NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

GUIDANCE DOCUMENT

"This guidance document is advisory in nature but is binding on an agency until amended by such agency. A guidance document does not include internal procedural documents that only affect the internal operations of the agency and does not impose additional requirements or penalties on regulated parties or include confidential information or rules and regulations made in accordance with the Nebraska Administrative Procedure Act. If you believe that this guidance document imposes additional requirements or penalties on regulated parties, you may request a review of the document."

Pursuant to
Neb. Rev. Stat. § 84-901.03

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services
Division of Developmental Disabilities

Incident Follow-up Guide

Updated May 2023

NEBRASKA
Good Life. Great Mission.

Table of Contents

Introduction

The instructions in this guide are intended for providers of Medicaid Home And Community-Based Services (HCBS) Developmental Disabilities (DD) Waiver services. This guide outlines current requirements for follow-up on reportable incidents: when follow-up must be completed, timelines for completing follow-up, what follow-up must include, and how follow-up is documented and submitted to the Department of Health and Human Services Division of Developmental Disabilities (DHHS-DD).

Follow-up includes an initial review and, depending on the nature of the incident and the initial review may include a more thorough full investigation. The purpose of incident follow-up is to assess whether supports and services were being provided as required immediately before, during, and after the incident, and to determine whether any further action should be taken to ensure the safety of the participant and others or reduce the frequency and severity of reportable incidents over time.

By completing the follow-up outlined in this guide, a provider has met the regulatory requirements for an investigation of each reportable incident (404 NAC 4-008.01.5.c).

When is Incident Follow-up Required?

Follow-up **must** be completed for **every** reportable incident (*each* medium and high general event report (GER) submitted in Therap).

Definitions for reportable incidents and instructions for completing the initial GER can be found in the Incident Reporting and GER Guide. **All** incidents defined as reportable in the Incident Reporting and GER guide must be reported to DHHS-DD as outlined in the guide.

No follow-up is required for non-reportable incidents a provider chooses to document in a low GER or elsewhere.

Timelines for Completing Required Incident Follow-up

The required follow-up must be completed and a summary submitted **in writing** to DHHS-DD according to the instructions in this guide within **14 calendar days of the *submission* of the initial GER** in order to meet regulatory requirements. There are *no* exceptions to this timeline, including when the 14th calendar day is a weekend or holiday. When this occurs, the written summary must still be submitted within 14 calendar days of the submission of the initial incident report.

When the follow-up is delayed for any reason, the reason for the delay must be documented in the summary of the follow-up. For example, when law enforcement or Adult Protective Services (APS) are investigating an allegation of abuse, neglect, or exploitation, they may ask the provider to put their investigation on hold until the law enforcement or APS investigation can be completed. When this occurs, it should be documented in the follow-up summary.

Who Completes Incident Follow-up?

The provider who submits the GER is responsible for the completion of the follow-up outlined in this guide. The provider may assign any employee or contractor to be responsible for incident follow-up; this person is called “the investigator” in this guide.

The investigator must:

- Have any knowledge, experience, or training needed to complete a thorough review and make recommendations to ensure the safety of the participant and others, and reduce the likelihood of future incidents;
- Have no involvement in the reported incident under review; and
- Be free from conflict of interest in order to objectively and impartially review the incident and incident report.

Incident Follow-up Requirements

Incident follow-up must meet the minimum requirements outlined in this section to meet the regulatory requirements for investigation (404 NAC 4-008.01.5.c). Depending on the nature and severity of the incident, some incidents may require only an initial review, while others may require a full investigation.

The incident follow-up must answer the following questions:

- Is the information in the GER complete and accurate?
- Were all applicable laws, regulations, waiver requirements, and DHHS-DD policies followed?
- Were all agency policies and procedures followed?
- Was the participant's Individual Support Plan (ISP) followed?
- Are all the participant's needs and risks adequately addressed by the supports in the current ISP? When not adequately addressed, did this contribute to the incident?
- Are there any patterns or trends of similar incidents over the past six months?
- Was any action taken at the time the incident occurred to maintain the safety and well-being of the participant?

The incident follow-up must also include recommendations to address any concerns or contributing factors identified.

See *Guidelines for Answering Follow-up Questions* for a description of what should be considered in answering these questions.

Ensure Safety

The first step in incident follow-up is to ensure the safety of the participant and others while follow-up is ongoing. The investigator should review the incident and action taken to confirm the provider's actions immediately after the incident were adequate to protect the participant and others. Action taken to protect the participant may include separating involved staff or other participants, temporary safety plans, or other actions, based on the nature of the incident.

When appropriate actions were not taken to protect the participant and others at the time of the incident, this must be addressed by the provider immediately upon being identified by the investigator.

