



# 2024 DD Inspections Kickoff Training

Preparing Licensed Providers of Developmental Services for the 2024 Annual Inspection Process



- **Mackenzie Glassco, Associate Director of Quality & Compliance**
    - [Mackenzie.Glassco@dbhds.virginia.gov](mailto:Mackenzie.Glassco@dbhds.virginia.gov)
  - **Karen Matthews, Quality Improvement Review Specialist**
    - [Karen.Matthews@dbhds.virginia.gov](mailto:Karen.Matthews@dbhds.virginia.gov)
  - **Larisa Terwilliger, Training Coordinator**
    - [Larisa.Terwiliger@dbhds.virginia.gov](mailto:Larisa.Terwiliger@dbhds.virginia.gov)
- 



# Jae Benz

## Director of Licensing

**Department of  
Behavioral Health and  
Developmental Services  
(DBHDS)**

**Office of Licensing**



**Mission:**

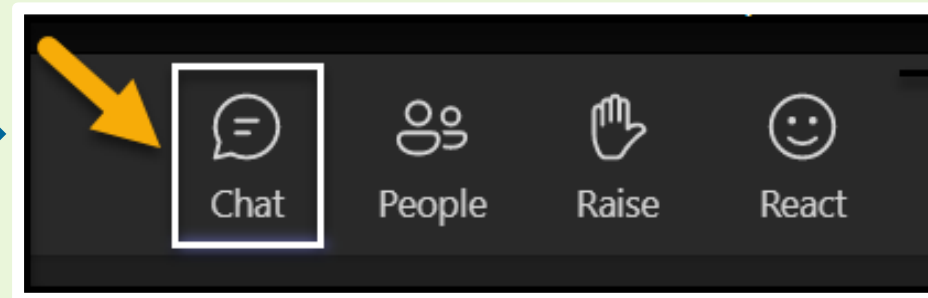
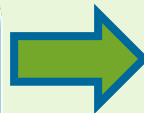
To be the regulatory authority for DBHDS licensed service delivery systems through effective oversight.



**Vision:**

The Office of Licensing will provide consistent, responsive, and reliable regulatory oversight to DBHDS licensed providers by supporting high quality services to meet the diverse needs of its clients.

Use the Chat feature to access the link for the 'Q&A' session.



Training video and PowerPoint presentation will be posted on the Office of Licensing website.

Thank you for participating in the Q&A portion of the 2024 DD Inspections Kickoff Training!

Please enter your questions below. Questions will be answered by an Office of Licensing representative during the Q&A portion of today's training.

1. Please type your question here. If you have multiple questions, please submit each question separately.

Enter your answer

Submit

## Be Informed

- about Office of Licensing expectations for providers related to 2024 Developmental Services Inspections

## Understand

- the minimum regulations being reviewed

## Be Familiar

- with Office of Licensing resources and training materials and how to locate them

## Be Confident

- that your agency can achieve success with your 2024 Developmental Services Inspection!



# DOJ Settlement Agreement

**The Commonwealth of Virginia continues to be tasked with showing progress towards coming into compliance with the Commonwealth's Settlement Agreement with the United States Department of Justice as well as complying with inspections requirements pursuant to Virginia Code and DBHDS Licensing Regulations. Providers of developmental services will receive an annual unannounced inspection each calendar year.**



Measure	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22	Q1FY23	Q2 FY23	Q3 FY23	Q4 FY23	Q1 FY24
<b>Goal</b>	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%
Designated person with training or experience responsible for risk management function	80%	75%	75%	76%	81%	78%	72%	66%	90%	80%	73%
Implements a written plan	90%	88%	91%	87%	86%	87%	88%	89%	90%	84%	85%
Conducts annual systemic risk assessment	90%	83%									
- environment of care	89%	82%	84%	77%	90%	88%	83%	79%	89%	87%	82%
- clinical assessment/reassessment	86%	75%	80%	77%	88%	84%	80%	80%	84%	87%	80%
-staff competence / adequacy of staffing	88%	75%	79%	77%	90%	85%	82%	80%	83%	85%	79%
- use of high risk procedures	86%	73%	79%	74%	87%	82%	80%	74%	85%	84%	78%
- review of serious incidents	90%	80%	83%	83%	91%	87%	83%	83%	89%	86%	77%
Systemic risk assessment incorporates risk triggers and thresholds	88%	71%	76%	83%	79%	76%	75%	68%	85%	78%	69%
Conducts annual safety inspection	93%	87%	92%	82%	89%	95%	92%	91%	97%	95%	92%





Measure		Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4FY22	Q1 FY23	Q2 FY23	Q3FY23	Q4FY23	Q1 FY24
Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	620A	90%	91%	94%	93%	93%	94%	94%	94%	93%	94%	91%
The QI program uses standard QI tools, including RCA and has a QI plan	620B	90%	85%	92%	92%	93%	93%	92%	89%	91%	88%	87%
The QI Plan shall:	620C	93%	90%									
- Be reviewed and updated annually	620C1	83%	78%	82%	71%	84%	86%	84%	89%	89%	87%	76%
- Define measurable goals and objectives	620C2	81%	75%	80%	74%	80%	86%	81%	84%	89%	82%	74%
- Include & report on statewide measures	620C3	92%	71%	92%	94%	88%	94%	89%	100%	100%	70%	87%
- Monitor implementation & effectiveness of approved CAPs	620C4	76%	70%	79%	67%	72%	78%	79%	79%	80%	77%	65%
- Include ongoing monitoring and evaluation of progress toward meeting goals	620C5	79%	76%	81%	71%	76%	82%	82%	81%	87%	82%	70%
The providers P&P includes criteria used to:	620D	88%	86%									
- Establish measureable goals & objectives	620D1	78%	72%	75%	73%	84%	84%	88%	86%	84%	82%	83%
- Update the QI plan	620D2	76%	73%	79%	70%	89%	86%	86%	90%	90%	88%	85%
- Submit revised CAPs when not effective	620D3	68%	63%	68%	66%	77%	78%	79%	75%	81%	75%	74%
Input from individuals about services & satisfaction	620E	81%	77%	85%	86%	78%	81%	87%	80%	92%	89%	82%



The Commonwealth shall ensure that the licensing process assesses the adequacy of supports and services provided to individuals with Developmental Disabilities receiving services licensed by DBHDS.

The Office of Licensing developed the Compliance Determination Chart, a crosswalk that ties the eight domains outlined in the settlement agreement to specific (corresponding) regulations.



All regulations listed in the crosswalk are reviewed and given a compliance rating during every annual inspection.



Domain	All Services <u>Except</u> Case Management for Individuals with Developmental Disabilities		Case Management Services for Individuals with Developmental Disabilities	
	Corresponding Regulations to be Checked for Compliance	Corresponding Documents Required to be Reviewed	Corresponding Regulations to be Checked for Compliance	Corresponding Documents Required to be Reviewed
<p><b>Safety and Freedom from Harm</b></p> <p>Settlement Agreement (SA) <b>examples</b> include neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations)</p>	<ul style="list-style-type: none"> <li>12VAC35-105-160.C</li> <li>12VAC35-105-160.D.2</li> <li>12VAC35-105-160.E</li> <li>12VAC35-105-665A.6</li> <li>12VAC35-105-780(5)</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly reviews of all serious incidents including Level I, Level II and Level III incidents</li> <li>Progress Notes</li> <li>Root cause analysis for Level II and Level III serious incidents.</li> <li>Root Cause Analysis policy</li> <li>Parts I-V of ISP including safety plan and falls risk plan</li> <li>Quarterly reviews of medication errors</li> </ul>	<ul style="list-style-type: none"> <li>12VAC35-105-160.C</li> <li>12VAC35-105-160.D.2</li> <li>12VAC35-105-160.E</li> <li>12VAC35-105-665A.6</li> <li>12VAC35-105-1240 (7)</li> <li>12VAC35-105-1240 (12)</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly reviews of all serious incidents including Level I, Level II and Level III incidents</li> <li>Root cause analysis for Level II and Level III serious incidents.</li> <li>Root Cause Analysis policy</li> <li>Parts I-V of ISP including safety plan and falls risk plan</li> <li>Clear documentation that at each face to face meeting the CM is documenting that services are being provided in accordance with individual's ISP</li> <li>Informed choice form</li> </ul>
<p><b>Physical, Mental and Behavioral Health and Well-Being</b></p> <p>SA <b>examples</b> include access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status)</p>	<ul style="list-style-type: none"> <li>12VAC35-105-675A</li> <li>12VAC35-105-675B</li> <li>12VAC35-105-675C</li> <li>12VAC35-105-810</li> </ul>	<ul style="list-style-type: none"> <li>Re-assessments completed because of changes in status</li> <li>Changes made to the ISP as a result of a reassessment</li> <li>Quarterly reviews</li> <li>Behavior plan, assessment that plan was based on</li> <li>Documentation to show staff was trained on plan, date, by whom</li> </ul>	<ul style="list-style-type: none"> <li>12VAC35-105-1240(1)</li> <li>12VAC35-105-1240(4)</li> <li>12VAC35-105-1240 (11)</li> </ul>	<ul style="list-style-type: none"> <li>CM notes showing individual linked to services as identified in assessments or steps to show making attempts</li> <li>CM notes showing monitoring of individual's conditions and medications; accessing medical services</li> </ul>

Domain	All Services <u>Except</u> Case Management for Individuals with Developmental Disabilities		Case Management Services for Individuals with Developmental Disabilities	
	Corresponding Regulations to be Checked for Compliance	Corresponding Documents Required to be Reviewed	Corresponding Regulations to be Checked for Compliance	Corresponding Documents Required to be Reviewed
<p><b>Avoiding Crises</b> SA <b>examples</b> include Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system)</p>	<ul style="list-style-type: none"> <li>12VAC35-105-665.A.7</li> </ul>	<ul style="list-style-type: none"> <li>Crisis/relapse plan as appropriate for individual and incorporated into ISP</li> </ul>	<ul style="list-style-type: none"> <li>12VAC35-105-665A.7</li> </ul>	<ul style="list-style-type: none"> <li>Crisis/relapse plan as appropriate for individual and incorporated into ISP</li> <li>REACH referral and service-specific plans as a resources for preventing and managing crises events</li> </ul>
<p><b>Stability</b> This domain will be measured through QSR</p>	<ul style="list-style-type: none"> <li>This is measured by crisis services</li> </ul>		<ul style="list-style-type: none"> <li>12VAC35-105-1245</li> </ul>	<ul style="list-style-type: none"> <li>Completed Onsite Visit Tool (OSVT)</li> </ul>



Domain	All Services <u>Except</u> Case Management for Individuals with Developmental Disabilities		Case Management Services for Individuals with Developmental Disabilities	
	Corresponding Regulations to be Checked for Compliance	Corresponding Documents Required to be Reviewed	Corresponding Regulations to be Checked for Compliance	Corresponding Documents Required to be Reviewed
<p><b>Choice and Self-Determination</b></p> <p>SA <b>examples</b> include service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services</p>	<ul style="list-style-type: none"> <li>12VAC35-105-660.D.3</li> <li>12VAC35-105-675.D.3</li> </ul>	<ul style="list-style-type: none"> <li>For changes made to the ISP (part V) there should be documentation at the provider level that regulatory requirements were met (notes attached to ISP etc.)</li> <li>Signature sheet for ISP; and</li> <li>Quarterly reviews with required signatures</li> </ul>	<ul style="list-style-type: none"> <li>12VAC35-105-660.D.1</li> <li>12VAC35-105-660.D.2</li> <li>12VAC35-105-660.D.3</li> <li>12VAC35-105-675.D.3</li> <li>12VAC35-105-1255</li> </ul>	<ul style="list-style-type: none"> <li>Informed choice for annual ISP development</li> <li>Documentation if no alternative services are available</li> <li>For changes made to the ISP (Part V) there should be documentation at the provider level that regulatory requirements were met (notes, attached to ISP etc.)</li> <li>Signature sheet for ISP; and</li> <li>Quarterly reviews with required signatures</li> <li>Policy describing how individuals are assigned case managers and how they can request a change</li> </ul>
<p><b>Community Inclusion</b></p> <p>SA <b>examples</b> include community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals</p>	<ul style="list-style-type: none"> <li>12VAC35-105-610</li> </ul>	<ul style="list-style-type: none"> <li>Proof of participation in community activities in accordance with the individual's ISP.</li> <li>This applies to residential and day support services</li> </ul>	<ul style="list-style-type: none"> <li>12VAC35-105-1240.4</li> </ul>	<ul style="list-style-type: none"> <li>Documentation showing individual linked to supports consistent with the ISP; and</li> <li>Documentation that the case manager located, developed, or obtained needed services.</li> </ul>



Domain	All Services <u>Except</u> Case Management for Individuals with Developmental Disabilities		Case Management Services for Individuals with Developmental Disabilities	
	Corresponding Regulations to be Checked for Compliance	Corresponding Documents Required to be Reviewed	Corresponding Regulations to be Checked for Compliance	Corresponding Documents Required to be Reviewed
<p><b>Access to services</b> SA <b>examples</b> include waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency)</p>	<ul style="list-style-type: none"> <li>12VAC35-105-645.B</li> <li>12VAC35-105-693.C</li> </ul>	<ul style="list-style-type: none"> <li>Admission screenings</li> <li>Discharge plan and discharge summary for last individual discharged from service</li> </ul>	<ul style="list-style-type: none"> <li>12VAC35-105-1240.6</li> </ul>	<p>CM notes and reviews show:</p> <ul style="list-style-type: none"> <li>There is documentation of coordination with other service providers as needed via CM notes or signature sheets</li> </ul>
<p><b>Provider Capacity</b> SA <b>examples</b> include caseloads, training, staff turnover, provider competency</p>	<ul style="list-style-type: none"> <li>12VAC35-105-665.D</li> <li>12VAC35-105-450</li> </ul>	<ul style="list-style-type: none"> <li>Most recent proof of DD competency completed</li> <li>Proof staff trained on individuals ISPs for those individuals reviewed</li> <li>Training policy</li> <li>Proof staff have received training at frequency outlined in policy</li> <li>DSP and Supervisor Assurance</li> </ul>	<ul style="list-style-type: none"> <li>12VAC35-105-1240.5</li> </ul>	<p>CM notes and reviews show:</p> <ul style="list-style-type: none"> <li>There is documentation of locating, developing, or obtaining needed services?</li> <li>If needed services were not available.</li> </ul>



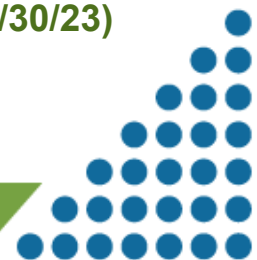
**Regulatory Compliance Below 86% for Providers of Developmental Services**

Domain	Regulation Number
Safety and Freedom from Harm	12VAC35-105-160.C
Safety and Freedom from Harm	12VAC35-105-160.D.2
Safety and Freedom from Harm	12VAC35-105-160. E.1.a, 160.E.1.b and 160.E.1.c
Provider Capacity	12VAC35-105-450
Safety and Freedom from Harm	12VAC35-105-665.A.6
Provider Capacity	12VAC35-105-665.D
Choice and Self-Determination	12VAC35-105-675.D.3

*Increased by almost 4%. Way to go, providers!*

*Easy win!*

**\*Based on 6<sup>th</sup> and 7<sup>th</sup> Semi-Annual AOS Report data (7/1/22-12/31/22 and 1/1/23-6/30/23)**





DBHDS | Virginia Department of Behavioral Health and Developmental Services

### DOJ Indicators - DSI Reporting Compliance

#### Region

- Select all
- Region 1 Western
- Region 2 Northern
- Region 3 Southwest
- Region 4 Central
- Region 5 Eastern

#### Time Period

1/1/2023 12/31/2023

#### Services Provided

- Select all
- Case Management
- Children's Residential Services
- Day Support/Day Treatment
- In-Home Respite Services
- Outpatient
- Residential Services

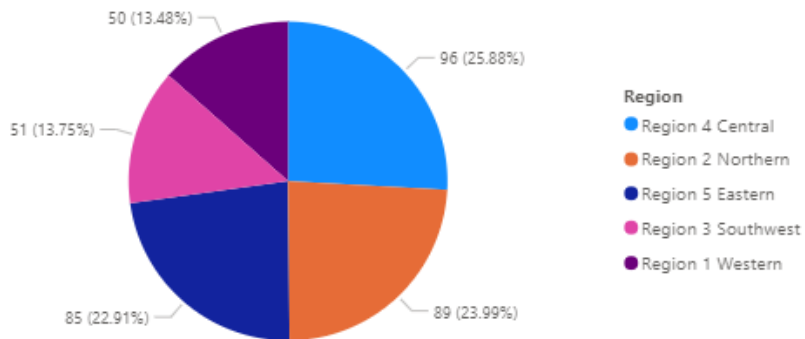
#### Diagnosis

- Select all
- Brain Injury
- Developmental Disability
- Mental Health
- Substance Abuse

