

December 23, 2019

Community NeuroRehab of Iowa
West Des Moines, IA 50073

Dear Angie Weis:

Iowa Medicaid Enterprise (IME) Home and Community Based Services (HCBS) and Community-Based Neurobehavioral Rehabilitation Services (CNRS) Quality Improvement Organization (QIO) Services staff The Iowa Medicaid Enterprise (IME) Home and Community Based Services (HCBS) Quality Improvement Organization (QIO) Services conducted a Community-Based Neuro-behavioral Rehabilitation Service (CNRS) review with your organization on December 13, 2019. This onsite review was conducted in accordance with the requirements of the Iowa Administrative Code (IAC).

Please review this CNRS Review Report for any corrective actions that are necessary for your organization. Also enclosed is a *Provider Acknowledgement* form that must be signed by the chief administrative officer and the chairperson of the governing body. If corrective action is indicated, a formal Corrective Action Plan (CAP) must be submitted. The CAP and/or the signed *Provider Acknowledgement* form must be returned within 30 calendar days of the date of this letter.

Please submit the signed statement and any required corrective action via the Iowa Medicaid Portal Access (IMPA). Please select HCBS QA Oversight as the document type when uploading. For instructions on uploading the requested documentation, please see IL 1734-MC-FFS-D.

Thank you for your assistance and the support received from your staff in completing this onsite review. For questions, please contact me by phone at 515-974-3038 or email at cackers@dhs.state.ia.us.

Sincerely,

Courtney Ackerson, HCBS/CNRS QIO Services Specialist
Iowa Medicaid Enterprise, HCBS/CNRS QIO Services

Attachments:

- Attachment A: Review Report
- Attachment B: Provider Acknowledgement

cc: Iowa Department of Human Services



Community-Based Neuro-behavioral Rehabilitation Service (CNRS) Review Report

Organization Name: Community Neuro Rehab of Iowa

Review Date: December 13, 2019

Report Date: December 23, 2019

Lead Reviewer: Courtney Ackerson

Other Review Team Members:

Member Records Reviewed: 10

Personnel Records Reviewed: 10

Definition of terms:

Self-Assessment Response: The provider's response on the annual provider self-assessment.

Included in Policy: The requirement is determined to be included in the provider's policy.

Evidence Submitted: Provider submitted or provided evidence that supports the provider's self-assessment response.

Corrective Action Plan: Evidence was not submitted or provided to support the provider's adherence to their response on the annual Provider Self-Assessment, or the provider did not provide evidence they possess policies that address this requirement. Corrective Action Plan (CAP) requirements are supported by the provider's completed self-assessment, Iowa Administrative Code (IAC), Iowa Code, and the Health Insurance Portability and Accountability Act (HIPAA) and the Code of Federal Regulations (CFR).

CORRECTIVE ACTION GUIDELINES

This report contains comments and corrective actions. Specific standards from the Code of Iowa and Iowa Administrative Code (IAC) may be cited. Any commendations listed are areas which the review team found to be exemplary and are intended to reinforce your accomplishments. Any recommendations listed are suggested actions. Corrective actions are required to come into compliance with Code of Iowa, IAC, your policies, or the responses identified on the Provider Quality Management Self-Assessment that was submitted by your organization.

The review report may identify areas of service delivery that will require changes in policies or procedures. When changes are required, the report will give parameters in which to develop corrective actions. You have 30 days from the date of this report to develop a plan of correction. The HCBS/CNRS QIO Services Specialist assigned to your organization will work with you to develop a timeline to implement the corrective actions. The HCBS/ CNRS QIO Services Specialist will monitor the corrective actions, either in writing or in person, to assure implementation of the corrective actions.

When developing corrective actions, please consider the following:

1. Do corrective actions require procedural changes?
2. Do corrective actions require updates in member files and personnel files?
3. What measures, such as staff training, will be necessary to begin implementation of the corrective actions?
4. When will the corrective actions be reviewed and/or approved by the governing body?
5. When will implementation of corrective actions begin?

It will be necessary to include the enclosed *Provider Acknowledgment* statement dated and signed by the Chief Administrative Officer or Executive Director and President or Chairperson of the governing body which states that you will actively work to correct the areas noted in the review report. Only the signed statement needs to be returned, not the body of this report.

Assistance is available upon request to help you correct noted areas of deficiency. For technical assistance or questions about this report, you may contact Courtney Ackerson, HCBS/CNRS QIO Services Specialist, at 515-974-3038 or cackers@dhs.state.ia.us.