Initial Review

The initial review is completed for **all** reportable incidents, regardless of type or severity.

- The initial review *must* include a review of the approved GER and the relevant portions of the participant's ISP, at a minimum.
- It may also include a review of other supporting documentation and interviews with staff and participants involved, as needed, to answer the follow-up questions listed above.

- When the investigator requires additional information to answer the follow-up questions, it is not required that they complete a full investigation. However, the investigator should review any additional documentation or interview any participants or staff involved to get the information needed to answer the follow-up questions.

Full Investigation

A full investigation is required:

- For all reported incidents in the following categories:
    - Participant deaths;
    - Situations that adversely affect the physical or emotional well-being of an individual served;
    - Incidents of suspected or alleged abuse, neglect, or exploitation; and
    - Emergency safety situations that require the use of emergency safety interventions
    - Use of prohibited practices; or
- When the initial review indicates:
    - A full investigation is needed to ensure the safety of the participant or others due to the circumstances or severity of the incident;
    - Staff involved did not follow applicable laws, regulations, requirements, agency policies, or the participant's ISP, and the incident may have been prevented had the staff followed all policies and requirements as written; or
    - Staff did not follow applicable laws, regulations, requirements, agency policies, or the participant's ISP, and the initial review indicates it is not an isolated occurrence; or
- When directed to complete a full investigation by the participant's team or DHHS-DD immediately following the incident or upon reviewing the summary of the initial review.

When a full investigation is required, the investigator must:

- Complete all initial review requirements;
- Interview all staff involved in the incident;
- Interview all staff who witnessed the incident or others who may have relevant information;
- Interview the participant(s) involved in the incident, unless the ISP team has determined that it may be potentially traumatic or result in a behavioral episode to interview them;
- Review all potentially relevant documentation, including but not limited to:
    - Daily logs/T-logs from the days surrounding the incident;
    - Behavior support plans (BSP)/habilitation plans and data from the days surrounding the incident;
    - Recent medical documentation from physicians/hospitals treating the participant;
    - Medical protocols/plans and data from the days surrounding the incident;
    - Staff logs, mileage logs, medication administration records (MARs), or any other documentation kept by the provider which could have relevant information; and
    - Photographs, audio, or video evidence.

Recommendations

The investigator must make recommendations to address **all identified concerns or contributing factors discovered during the course of the incident follow-up.** For example, policies are not followed or the participant's plan is not implemented as written.

- Recommendations for the agency provider may include, but are not limited to:
    - Providing training/education to staff involved in the incident;
    - Providing training/education to all staff working at a specific site or agency-wide;
    - Review of staffing for a specific participant or at a specific site;
    - Review of provider policies and procedures for potential revision; and
    - Suggested modifications of environments.
- Recommendations for Service Coordination or the ISP team may include, but are not limited to:
    - Consider review and revision of the participant's plan and/or supports;
    - Consider referral for medical care, medication review, or therapy; and
    - Consider referral for new assessments.

Recommendations must include timeframes for completion to ensure all identified concerns are addressed in a timely manner to ensure the safety of the participant and others.

The follow-up on all recommendations must be documented in the follow-up summary to demonstrate that the responsible personnel reviewed the recommendations and either took action to address the identified concern or provided justification for why the recommended action was not taken.

When recommendations are completed, the provider must upload evidence of completion to the supporting documentation section of the *GER Resolution*. Supporting documentation may include but is not limited to training records, revised policy and procedures, plan changes, evidence of environmental modifications or repairs, etc.

Upon quality assurance review by DHHS-DD or Liberty, the provider or ISP team may be required to take additional actions to remediate any issues that were not adequately addressed.

Examples of possible remediation activities and timelines for completion:

Corrective Action Category	Time Frame for Remediation
Alleged Perpetrator corrective action to include training	Must be done prior to working with participants.
General Re-training	Staff/Providers directly involved in the incident – no more than 10 business days. Other staff/providers as deemed necessary – no more than 30 business days.
Revision/Development of Policies and Procedures	No more than 30 business days.
Critical Event Response (i.e., medication error resulting in hospitalization)	No more than 5 business days.
Environmental Modifications (i.e., repairs)	Potential for significant injury/illness – prior to participant(s) return All Others – request/referral for repairs must be made within 30 business days with ongoing evidence of requests until repairs are made.
Other	Negotiable – within a reasonable time but no more than 90 business days.

Documenting Incident Follow-up

There must be written documentation of all aspects of incident follow-up, including:

- All information gathered, through review of documentation and interviews, which is not already documented in the GER;
- A summary of the review of the follow-up questions and any concerns identified;
- Any other issues identified during the course of incident follow-up; and
- Recommendations for addressing all concerns identified.

It is required for written documentation of the incident follow-up to be submitted to DHHS-DD using the *GER Resolution* form in Therap.

