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STANDARD	REFERENCES	SUPPORTING EVIDENCE & SCORING
SECTION 1 - GENERAL ADMINISTRATIVE OVERSIGHT		
1.1 The provider has adequate policy and/or procedure to protect confidential and individually identifiable information from unauthorized use or disclosure, including: 1. Protections for physical facility access. 2. Protections for electronic access. 3. Media and device controls. 4. Physical safeguards for workstations. 5. Procedures for allowing and removing access according to role-based employment	*HIPAA/HITECH* *42 CFR Part 2* *MH Code 330.1748*	**Supporting Evidence:** Computer safeguards (e.g., screen locks, password use, and regular password expiration), paper file safeguards (locking paper files when not in use), IT policies and/or procedures, policies and/or procedures around verbal/written sharing of customer information with others (such as with family members, law enforcement and/or other health professionals). **Scoring: 2** - No concerns. Ample precautions to protect confidential information are in place. **1** - One or two minor suggestions for improvement. **0** - Improvement needed in several areas; or potential for serious violation of privacy was noted.
1.2 The organization has developed and adopted a "Code of Conduct" (or its equivalent) for its employees regarding ethical and legal practice expectations. A provider may choose to comply with the SWMBH Code of Conduct in lieu of developing its own code of conduct (must have written certification that they have received, read and will abide by SWMBH's Code of Conduct).	*PIHP Policy 10.1*	**Supporting Evidence:** A copy of the organization's Code of Conduct or acknowledgement of use of the SWMBH Code of Conduct. For evidence of "adoption" of the code of conduct - training records, policy and/or procedure regarding dissemination of the code, employee handbook with the code, posting of ways to report fraud, waste, and abuse. **Scoring: 2** - Code of conduct is in place and evidence supports its adoption in the organization. **1** - Code of conduct has been developed or accepted from SWMBH, but efforts are not being made to make staff aware of its content or purpose. **0** - No code of conduct in place.
1.3 Staff know what to do if they suspect Medicaid fraud or abuse within the organization.	*Deficit Reduction Act; Patient Protection & Affordable Care Act of 2010; HealthCare & Education Reconciliation Act of 2010*	**Supporting Evidence**: Interviews with staff members. Scoring: **2** - Staff consistently know who to report possible Medicaid fraud and abuse to, various ways to report (phone, email, etc.). **1** - Not all staff interviewed knew who or how to report possible Medicaid fraud and abuse. **0** - Staff appear to be unaware of Medicaid fraud and abuse reporting.
SECTION 2 - QUALITY IMPROVEMENT		
2.1 Plan(s) for Improvement in response to citations / recommendations from the most recent reviews (licensing, MDHHS, PIHP or accrediting body, etc.) has been submitted to the appropriate agency.	*Provider Contract requirement*	**Supporting Evidence:** Plan(s) for improvement submitted to monitoring agencies complete with dates and corrective action plans. **Scoring: 2** - Plan(s) complete and submitted within time frames, or no recommendations or citations from recent reviews. **1** - Plan(s) does not address all items for correction or not completed within time frames. **0** - No response has been implemented to citations/recommendations from recent reviews.
2.3 All citations by PIHP, CMH and MDHHS BH/IDD or licensing divisions have been corrected.	*Provider Contract requirement*	**Supporting Evidence:** Documentation of trainings conducted, repairs made, changes made to policies, forms, procedures, etc., as identified in corrective action plan(s). **Scoring: 2** - Follow up complete and done within time frames, or no recommendations or citations from recent reviews. **1** - Improvements address most, but not all, items cited for correction, or not completed within time frames. **0** - No response or very limited response implemented to address citations/recommendations and due date is past.

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2.4 Strategies to prevent the same incident from reoccurring are consistently documented in incident reports. Addendums to the individual plans of service are developed to address trends/concerns identified, as needed.	*AFC Licensing Rules R 400.14311*	**Supporting Evidence:** Incident reports from the three months prior to the on-site review will be reviewed (the CMH will review incident reports for their customers only). Incident reports will be reviewed to determine if they describe specific actions that the organization will take to prevent incidents from re-occurring. If trends or concerns are identified in incident reports, the reviewer will request to see that plan addendums were developed to address them. **Scoring: 2** - Incident reports consistently describe actions that the organization will take to prevent incidents from re-occurring. If trends or concerns are identified in incident reports, plan addendums are developed to address them. **1** - Incident reports describe actions that the organization will take to prevent incidents from re-occurring, with 1-2 exceptions. **0** - Follow up responses in incident reports are frequently vague or identified trends/concerns not thoroughly addressed as needed with plan addendums.
