certified provider is in substantial compliance with applicable standards, and DDS believes the certified provider is willing and able to remain in substantial compliance.~~

~~If the certified provider has made considerable progress toward substantial compliance with applicable certification standards during the period of Provisional Certification, the DDS Director or designee may grant an extension before a Moratorium on Expansion is imposed.~~

~~H. Specific Service Prohibition.~~

~~A Specific Service Prohibition is an Enforcement Remedy that DDS may impose when DDS finds that a certified provider harmed a consumer. DDS may impose the prohibition against serving a specific individual or individuals or against a specific class of individuals. The prohibition may be permanent or for a specific term depending on the circumstances of the case.~~

~~I. Certification Revocation.~~

~~When considering whether to revoke the certification of a certified provider, DDS considers many factors, particularly the provider's noncompliance history (e.g., it is consistently in and out of noncompliance), the effectiveness of alternative Enforcement Remedies when previously imposed, and whether the certified provider has failed to follow through on an alternative Enforcement Remedy (e.g. directed plan of correction or directed in-service training). These considerations are not all inclusive but factors to consider when determining whether Certification Revocation is appropriate in a given case.~~

~~*Immediate Jeopardy.* When there is immediate jeopardy to the health or safety of an individual served, DDS revokes the certification of a certified provider to be effective within thirty (30) calendar days of the last day of the Certification Review that found the immediate jeopardy if the immediate jeopardy is not removed before then. If the certified provider provides a written and timely credible allegation that the immediate jeopardy has been removed, DDS will conduct a follow-up~~

~~Abbreviated Survey prior to revocation if possible. In order for a Certification Revocation to be reversed, the immediate jeopardy must be removed even if the underlying deficiencies have not been fully corrected.~~

~~No Immediate Jeopardy. Certification Revocation is always an option that may be imposed for the noncompliance of any certified provider regardless of whether or not immediate jeopardy is present. When there is not immediate jeopardy, DDS revokes the Regular Certification of a certified provider if the certified provider fails to achieve substantial compliance after one hundred and eighty (180) calendar days of Provisional Certification.~~

~~J. Voluntary Surrender of License.~~

~~If a certified provider intends to voluntarily surrender its certification, the director of the certified provider notifies DDS immediately. As a condition of certification, the program or program component agrees to assist DDS with transitioning consumers.~~

~~K. Transitioning Consumers.~~

~~DDS has the ultimate responsibility for transitioning consumers when a certification is revoked. In some instances, the certified provider may assume responsibility for the safe and orderly transition of consumers when the certification of the provider is revoked. However, this does not relieve DDS of its ultimate responsibility to transition consumers. The goal of transitioning consumers is to minimize the period of time during which consumers receive less than adequate care.~~

~~L. Exclusion.~~

~~Exclusion from contracting with all DHHS divisions and enrolling in the Arkansas Medicaid Program for a specific term is an Enforcement Remedy that may be imposed upon recommendation of DDS and approval by the DHHS Director.~~

~~M. Debarment.~~

~~Recommendation to appropriate federal regulatory agency for Permanent Debarment is an Enforcement Remedy that may be imposed upon recommendation of DDS and approval by the DHHS Director.~~

10. Solicitation.

~~A. "Solicitation" means the use of a method described in Section 10.B of this policy to attempt to unduly influence an individual served by a certified provider or his or~~

~~her family or guardian to transfer from one provider to another provider. Solicitation is prohibited by the all of the following:~~

- ~~1) A certified provider or any individual acting on behalf of the certified provider,~~
- ~~2) Any staff member of a certified provider or any individual acting on behalf of the staff member, and~~
- ~~3) Any individual who provides or has provided professional or direct care services for a certified provider or any individual acting on his or her behalf.~~

~~B. The following methods of solicitation are prohibited:~~

- ~~1) With the intent of soliciting consumers, hiring an individual who has been previously employed by or contracted with another certified provider who subsequently contacts consumers on the individual's caseload with the previous provider with the intent of inducing the consumer to transfer to the certified provider with which the individual is currently employed or contracted.~~