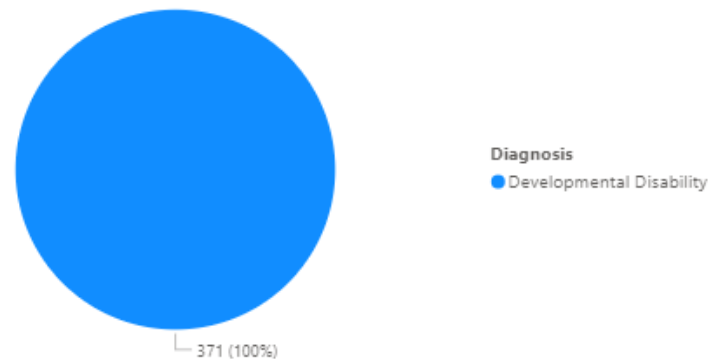
#### Provider Name

- Select all
- 1st Providence Home Care, LLC
- A & C Alternative Care, LLC
- A & J Residential, LLC
- A & T HEALTH CARE, INC.
- A Different World Home Services, LLC

Count of Citation by Region



Count of Citation by Diagnosis

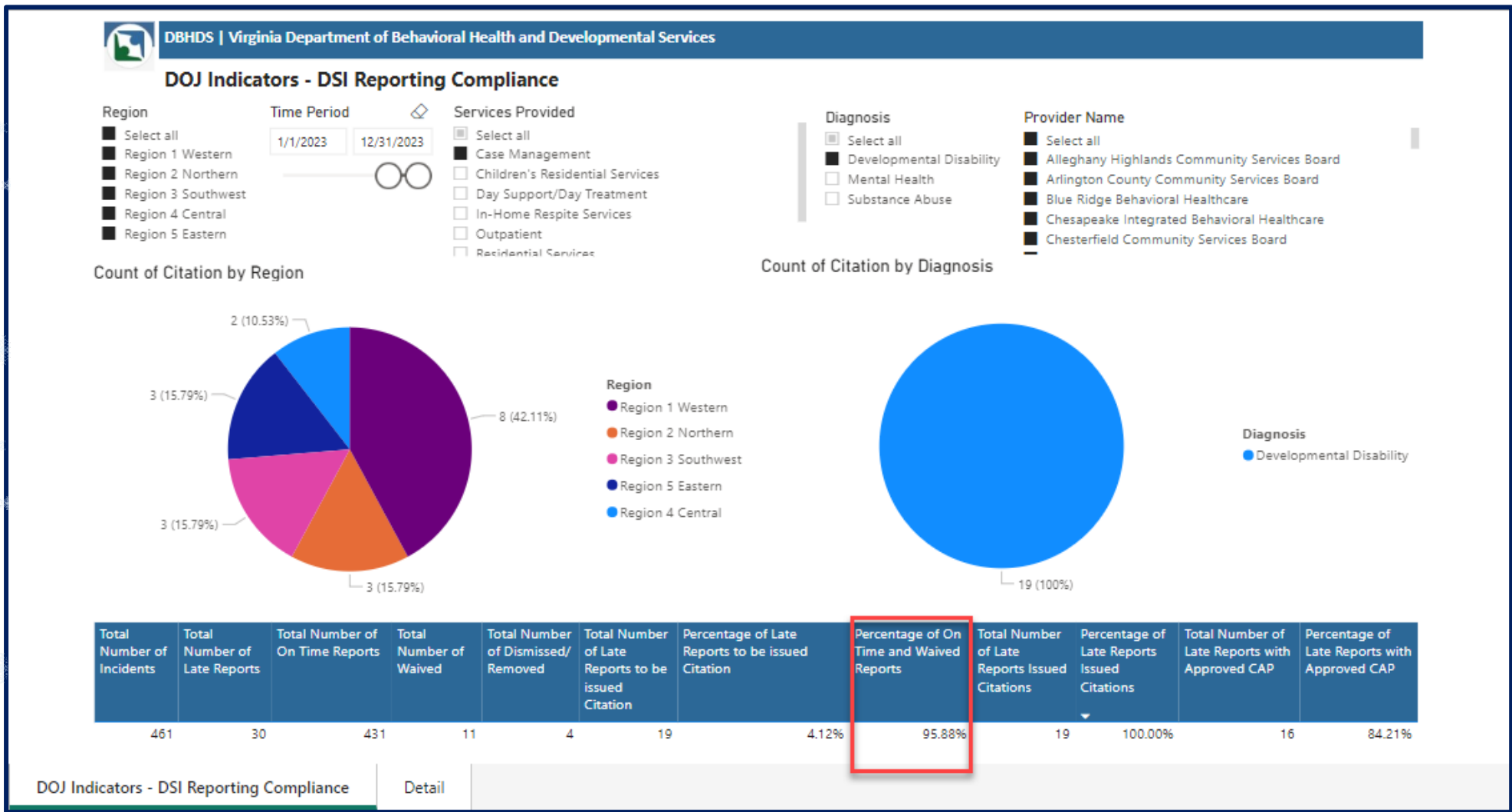


Total Number of Incidents	Total Number of Late Reports	Total Number of On Time Reports	Total Number of Waived	Total Number of Dismissed/Removed	Total Number of Late Reports to be issued Citation	Percentage of Late Reports to be issued Citation	Percentage of On Time and Waived Reports	Total Number of Late Reports Issued Citations	Percentage of Late Reports Issued Citations	Total Number of Late Reports with Approved CAP	Percentage of Late Reports with Approved CAP
9772	686	9086	303	41	384	3.93%	96.08%	371	96.61%	295	79.51%

DOJ Indicators - DSI Reporting Compliance

Detail



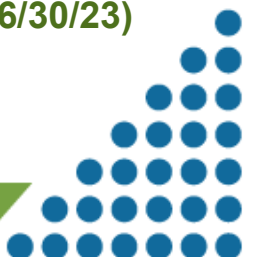




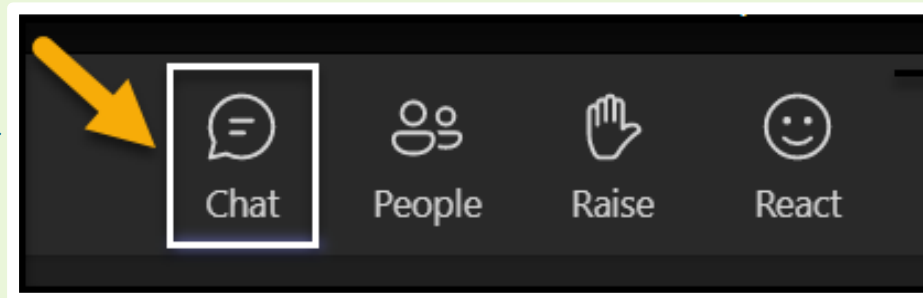
**Regulatory Compliance Below 86% Specific to  
*Case Management Providers of Developmental Services***

Domain	Regulation Number
Physical, Mental and Behavioral Health and Well-Being	<b>12VAC35-105-1240.4</b>
Safety and Freedom from Harm	<b>12VAC35-105-1240.7</b>
Physical, Mental and Behavioral Health and Well-Being	<b>12VAC35-105-1240.11</b>
Safety and Freedom from Harm	<b>12VAC35-105-1240.12</b>
Stability	<b>12VAC35-105-1245</b>
Choice and Self-Determination	<b>12VAC35-105-1255</b>

**\*Based on 6<sup>th</sup> and 7<sup>th</sup> Semi-Annual AOS Report data (7/1/22-12/31/22 and 1/1/23-6/30/23)**



Use the Chat feature to access the link for the 'Q&A' session.



Thank you for participating in the Q&A portion of the 2024 DD Inspections Kickoff Training!

Please enter your questions below. Questions will be answered by an Office of Licensing representative during the Q&A portion of today's training.

1. Please type your question here. If you have multiple questions, please submit each question separately.

Enter your answer

Submit

## Regulations & Guidance

- [Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services \[12 VAC 35 - 105\]](#)
- [LIC 16: Guidance for A Quality Improvement Program \(November 2020\)](#)
- [LIC 17: Guidance for Serious Incident Reporting \(November 2020\)](#)
- [LIC 18: Individuals with Developmental Disabilities with High-Risk Health Conditions \(June 2020 \)](#)
- [LIC 19: Corrective Action Plans \(CAPs\) \(August 2020\)](#)
- [LIC 20: Guidance on Incident Reporting Requirements \(August 2020\)](#)
- [LIC 21: Guidance for Risk Management \(August 2020\)](#)
- Policy and form templates remain in progress.





### *Samples*

- [Serious Incident Review and RCA Template Example 5 Whys Stories Victor \(July 2023\)](#)
- [Serious Incident Review and RCA Template Example 5 Whys Stories Billy \(June 2023\)](#)
- [Serious Incident Review and RCA Template Example 5 Whys Stories Jasmine \(June 2023\)](#)
- [Serious Incident Review and RCA Template Example 5 Whys Stories Sam \(June 2023\)](#)
- [Serious Incident Review and Root Cause Analysis Template \(November 2023\)](#)

### *Trainings*

- [Flow-Chart Incident Reviews \(April 2023\)](#)
- [QI-RM-RCA Webinar \(December 2021\)](#)
- [Regulatory Compliance with Root Cause Analysis Regulations Training \(December 2021\)](#)
- [Risk Management & Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation and Research – Handout \(December 2020\)](#)
- [Root Cause Analysis Training \(October 2020\)](#)

## **Risk Management *Attestation***

- [Updated Crosswalk of DBHDS Approved Attestation Trainings \(August 2022\)](#)
- [Updated Risk Management Attestation Form \(August 2022\)](#)

## ***Samples***

- [Systemic Risk Assessment Sample 1 Non-Residential Provider \(August 2023\)](#)
- [Systemic Risk Assessment Sample 2 Provider of a 4-Bed Group Home \(August 2023\)](#)
- [Systemic Risk Assessment Sample 3 Intensive In Home Service Provider \(August 2023\)](#)
- [Systemic Risk Assessment Sample 4 Medication Assistance Service \(August 2023\)](#)

## ***Tools and Templates***

- [Individual Risk Tracking Tool \(April 2023\)](#)
- [Monthly Risk Tracking Tool \(April 2023\)](#)
- [Instructional Video-Risk Tracking Tool \(April 2023\)](#)
- [Serious Incident Review and Root Cause Analysis Template \(November 2023\)](#)
- [Systemic Risk Assessment Template \(April 2023\)](#)

### Trainings

- Day 1: Minimizing Risk Session 1 Webinar (April 2023)
- Minimizing Risk Session 1 PowerPoint (April 2023)
- Day 2: Minimizing Risk Session 2 Webinar (April 2023)
- Minimizing Risk Session 2 PowerPoint (April 2023)
- Day 3: Minimizing Risk Session 3 Webinar (April 2023)
- Minimizing Risk Session 3 PowerPoint (April 2023)
- Flow-Chart Incident Reviews (April 2023)
- QI-RM-RCA Webinar (December 2021)
- Regulatory Compliance with Risk Management Regulations Training (December 2021)
- Risk Management Tips and Tools Training (June 2021)
- Risk Management & Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation & Research – Recorded Webinar (December 2020)
- Risk Management Training (November 2020)

### Care Concerns

- 2023 Care Concern Threshold Criteria Memo (February 2023)
- IMU Care Concern PowerPoint Training (February 2023)
- Risk Triggers and Threshold Handout (February 2023)

### *Memos*

- [Tracking of Level I Serious Incidents vs Baseline Behaviors Memo \(February 2023\)](#)

### *Samples*

- [Tools for Developing a Quality Improvement Program \(February 2022\)](#)
- [Sample Provider Quality Improvement Plan \(June 2021\)](#)

### *Trainings*

- [QI-RM-RCA Webinar \(December 2021\)](#)
- [Regulatory Compliance with Quality Improvement Regulations Training \(December 2021\)](#)
- [Quality Improvement Tips and Tools Training \(June 2021\)](#)
- [Risk Management & Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation & Research – Recorded Webinar \(December 2020\)](#)
- [Quality Improvement Training \(November 2020\)](#)

### *Additional Trainings*

- [Licensed Provider Coaching Seminar I](#)
- [Licensed Provider Coaching Seminar I YouTube Video](#)
- [Licensed Provider Coaching Seminar II](#)
- [Licensed Provider Coaching Seminar II YouTube Video](#)
- [Licensed Provider Coaching Seminar III](#)

### *Other Resources*

- A collection of guides, toolkits and training resources to help build quality improvement (QI) knowledge and skills has been posted to the DBHDS Office of Clinical Quality Management webpage: [Office of Clinical Quality Management](#)



## Serious Incident Reporting and CHRIS Training

- [Serious Incident Reporting-Covid-19 \(December 2022\)](#)
- [Individual and Systematic Risk – How to Report and Respond to Incidents \(April 2022\)](#)
- [Memo – Revoking A User Access \(February 2020\)](#)
- [CHRIS System Training \(May 2021\)](#)
- [Creating A New Serious Incident Case \(August 2019\)](#)
- [Creating A New Death Case \(August 2019\)](#)
- [Updating A Serious Incident \(August 2019\)](#)
- [Updating A Death Record \(August 2019\)](#)
- [DELTA Overview](#)

## Mortality Review

- [Mortality Review Committee Submission Checklist \(July 2022\)](#)
- [Mortality Review Document Submission Process \(January 2023\)](#)
- [Mortality Review Committee Document Submission Memorandum \(July 2019\)](#)
- [Contacting 911 Emergency Services \(December 2019\)](#)

On December 19, 2023, the Office of Licensing sent out the 2024 Annual Inspections for Providers of Developmental Services Memo via Constant Contact and posted it on the OL website.

Prior to the Office of Licensing going onsite, your Licensing Specialist will send you a CONNECT correspondence to request some of the documents outlined in the memo. If you are a CSB, and participating in the MART, those documents will be accessed through the repository. These documents are typically reviewed by your Specialist prior to going onsite.

The Office of Licensing will conduct an unannounced inspection.

The Licensing Specialist will review a sample of individual and employee/contractor records and inspect the physical environment, as applicable.


The Licensing Specialist will offer the provider an exit meeting where the specialist will share their preliminary findings. It is important that, at a minimum, the exit meeting be attended by the person responsible for submitting the CAP and the owner, if applicable.

If there are no citations, the OL will close the inspection. If there are regulatory violations, the Licensing Specialist will issue a licensing report.

Providers are responsible for submitting a Corrective Action Plan within 15 business days of receiving the licensing report.

- 2024 Annual Inspections for Providers of Developmental Services Memo (January 2024)





**COMMONWEALTH of VIRGINIA**  
 DEPARTMENT OF  
 BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES  
 Post Office Box 1797  
 Richmond, Virginia 23218-1797

NELSON SMITH  
COMMISSIONER

Telephone (804) 786-3921  
 Fax (804) 371-6638  
 www.dbhds.virginia.gov

**MEMORANDUM**

**To:** DBHDS Licensed Providers of Developmental Services  
**From:** Jae Benz, Director, Office of Licensing  
**Cc:** Veronica Davis, Associate Director for State Licensure Operations  
 Mackenzie Glassco, Associate Director of Quality & Compliance  
 Angelica Howard, Associate Director of Administrative & Specialized Units

**Date:** December 19, 2023, Revised January 2, 2024  
**Re:** 2024 Annual Inspections for Providers of Developmental Services

**Purpose:** The purpose of this memo is to remind providers of developmental services that, as is customary, the annual unannounced inspections begin again at the start of each calendar year. In January 2020, the Office of Licensing began sharing a checklist (Attachment A) of the minimum requirements licensing specialists (LS) review during a provider’s annual inspection as well as what document the LS will look at to determine compliance.

In accordance with V.G.3 of the Settlement Agreement, the Commonwealth is tasked with ensuring the licensing process assesses the adequacy of supports and services provided to individuals with developmental disabilities receiving services licensed by DBHDS. The Office of Licensing is also tasked with monitoring providers’ compliance with the Rules and Regulations for Licensing Providers. This involves monitoring the adequacy of individualized supports delivered by each provider. The Office of Licensing developed a crosswalk that ties the eight domains outlined in the Settlement Agreement to specific Licensing Regulations. All of the regulations listed in the checklist are checked during the annual inspection. In addition, the licensing specialist will be reviewing any regulations cited since the last annual inspection to ensure implementation of the corrective action plans in accordance with 12VAC35-105-170.G, 12VAC35-105-170.H and 12VAC35-105-620.C.4.