2.5 Documentation is present to support that individual's choices are implemented, when possible. This includes (but is not limited to) choices in meals and room decorations.	*MDHHS Contract Consumerism Attachment P.7.10.2.3* *DHHS Site Visit Protocol A.1*	**Supporting Evidence:** Evidence of resident choice in meal and activity selections and room decoration. Evidence of response to other requests made by customers. Other possibilities: inclusion of customers on staff, board, or committees; Consumer advisory meetings or resident meetings; Action taken in response to satisfaction survey results or comment boxes; **Scoring: 2** -Documentation is present to support that individuals' choices are implemented, when possible. **1** - There is evidence that customers choices are implemented in some areas but not all (e.g., room decoration but not food choices). **0** - neither of the above
SECTION 4 - FACILITY & MAINTENANCE (If applicable - when customers are served at a provider-owned location)		
4.3 Facility Grounds & Premises - driveway, surrounding yard areas, detached structures appear well maintained and free of obvious, litter, refuse, etc. (note: roof, exterior walls, doors, windows/screens, stairways, sidewalks, attached structure, etc.).	*DHHS Site Review Protocol D.3*	**Supporting Evidence:** The site review team will verify through a tour of the outside of the site that the facility is structurally sound and maintained in a safe condition for the occupants. **Scoring: 2** - Facility and premises well-maintained and in good condition. **1** - Facility and premises in need of minor repairs (<~$1000) or maintenance. **0** - Facility and premises in need of major repairs or maintenance (>~$1000).
4.4 Exits, corridors and hallways are free of obstruction.	*DHHS Site Review Protocol D.3*	**Supporting Evidence:** The site review team will verify through a tour of the site that exits, corridors, and hallways are free of obstruction to allow for safe ambulation for the occupants and emergency evacuation. **Scoring: 2** - Exits, corridors, and hallways are free of obstruction. **1** - Exits, corridors, and hallways have an obstruction that can be permanently corrected while review team is on site (example - moving a laundry basket). **0** - Exits, corridors, and hallways have multiple areas of obstruction, or at least one obstruction that requires planning by the facility for permanent correction (example - moving a Hoyer lift to a more practical location)
4.5 Facility Interior/Cleanliness - safe and sanitary environment is maintained throughout the facility (furnishings, flooring, walls, smells, cleanliness, housekeeping standards, etc.).	*DHHS Site Review Protocol D.3*	**Supporting Evidence:** The site review team will verify through a tour of the inside of the site that the facility is structurally sound and maintained in a safe condition for the occupancies. **Scoring: 2** - The interior is well-maintained and clean. **1** - The interior is in need of minor repairs, maintenance or cleaning (e.g., repairs/maintenance <~$1000, minor cleaning/housekeeping needs that could be alieved in an hour or less). **0** - The interior is in need of major repairs, maintenance or cleaning (e.g., repairs/maintenance >~$1000, cleaning/housekeeping needs that would take more than an hour to accomplish).

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4.6 Maintenance of Facility - there is evidence that maintenance issues are being appropriately addressed (invoices for repair / inspection / replacement of equipment, utilities, evidence of facility improvements, etc.).	*DHHS Site Review Protocol D.3*	**Supporting Evidence:** The site review team will verify through a review of maintenance records and site tour that facility and equipment upkeep is being adequately addressed. **Scoring: 2** - Equipment and appliances on the site are in good repair; fire alarms are tested and batteries replaced bi-annually, fire extinguishers are replaced when expired. **1** - One or two minor maintenance issues identified. **0** - More than two minor maintenance issues were identified, or one or more substantial issue.
4.7 Cleaning - supplies are stored in a safe location with restricted access.	*AFC Licensing Rules R400.14402-6 (SGH)*	Supporting Evidence: The site review team will verify that potentially dangerous cleaning materials (harsh cleansers, bleach, etc.) are stored and safeguarded in areas away from residents, with restricted access. Scoring: 2 - All potentially hazardous cleaning supplies are stored in a safe location with restricted access. 1 - Some potentially hazardous cleaning supplies are left accessible in areas where residents could access them. 0 - Cleaning supplies are all kept in a location where residents can access them.