~~Protected Health Information, such as consumer addresses and telephone numbers, are considered confidential and the property of the certified provider with which the individual was or is employed or contracted. An individual formerly employed or contracted with a certified provider may not disclose Protected Health Information without a signed release from the consumer according to HIPAA. If DDS finds that an individual has released Protected Health Information in a manner contrary to HIPAA, DDS will notify the appropriate licensing or certification entity and the Office of Inspector General of the U.S. Department of Health and Human Services.~~

~~When a consumer transitions between two (2) certified providers, the receiving provider shall indicate on the transition plan if the receiving provider has hired or contracted or intends to hire or contract an individual who previously served the transferring individual through the sending provider. If five (5) or more individuals transfer under the circumstances described in this paragraph, DDS contacts the individuals or their family members or guardians to determine if solicitation occurred.~~

- ~~2) Offering cash or gift incentives to an individual served or his or family or guardian to induce the individual served or his or her family or guardian to change providers,~~
- ~~3) Offering an individual served or his or her family or guardian free goods or services that are not available to other similarly stationed consumers to induce the individual served or his or her family or guardian to change providers,~~

- ~~4) Refusing to provide an individual served access to entitlement services for which the individual is eligible if the individual served or his or her family or guardian selects another certified provider to provide waiver services to the individual,~~
- ~~5) Making negative comments to a potential individual served, his or her family or guardian, or an advocate regarding the quality of services provided by another certified provider other than for the purpose of monitoring or official advocacy,~~
- ~~6) Promising to provide services in excess of those necessary to induce an individual served or his or her family or guardian to change programs,~~
- ~~7) Directly or indirectly giving an individual served or his or her family or guardian the false impression that the certified provider is the only agency that can provide the services desired by the individual served or his or her family or guardian, and~~
- ~~8) Engaging in any activity that DDS determines was intended to be solicitation as defined in Section 10.A of this policy.~~
- ~~C. Only an authorized DDS representative may offer an individual or his or her family or guardian provider choice.~~
- ~~D. DDS investigates claims of solicitation that appear to be consistent with the definition of solicitation in Section 10.A of this policy. If DDS makes a finding of prohibited solicitation, DDS imposes enforcement remedies under Section 9 consistent with the scope and severity of the solicitation. If a pattern of solicitation occurs, DDS may impose Licensure Revocation.~~
- ~~E. Marketing is distinguishable from solicitation and is considered an allowable practice. Examples of acceptable marketing practices include without limitation:
 - ~~1) General advertisement using traditional media,~~
 - ~~2) Distribution of brochures and other informational materials regarding the services provided by a certified provider if the brochures and materials are factual and honestly presented,~~
 - ~~3) Providing tours of a certified provider to interested individuals,~~
 - ~~4) Mentioning other services provided by the certified provider in which a consumer might have an interest, and~~
 - ~~5) Hosting informational gatherings during which the services provided by a certified provider are honestly described.~~~~

11. Procedural Guidelines: Change in Director.

- A. A certified provider shall provide DDS with written notification of a change in the director of the certified provider immediately upon resignation, discharge, or death of the director.
- B. Within sixty (60) calendar days after the effective date of a change in the director of a certified provider, DDS staff will conduct an Abbreviated Review of the certified provider to provide onsite technical assistance.

12. **Codes:** A certified provider is responsible for compliance with all applicable building codes, ordinances, rules, statutes and similar regulations that are required by city, county, state, or federal jurisdictions. Where such codes are not in effect, it is the responsibility of the certified provider to consult one of the national building codes generally used in the area for all components of the building type being used or constructed. Nothing in this policy relieves a certified provider these responsibilities.

13. **Appeals:** An appeal of any decision made under this policy may be filed according to procedures outlined in DDS Director’s Office Policy #1076.