- Some providers have their own forms for documenting incident follow-up.
- When a provider wants to continue using their own existing form to document incident follow-up but does not want to duplicate documentation in the *GER Resolution*, the provider may attach the completed form documenting the incident follow-up to the *GER Resolution*, as long as:
    - The attached form covers **all** required documentation outlined in this guide.
    - The follow-up questions and answers are all entered into the *GER Resolution* in the *Notes* section of the *Resolution Summary*.
    - All recommendations made by the investigator and progress towards addressing those recommendations are entered in the *GER Resolution* in the *Recommendations* section.

Required Notifications

When incident follow-up is complete, the investigator must notify the participant's Service Coordinator (SC) *via S-Comm*. This notification is the agency provider's evidence the incident follow-up summary was submitted to DHHS-DD (as required in 404 NAC). This notification is used by DHHS-DD to assess whether the provider met the required timelines in submitting documentation.

- When the provider makes revisions to the *GER Resolution* form after the form is "closed" and the SC has been notified, the SC must be notified of the changes made.
    - This requirement does not apply to updates made to the *GER Resolution* form to document the completion of recommendations made by the investigator.

The provider must also notify the participant and their guardian(s), when applicable, of the outcome of the follow-up.

Guidelines for Answering the Follow-up Questions

In order to answer the follow-up questions, the investigator will review the initial GER, the participant's ISP, and other relevant documentation, interview staff, and participants involved in the incident, and review relevant statutes, regulations, agency policies, and guidelines. The investigation should include the collection and review of **all** available information needed to answer the questions and make recommendations to address any identified concerns.

Is the information in the GER complete and accurate?

The investigator should consider:

- Does the GER contain all necessary information or is additional information needed?
- Are there any inconsistencies or inaccuracies in the GER?

When any issues with the GER are identified, the investigator must review additional documentation, complete interviews with staff and participants, and review evidence to resolve any inconsistencies or conflicting information and correct any inaccuracies.

Additional documentation may include:

- ISP;
- Safety Plan;
- Behavior Support Plan;
- Other safety or medical plans/protocols;
- Relevant medical documentation such as physician contact forms or discharge instructions;
- T-Logs; and
- Past GERs and *GER Resolutions* for similar incidents.

Were all applicable laws, regulations, waiver requirements, and DHHS-DD policies followed?

This question relates to things that occurred which **directly** relate to the incident being reviewed, including immediately before, during, and immediately after the incident.

The investigator should consider:

- Were any supports or interventions used during the incident prohibited by state law, state regulations governing developmental disabilities services, or Medicaid HCBS DD Waiver requirements?
- Did any employee or contractor of the agency provider allegedly commit abuse, neglect, or exploitation of a child or vulnerable adult in violation of state law?
- When the incident involved potential abuse, neglect, or exploitation, was a report made to the Abuse/Neglect Hotline or law enforcement, as required by state law?
- When any potentially restrictive measure was used, was it compliant with state regulations governing developmental disabilities services? This includes whether it was used with approval from the ISP team, consent from the participant/guardian, and approval from a rights review committee.
- When any staff have a professional license or certification, were they compliant with relevant laws/regulations which govern their licensed or certified role? This includes medication aides or nurses.
- When the incident took place in a licensed facility, were all licensure regulations for the facility followed?

*When it is identified any applicable law, regulation, waiver requirement, or DHHS-DD policy was **not** followed, the provider is responsible for taking action to address the identified issue, based on the recommendation of the investigator.*

Were all agency policies and procedures followed?

This question relates to things that occurred which **directly** relate to the incident being reviewed, including immediately before, during, and immediately after the incident.

The investigator should consider whether any applicable agency policies and procedures were not followed, such as those related to:

- Use of restraint or emergency safety intervention;
- Emergency preparedness;
- Medication administration;
- Provider-wide seizure protocol;
- When to consult with provider medical staff; and

- When to consult with a supervisor, on-call supervisor, or administrative staff.

*When it is identified any applicable agency policy or procedure was **not** followed, the provider is responsible for taking action to address the identified issue, based on the recommendation of the investigator.*

Was the participant's ISP followed?

This question relates to things that occurred, that **directly** relate to the incident being reviewed, including immediately before, during, and immediately after the incident.

The investigator should consider:

- Did staff provide supervision of the participant as outlined in the ISP?
- Did staff follow the participant's behavior support plan?
- Did staff follow the safety plan?
- Did staff follow any other procedures/plans/protocols outlined in the ISP?
- Were all supports and interventions used correctly (for example, used at the right time, in the right situation, in the right way, etc.)?