Attachment A

Regulation Number	Regulatory Text	Documents Used to Determine Compliance	Submit via CONNECT OR Review on-site	Signature Required (Yes or No)
<p>*12VAC35-105-160.C Must be reviewed for all services including case management</p>	<p>The provider shall collect, maintain, and review at least quarterly <u>all serious incidents</u>, including Level I serious incidents, as part of the quality improvement program in accordance with 12VAC35-105-620 to include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.</p>	<p>Last <b>two</b> quarterly reviews of all serious incidents including Level I, Level II and Level III incidents.</p> <ul style="list-style-type: none"> <li>• Must include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.</li> <li>• If the provider does not have any Level I, II, or III serious incidents to review during the last two quarters, the provider must look back to 1/1/2023 to see if they had any serious incidents and provide the quarterly review for those.</li> <li>• If there were no serious incidents within the past year, the provider will be cited for non-compliance if there is no documentation to reflect why a quarterly review was not completed.</li> <li>• If there were no serious incidents within the past year, the provider will be cited for non-compliance if the provider does not have a form to show what the provider would use to document serious incidents if they were to occur.</li> </ul>	<p>Review on-site</p>	
<p>*12VAC35-105-160.D.2 Must be reviewed for all services including case management</p>	<p>The provider shall collect, maintain, and report or make available to the department the following information: Level II and Level III serious incidents shall be reported using the department's web- based reporting application and by</p>	<p>Provider does not need to submit Level II or Level III serious incidents for review because the LS will review progress notes, quarterly reviews, medical information, and ISPs to ensure anything that meets the criteria for a serious incident was reported. The LS will use the Death and Serious Incident by Type and Status Query for a list of all reported incidents.</p> <ul style="list-style-type: none"> <li>• Note: The Incident Management Unit (IMU) monitors reporting of serious incidents each business day. Please review <u>Guidance for Serious Incident Reporting and the Guidance on Incident Reporting</u></li> </ul>	<p>Review on-site</p>	





## Clarification - Citing Regulations



- **The Office of Licensing does not cite the higher regulation for regulations that include sub-regulations because from a regulatory perspective each sub item is its own regulation.**
- **If a regulation has multiple sub-regulations and there is no documentation to demonstrate compliance, then the provider would be cited for each sub-regulation.**
- **Citing this way is also beneficial for OL data collection and analysis as it allows us to identify areas of non-compliance with increased accuracy. This data guides the development of resources, tools and trainings to address those areas.**



## **12VAC35-105-645.**

### **Initial contacts, screening, admission, assessment, service planning, orientation and discharge.**

- **B. The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the:**
  - 1. Date of contact;**
  - 2. Name, age, and gender of the individual;**
  - 3. Address and telephone number of the individual, if applicable;**
  - 4. Reason why the individual is requesting services; and**
  - 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service.**



## Regulations Overview Part I:

The following regulations are applicable to  
All DD Providers of Case Management Services  
and Non-Case Management Services



**Regulation  
12VAC35-105-160.C**

**The provider shall collect, maintain, and review at least quarterly all serious incidents, including Level I serious incidents, as part of the quality improvement program in accordance with 12VAC35-105-620 to include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.**

## Important Definition



***"Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident.***

## Documents Used to Determine Compliance: 160.C

Last two quarterly reviews of all serious incidents - including Level I, Level II and Level III incidents.

Must include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.


If the provider does not have any Level I, II, or III serious incidents to review during the last two quarters, the provider must look back to 1/1/2023 to see if they had any serious incidents and provide the quarterly review for those.

If there were no serious incidents within the past year, the provider will be cited for non-compliance if there is no documentation to reflect why a quarterly review was not completed.

If there were no serious incidents within the past year, the provider will be cited for non-compliance if the provider does not have a form to show what the provider would use to document serious incidents if they were to occur.

# Tracking of Level I Serious Incidents vs Baseline Behaviors Memo (February 2023)





COMMONWEALTH of VIRGINIA

DEPARTMENT OF  
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES  
Post Office Box 1797  
Richmond, Virginia 23218-1797

Telephone (804) 786-3921  
Fax (804) 371-6638  
www.dbhds.virginia.gov

NELSON SMITH  
COMMISSIONER

**MEMORANDUM**

**To:** DBHDS Licensed Providers

**From:** Jae Benz, Director, DBHDS Office of Licensing

**Date:** February 14, 2023

**Re:** Tracking of Level I Serious Incidents vs. Baseline Behaviors

---


**Purpose:** Based on stakeholder feedback, and in an effort to increase provider compliance with 12VAC35-105-160, the DBHDS Office of Licensing is providing supplemental information regarding the tracking of Level I serious incidents and potential, "baseline behaviors" demonstrated by individuals receiving services from a licensed provider.

As a reminder:

**12VAC35-105-20. Definitions**

- "**Serious incident**" means any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual. The term "serious incident" includes death and serious injury.
- "**Level I serious incident**" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident. *Level I serious incidents do not result in significant harm to individuals but may include events that result in minor injuries that do not require medical attention or events that have the potential to cause serious injury, even when no injury occurs.*

The provider shall collect, maintain, and review at least quarterly *all serious incidents, including Level I serious incidents*, as part of the quality improvement program in accordance with 12VAC35-105-620 to include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.



**Regulation  
12VAC35-105-160.D.2**

The provider shall collect, maintain, and report or make available to the department the following information: Level II and Level III serious incidents shall be reported using the department's web-based reporting application and by telephone or email to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery. Reported information shall include the information specified by the department as required in its web-based reporting application, but at least the following: the date, place, and circumstances of the serious incident. For serious injuries and deaths, the reported information shall also include the nature of the individual's injuries or circumstances of the death and any treatment received. For all other Level II and Level III serious incidents, the reported information shall also include the consequences that resulted from the serious incident. Deaths that occur in a hospital as a result of illness or injury occurring when the individual was in a licensed service shall be reported.

# Important Definitions



- ***Serious Incident:*** Any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual. This includes death and serious injury.
- ***Serious Injury:*** Any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner.

# Important Definitions



- **Level II Serious Incident:**

- A serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident.
- Includes a significant harm or threat to the health and safety of others caused by an individual.

- **Level II Serious Incidents Include:**

1. A serious injury;
2. An individual who is or was missing;
3. An emergency room visit;
4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with the individual's Wellness Recovery Action Plan shall not constitute an unplanned admission for the purposes of this chapter;
5. Choking incidents that require direct physical intervention by another person;
6. Ingestion of any hazardous material; or
7. A diagnosis of:
  - a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer;
  - b. A bowel obstruction; or
  - c. Aspiration pneumonia.

# Important Definitions



- **Level III Serious Incident:**
  - A serious incident whether the incident occurs while in the provision of a service or on the provider's premises and results in:
    - a) Any death of an individual;
    - b) A sexual assault of an individual; or
    - c) A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.



## Documents Used to Determine Compliance: 160.D.2


Providers do not need to submit Level II or Level III serious incidents for review because the LS will review progress notes, quarterly reviews, medical information, and ISPs to ensure anything that meets the criteria for a serious incident was reported. The LS will use the Death and Serious Incident by Type and Status Query for a list of all reported incidents.

The Incident Management Unit (IMU) monitors reporting of serious incidents each business day. Please review:

[Guidance for Serious Incident Reporting](#)  
and  
[Guidance on Incident Reporting Requirements](#)

If, during an annual inspection or an investigation, the Licensing Specialist identifies serious incidents that should have been reported, but were not reported at all, or that were not reported within 24 hours of their occurrence and for which a licensing report has not already been issued, then the Licensing Specialist will issue a licensing report for late reporting.

If it is determined that a Level II or Level III serious incident occurred, and the provider did not report it to the department, the provider will be cited for non-compliance with 160.D.2.



**Take advantage of these Risk Tracking tools,  
designed to guide you towards success!**

- [Individual Risk Tracking Tool \(April 2023\)](#)
- [Monthly Risk Tracking Tool \(April 2023\)](#)
- [Instructional Video-Risk Tracking Tool \(April 2023\)](#)

### Related to 160.C

Collect, maintain, and review at least quarterly all serious incidents.

Includes Level I serious incidents.

Help with an analysis of trends, potential systemic issues or causes, remediation, and documenting mitigating strategies.

### Informs 520.C and 520.D

Can help inform your systemic risk assessment.

Incorporates uniform risk triggers and thresholds which are defined by the department as care concerns.

### DBHDS DOJ Curative Action

DBHDS develop and disseminate a tool that providers may use to identify and track serious incidents, including Level I serious incidents.

DBHDS address what constitutes a Level I serious incident and include examples.

DBHDS provide a list of common risks and conditions faced by individuals with DD.



# Excel Risk Tracking Tool Instructions

(April 2023)

Mary Beth Cox, MSW, MPH  
Quality Improvement Coordinator  
DBHDS Office of Clinical Quality Management  
[Marybeth.Cox@dbhds.virginia.gov](mailto:Marybeth.Cox@dbhds.virginia.gov)

[Instructional Video-Risk Tracking Tool \(April 2023\)](#)



**Regulations  
12VAC35-105-160.E.1.a,  
160.E.1.b and 160.E.1.c**

**A root cause analysis shall be conducted by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises.**

**The root cause analysis shall include at least the following information:**

- a. A detailed description of what happened;**
- b. An analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and**
- c. Identified solutions to mitigate reoccurrence and future risk of harm when applicable.**

The focus of a  
Root Cause Analysis is  
on prevention,  
not  
blame or punishment.



# 12VAC35-105-160.E.1.a

## a. A detailed description of what happened;

- *Provider may copy information included within the Injury/Incident Description/Circumstances field of CHRIS or include a step-by-step detailed account of the incident*

# 12VAC35-105-160.E.1.b

**b. An analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider**

- *Analysis of trends and potential systemic issues or causes; analysis of why incident happened; identification of all underlying causes of the incident that were in the control of the provider*
- *While our regulations do not require use of another tool to analyze trends, providers are required to include their analysis*



# 12VAC35-105-160.E.1.c

**c. Identified solutions to mitigate its reoccurrence and future risk of harm when applicable.**

- *Solutions to mitigate the potential for future incidents*

## Documents Used to Determine Compliance: 160.E.1.a, b and c

Two most recent root cause analyses for Level II and Level III serious incidents that occurred during the provision of a service or on the provider's premises.

Please review:


[Serious Incident Review and Root Cause Analysis Template \(November 2023\)](#)

If a root cause analysis was not completed for a Level II or Level III serious incident or it was not completed within 30 days of discovery, the provider will be cited for non-compliance with 160.E.1.a, 160.E.1.b and 160.E.1.c.

# Serious Incident Review and Root Cause Analysis Template (November 2023)



Office of Licensing	
Serious Incident Review and Root Cause Analysis TEMPLATE	
Individual's Name and I.D. Number:	Date of Incident:
	Date of Discovery of Incident:
	Incident Report #:
	Review Completed Date:
	Review Completed By:
Individual's DOB:	Program:
Location of Incident:	Type of Incident:
Service Received at Time of Incident:	Sources of Information: <input type="checkbox"/> Record Review <input type="checkbox"/> Policy Review <input type="checkbox"/> Interview with Individual <input type="checkbox"/> Interview with Staff <input type="checkbox"/> Human Rights Investigation <input type="checkbox"/> Other:
Is this the first incident of this kind? <input type="checkbox"/> Yes <input type="checkbox"/> No, when did this occur before?	Is this addressed in the ISP? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Detailed description of what happened (Provider may copy information included within the Injury/Incident Description/Circumstances field of CHRIS or include a step-by-step detailed account of the incident):	
Analysis of Incident (Analysis of trends and potential systemic issues or causes; analysis of why incident happened; identification of all underlying causes of the incident that were in the control of the provider):	
Quality Improvement Tool used during review: <input type="checkbox"/> 5 Whys <input type="checkbox"/> Fishbone <input type="checkbox"/> FMEA <input type="checkbox"/> Other: (While our regulations do not require use of another tool to analyze trends, providers are required to include their analysis)	
Recommendations/Action Plan (Solutions to mitigate the potential for future incidents):	
<input type="checkbox"/> There are no recommendations at this time. There were no underlying causes under the provider's control.	
<input type="checkbox"/> Recommendation(s)/Technical Assistance:	
<b>Disclaimer:</b> This template was completed in accordance with 12VAC35-105-160. In order to ensure completion within the 30-day regulatory timeframe, the most available information/resources were utilized to complete this review.	



## Serious Incident Review and RCA Examples - developed just for YOU!

- Serious Incident Review and RCA Template Example 5 Whys Stories Victor (July 2023)
- Serious Incident Review and RCA Template Example 5 Whys Stories Billy (June 2023)
- Serious Incident Review and RCA Template Example 5 Whys Stories Jasmine (June 2023)
- Serious Incident Review and RCA Template Example 5 Whys Stories Sam (June 2023)

Regulations  
12VAC35-105-160.E.2.a,  
160.E.2.b, 160.E.2.c  
and 160.E.2.d

The provider shall develop and implement a root cause analysis policy for determining when a more detailed root cause analysis, including convening a team, collecting and analyzing data, mapping processes, and charting causal factors, should be conducted. At a minimum, the policy shall require for the provider to conduct a more detailed root cause analysis when:

- a. **A threshold number**, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II serious incidents occur to the same individual or at the same location within a six-month period;
- b. **Two or more of the same Level III serious incidents** occur to the same individual or at the same location within a six-month period;
- c. **A threshold number**, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II or Level III serious incidents occur across all of the provider's locations within a six-month period; or
- d. **A death** occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.

# 12VAC35-105-160.E.2.a

a. At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when:

- A **threshold number**, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II serious incidents occur to the same individual or at the same location within a six-month period;

## 12VAC35-105-160.E.2.b

b. At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when:

- **Two or more of the same Level III serious incidents** occur to the same individual or at the same location within a six-month period;

# 12VAC35-105-160.E.2.c

- c. At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when:
- A **threshold number**, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II serious incidents occur across all the provider's locations within a six-month period;

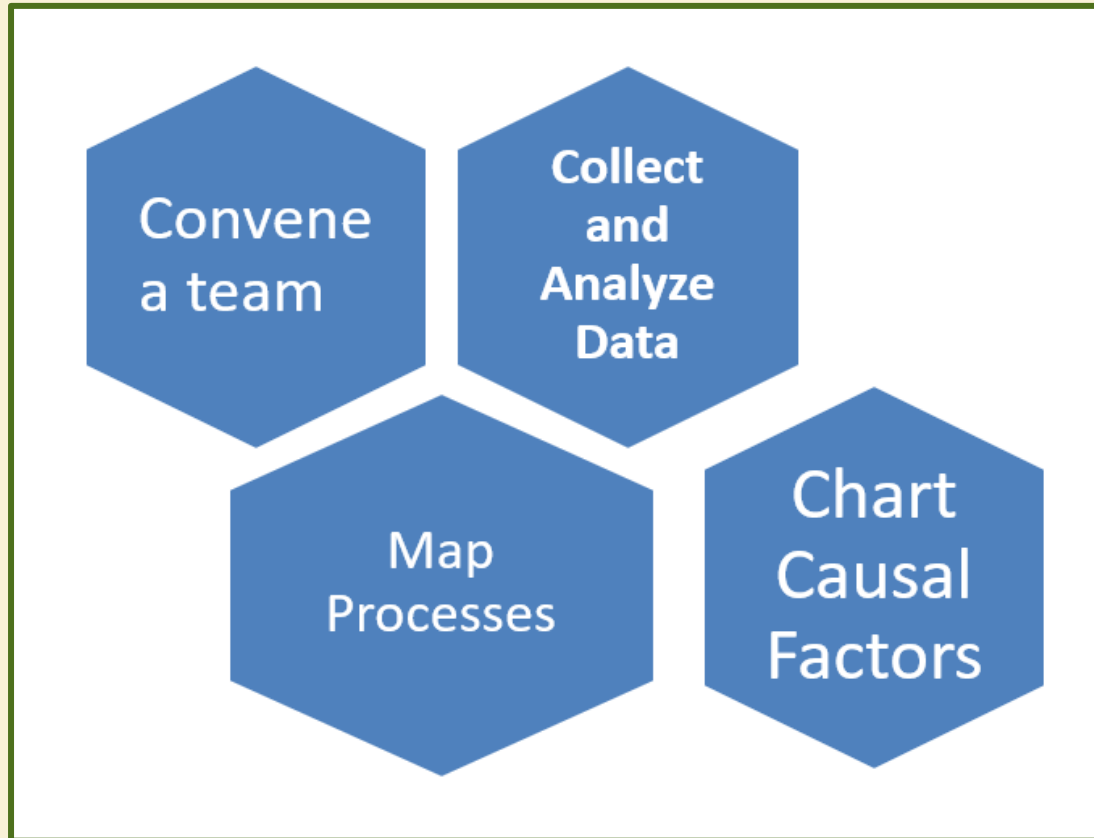


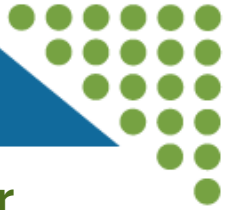
# 12VAC35-105-160.E.2.d

d. At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis:

- A **death** occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.

# What is a more detailed RCA?





**12VAC35-105-160.E.2:** The provider shall develop and implement a root cause analysis policy for determining when a more detailed root cause analysis, including convening a team, collecting and analyzing data, mapping processes, and charting causal factors, should be conducted. At a minimum, the policy shall require for the provider to conduct a more detailed root cause analysis when:

Regulation Text	Example Policy
<p><b>160.E.2.a:</b> A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II serious incidents occur to the same individual or at the same location within a six-month period;</p>	<p><i>Acme Residential will conduct a more detailed root cause analysis when there are <b>five (5)</b> similar Level II serious incidents that occur to the same individual or at the same location within a six-month period.</i></p> <p>*The provider must establish a threshold number to include within their policy.</p>
<p><b>160.E.2.b:</b> Two or more of the same Level III serious incidents occur to the same individual or at the same location within a six-month period;</p>	<p><i>Acme Residential will conduct a more detailed root cause analysis when there are two or more of the same Level III serious incidents that occur to the same individual or at the same location within a six-month period.</i></p>



Regulation Text	Example Policy
<p><b>160.E.2.c.</b> A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II or Level III serious incidents occur across all of the provider's locations within a six-month period; or</p>	<p><i>Acme Residential will conduct a more detailed root cause analysis when there are <b>eight (8)</b> similar Level II or Level III serious incidents that occur across all of the provider's locations within a six-month period.</i></p> <p>*The provider must establish a threshold number to include within their policy.</p>
<p><b>160.E.2.d:</b> A death occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.</p>	<p><i>Acme Residential will conduct a more detailed root cause analysis when a death occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.</i></p> <p>*This more detailed RCA would be required if the death occurred during the provision of a service or on the provider's premises.</p>

\*A provider's RCA policy can be part of the provider's Serious Incident Reporting policy.