DDS Certification Sanctions
Matrix Appendix A

Severity of Noncompliance	Scope of Noncompliance		
	Isolated	Pattern	Pervasive
	“J”	“K”	“L”
Level 4	<p><i>*Substandard Quality of Care</i> Plan of Correction Directed Plan of Correction Directed In-Service Training Refer to Audit for Investigation State Monitoring Specific Service Prohibition Transition Consumers Exclusion Debarment</p>	<p><i>*Substandard Quality of Care</i> Plan of Correction Directed Plan of Correction Directed In-Service Training Refer to Audit for Investigation State Monitoring Moratorium on New Admissions Moratorium on Expansion Specific Service Prohibition Transition Consumers Certification Revocation Exclusion Debarment</p>	<p><i>*Substandard Quality of Care</i> Plan of Correction Directed Plan of Correction Directed In-Service Training Refer to Audit for Investigation State Monitoring Moratorium on New Admissions Moratorium on Expansion Specific Service Prohibition Transition Consumers Certification Revocation Exclusion Debarment</p>
	“G”	“H”	“I”
Level 3	<p><i>*Substandard Quality of Care</i> Plan of Correction Directed Plan of Correction Directed In-Service Training</p>	<p><i>*Substandard Quality of Care</i> Plan of Correction Directed Plan of Correction Directed In-Service Training</p>	<p><i>*Substandard Quality of Care</i> Plan of Correction Directed Plan of Correction Directed In-Service Training</p>

	Refer to Audit for Investigation State Monitoring Specific Service Prohibition	Refer to Audit for Investigation State Monitoring Moratorium on New Admissions Moratorium on Expansion Specific Service Prohibition Transition Consumers Certification Revocation Exclusion	Refer to Audit for Investigation State Monitoring Moratorium on New Admissions Moratorium on Expansion Specific Service Prohibition Transition Consumers Certification Revocation Exclusion Debarment
	“D”	“E”	“F”
Level 2	Plan of Correction Directed Plan of Correction Directed In-Service Training Refer to Audit for Investigation	Plan of Correction Directed Plan of Correction Directed In-Service Training Refer to Audit for Investigation	<u>*Substandard Quality of Care</u> Plan of Correction Directed Plan of Correction Directed In-Service Training Refer to Audit for Investigation State Monitoring Moratorium on New Admissions Moratorium on Expansion
	“A”	“B”	“C”
Level 1	No Plan of Correction No Remedies Commitment to Correct	Plan of Correction	Plan of Correction

The DDS Certification Sanctions Matrix is used to promote consistent practices in imposing Enforcement Remedies. Deviations based on particular circumstances are appropriate and expected.

*Substandard Quality of Care:

Substandard Quality of Care is any noncompliance with Individual/Parent/Guardian Rights and Service Provision Standards that constitutes immediate jeopardy to the health or safety of an individual served, or a pattern of or widespread actual harm that is not immediate jeopardy, or a widespread potential for more than minimal harm that is not immediate jeopardy with no actual harm.

State Monitoring is imposed when DDS has found a certified provider to have provided substandard quality of care on three (3) consecutive Certification Reviews.

Factors Considered When Selecting Enforcement Remedies: In order to select the appropriate Enforcement Remedy(ies) for noncompliance, the seriousness of the deficiency(ies) is first assessed because specific levels of seriousness correlate with specific remedies. These factors are listed below. They relate to whether the deficiencies constitute:

- No actual harm with a potential for minimal harm,
- No actual harm with a potential for more than minimal harm but not immediate jeopardy,
- Actual Harm that is not immediate jeopardy, or
- Immediate jeopardy to the health or safety of an individual served,

~~AND whether deficiencies~~

- ~~• Are Isolated~~
- ~~• Constitute a pattern, or~~
- ~~• Are Widespread.~~

~~Additional Factors that may be considered in selecting Enforcement Remedy(ies) include without limitation:~~

- ~~• The relationship of one deficiency to other deficiencies,~~
- ~~• The prior history of noncompliance in general, and specifically with reference to the cited deficiency(ies), and~~
- ~~• The likelihood that the selected remedy(ies) will achieve correction and continued compliance.~~

MARK-UP