*When it is identified any supports or services were **not** provided as specified in the ISP, the provider or ISP team is responsible for taking action to address the issue, based on the nature of the issue and the recommendation of the investigator.*

- When the issue is related to staff training or with parts of the ISP written by the provider (such as a safety plan or habilitation program), the provider is responsible for addressing the issue.
- When the issue is related to how the needed supports and services are documented in the ISP (for example, when the ISP does not contain sufficient information to correctly implement needed supports/interventions or is written in a way that is difficult for staff to understand), the ISP team is responsible for addressing the issue.

Are there participant needs or risks that contributed to the incident and may not be adequately addressed by current supports?

The investigator should consider whether the incident could have been prevented or minimized if different supports or interventions were identified in the ISP to address the participant's needs/risks. This could include:

- New interventions not currently in the ISP
- Changes to current interventions to better meet the participant's needs

When it is identified changes to the participant's current supports may be beneficial in preventing or reducing future incidents, the ISP team is responsible for reviewing the participant's plan to determine if revision is appropriate, based on the recommendation of the investigator.

Are there any relevant patterns or trends of similar incidents, circumstances, or other factors over the past six months?

The investigator should review all reportable incidents for the participant over the past six months to determine if there have been other incidents similar to the incident being investigated.

When there have been similar incidents, the investigator should consider:

- Are there any common factors/patterns to the similar incidents?

- This could include similar times of day, days of the week, staff present, peers present, location, activity, etc.

- Does the frequency of similar incidents appear to be increasing, decreasing, or remaining the same?
    - When the frequency is increasing or remaining the same, the investigator should review actions taken in response to the previous incidents to determine if different actions or changes to the participant's plan may be more effective going forward.

When any trends, patterns, increasing frequency, etc. are identified in the review of similar incidents, the provider or the ISP team is responsible for taking action to address the issue, based on the recommendation of the investigator.

- When the issue is related to staff training, parts of the plan written by the provider (such as a safety plan), or other factors under the provider's control, the provider is responsible for addressing the issue.
- When the issue can be addressed through a review of or changes to the participant's plan, the ISP team is responsible for addressing the issue.

Were all needed actions taken at the time of the incident to ensure the safety of the participant and others?

Based on the nature of the incident, it may be necessary to take immediate action to ensure the safety of the participant, including changes to staffing/personnel, modification of the environment, seeking medical attention, or contacting law enforcement.

The investigator reviews action taken immediately after the incident. When it is identified that needed action was not taken to maintain the participant's safety, the investigator is responsible for immediately notifying the appropriate staff to ensure action is taken to maintain the participant's safety as soon as possible.

The provider is responsible for taking action when no action was taken at the time of the incident, based on the recommendation of the investigator.

Quality Review of GER Resolution

All High GERS and a sample size of medium GERS will receive a quality review by Liberty Healthcare or DHHS-DD. Through this process, the *GER resolution* and recommendations made by the provider and ISP team will be reviewed for:

- Quality and thoroughness: Were all questions answered appropriately and accurately?
- Remediation Appropriateness: Do the recommendations made by the provider/ISP team address all concerns noted and are they appropriate for the event type?
- Remediation Completion: Were the recommendations made by the provider ISP team completed on time and was evidence provided?

If any issues are identified, or further information is needed, the Liberty Incident Review Specialist (IRS) or DHHS-DD Quality Specialist will SCOMM the provider requesting additional items. The provider will review the recommendations made by Liberty and DHHS, and has the option to agree with the recommendations or disagree.

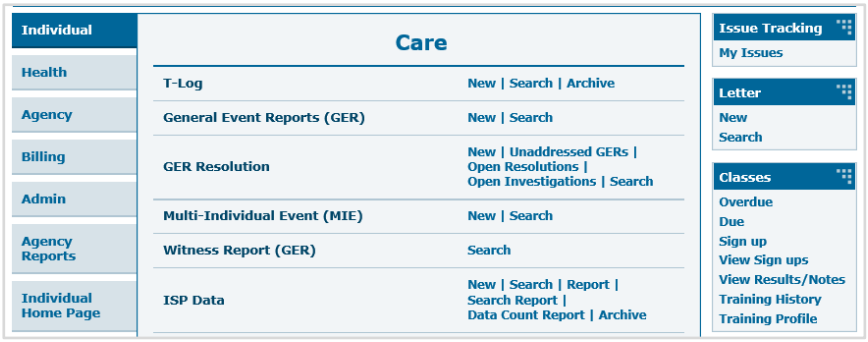
- If the provider agrees, they will have two business days to update the *GER Resolution*. Liberty or DHHS will continue to monitor the resolution for completion and evidence.

- If the Provider does not agree, they will SCOMM the requesting party with justification for the disagreement. The Liberty IRS will escalate the incident to the Incident Review Manager (IRM) for further review.
    - If the Incident Review Manager agrees with the provider's justification, the IRS will update the Quality Review to reflect the agreement.
    - If the IRM does not agree with the provider's justification, the provider will receive a SCOMM on the same day as the decision with the recommendations that must be entered into the resolution and completed by the provider.