**Documents Used to Determine Compliance: 160.E.2.a, b, c and d**

**Root cause analysis policy with thresholds for each sub regulation.**

**Regulations 160.E.2.b and 160.E.2.d have a mandated threshold.**

**Providers must determine their own threshold number for regulations 160.E.2.a and 160.E.2.c.**

**A root cause analysis completed as a result of a threshold being met, if applicable. If the provider does not have a Root Cause Analysis policy, the provider will be cited for non-compliance with 160.E.2.a, 160.E.2.b, 160.E.2.c and 160.E.2.d.**

**If a more detailed Root Cause Analysis was not completed by the provider due to meeting a threshold, the provider will be cited for non-compliance with the specific regulation.**

**12VAC35-105-450**

**The provider shall provide training and development opportunities for employees to enable them to support the individuals receiving services and to carry out their job responsibilities. The provider shall develop a training policy that addresses the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and accessible to the department.**

*Easy win!*

# Provider Readiness Education Program

Monthly beginning January 2024  
MS Teams, Registration needed

## Topics include:

- Know all regs (OL, OHR, DMAS, HCBS)
- Required training list
- HCBS Settings Regulations
- WaMS and COVLC
- Intro to DD
- ISP
- Documentation
- Orientation and Competencies
- Provider Network Listserv
- DBHDS and CRCs
- Settlement Agreement
- Working with CSBs
- Marketing and Billing
- Choice and Person-centeredness
- Health and safety and risk

Questions: contact [jennifer.kurtz@dbhds.virginia.gov](mailto:jennifer.kurtz@dbhds.virginia.gov)

## Documents Used to Determine Compliance: 450

For DSPs,  
the completed  
DMAS DSP  
Assurance form  
and a copy of the  
DSP orientation test.

For supervisors,  
the completed  
DMAS Supervisor  
Assurance form and  
copy of the certificate  
of completion.

Training policy  
and training records  
for employees  
being reviewed.

If any component of  
the required training  
policy is missing, the  
provider will be cited  
for non-compliance  
with 450.

If there is no  
documented evidence  
of training for the  
employee or contactor,  
the provider will be  
cited for non-  
compliance with 450.



**12VAC35-105-520.A**

**The provider shall designate a person responsible for the risk management function who has completed department approved training, which shall include training related to risk management, understanding of individual risk screening, conducting investigations, root cause analysis, and the use of data to identify risk patterns and trends.**



**Submit  
via  
CONNECT**

# UPDATED ATTESTATION FORM – EFFECTIVE AUGUST 2022

• Updated Crosswalk of DBHDS Approved Attestation Trainings (August 2022)

• Updated Risk Management Attestation Form (August 2022)

Topic Area	Name of DBHDS Approved Training Completed	Training Completion Date
	<p>*** Note: Check the associated DBHDS approved training(s) completed by the designed Risk Manager</p>	
Risk Management	<p><input type="checkbox"/> Risk Management and Quality Improvement Strategies Webinar by CDDER <a href="http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds-risk-management-webinar-final-12-10-2020-handout-with-notes-(1).pdf">http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds-risk-management-webinar-final-12-10-2020-handout-with-notes-(1).pdf</a></p> <p>Or</p> <p><input type="checkbox"/> Office of Licensing PPT Training on Quality Improvement – Risk Management (Nov 2020) <a href="http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-management-training-(november-2020).pdf">http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-management-training-(november-2020).pdf</a></p> <p>Or</p> <p><input type="checkbox"/> Office of Licensing Quality Improvement – Risk Management Tips and Tools (June 2021) <a href="https://dbhds.virginia.gov/assets/doc/QMD/OL/risk-management-quality-improvement-tips-and-tools-june-2021.pdf">https://dbhds.virginia.gov/assets/doc/QMD/OL/risk-management-quality-improvement-tips-and-tools-june-2021.pdf</a></p>	Click or tap to enter a date.
Understanding of Individual Risk Screening	<p><input type="checkbox"/> Risk Management and Quality Improvement Strategies Webinar by CDDER <a href="http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds-risk-management-webinar-final-12-10-2020-handout-with-notes-(1).pdf">http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds-risk-management-webinar-final-12-10-2020-handout-with-notes-(1).pdf</a></p> <p>Or</p> <p><input type="checkbox"/> Office of Licensing PPT Training on Quality Improvement – Risk Management (Nov 2020) <a href="http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-management-training-(november-2020).pdf">http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-management-training-(november-2020).pdf</a></p>	Click or tap to enter a date.
Conducting Investigations	<p><input type="checkbox"/> OHR Investigating Abuse &amp; Neglect: An Overview for Community Providers <a href="https://dbhds.virginia.gov/assets/doc/QMD/human-rights/ohr-2021-statewide-training-calendar_current1.docx">https://dbhds.virginia.gov/assets/doc/QMD/human-rights/ohr-2021-statewide-training-calendar_current1.docx</a></p> <p><a href="https://www.youtube.com/watch?v=4wB4dx-olyk">https://www.youtube.com/watch?v=4wB4dx-olyk</a></p>	Click or tap to enter a date.
Root Cause Analysis	<p><input type="checkbox"/> Risk Management and Quality Improvement Strategies Webinar by CDDER <a href="http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds-risk-management-webinar-final-12-10-2020-handout-with-notes-(1).pdf">http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds-risk-management-webinar-final-12-10-2020-handout-with-notes-(1).pdf</a></p> <p>Or</p> <p><input type="checkbox"/> Office of Licensing PPT Training on Root Cause Analysis (Nov 2020) <a href="http://www.dbhds.virginia.gov/assets/doc/QMD/OL/root-cause-analysis-training-(november-2020).pdf">http://www.dbhds.virginia.gov/assets/doc/QMD/OL/root-cause-analysis-training-(november-2020).pdf</a></p>	Click or tap to enter a date.
Use of Data to Identify Risk Patterns and Trends	<p><input type="checkbox"/> Risk Management and Quality Improvement Strategies Webinar by CDDER <a href="http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds-risk-management-webinar-final-12-10-2020-handout-with-notes-(1).pdf">http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds-risk-management-webinar-final-12-10-2020-handout-with-notes-(1).pdf</a></p> <p>Or</p> <p><input type="checkbox"/> Office of Licensing PPT Training on Quality Improvement – Risk Management (Nov 2020) <a href="http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-management-training-(november-2020).pdf">http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-management-training-(november-2020).pdf</a></p>	Click or tap to enter a date.

**Documents Used to Determine Compliance: 520.A**

Name of the person responsible for the risk management function.

Job description for this employee must reflect that all or part their responsibilities include those of the risk management function.

A completed (signed and dated) DBHDS Risk Management Attestation. Updated Risk Management Attestation Form. The Attestation should include the date the risk manager participated in a webinar or reviewed the presentation on the Office of Licensing webpage.

If the RM attestation does not demonstrate proof of training for each topic area the provider will be cited for non-compliance with 520.A.

Only training outlined in the DBHDS Crosswalk of Approved Training meets these requirements. Updated Crosswalk of DBHDS Approved Risk Management Training

**12VAC35-105-520.B**

**The provider shall implement a written plan to identify, monitor, reduce, and minimize harms and risk of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability**



**Submit  
via  
CONNECT**

**Documents Used to Determine Compliance: 520.B**

**Risk management plan.**

**As required by 12VAC35-105-620, a provider's risk management plan may be a standalone risk management plan or it may be integrated into the provider's overall quality improvement plan. Risk management plans and overall risk management programs should reflect the size of the organization, the population served, and any unique risks associated with the provider's business model.**

**If the risk management plan does not address all the required components as outlined in the regulation, the provider will be cited for non-compliance with 520.B.**

A tool for proactively identifying systemic risks  
*before* adverse events occur.

Where to begin:

Determine a format

Determine who will conduct the risk assessment  
(leadership, risk manager, committee)

**12VAC35-105-520.C.1-5**

The provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services. The risk assessment review shall address at least the following:

1. The environment of care;
2. Clinical assessment or reassessment processes;
3. Staff competence and adequacy of staffing;
4. Use of high-risk procedures, including seclusion and restraint; and
5. A review of serious incidents.



Submit  
via  
CONNECT

## 12VAC-35-105-520.C.1

### 1. The environment of care

The “environment of care” means the physical environment where services are provided, such as the building and physical premises. A review of the environment of care should consider the results of the annual safety inspection conducted pursuant to 12VAC35-105-520.E, when applicable, but is broader than a safety inspection.

Examples include:

- The location where services are provided;
- How the area where services are provided is arranged;
- Any special protective features that may be present;
- The location, amount, and condition of safety equipment;
- The condition and temperature regulation of refrigerators that store food or medications;
- Security of medication storage;
- Condition of electrical cords, outlets, and electrical equipment;
- The adequacy, suitability, and condition of lighting; and
- Any other physical features that could present safety risks if not properly arranged, secured, maintained, or otherwise addressed.



## 12VAC-35-105-520.C.2

### 2. Clinical assessment or reassessment processes

#### Examples include:

- Physical exams that are completed prior to admission or any time that there is a change in the individual's physical or mental condition;
- Reassessments include: (i) reviews of incidents in which the individual was involved, and (ii) reviews of the individual's health risks;
- Persons designated as responsible for the risk management function need not be engaged in the clinical assessment or reassessment process but should review these processes during the risk assessment review process. For example, are assessment processes effectively identifying and mitigating risks unique to each individual?

## 12VAC-35-105-520.C.3

### 3. Staff competence and adequacy of staffing

Examples of factors related to staff competency and adequacy of staffing include whether:

- All employees meet minimum qualifications to perform their duties;
- All employees complete orientation training prior to being assigned to perform direct care work;
- All employees have undergone background checks;
- All employees have completed abuse and neglect training;
- All employees have up to date CPR certification;
- Employees who administer medications have received required training;
- Employees have completed additional training applicable to their job functions, such as initial and annual fire safety training;
- Staffing schedules are consistent with the provider's staffing plan; and
- The staffing plan continues to be adequate to meet the needs of the individuals being served. Reviews of serious incidents over the prior year may help to inform this consideration.

## 12VAC-35-105-520.C.4

### 4. Use of high-risk procedures, including seclusion and restraint

High risk procedures may involve questions such as:

- Is the use of seclusion and restraint, in compliance with Human Rights Regulations?
- Are high-risk procedures reviewed regularly?
- Are the staff trained to implement high risk procedures?
- Are high risk procedures properly authorized and reviewed per policy, regulation, and law?

## 12VAC-35-105-520.C.5

### 5. A review of serious incidents.

- Examples of considerations related to serious incidents include whether:
  - All serious incidents (Level I, Level II, and Level III) are reviewed at least quarterly.
  - What trends are identified?
  - What kinds of incidents are reported? Are they related in terms of the type of incident?
  - Were there similar incidents that appeared close together in time? Was there anything unique that took place at that time?
  - Are there any patterns relevant to the specific time of day, day of week, location, program, certain types of activities, presence of other people or visitors?
  - Reflect on what has been learned from Root Cause Analyses and Care Concerns.

## 12VAC-35-105-520.C.5

### 5. A review of serious incidents.

#### Questions to ask yourself:

- Do we use data at the individual and/or provider level, including at minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm (defined as care concerns) in the events reported?
- Is there evidence that we are tracking data in order to evaluate trends and patterns over time, including year-over-year as applicable?
- After a year of tracking data, did we use the baseline data to assess the effectiveness of our Risk Management System?
- Did we use this data to summarize findings and make recommendations which may include remediation and planned/implemented steps taken to mitigate the potential for future incidents?

## Documents Used to Determine Compliance: 520.C.1, 2, 3, 4 and 5

The Annual Systemic Risk Assessment requires the provider to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services for at least the following:

**520.C.1:  
Environment  
of Care**

**520.C.2:  
Assessment  
and  
Reassessment  
Processes**

**520.C.3:  
Staff Competence  
and  
Adequacy of  
Staffing**

**520.C.4:  
Use of  
high-risk  
procedures**

**520.C.5:  
Serious  
Incidents**

**12VAC35-105-520.D**

**The systemic risk assessment process shall incorporate uniform risk triggers and thresholds as defined by the department.**

**Submit via CONNECT**

# Risk Trigger

- Incident or condition that can cause harm to an individual
- Examples: fall, seizure, UTI, dehydration

# Threshold

- Setting an amount or number of risks that help determine when further actions may be needed
- Example: Two within a 90-day time frame



## Serious Incident Reporting resources available on the Office of Licensing website:

- [2023 Care Concern Threshold Criteria Memo \(February 2023\)](#)
- [IMU Care Concern PowerPoint Training \(February 2023\)](#)
- [Risk Triggers and Threshold Handout \(February 2023\)](#)



## Documents Used to Determine Compliance: 520.D

Proof the systemic risk assessment process incorporates uniform risk triggers and thresholds as defined by the department

DBHDS has defined risk triggers and thresholds as care concerns which are identified through the IMUs review of serious incident reporting.

If a provider has not had any care concerns, their systemic risk assessment review process will still need to outline how they would address care concerns if they were to occur.

Providers will be able to generate CHRIS reports on incidents that have been identified as Care Concern Thresholds.

If the provider's systemic risk assessment does not address care concerns, the provider will be cited for non-compliance with 520.D.

If the provider has not had any care concerns and the systemic risk assessment does not include a section to address care concerns if they were to occur, the provider will be cited for 520.D.

\*Providers may access the [Provider Excel Individual Care Concern Threshold LSA notification](#) for a list of individuals who have met the Care Concern Thresholds. Case Managers can run the [Excel-CM Report Care Concern Threshold LSA notification](#) for a report of any individual served by them regardless of provider. Both of these notifications can be found in CHRIS under Individual Care Concern.

# Systemic Risk Assessment Template (April 2023)

## 12VAC35-105-520.C.1-5 and 520.D

**Office of Licensing**

*Disclaimer:* This document may be used as a template for a provider's Annual Systemic Risk Assessment pursuant to the requirements outlined in 12VAC35-105-520. This template should be individualized to your agency and scope of services provided.  
This is not a required template for a provider's Annual Systemic Risk Assessment; however, utilization of this template will assist providers in achieving compliance with the regulatory requirements of 12VAC35-105-520.  
Be sure to sign and date the last page.

Annual Systemic Risk Assessment TEMPLATE

Provider Name:

Policy #:

Regulation: 12VAC35-105-520

Effective:

Revised:


Risk Areas	Findings	Risk Score (N/A if not used)	Recommendation(s)	Comments/Actions	Add to Risk Management (RM) Plan (Yes/No/NA)	Date
Environment of Care						
Example: Compliance with all licensing regulations for Physical Environment and Fire Inspections						
Example: Fire extinguishers are sufficient in number and of the appropriate type						

1

**Office of Licensing**

Risk Areas	Findings	Risk Score (N/A if not used)	Recommendation(s)	Comments/Actions	Add to Risk Management (RM) Plan (Yes/No/NA)	Date
Example: Exits are clearly marked						

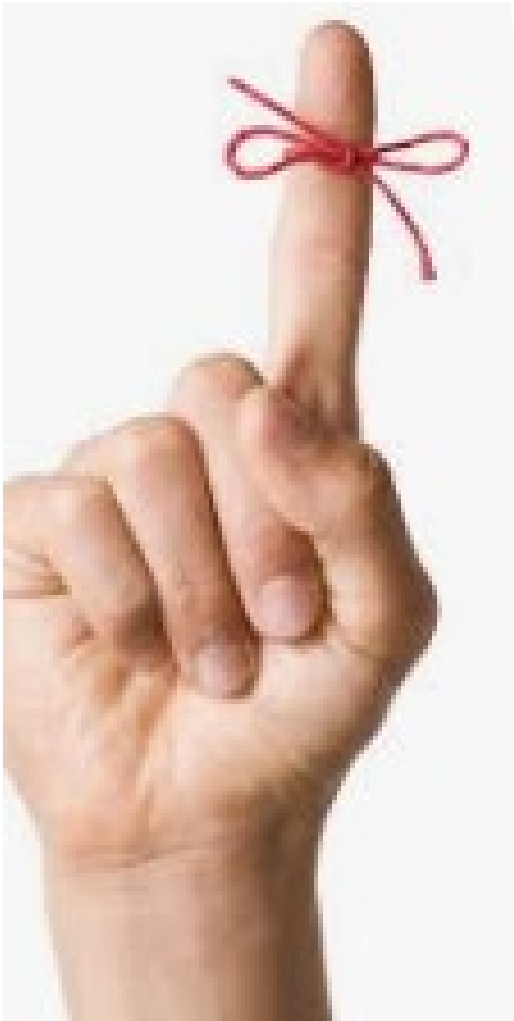
Clinical Assessment and Reassessment Process