4.8 Pets - if an agency has a pet or therapy animal on the premises, vaccination records should be available for review.	*DHHS site review*	Supporting Evidence: The site review team will verify through review of pet records that pet is free of communicable disease and vaccinations are current (N/A for homes without pets). Scoring: 2 - Veterinary/vaccination records kept on site and are current. 0 - Veterinary records not on site or not current.
SECTION 5 - MEDICATION MANAGEMENT (For providers who are dispensing medication)		
5.4 Medication supplies are stored in the container received from the pharmacy and stored in a locked location.	*AFC Licensing Rules R400.14312 (SGH); R400-1418 (FH)*	**Supporting Evidence:** The site review team will verify that medication supplies are stored in the container received from the pharmacy and stored a locked location. **Scoring: 2** - All medication supplies are stored in the container received from the pharmacy and stored a locked location. **1** - Some medications not stored in pharmacy container but still clearly labeled with name, medication, dosage, and dosing information. **0** - Medications not stored in locked area or consistently stored in non-pharmacy containers.
5.5 Topical/inhalant medications are maintained separately from oral medications.	*DHHS Recommendation from Site Review*	**Supporting Evidence:** The site review team will verify that topical/inhalant medications are maintained separately from oral medications. (N/A if no topical/inhalant medications used) **Scoring: 2** - All topical/inhalant medications are maintained separately from oral medications. **1** - Topical/inhalant medications are maintained separately from oral medications with 1-2 exceptions. **0** - No topical/inhalant medications are maintained separately from oral medications.
5.6 A provider shall record the administration of all medication in the recipient's clinical record, including 1) the dosage; 2) label instructions for use; 3) time to be administered; 4) the initials of the person who administers the medication, which shall be entered at the time the medication is given; 5) a resident's refusal to accept prescribed medication or procedures.	*Michigan Mental Health Code R 330.7158*	**Supporting Evidence:** The site review team will review at least 2 months' medication logs, medication containers, and physician instructions to ensure completeness and accuracy of information. **Scoring: 2** - Medication logs appear to be completed fully and accurately. **1** - One to two minor errors are evident on medication logs such as failure to initial a medication administration that is otherwise documented. **0** - Multiple (more than two) errors or potentially harmful error(s) noted.

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5.7 A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported and recorded.	*Michigan Mental Health Code R 330.7158*	**Supporting Evidence:** The site review team will review at least 2 months' medication logs, medication containers, and physician instructions to ensure completeness and accuracy of information. Medication errors should be appropriately reported. Medication errors with the potential for adverse reactions should be reported to the prescriber of the medication, such as if a person didn't get blood thinners, cardiac medications, or insulin; or if those types of medications were given to the wrong person. Other types of medication errors that could result in less serious adverse health reactions should be reported to poison control, or the pharmacy. One missed multivitamin, OTC medication, other non-essential medications for health such as anxiety medication do not require reporting to poison control or pharmacy. All medication errors must be noted in an incident report and in the person's record. **Scoring: 2** - Medication error(s)/refusal(s) properly documented with appropriate follow up (e.g., contact to physician and documentation of instructions). **1** - One to two minor errors. **0** - Multiple (more than two) errors or potentially harmful error(s) noted. This item is N/A if no medication refusals or medication errors.
5.8 Sharps Disposal - container is on site if sharps are being used in the facility.	*OSHA Bloodborne Pathogens standard (29 CFR 1910.1030)*	**Supporting Evidence:** The site review team will verify that containers are clearly labeled as Bio-Hazard and kept in a secure area (for specialized residential) or in secure containers. (N/A if no sharps being used) **Scoring: 2** - Sharps containers are being used which are clearly labeled as Bio-Hazard and kept in a secure area or secure containers. **1** - Sharps containers are being used and kept in a secure area/secure containers, but are not clearly labeled as Bio-Hazard. **0** - Sharps containers not being used, or being used but not kept in a secure area or in secure containers.