Further provider disagreement may be made by submitting a complaint form: https://dhhs.ne.gov/Pages/Division-of-Developmental-Disabilities-Complaint-Form.aspx.

Submitting Required Documentation in Therap

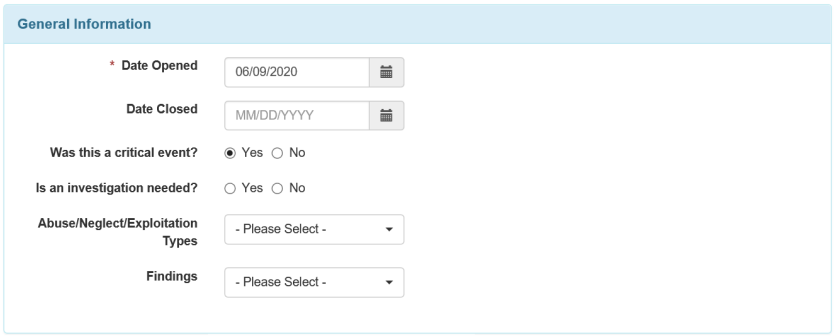
<table>
<tr><td colspan="2">Documentation of the required follow-up for each reportable incident must be submitted using the GER Resolution form in Therap. When a provider completes a follow-up on a reportable incident but does not submit documentation of the follow-up as outlined in this guide, the provider has not met the regulatory requirements to submit documentation of an investigation to DHHS-DD.</td></tr>
<tr><td>To document the investigation, go to the Individual tab in Therap and select Unaddressed GERs under GER Resolution.

In the list of unaddressed GERs, select the GER for which the investigation is being documented and click Next.</td><td> 
</td></tr>
<tr><td>In the GER Resolution form, the GER Information section contains the participant’s information, the date of the event in the linked GER, and a link to the GER.

Before beginning to complete subsequent sections of the GER Resolution form, be sure the linked GER is the same GER for which the investigation is being documented.</td><td> 
</td></tr>
</table>

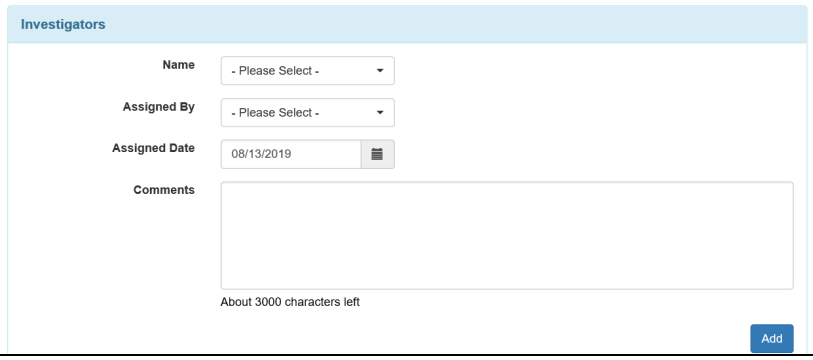
In the *General Information* section:

- *Date Opened* is the date incident follow-up was started.
- *Date Closed* is the date incident follow-up was finished and SC notified via S-COMM.
- *Was this a critical event?* should be marked *Yes* for all follow-ups of reportable incidents. When a provider chooses to complete a *GER Resolution* form for low GERs, this would be marked *No.*
- *Is an investigation needed?* should be marked *Yes*.
- When the reported incident involves suspected/alleged abuse, neglect, or exploitation, and it was accepted for investigation by DHHS-CFS, the next two items **must** be completed.
    - Under *Abuse/Neglect/ Exploitation Types*, select the option from the dropdown which most closely corresponds to the reported incident.
    - Under *Findings,* select *Abuse, Neglect,* or *Exploitation* when the incident was substantiated. When CFS determined no abuse/neglect/exploitation took place, select *Unsubstantiated.*
    - When the investigation by DHHS-CFS is not complete when the *GER resolution* is due, this should be documented in the body of the report.



In the *Investigators* section:

- *Name* is the name of the assigned investigator.
- The provider may choose to document who assigned the investigator and when, but it is not required.