**Review these  
Systemic Risk Assessment Samples  
and set yourself up for success!**

- [Systemic Risk Assessment Sample 1 Non-Residential Provider \(August 2023\)](#)
- [Systemic Risk Assessment Sample 2 Provider of a 4-Bed Group Home \(August 2023\)](#)

**Additional samples for services other than DD are available on the website as well.**



## Don't forget, the Systemic Risk Assessment (SRA) has six components! 520.C.1-5 and 520.D

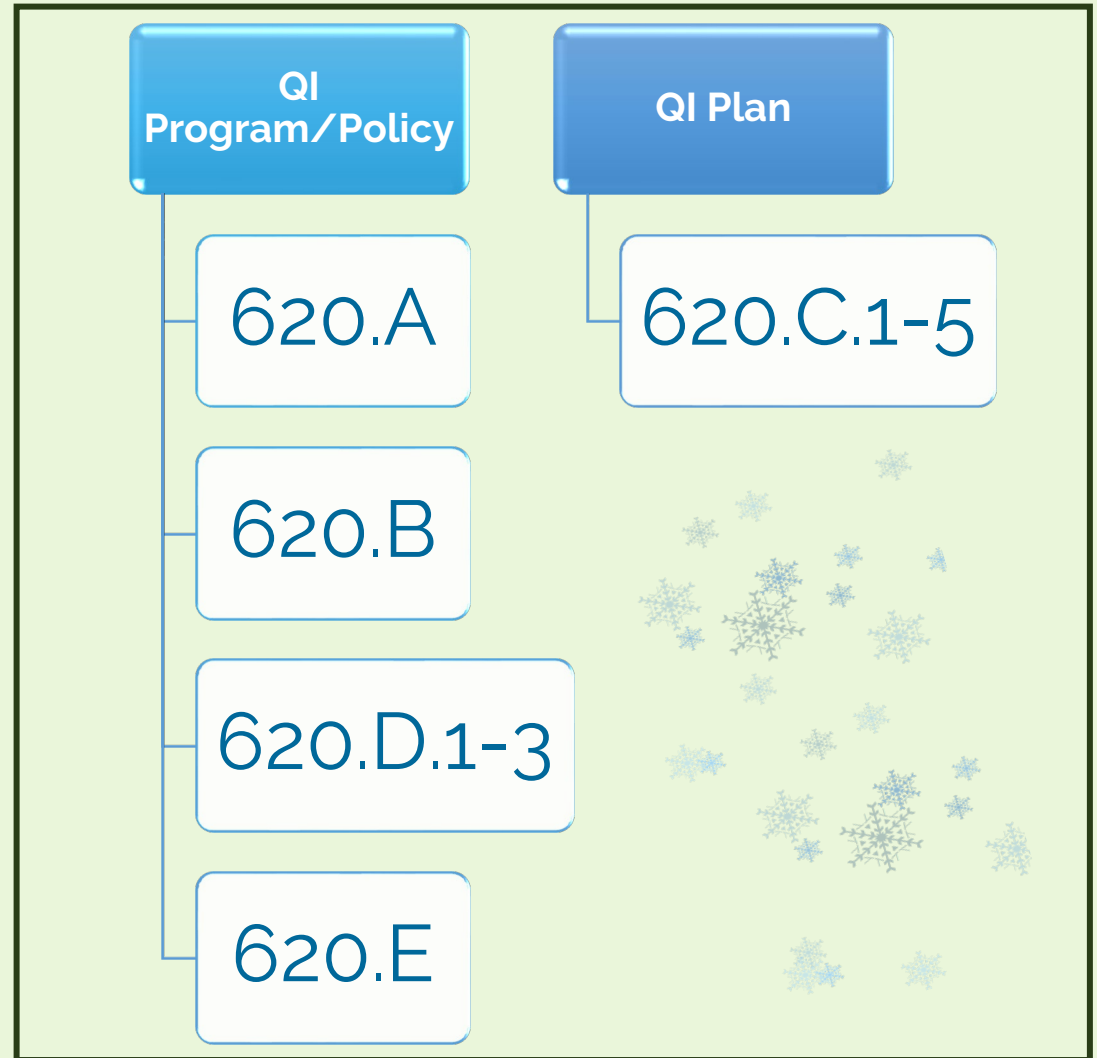
**12VAC35-105-520.C.** *The provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services. The risk assessment review shall address at least the following:*

- 1. The environment of care;*
- 2. Clinical assessment or reassessment processes;*
- 3. Staff competence and adequacy of staffing;*
- 4. Use of high-risk procedures, including seclusion and restraint; and*
- 5. A review of serious incidents.*

### **AND**

**12VAC35-105-520.D.** *The systemic risk assessment review process shall incorporate uniform risk triggers and thresholds. These are defined by the department as Care Concerns.*

- The provider's Quality Improvement (QI) Program/Policy should be distinct from their Quality Improvement Plan.
- A policy is *not* a substitute for a Quality Improvement Plan.



**12VAC35-105-620.A**

**The provider shall develop and implement written policies and procedures for a quality improvement program sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis.**

**Submit  
via  
CONNECT**

- ✓ **A quality improvement (QI) program is the structure used to implement quality improvement efforts. The structure of the program shall be documented in the provider's policies and includes:**
- ✓ **Guiding principles regarding quality improvement sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis.**
- ✓ **Structure or persons assigned to monitor and implement quality improvement efforts**
- ✓ **Procedures for evaluating clinical and service quality (record reviews, utilization reviews, customer satisfaction surveys)**
- ✓ **Quality improvement tools, including RCA, and includes a Quality Improvement Plan**
- ✓ **Criteria the provider will use to:**
  - **Establish measurable goals and objectives;**
  - **Update the provider's quality improvement plan; and**
  - **Submit revised corrective action plans to the department for approval or continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies when reviews determine that a corrective action was fully implemented but did not prevent the recurrence of the cited regulatory violation or correct a systemic deficiency pursuant to 12VAC35-105-170.**



**Documents Used to Determine Compliance: 620.A**

**Current QI policies and procedures (that demonstrate the provider has a program).**

**A quality improvement (QI) program is the structure used to implement quality improvement efforts. The structure of the program shall be documented in the provider's policies.**

**If the quality improvement program does not address all the required components as outlined in 620.A, the provider will be cited for non-compliance.**

**The QI Program/Policy must include the elements outlined in 620.A, 620.B, 620.D.1, 620.D.2 and 620.D.3.**

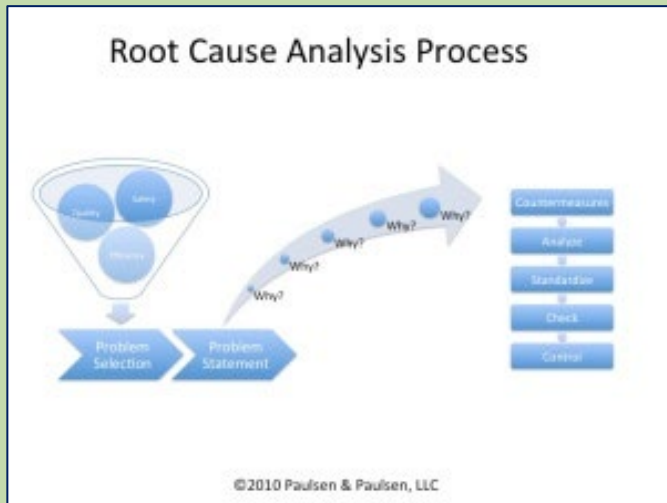
**12VAC35-105-620.B**

**The quality improvement program shall utilize standard quality improvement tools, including root cause analysis, and shall include a quality improvement plan.**

**Submit via CONNECT**

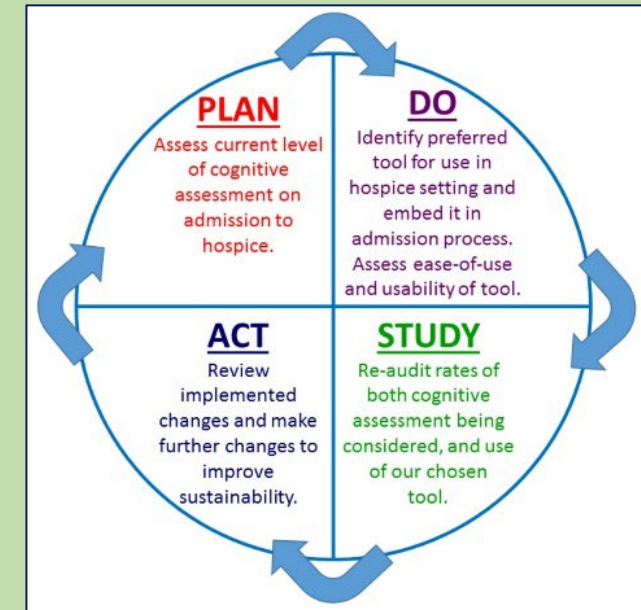
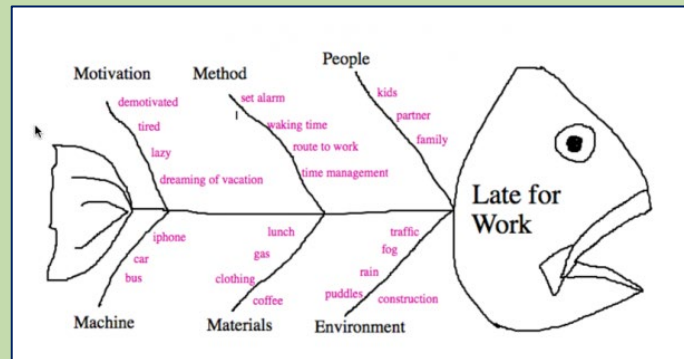
# 12VAC35-105-620.B:

The quality improvement program shall utilize standard quality improvement tools, including root cause analysis and shall include a quality improvement plan.



Examples Include:

- ✓ Pareto Charts
- ✓ Failure Mode and Effect Analysis (FMEA)
- ✓ 5 Whys
- ✓ Fishbone Diagram
- ✓ Scatter Diagram
- ✓ Affinity Diagram
- ✓ Plan Do Study Act



Documents Used to Determine Compliance: 620.B

Current QI policy/program lists quality improvement tools used, including root cause analysis.

If the Quality Improvement Policy/Program does not list the quality improvement tools used by the provider, including root cause analysis, the provider will be cited for non-compliance with 620.B.

If there is no evidence of the utilization of the QI tools, the provider will be cited for non-compliance with 620.B.

If the provider does not have a QI Plan, the provider will be cited for non-compliance with 620.B. Additionally, the provider will be cited for 620.C.1, 620.C.2, 620.C.3 (if applicable), 620.C.4 and 620.C.5.

**12VAC35-105-620.C.1-5****The quality improvement plan shall:**

1. Be reviewed and updated at least annually;
2. Define measurable goals and objectives;
3. Include and report on statewide performance measures, if applicable, as required by DBHDS;
4. Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170; and
5. Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives.



Submit  
via  
CONNECT

12VAC35-105-20 defines a quality improvement plan as “a detailed work plan developed by provider that defines steps the provider will take to review the quality of services it provides and to manage initiatives to improve quality. A quality improvement plan consists of systematic and continuous actions that lead to measurable improvement in the services, supports, and health status of the individuals receiving services.”

# Important Definition



- ***Quality Improvement Plan:*** A Quality Improvement Plan means a detailed work plan developed by a provider that defines steps the provider will take to review the quality of services it provides and to manage initiatives to improve quality. A quality improvement plan consists of systematic and continuous actions that lead to measurable improvement in the services, supports, and health status of the individuals receiving services.

Remember, the Quality Improvement Program must include a Quality Improvement Plan!

## 12VAC35-105-620.C.1



### C. The quality improvement plan shall:

#### 1. Be reviewed and updated at least annually

- As the provider you decide on what annual means. Is that calendar year or fiscal year? Etc.
- Can be a standalone plan or the risk management plan maybe be integrated into the provider's overall Quality Improvement Plan
- There is no specific template required for creating a quality improvement plan
- It must be dated to demonstrate that it was updated at least annually

## 12VAC35-105-620.C.2

### C. The quality improvement plan shall: 2. Define measurable goals and objectives

- Identifying goals and objectives may start with consideration of the individuals served and the types of services provided.
- The regulation does not require the provider to set a specific number of goals and objectives.
- What is the measure to be used? Count, percent, rate, etc.
- Is it clear what is being measured and why?
- What is the frequency of measurement? Weekly, monthly, quarterly, etc.
- What collection methods and sources of data are available?
- Who will be accountable for collecting data, analyzing data, and ensuring that relevant goals or objectives are met?





C. The quality improvement plan shall:

3. Include and report on statewide performance measures, if applicable, as required by DBHDS

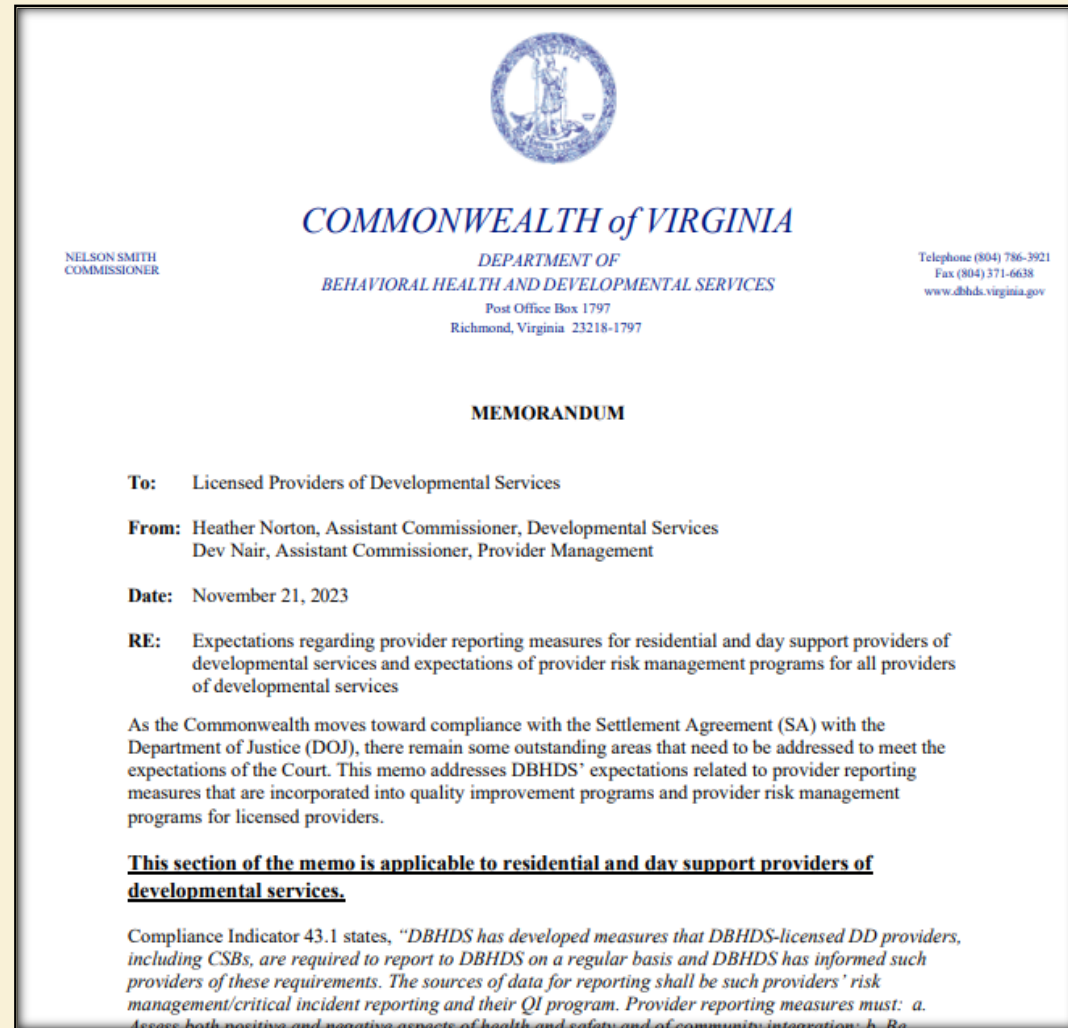
Therefore, providers will be expected to track community integration as a statewide performance measure through their quality improvement plan, as required by 12VAC35-105-620.C.3.

To meet this requirement, **each residential and day support provider** should have in their Quality Improvement Plan a specific measurable goal and objective(s) that addresses the promotion/participation in community integration:

*Meaningful work* is defined as individual supported employment or group supported employment in a setting where individuals have the opportunity to interact with non-disabled individuals.

*Meaningful community inclusion* is defined as activities that are delivered in a group of three individuals or fewer, are based on the person's preferences and choice, and completed with people the person prefers to engage with. For example, all activities are not with the four people I live with. Meaningful community inclusion can include activities that are done with paid and natural supports.

Expectations Regarding Provider Reporting Measures for Residential and Day Support Providers of Developmental Services and Expectations of Provider Risk Management Programs for All Providers of Developmental Services (November 2023)



- **Meaningful Work**

- **Example Goal:** By December 31, 2024, ABC day support/residential will increase the number of individuals in the program who are employed by 15%.

- **Example Objective:** ABC day support/residential talks with individuals at least monthly about their interest in employment.

- **Example Objective:** ABC day support/residential works with case management services at least quarterly to refer people to DARS.