SECTION 6 - EMERGENCY RESPONSE (If applicable - when customers are served at a provider-owned location)		
6.1 Program has a comprehensive set of written Emergency Response Procedures containing clear instructions in response to fire, severe weather, medical emergencies, the plan for the continuation of services and emergencies while transporting individuals served, if applicable.	*DHHS Site Review Protocol D.3 AFC Licensing Rules R400.14318 (SGH); R400.1438 (FH)*	**Supporting Evidence:** Written procedures. **Scoring: 2** - Procedures are clear and address each of the following - response to fire, severe weather, and medical emergencies; a plan for the continuation of services in event of emergency, and a plan for transporting individuals in the event of an emergency. **1** - Procedures do not address one of the required elements or are not clear. **0** - Procedures do not address two or more of more of the required elements.
6.2 Emergency evacuation maps/routes are displayed in prominent locations at the facility (when customers are served at a provider-owned location)	*DHHS Site Review Protocol D.3*	**Supporting Evidence:** Posted evacuation routes with exiting route specified. **Scoring: 2** - Map(s) posted prominently with specified exiting route(s) marked. **1** - Map(s) not posted prominently or do not clearly mark exiting route(s). **0** - No map(s) posted.
6.3 Fire drills (various shifts) are conducted per requirements and are properly documented and evaluated.	*AFC Licensing Rules R400.14318(5) and Suppl #4 DMH Adm; Rules R330.1803 #3, #5 & #6*	Supporting Evidence: Log of drills along with documentation of result of drill and corrective action planned if necessary. Scoring: 2 - Emergency drills (typically fire drills but may be other types) occur and are documented during daytime, evening, and sleeping hours at least once per quarter. Follow up actions are documented and implemented as necessary at least 95% of the time. 1 - No more than one missed drill in the past year. Follow up actions are documented and implemented as necessary at least 75% of the time. 0 - More than one missed drill in the past year. Follow up actions documented and taken less than 75% of the time.

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6.4 Tornado drills (at least once per year) are properly documented and evaluated.	*Historical interpretation of AFC Licensing Rules R400.1438 (SGH); R400.1438 (FH)*	Supporting Evidence: Log of drills along with documentation of result of drill and corrective action planned if necessary. Scoring: 2 - At least one tornado drill occurred over the past year. If corrective action needed, follow up action was documented and made. 1 - At least one tornado drill occurred, but there was necessary follow up action which did not occur. 0 - No tornado drills in the past year.
6.5 First Aid & Spill Kits available and in good condition.	*DHHS Recommendation from Site Review*	Supporting Evidence: Kits. Items sealed or replaced when used. Scoring: 2- Both first aid and spill kits available, and both in good condition. 1 - One type of kit unavailable or in poor condition. 0 - Neither type of kit available or both in poor condition. *adjust the kit to meet the healthcare needs of your clients, *replace items that are used, *keep first aid kits in company vehicles (portable ones) □ Adhesive bandages, various sizes □ 2 x 2 and 4 x 4 sterile dressings □ Conforming roller gauze bandage □ Triangular bandages □ 3 x 3 sterile gauze pads □ 4 x 4 sterile gauze pads □ Roll 3" cohesive bandage □ Germicidal hand wipes or waterless alcohol-based hand sanitizer □ Antiseptic wipes □ (2) pairs large medical grade non-latex gloves □ Adhesive tape, 2" width □ Anti-bacterial ointment □ Cold pack □ CPR breathing barrier, such as a face shield □ Blood spill kit
6.6 Carbon monoxide detectors are present and in working order.		Supporting Evidence: Kits. Items sealed or replaced when used. Scoring: 2- Both first aid and spill kits available, and both in good condition. 1 - One type of kit unavailable or in poor condition. 0 - Neither type of kit available or both in poor condition.
6.7 Emergency Evacuation Bag kept in an accessible area and equipped with items that can be of assistance in case of an emergency evacuation (i.e., emergency contact #s including guardians, water, food, FA supplies, blankets, flashlights, portable radio, batteries, etc., all with current expiration dates).	*DHHS Recommendation from Site Review*	Supporting Evidence: Bag. Emergency bags are complete, consumer profiles are present and contain current information, food items are labeled with expiration dates and the emergency bags are monitored to ensure that foods are removed prior to the date of expiration. Scoring: 2- Bag present with all necessary items accounted for, with good expiration dates and in good condition. 1 - Bag present but some items in poor/expired condition. 0 - No bag, or bag present but some items missing or in insufficient quantities to meet all residents' needs.