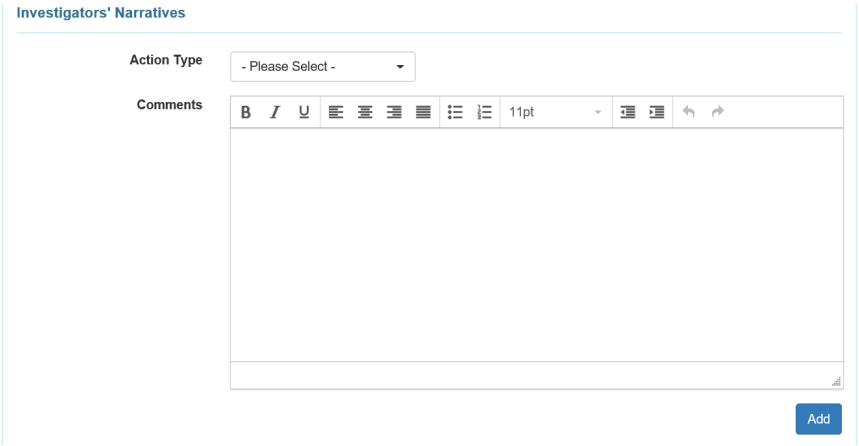


In the *Investigators' Narratives* section, the investigator provides a summary of the information reviewed during the incident follow-up, including documentation reviewed and witnesses interviewed.

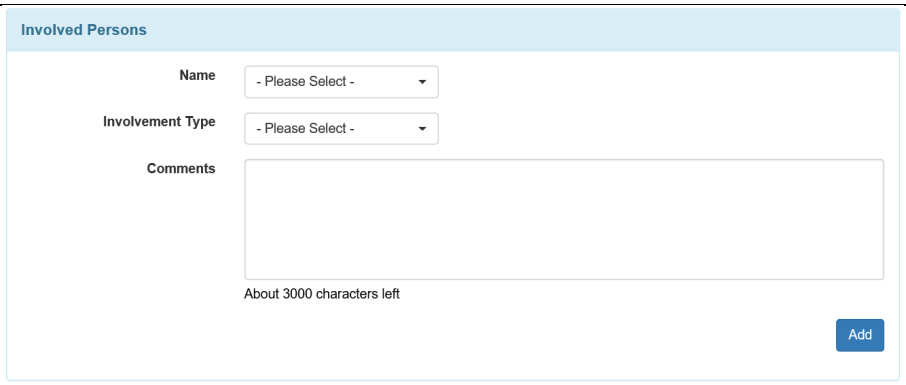
- Any documentation or photographs reviewed should be summarized under the *Evidence* category.
- Any witnesses providing information should be summarized under the *Interviews* category.
- Other information should be entered under the *Other* category.

The summary doesn't need to be lengthy or comprehensive but should include all information relevant to any concerns identified or conclusions reached by the investigator.

A separate record should be added for each document reviewed, person interviewed, etc.