- **Example Objective:** ABC day support/residential modifies their staffing pattern weekly to support people who are working.

- **Meaningful Community Inclusion (individual participation in community outings)**

- **Example Goal:** By December 31, 2024, each person with ABC day support/residential will go out with staff with no more than a 1:3 ratio at least monthly.

- **Example Objective:** ABC day support/residential talks with individuals about their interests at least weekly. OR

- **Example Objective:** ABC day support/residential coordinates with friends of individuals at least monthly to coordinate an activity.

- **Meaningful Community Inclusion (non-large group activities)**

- **Example Goal:** By December 31, 2024, each person who attends ABC day support will have the opportunity to participate in an activity in their community without their peers at least quarterly.

- **Example Objective:** ABC day support talks with individuals about their interests at least monthly.

- **Example Objective:** ABC day support schedules staff to support individuals for one-to-one activity at least weekly.

- **Example Objective:** ABC day support coordinates with friends of individuals to coordinate an activity at least monthly.

## 12VAC35-105-620.C.4



### C. The quality improvement plan shall:

#### 4. Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170

- The provider's quality improvement plan should include the process the provider will use to monitor the implementation of CAPs, including criteria for when a CAP will no longer be subject to monitoring.
- A provider may develop a measurable goal/objective that is related to corrective actions, but a provider does not need to establish goals/objectives for each corrective action. A consideration may be made to develop a goal/objective for systemic corrective actions.
- Anytime a provider is issued a CAP, they should review their QI plan and decide if the current QI plan for monitoring their CAPs

## 12VAC35-105-620.C.5



### C. The quality improvement plan shall:

#### 5. Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives

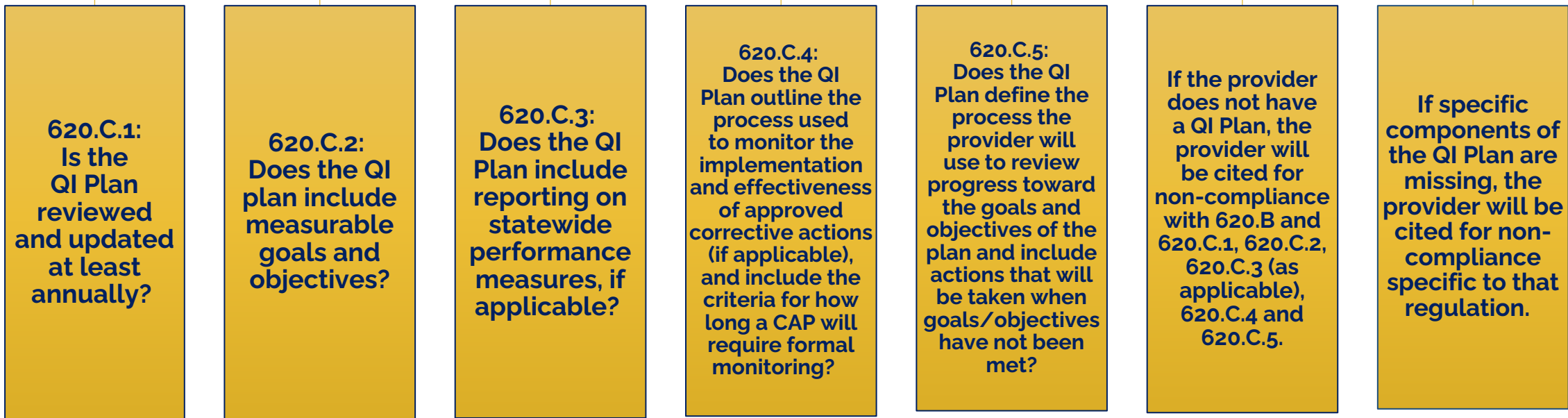
- There is a defined process in place for monitoring defining when and how the provider will review progress toward the goals and objectives.
- This may occur through establishing a quality council that regularly meets to review progress or through an established meeting structure.
- This process should include an evaluation as to whether the goals and objectives of the quality improvement plan were met, whether the goals and objectives should be revised, and if a new quality improvement initiative should be considered to better meet the goals and objectives.

**Documents Used to Determine Compliance: 620.C.1, 2, 3, 4 and 5**


**Current Quality Improvement Plan:**

When assessing compliance, the licensing specialist will review the QI Plan to ensure that it contains each of the elements specified in 620.C.1-C.5; and that the provider has evidence of implementing each element.

This may include documentation of:



If you are a DD provider of residential and/or day support services, please refer to the Office of Developmental Services Memo as it relates to 620.C.3: *“Expectations Regarding Provider Reporting Measures and Provider Risk Management Programs for Providers of Developmental Services Memo”*



**12VAC35-105-620.D.1,  
620.D.2 and 620.D.3**

The provider's policies and procedures shall include the criteria the provider will use to:

1. Establish measurable goals and objectives ;
2. Update the provider's quality improvement plan; and
3. Submit revised corrective action plans to the department for approval or continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies when reviews determine that a corrective action was fully implemented but did not prevent the recurrence of the cited regulatory violation or correct a systemic deficiency pursuant to 12VAC35-105-170.



Submit  
via  
CONNECT

Documents Used to Determine Compliance: 620.D.1,2 and 3

The provider's QI Policy/Program (620.A) must address 620.D.1, 620.D.2 and 620.D.3.

**620.D.1:** Providers need to explain (outline the criteria) when they will establish or update goals/objectives. For example, when a goal has been met, when the goal has been assessed as not effective to meet the needs, etc.

**620.D.2:** Providers need to explain (outline the criteria) when they will update their quality improvement plan. For example, at least annually, when a new service is added, etc.

**620.D.3:** In accordance with 170, when reviews determine that a corrective action was fully implemented but did not prevent the recurrence of the cited regulatory violation or correct a systemic deficiency the provider needs to explain (include the criteria) for when:


**1.** They will submit a revised CAP to the department for approval and **2.** When they will continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation.



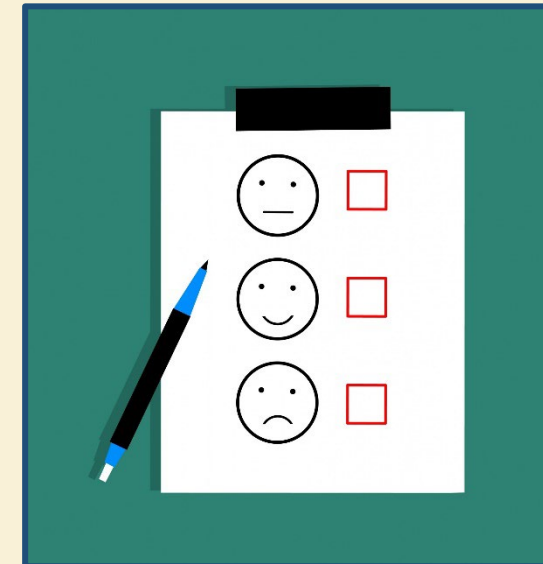


**12VAC35-105-620.E**

**Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality improvement plan. The provider shall implement improvements, when indicated.**



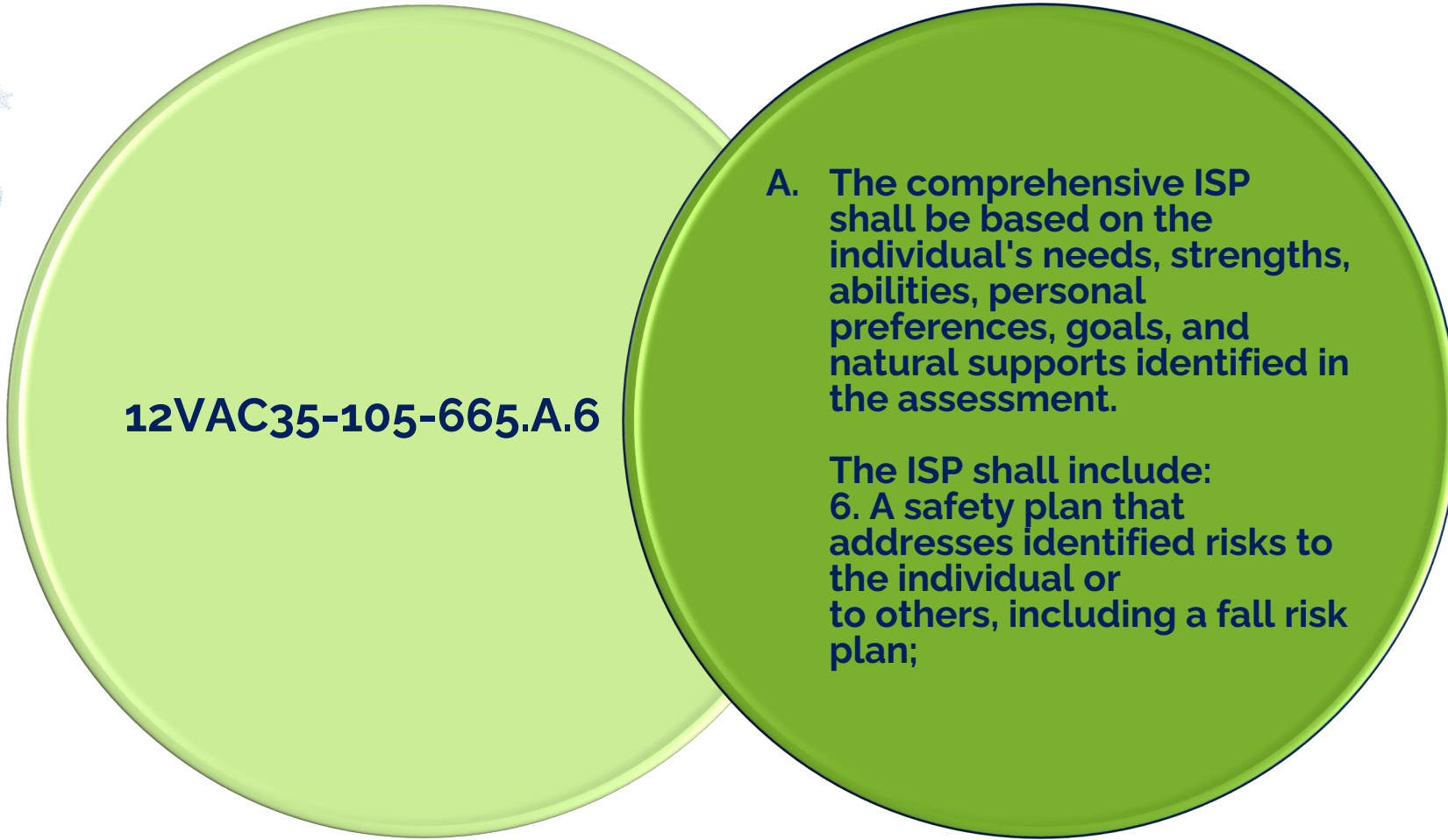

- A provider's quality improvement plan must incorporate input from individuals and their authorized representatives, when applicable, including input related to the level of satisfaction with the level of participation for individuals related to service planning; and, when improvements are indicated based on this input, such improvements shall be implemented.
- A providers quality improvement policy should include the procedures for how this input will be obtained.
- No requirement for how frequent a provider requests input from individuals/AR's (i.e. quarterly, annually, etc..)
- No requirement on the method a provider uses to obtain input (i.e. surveys, phone call, etc..)
- Satisfaction of services should be documented by the provider
- Providers are required to collect and analyze input from individuals receiving services and their authorized representatives
- Providers are required to implement improvements based on results of the input received



**Documents Used to Determine Compliance: 620.E**

**QI Plan; and**



**Proof that input was requested from individuals/AR and documentation of implemented improvements made as a result of analysis.**



**12VAC35-105-665.A.6**

**A. The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the assessment.**

**The ISP shall include:  
6. A safety plan that addresses identified risks to the individual or to others, including a fall risk plan;**



Documents Used to Determine Compliance: 665.A.6

Parts I-V of ISP, including  
Safety Plan and Falls Risk Plan

**12VAC35-105-665.D**

**Employees  
or contractors who are  
responsible for implementing  
the ISP shall demonstrate a working  
knowledge of the objectives and  
strategies contained in the  
individual's current  
ISP, including an individual's  
detailed health and  
safety protocols.**



## Documents Used to Determine Compliance: 665.D

Proof of most recent DD competency completed. For more information related to the required competencies, please refer to the DSP and DSP Supervisor DD Waiver Orientation and Competencies Protocol

Proof of staff training on individual's ISP, including health and safety protocols.



**12VAC35-105-675.D.3**

**D. The provider shall complete quarterly reviews of the ISP at least every three months from the date of the implementation of the comprehensive ISP.**

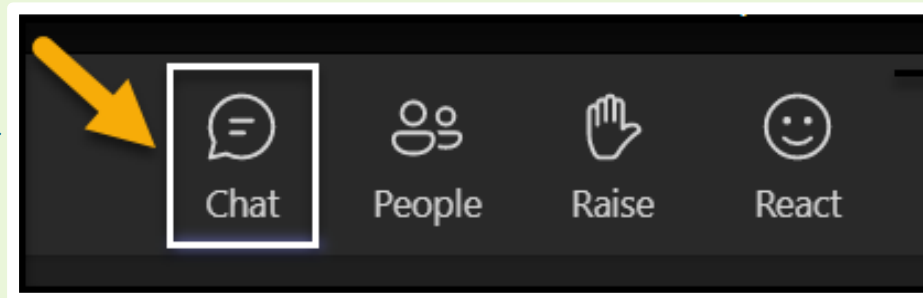
**3. For goals and objectives that were not accomplished by the identified target date, the provider and any appropriate treatment team members shall meet to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed. Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due.**



**Documents Used to Determine  
Compliance: 675.D.3**

**Last 2 quarterly reviews**

Use the Chat feature to access the link for the 'Q&A' session.



Thank you for participating in the Q&A portion of the 2024 DD Inspections Kickoff Training!

Please enter your questions below. Questions will be answered by an Office of Licensing representative during the Q&A portion of today's training.

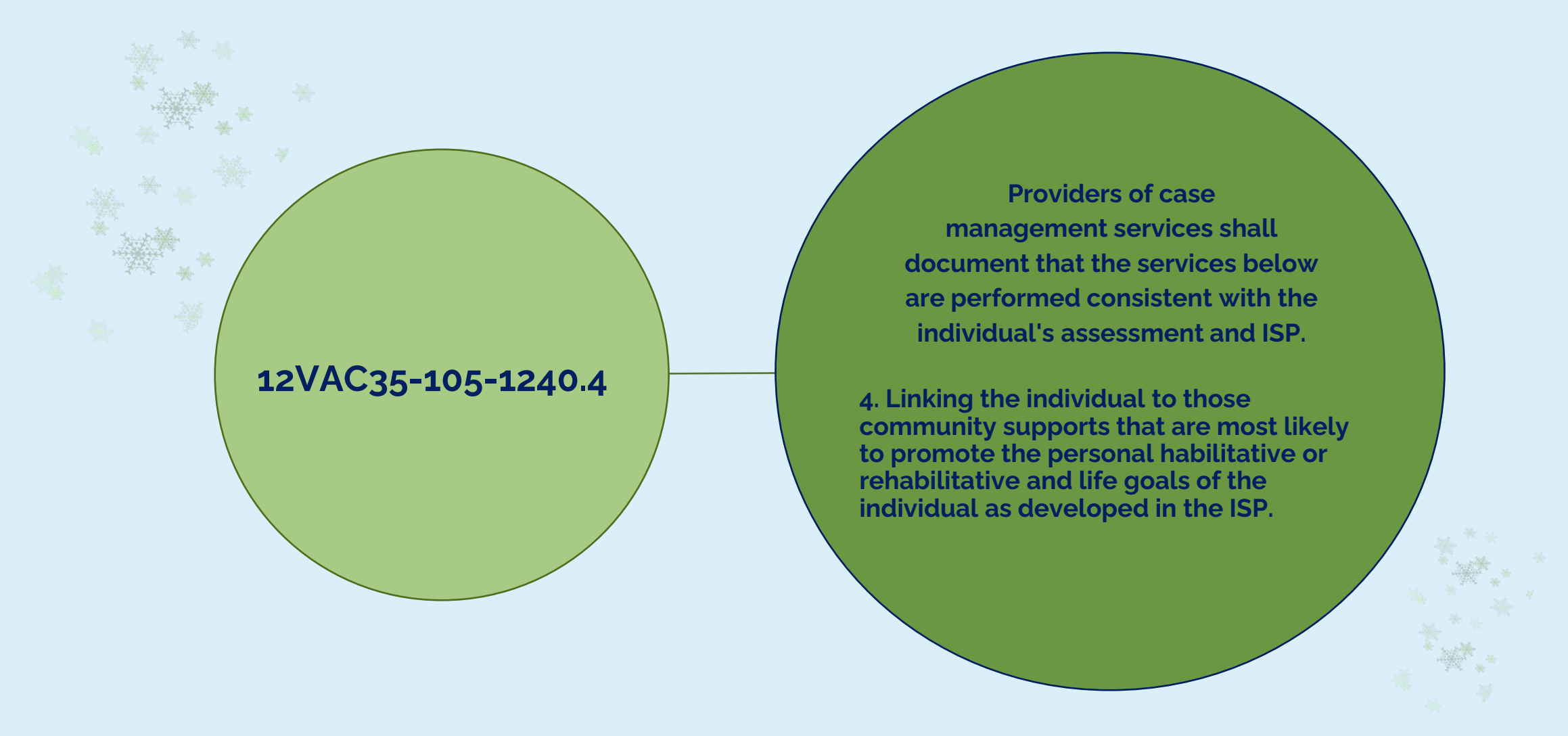
1. Please type your question here. If you have multiple questions, please submit each question separately.