SECTION 7 - TRAINING		
A - All Direct Service Staff		
7.A.1 Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) (within 30 days of hire; annual update thereafter).	*MH Code: 330.1755(5)(f)*	**Supporting Evidence:** For all training and personnel items, the review team will verify by a review of staff personnel files or training records. **Scoring: 2** - 95-100% of staff selected completed each required training item within the stated timeframes. **1** - 75-94.4% of staff completed the required training item within the stated timeframes. **0** – Less than 75% of staff have completed the training within the stated timeframes.

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7.A.2 Person-Centered Planning (aka Individualized Service Planning) (within 60 days of hire; annual update thereafter).	*MDHHS Master Contract Attachment P.4.4.1.1*	**Supporting Evidence:** For all training and personnel items, the review team will verify by a review of staff personnel files or training records. **Scoring: 2** - 95-100% of staff selected completed each required training item within the stated timeframes. **1** - 75-94.4% of staff completed the required training item within the stated timeframes. **0** – Less than 75% of staff have completed the training within the stated timeframes.
7.A.3 Cultural Diversity / Competency / Awareness (within 6 months of hire; annual update thereafter).	*MDHHS Master Contract Part II(A); 4.5* *42 CFR 438.206*	
7.A.4 Blood borne Pathogens (Preventing Disease Transmission, Infection Control) (within 30 days of hire; annual update required).	*MIOSHA R 325.70016*	
7.A.5 Limited English Proficiency (LEP) (within 6 months of hire).	*MDHHS Master Contract Part I; 18.16* *Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination*	
7.A.6 HIPAA (within 30 days of hire).	*45 CFR 164.308(a)(5)(i) &* *45 CFR 164.503.(b)(1)*	
7.A.7 Corporate Compliance (within 30 days of hire; annual update thereafter).	*Medicaid Integrity Program (MIP)* *Deficit Reduction Act (DRA)*	
7.A.8 Individual Plans of Service and Ancillary Plans (there is evidence that staff have been trained in the IPOS and in any applicable Support Plan for Individuals in their care before the provision of direct care [Behavior Treatment Plan, PT, OT, Nursing, etc.]).	*Michigan Mental Health Code 330.1708*	**Supporting Evidence:** Staff meeting minutes, training sign-ins, staff files. **Scoring: 2** - 95-100% of staff selected completed each required training item within the stated timeframes. **1** - 75-94.4% of staff completed the required training item within the stated timeframes. **0** – Less than 75% of staff have completed the training within the stated timeframes.
7.A.9 Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior (MDHHS approved curriculum if restricted interventions included) (within 30 days of hire and annual updates, if working with individuals with challenging behavior)	*MDHHS Master Contract Attachment P.1.4.1 and R 330.1806*	
7.A.10 Customer Services within 30 days of hire and annually for all in the following roles: - Psychiatrists/Nurses- - Peer support specialists - Recovery coaches - Reception staff - Service supervisors/directors of the above listed staff - Minimum one person per site for all other services (MH and SUD)	*MDHHS Master Contract Attachment P.1.4.1 and R 330.1806* *42 CFR 438.400-424* *MDHHS Master Contract Attachment P 6.3.1.1*	
B - Specialized Residential Services		
7.B.1 CPR (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years).	*R 400.14204*	Supporting Evidence: For all training items, the review team will verify by a review of staff personnel files or training records. Scoring: 2: 95-100% of staff selected completed each required training item within the stated timeframes. 1: 75-94.4% of staff completed the required training item within the stated timeframes. 0 – Less than 75% of staff have completed the training within the stated timeframes.
7.B.2 First Aid (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years). BHT Behavior Technicians must have first aid certifications.	*Medicaid Provider Manual 2.4*	Supporting Evidence: For all training items, the review team will verify by a review of staff personnel files or training records. Scoring: 2: 95-100% of staff selected completed each required training item within the stated timeframes. 1: 75-94.4% of staff completed the required training item within the stated timeframes. 0 – Less than 75% of staff have completed the training within the stated timeframes.

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7.B.16	Role of Direct Care Workers/Working with People (prior to working independently with customers or as lead staff; or within 90 days of hire).	*Specialized Residential Licensing Rules R 330.1806*	Supporting Evidence: For all training items, the review team will verify by a review of staff personnel files or training records. Scoring: 2: 95-100% of staff selected completed each required training item within the stated timeframes. 1: 75-94.4% of staff completed the required training item within the stated timeframes. 0 – Less than 75% of staff have completed the training within the stated timeframes.