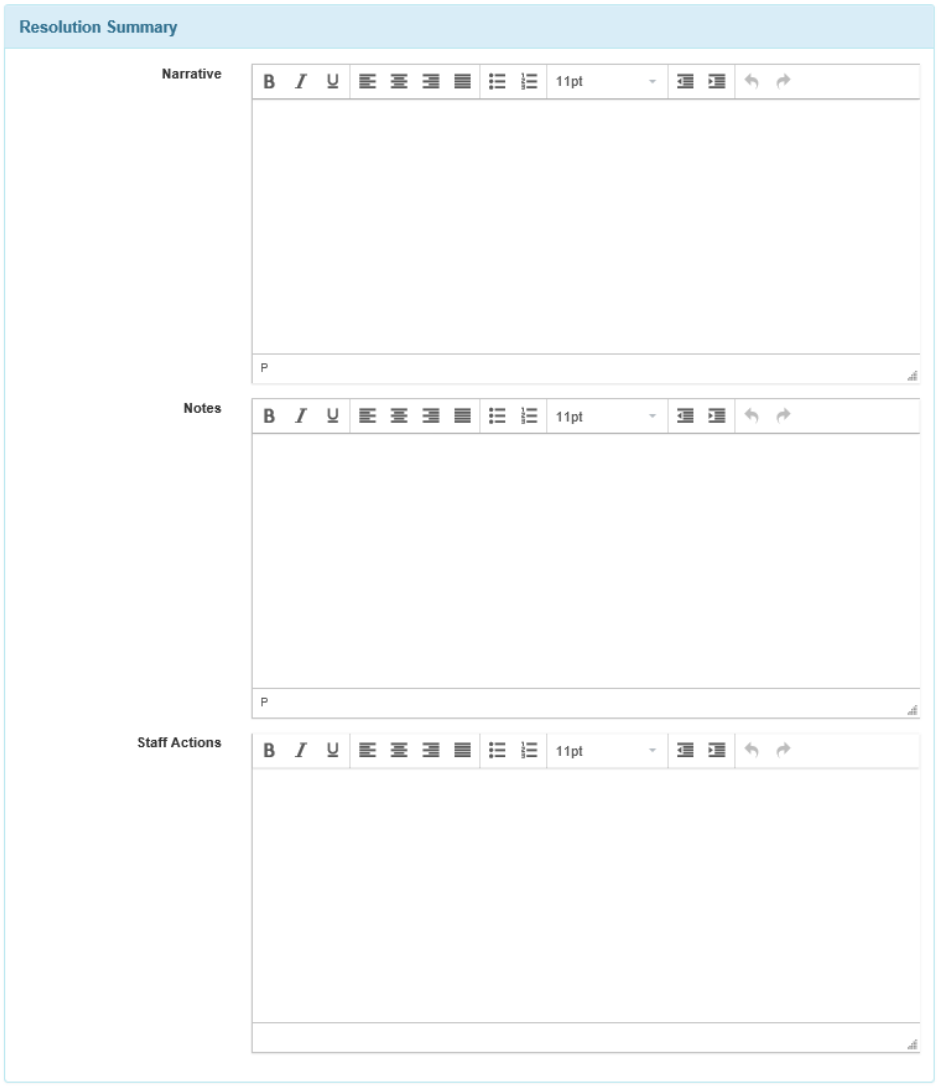


In the *Involved Persons* section, the provider may choose to list people involved in the incident, but it is not required, as this information is in the GER.



In *Resolution Summary*, the investigator provides a summary of the incident follow-up and any identified concerns.

- *Narrative*: A summary of the relevant points of the incident follow-up and any conclusions reached by the investigator.
- *Notes*: The seven Follow-up Questions and the answers identified in the course of incident follow-up. When any questions identify an issue or concern, those issues and concerns must be summarized.
    - When a provider chooses to use an existing form to document the summary of the investigation, ***this section must still be completed.***
- *Staff Actions*: Summary of any provider action taken related to the incident, including any actions already taken to address recommendations of the investigator.

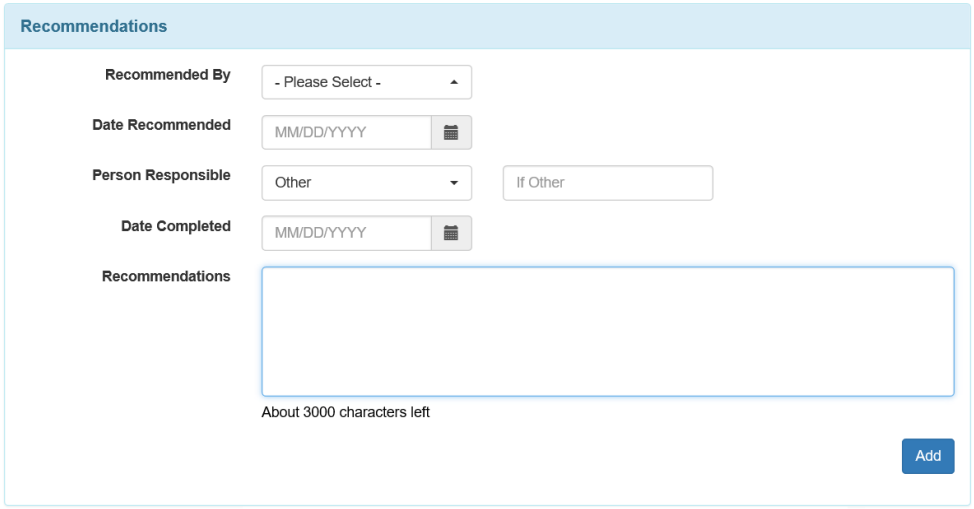


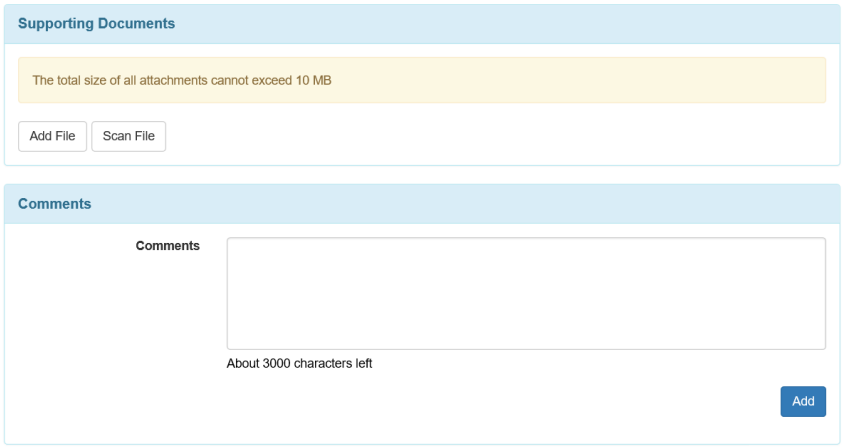
In *Recommendations*, all the investigator's recommendations should be listed. At a minimum, the recommendation, due date, and the person responsible for addressing it must be documented.