Enter your answer

Submit

## Regulations Overview Part II:

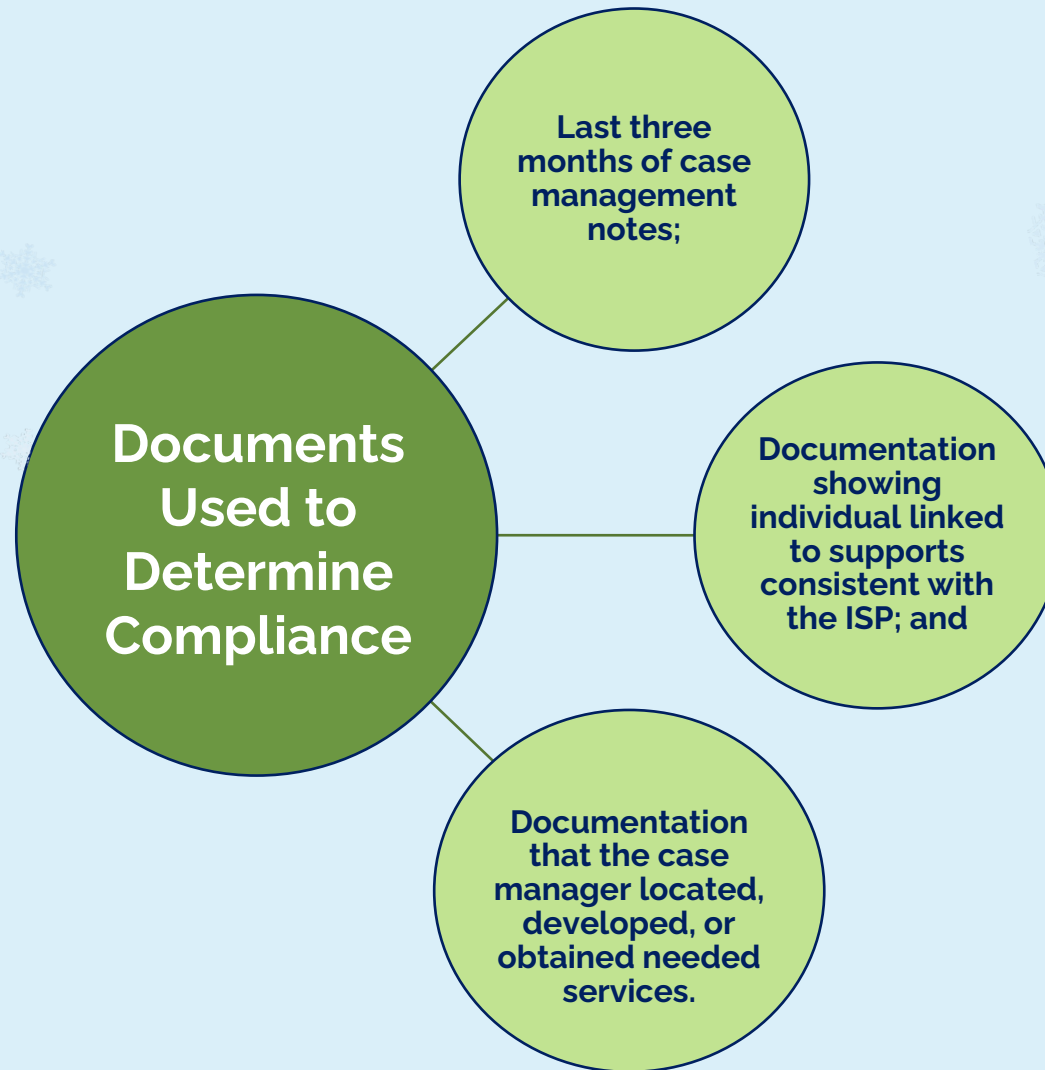
The following regulations are applicable only to Providers of Case Management Services



**12VAC35-105-1240.4**

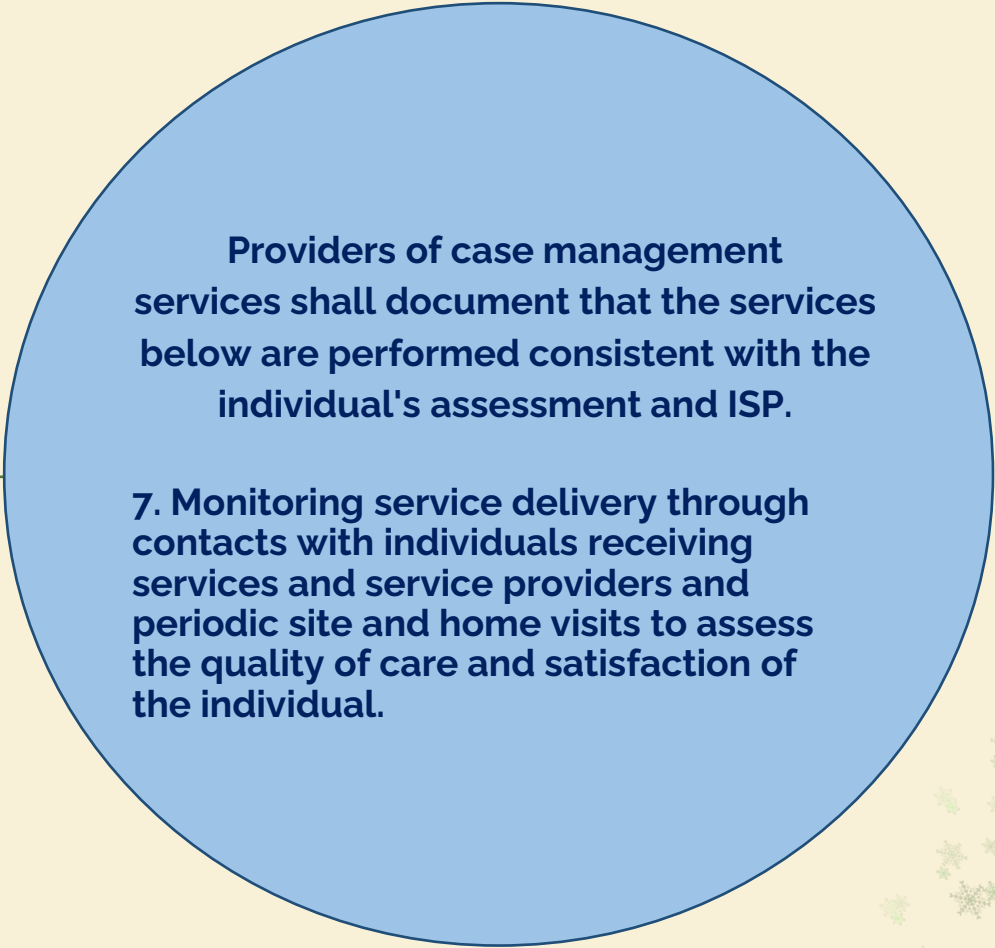
**Providers of case management services shall document that the services below are performed consistent with the individual's assessment and ISP.**

**4. Linking the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative and life goals of the individual as developed in the ISP.**



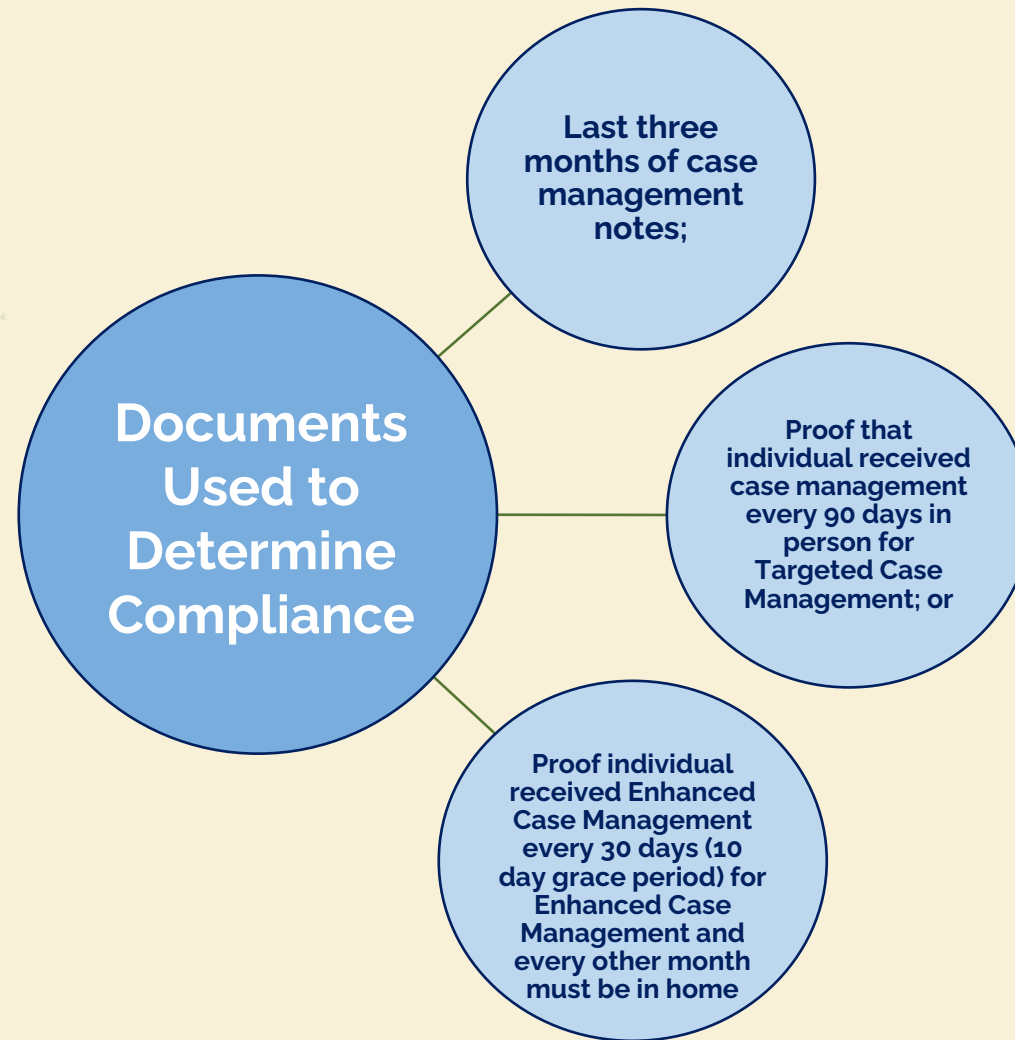


**12VAC35-105-1240.7**



**Providers of case management services shall document that the services below are performed consistent with the individual's assessment and ISP.**

**7. Monitoring service delivery through contacts with individuals receiving services and service providers and periodic site and home visits to assess the quality of care and satisfaction of the individual.**

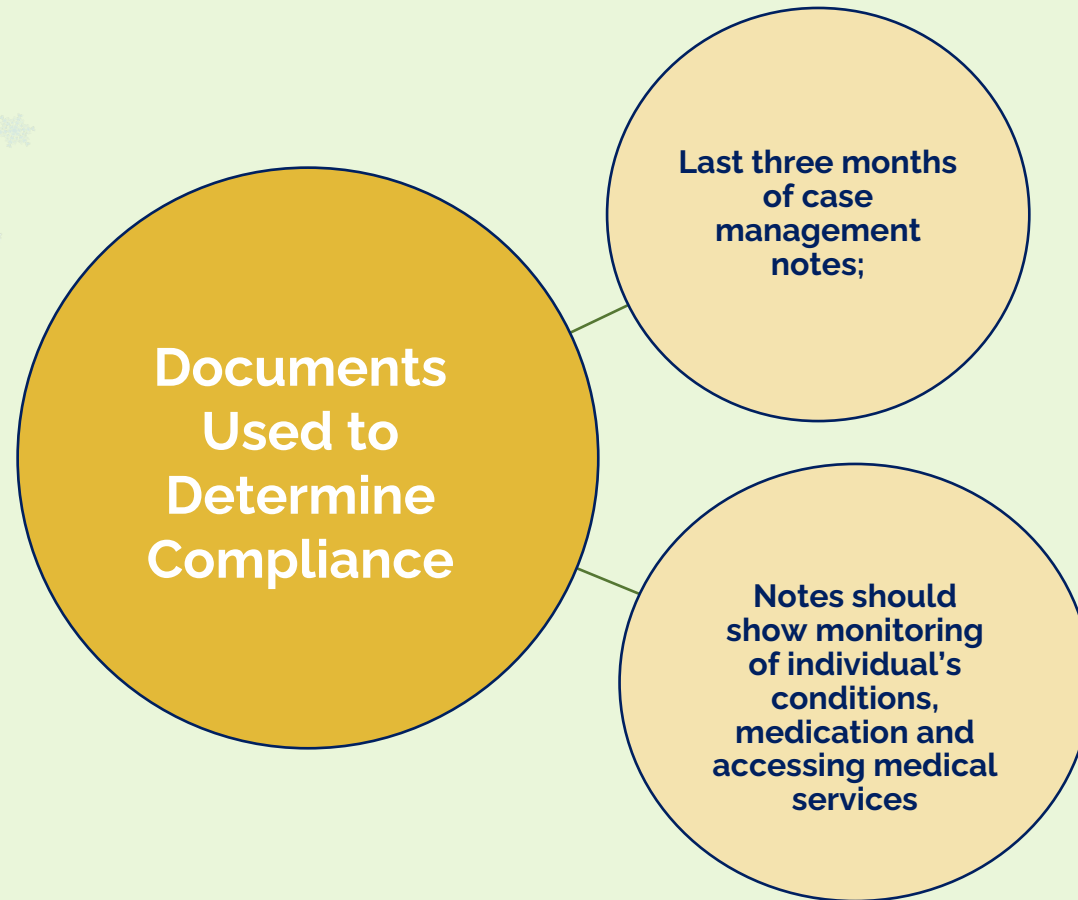


**12VAC35-105-1240.11**

**Providers of case management services shall document that the services below are performed consistent with the individual's assessment and ISP.**

**11. Knowing and monitoring the individual's health status, any medical conditions, and his medications and potential side effects, and assisting the individual in accessing primary care and other medical services, as needed.**