7.B.17	Health Administration (prior to working independently with customers or as lead staff; or within 90 days of hire).	*Specialized Residential Licensing Rules R 330.1806*	
7.B.18	Medication Administration (prior to working independently with customers or as lead staff; or within 90 days of hire).	*Specialized Residential Licensing Rules R 330.1808*	
7.B.19	Nutrition (prior to working independently with customers or as lead staff; or within 90 days of hire).	*Specialized Residential Licensing Rules R 330.1809*	
7.B.20	Emergency Preparedness (prior to working independently with customers or as lead staff; or within 90 days of hire).	*Specialized Residential Licensing Rules R 330.1810*	
7.B.21	Introduction to Special Needs MI/DD (prior to working independently with customers or as lead staff; or within 90 days of hire).	*Specialized Residential Licensing Rules R 330.1811*	
SECTION 8 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS CAFAS/PECFAS training (prior to administering and booster every two years - CMHPs)			
8.4	Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire using the protocol required by SWMBH policy 2.16, including documentation of approval of waiver for employees with exclusionary convictions.	*Contract Requirement; Public Act 59 (PA 218 400.734a); 5) AFC Licensing Rules: R.400.14201.13 (SGH); R.400.1404.6 (FH); PIHP Policy 2.16*	**Supporting Evidence:** The review team will verify by a review of staff personnel files that AFCs and hospitals are using the Michigan Workforce Background Check System and that each employee was registered prior to hire. For other services, it will be verified through a review of files that criminal background checks were completed prior to hire and bi-annually thereafter. Documentation of approved waiver must be present for employees with exclusionary convictions. If the Michigan Workforce Background Check System is being used, annual checks are not needed. **Scoring: 2** - 95-100% of staff selected meet criteria and have required documentation. **1** - 75-94.4% of staff selected meet criteria and have required documentation. **0** – Less than 75% staff selected meet criteria and have required documentation. Note: For AFCs and inpatient, if hired prior to 2001, there was no criminal background check requirement prior to hire; however, annual checks were required from 2001 forward unless exempt. Finger printing became required in 2006.
8.5	Driver's License: A) there is documented evidence of verification of status of driver's license at the time of hire and B) ongoing monitoring of the status of the driver's license of every staff member who transports persons served.	*SWMBH Contract requirement*	**Supporting Evidence:** The review team will verify by a review of staff personnel files that driver's license checks have been completed prior to hire and annually thereafter for staff who transport persons served. **Scoring: 2** - 95-100% of staff selected meet criteria and have required documentation. **1** - 75-94.4% of staff selected meet criteria and have required documentation. **0** – Less than 75% staff selected meet criteria and have required documentation.

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8.6	Personnel Performance Management: there is documented evidence that program has an adequate system to support, monitor and complete at least annual performance evaluations of staff who provide direct care services.	*DHHS Site Visit Protocol B.1.3, 4.4.2(e), 5.4.2, 6.4.2, 7.4.1, 8.3.2*	**Supporting Evidence:** The review team will verify by a review of staff personnel files that performance evaluations are completed minimally on an annual basis. The team will verify through interview and review supervision notes (if applicable) that the organization has a system in place for the clinical supervision of clinical staff members. **Scoring: 2** - 95-100% of staff selected had an annual performance evaluation; the organization has a system in place for providing clinical supervision to credentialed staff. **1** - 75-94.4% of staff selected had an annual performance evaluation and the organization has a system in place for providing clinical supervision to credentialed staff. **0** – Less than 75% staff selected had an annual performance evaluation; or the organization does not have a system in place for providing clinical supervision to credentialed staff.
8.7	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each employee is to be run through OIG and SAM exclusion databases prior to hire and annually thereafter.	*PIHP Policy 10.13*	**Supporting Evidence:** The review team will verify by a review of staff personnel files that monitoring for exclusion from federal healthcare programs occurs prior to hire and annually thereafter. (Note - individuals with controlling interests in the organization may have ongoing OIG exclusion checks run through SWMBH's compliance dept. If it's confirmed that SWMBH has been supplied with all necessary information to run the checks, full credit should be given for those individuals for OIG screening). **Scoring: 2** - 95-100% of staff selected meet criteria and have required documentation. **1** - 75-94.4% of staff selected meet criteria and have required documentation. **0** – Less than 75% staff selected meet criteria and have required documentation.