When a recommendation has been addressed, the *Date Completed* should be filled in.

A separate record should be added for each recommendation.

When a provider chooses to use an existing form to document the summary of the investigation, this section must still be completed.



In *Supporting Documents*, the provider may attach any additional information, documents, or photographs they deem relevant as well as evidence of completed recommendations, such as training records • When the provider chooses to use an existing form to document the summary of the investigation, it must be attached here. *Comments* can be used for any information that does not fit in elsewhere in the *GER Resolution* form.	

Targeted Analysis

A Targeted Analysis is a systematic and comprehensive assessment that supports responsible parties in identifying important root causes of incidents and system gaps, in a way to mitigate future incidents.

Upon completion of the Quality Review of both the General Event Report (GER) and the *GER Resolution,* the incident will be reviewed by a Liberty Healthcare IRS to determine if a Targeted Analysis is required.

Targeted Analysis Activities will be initiated when at least one of the following criteria is met:

- APS Substantiated abuse, neglect, or exploitation events;
- Incident is flagged for an “Others-At-Risk” event, and there has been one or more HIGH notification level event(s) in the previous 30 days for the participant;
- Incident involves any use of prohibited practices or unauthorized use of restraints resulting in a negative outcome such as injury, death, police intervention, or hospitalization;
- Incident demonstrates a trend of two or more incidents related occurring within 30 days for significant injuries, financial issues, unexplained hospitalizations, increased number of falls, frequent police calls to the site, or ongoing staffing issues;
- Incident demonstrating a trend of two or more medication errors resulting in adverse outcomes such as hospitalization;
- Incident involving a missing participant for 24 hours or longer;
- Incident demonstrating a significant trending of similar incidents across a provider; or
- Others as determined based on the seriousness of the event.

The Targeted Analysis may involve multiple steps, including both a desk review and onsite activities.

Desk Review

To begin the Targeted Analysis process, the IRS will send an email or letter notifying the following parties that a Targeted Analysis will be initiated:

- The service provider;

- The participant; and
- The participant's legal representative, as applicable.

The IRS will review all pertinent documents available inside of Therap. When further information is needed to complete the desktop review, the IRS will request further documentation from the service provider. The service provider will have one business day to return the requested documents and information to the IRS.

Documentation requests may include, but are not limited to:

- Daily logs relevant to the participant's care, staffing, and day-to-day events (which may be in the form of paper shift notes or other paper documentation held by the provider);
- Medical documentation not found in Therap;
- Human and Legal Rights committee reviews, decisions, and meeting notes as applicable;
- Relevant provider policies, procedures, or expectations;
- Medical and Safety Protocols/Plans/Risk Plans;
- Staff training records;
- Staff schedules, mileage logs, or other staff documentation; and
- Any other documentation not found in Therap relevant to the incident as deemed appropriate by the Incident Review Specialist.

When the IRS cannot adequately create a Targeted Analysis brief with action plans from the desk review, the incident will move on to an On-site Targeted Analysis.

On-Site Targeted Analysis

On-Site reviews are a collaborative effort to identify the root cause of an incident and require key personnel to be present for participation.

Required personnel will include:

- Provider personnel involved directly in the incident;
- Agency provider decision-makers;
- One to two Liberty Incident Review Team members;
- Participant's team members, as applicable; and
- The participant (if their presence would not cause any undue mental anguish).

The On-Site targeted analysis will typically take four hours or less to complete, depending on the nature of the incident being reviewed. The provider will be responsible for creating a secure environment to complete all activities and ensuring that all needed parties are present.

On-site activities will include, but are not limited to:

- Interviews with involved parties;
- Visits to involved locations;
- Further documentation requests/review; and
- Round-robin collaborative meeting.

Targeted Analysis Brief – Action Plans

When all Targeted Analysis activities are finished, Liberty Healthcare will complete a Targeted Analysis Brief including a description of completed activities, reviewed documents, and identified action plans. Upon approval of the brief, a copy will be made available to the provider responsible for completing the action steps. The

action steps will have clearly identified goals, due dates, and required verification documents to close the action plan. The provider is required to complete all action steps by their due date and provide evidence of completion via Therap SCOMM to the assigned Incident Review Specialist.

Action Steps may include, but are not limited to:

- Personnel training;
- Policy/Procedure creation or revision;
- Environmental repairs or updates;
- Person-Centered Plan revisions or updates;
- Referral for specialty consult (such as a physician, occupational therapist, physical therapist, or psychiatric services); and
- Other as deemed necessary by the Targeted Analysis activities.

The Action Plan will be monitored by Liberty and DHHS-DD at least once every five days until all action steps are completed and verified by the provider.