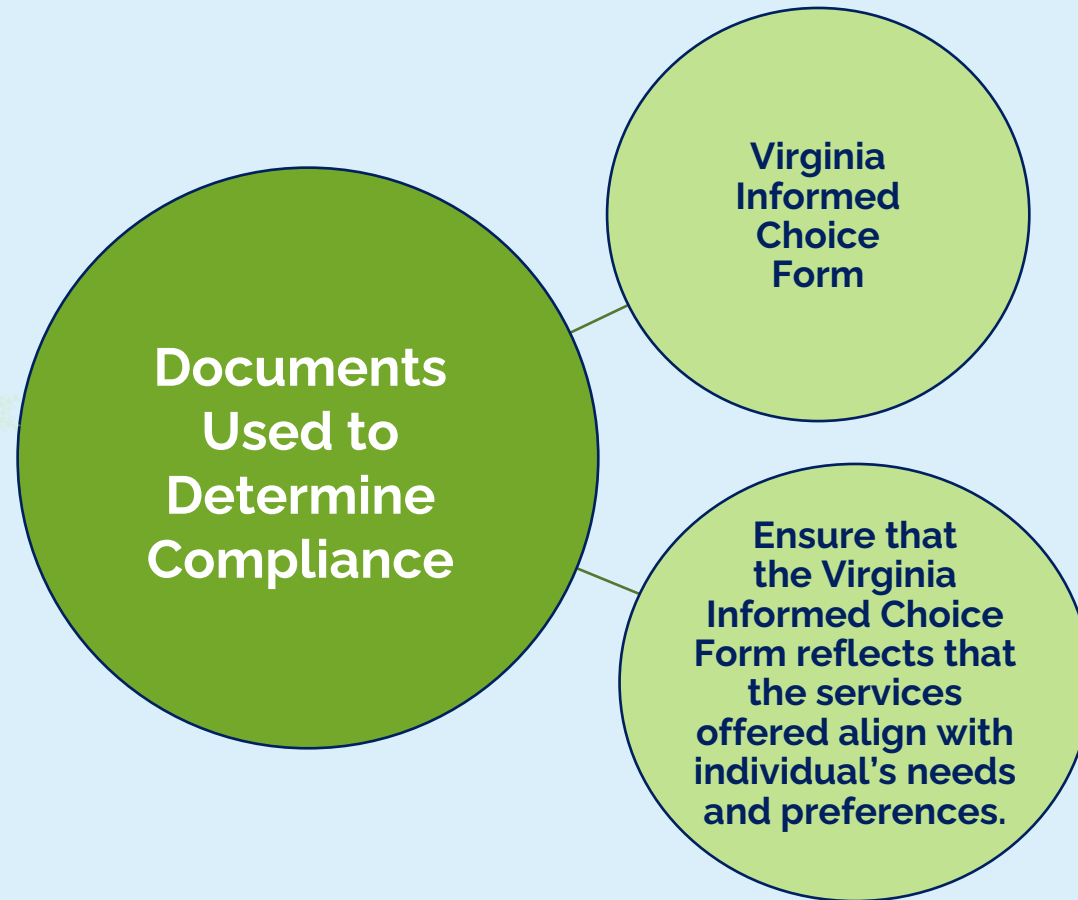


**12VAC35-105-1240.12**



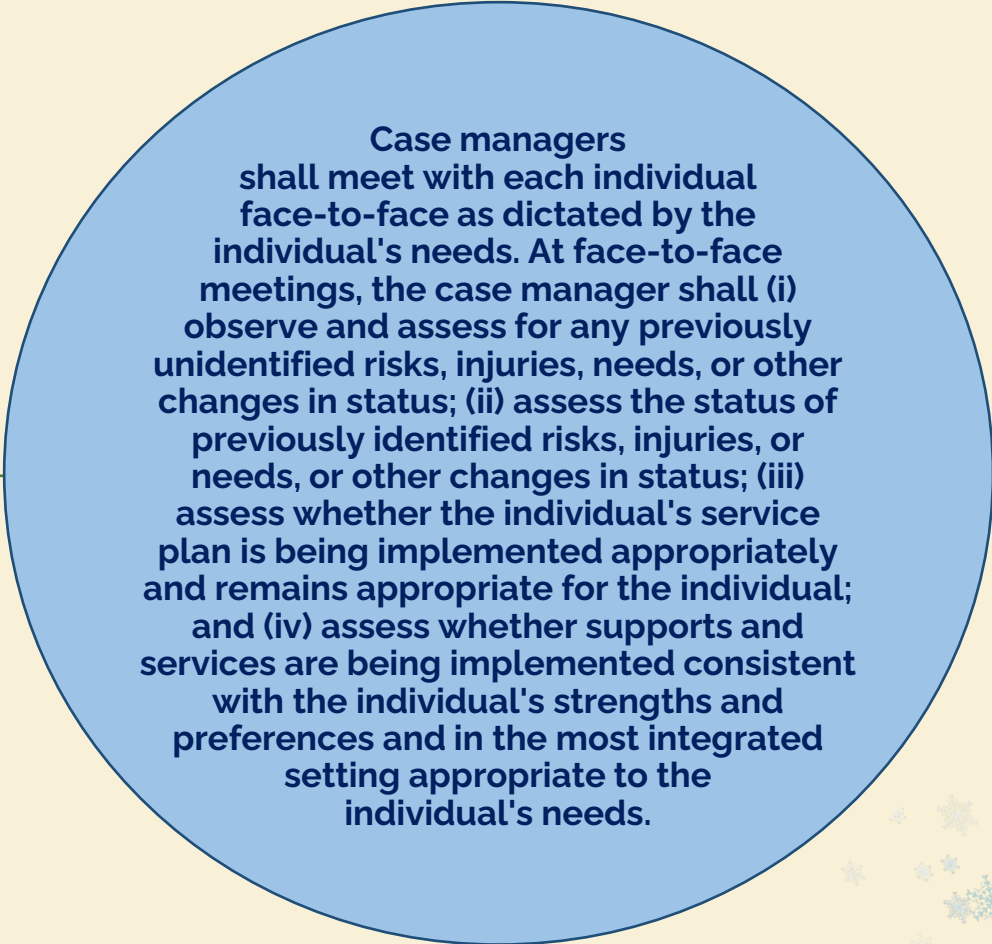
**Providers of case management services shall document that the services below are performed consistent with the individual's assessment and ISP.**

**12. Understanding the capabilities of services to meet the individual's identified needs and preferences and to serve the individual without placing the individual, other participants, or staff at risk of serious harm.**

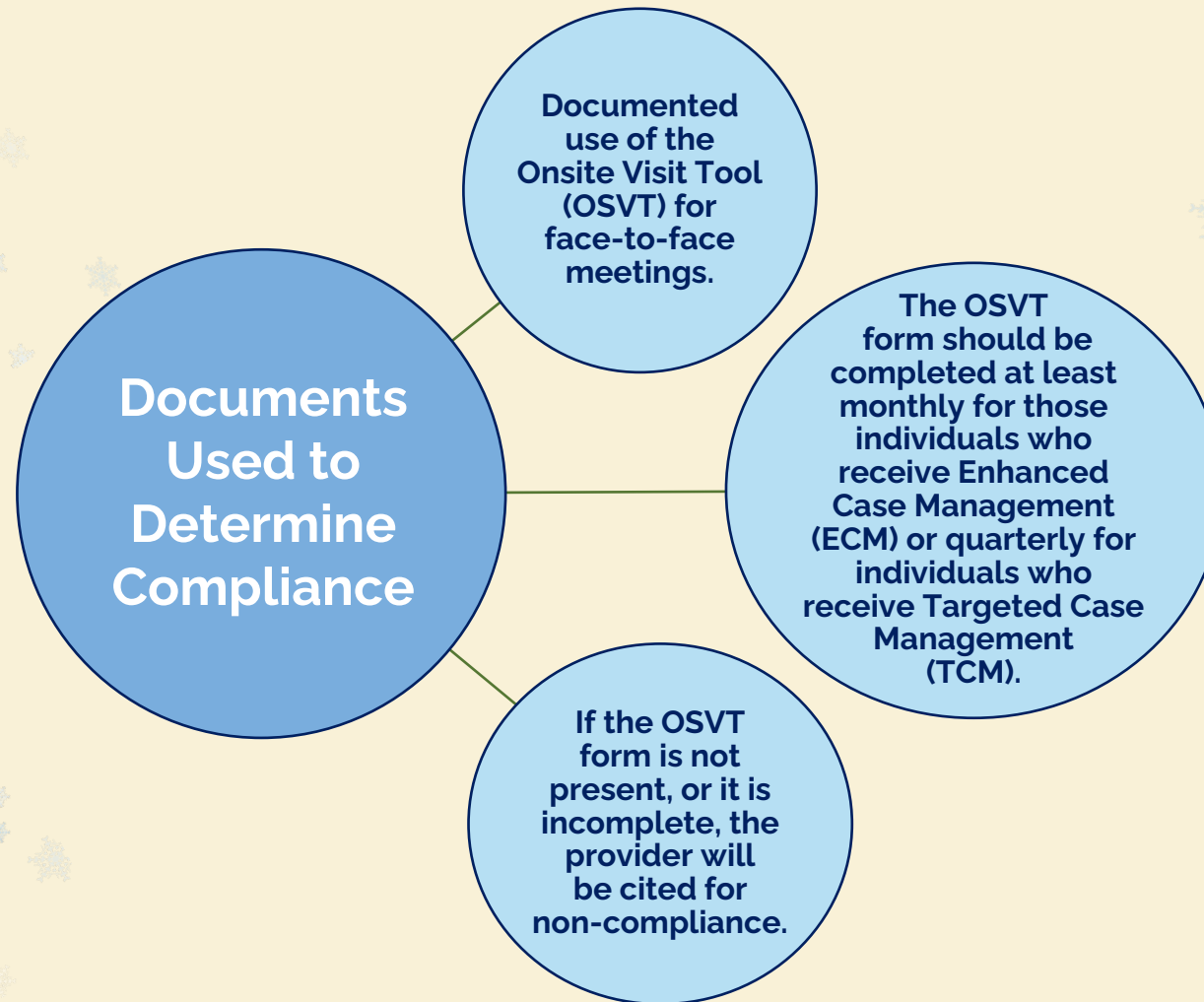




**12VAC35-105-1245**

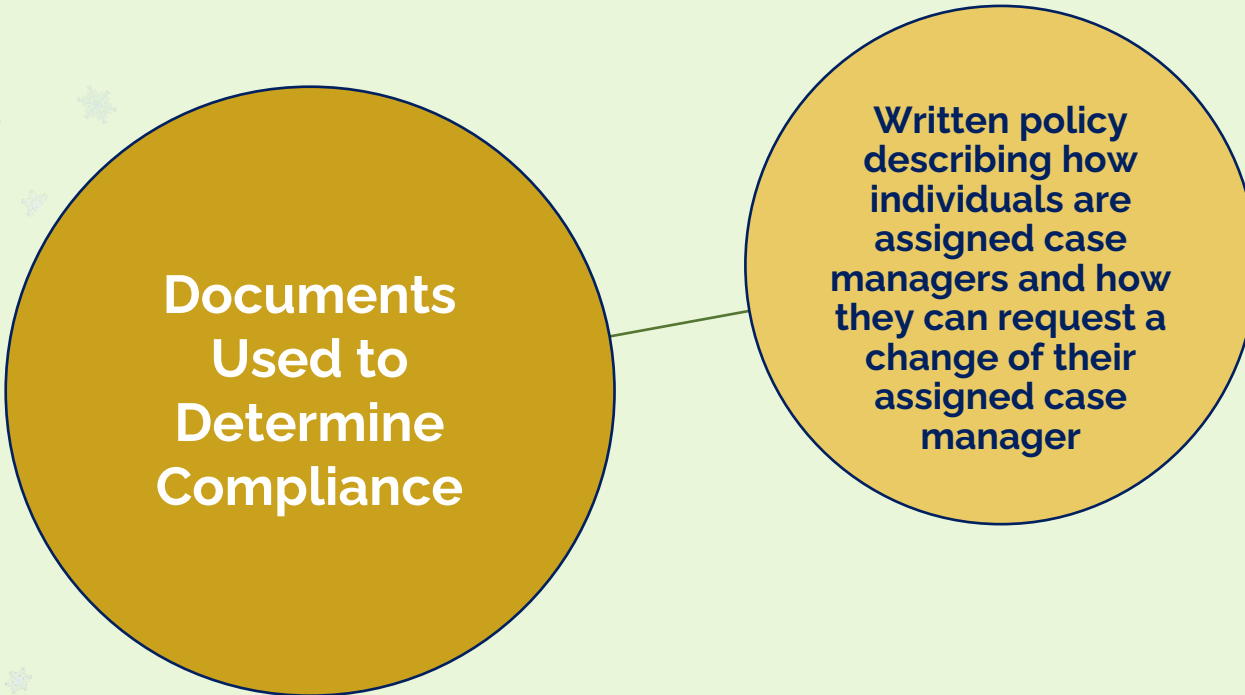


Case managers shall meet with each individual face-to-face as dictated by the individual's needs. At face-to-face meetings, the case manager shall (i) observe and assess for any previously unidentified risks, injuries, needs, or other changes in status; (ii) assess the status of previously identified risks, injuries, or needs, or other changes in status; (iii) assess whether the individual's service plan is being implemented appropriately and remains appropriate for the individual; and (iv) assess whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.



**12VAC35-105-1255**

**The provider shall implement a written policy describing how individuals are assigned case managers and how they can request a change of their assigned case manager.**





# Corrective Action Plans (CAPs): An Overview





**12VAC35-105-170.A  
&  
12VAC35-105-170.B**

- A. If there is noncompliance with any applicable regulation during an initial or ongoing review, inspection, or investigation, the department shall issue a licensing report describing the noncompliance and requesting the provider to submit a corrective action plan for each violation cited.
- B. The provider shall submit to the department a written corrective action plan for each violation cited.

**12VAC35-105-170.C**

**C. The corrective action plan shall include a:**

- 1. Detailed description of the corrective actions to be taken that will minimize the possibility that the violation will occur again and correct any systemic deficiencies;**
- 2. Date of completion for each corrective action; and**
- 3. Signature of the person responsible for oversight of the implementation of the pledged corrective action**

12VAC35-105-170.D  
&  
12VAC35-105-170.E

D. The provider shall submit a corrective action plan to the department within 15 business days of the issuance of the licensing report. One extension may be granted by the department when requested prior to the due date, but extensions shall not exceed an additional 10 business days.

**An immediate corrective action plan shall be required if the department determines that the violations pose a danger to individuals receiving the service.**

E. Upon receipt of the corrective action plan, the department shall review the plan and determine whether the plan is approved or not approved. The provider has an additional 10 business days to submit a revised corrective action plan after receiving a notice that the department has not approved the revised plan. If the submitted revised corrective action plan is not approved, the provider shall follow the dispute resolution process identified in this section.

**12VAC35-105-170.F**

**F. When the provider disagrees with a citation of a violation or the disapproval of a revised corrective action plan, the provider shall discuss this disagreement with the licensing specialist initially. If the disagreement is not resolved, the provider may ask for a meeting with the licensing specialist's supervisor, in consultation with the director of licensing, to challenge a finding of noncompliance. The determination of the director is final.**

Virginia.gov Agencies | Governor

**VIRGINIA**  
REGULATORY TOWN HALL

Home >

**Agency** Department of Behavioral Health and Developmental Services

**Guidance Document Information**

<b>Title</b>	Corrective Action Plans (CAPs)
<b>Document ID</b>	LIC 19
<b>Summary</b>	Purpose: This document provides guidance to DBHDS licensed providers on how to develop and implement an acceptable correction action plan (CAP). Questions should be directed to Jae Benz, phone -- (804) 786-1747 or email -- jae.benz@dbhds.virginia.gov.
<b>Effective Date</b>	8/22/2020
 <a href="#">View document text</a>	Posted On 12/20/2022 <i>Document on Town Hall</i>
<b>Explanation or Citations</b>	Regulations addressed: Note all regulatory language is formatted in italics while guidance language is in plain text located within boxes under the label "guidance." 12VAC35-105-20. Definitions 12VAC35-105-170. Corrective Action Plan Settlement Agreement indicators addressed: V.C.4.8

This document applies to all boards for this agency

**Public Comment Forums / Change History**

Proposed Change	Register Date	Status
<a href="#">This document provides guidance to DBHDS licensed providers on how to develop and implement an acceptable correction action plan (CAP).</a>	6/22/2020	Forum ended on 7/22/2020 with 22 Comments.

[Back to showing guidance documents for this agency](#)

Virginia Department of Behavioral Health & Developmental Services

**DBHDS Office of Licensing**  
**Guidance on Corrective Action Plans (CAPs)**

**Effective:** August 22, 2020

**Purpose:** This document provides guidance to DBHDS licensed providers on how to develop and implement an acceptable corrective action plan (CAP).

**Regulations addressed:** Note all regulatory language is formatted in italics while guidance language is in plain text located within boxes under the label "guidance."  
12VAC35-105-20. Definitions  
12VAC35-105-170. Corrective Action Plan

**Settlement Agreement indicators addressed:**  
V.C.4.8

**Guidance:**

**12VAC35-105-20. Definitions.**  
The following definitions are relevant to this guidance document.

"Corrective action plan" means the provider's pledged corrective action in response to cited areas of noncompliance documented by the regulatory authority.

"Systemic deficiency" means violations of regulations documented by the department that demonstrate multiple or repeat defects in the operation of one or more services.

**Guidance:**

The development, implementation, and monitoring of CAPs are important components of a provider's overall quality improvement process. Adequate CAPs address identified deficiencies on both an individual and systemic level.

**12VAC35-105-170. Corrective action plan.**  
A. If there is noncompliance with any applicable regulation during an initial or ongoing review, inspection, or investigation, the department shall issue a licensing report describing the noncompliance and requesting the provider to submit a corrective action plan for each violation cited.

DBHDS, LIC19, August 2020 5

## LIC 19: Corrective Action Plans (CAPs) (August 2020)



**12VAC35-105-170.G  
&  
12VAC35-105-170.H**

**G. The provider shall implement their written corrective action plan for each violation cited by the date of completion identified in the plan.**

**H. The provider shall monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 12VAC35-105-620. If the provider determines that an approved corrective action was fully implemented, but did not prevent the recurrence of a regulatory violation or correct any systemic deficiencies, the provider shall:**

- 1. Continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies; or**
- 2. Submit a revised corrective action plan to the department for approval.**

## Tips and Reminders Related to Corrective Action Plans (CAPs)

Providers need to ensure that Corrective Action Plans are submitted by the due date.

An immediate CAP will be required if the department determines that the violations pose a danger to individuals receiving the service which would be identified as a Health & Safety CAP.

If an extension is needed, it must be requested via CONNECT PRIOR to the due date. Extensions will not be given for H&S violations

The provider must monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 12VAC35-105-620.

There has been a notable increase in DBHDS licensed providers not submitting CAPs by the due date. Providers that do not submit or implement an adequate CAP may be subject to progressive action including reduction of license status, denial or revocation of a license in accordance with the regulation below.

In accordance with 12VAC35-105-110.7, a provider or applicant who fails to submit or implement an adequate CAP may have their license denied, revoked, or suspended.

For additional details on how to respond to a CAP, please refer to: [Guidance Document LIC 19: Corrective Action Plans \(CAPs\)](#) (August 2020), located on the OL website in the regulations and guidance section.

## Help US to Help YOU!

- At the conclusion of today's training, you will receive an email with this link to a brief survey about today's training:

[Survey: 2024 DD Inspections Kickoff Training](#)

- You can also scan this QR code to complete the Survey on your mobile device ----->
- Completing the Survey provides an opportunity for you to share your feedback and assists us with improving future training events.





**Reminders:**

- This PowerPoint presentation and recording will be available on the Office of Licensing website soon.
- Links to all resources noted throughout this presentation will also be included.
- You will receive an email shortly with the link to complete the Survey.





**We wish you all a whimsical winter!  
Thank you for being part of our team!**