SECTION 9 - HOME AND COMMUNITY BASED SERVICES - CONSULTATIVE			
9.1	*Residents have access to their personal funds.*	*DHHS site visit 42 CFR Part 430, 431 et al.*	***Standards:*** *Customers can control their own resources and finances and access their money if desired.* ***Methods:*** *Discussions with customers* ***Sample Probing Questions*** *• Do you have the option of having personal bank accounts?* *• How does the facility ensure recipients have access to their funds when they want access?*
9.2	*Does each individual have a residential agreement for the residential setting, which is in compliance with the Resident Care Agreement BCAL- 3266 requirement?*	*DHHS site visit 42 CFR Part 430, 431 et al.*	***Standards:*** *The customer has landlord/tenant protections, is protected from eviction and afforded appeal rights just as persons not receiving Medicaid HCB services.* ***Methods:*** *Discussion with provider and customer.* ***Sample Probing Questions*** *• Does the recipient have a current residency agreement using the LARA approved form?* *• Do customers know their housing rights?* *• Is there an appeal process for 30-day notices?*
9.3	*Can individuals close and lock their bedroom and bathroom doors (with locks that may be unlocked from the inside with one turn of the doorknob)?*	*DHHS site visit 42 CFR Part 430, 431 et al.*	***Standards:*** *Customers have the right to privacy including lockable doors to their living quarters unless the recipient's physical or cognitive condition means their safety could be compromised if afforded privacy. Reasons to impede a person's right to privacy are fully and accurately documented in the assessment and treatment plan.* ***Methods:*** *Observation and discussions with customers.* ***Sample Probing Questions*** *• Does the recipient's room and bathroom have a locking door?* *• Can the recipient's room and bathroom be unlocked from the inside with one turn of the handle?*

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9.4 Do individuals have options for who provides their supports and services within the home?	*DHHS site visit* *42 CFR Part 430, 431 et al.*	***Standards:*** *Customers have input into who provides their personal care and other supports and services.* ***Methods:*** *Discussions with provider and customers.* ***Sample Probing Questions*** *• Do individuals have choices regarding who provides their personal care or other supports?* *• Are options available to individuals regarding who provides their personal care or other supports?*
9.5 Do individuals arrange and control their personal schedule of daily appointments and activities?	*DHHS site visit* *42 CFR Part 430, 431 et al.*	***Expectation:*** *Customers are allowed to choose how to spend their day including their sleeping schedule (e.g., wake up and bedtimes, scheduled or unscheduled naps) and are allowed to vary their schedule at will in accordance with their person-centered plan.* ***Methods:*** *Observation.* ***Sample Probing Questions*** *• How does the facility ensure a recipient knows they do not have to follow a prescribed schedule for activities of daily living and social activities?*
9.6 Does the setting place restrictions on an individual's ability to come and go from the home setting?	*DHHS site visit* *42 CFR Part 430, 431 et al.*	***Standards:*** *Customers have full access to the community and are allowed to come and go from the facility, as they desire, unless the recipient's safety would be jeopardized. Home is free of gates, locked doors, or other ways to block entering/exiting. Reasons to restrict movement are documented in the facility's recipient record. Attempts to mitigate safety issues prior to revoking a recipient's right to freedom of movement are documented in the assessment and treatment plan.* ***Methods:*** *Observation and discussions with provider and customers.* ***Sample Probing Questions*** *• Are customers able to come and go from the facility and its grounds when they wish?* *• Does the facility impose a curfew, or otherwise restrict customers' ability to enter or leave the facility at will?*
9.7 Is accessible transportation available for individuals to make trips within the community?	*DHHS site visit* *42 CFR Part 430, 431 et al.*	***Standards:*** *Transportation is provided or arranged to community activities such as shopping, restaurants, religious institutions, senior centers, etc. The facility should have a policy for requesting transportation and customers should be made aware of the policy.* ***Methods:*** *Discussion with provider. Observe sign-up sheets, instructions on how to request transportation, etc.* ***Sample Probing Questions*** *• Provide/describe the facility's policies and procedures regarding transportation to community activities?*