Provider Name: Community NeuroRehab of Iowa - Coralville				
Review Date: 12/13/2019				
I. Provider Eligibility				
In order to be eligible to provide Community-Based Neurobehavioral Rehabilitation Services (CNRS), agencies must demonstrate that they understand and are				
Oversight of Governing Body				
	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. The agency's governing body has an active role in the administration of the organization	Yes	NA	Yes	No
2. The agency's governing body receives and uses input from local community, stakeholders, members participating in services, and employees and provides oversight that ensures, the provision of high-quality supports and services to the member	Yes	NA	Yes	No
Review Comments:				
Community NeuroRehab of Iowa, referred to as "CNR" throughout this report, submitted recent board meeting agendas for multiple months of board meetings. This governing body oversees all four homes that the agency currently operates under CNRS. The two Coralville area homes were reviewed for this report, Glen Oaks and Auburn Hills. The governing body consists of four members, one of which is the CEO, Tom Brown. The agendas submitted demonstrate activities in the meeting such as a review of quality assurance information and audits or reviews from accrediting agencies. This section of the agenda also indicates what the agency is in the process of doing to follow up with these audits/reviews. They address items in "compliance" such as licensing, CARF accreditation, and survey preparations. The agency also notes in these agendas operating issues, facility maintenance, authorizations for services, and credentialing with the MCOs. The agency noted in the previous review that all members of the board are the three owners and CEO of the agency. They receive and use input from the community by including community and stakeholder feedback into their quality improvement process through a survey process. The agency is encouraged to explore ways to demonstrate local community involvement in the governing body.				
CAP Comments:				
n/a				
Organizational Standards				
	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. The mission statement encompasses member's needs, desires, and abilities	Yes	Yes	Yes	No
2. The organization is fiscally sound and established fiscal accountability	Yes	Yes	Yes	No
Review Comments:				
CNR's mission statement is as follows: "Community NeuroRehab provides individualized and intensive neurobehavioral rehabilitation services to optimize the cognitive, physical, medical, behavioral and psycho-social functioning of each participant. Community NeuroRehab is committed to the development of mutually reinforcing partnerships with participants and their support systems, and embraces our Guiding Principles." The agency noted that this statement can be found in multiple locations including the website (www.communityneurorehab.com), marketing materials, and within all residential locations. The two sites toured as a part of this review had the mission and values posted within the common living quarters of the home which was consistent with policy. Prior to the on-site review, and consistent with their previous review of the Des Moines, Iowa locations, CNR submitted their external financial audit summary. This indicated that the agency's financial records are within the accounting principals generally accepted in the United States of America.				
CAP Comments:				
n/a				
Staff Qualifications				
	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. The program administrator is a Certified Brain Injury Specialist Trainer (CBIST) through the Academy of Certified Brain Injury Specialists or a certified brain injury specialist under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441 IAC 83.81(249A) with additional certification as approved by the department.	Yes	Yes	Yes	No
2. A minimum of 75 percent of the organization's administrative and direct care personnel (1) have a bachelor's degree in human services-related field, (2) have an associate's degree in human services with two years of experience working with individuals with brain injury, (3) are in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury, or (4) are certified brain injury specialists or have other brain injury certification as approved by the department.	Yes	Yes	Yes	No
Review Comments:				
CNR submitted certificates from Dave Shields as evidence of program administrator being the ACBIS trainer. The agency has multiple certified trainers within the organization. While on site, the agency submitted a list of staff and their qualifications in line with IAC standards. They submitted a list of 19 direct care staff and four administration staff with 22 of them meeting at least one of the four criteria in this section. The agency maintains CBIS certificates on file. There are no deficits in this area.				
CAP Comments:				
n/a				

II. Training Requirements				
Prior to providing direct service and ongoing, employees receive training related to:	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. The department-approved brain injury training modules	Yes	Yes	Yes	No
2. Member rights	Yes	Yes	Yes	No
3. Confidentiality and privacy	Yes	Yes	Yes	No
4. Dependent adult and child abuse prevention and mandatory reporter training	Yes	Yes	Yes	No
5. Individualized rehabilitation treatment plans	Yes	Yes	Yes	No
6. Major mental health disorder basics	Yes	Yes	Yes	No
7. Department-approved training by qualified professionals on physical restraint techniques. (The agency should keep record of this training with attendance and only those who have completed the training use or take part in restraining techniques.)	NA	NA	NA	No
Within 30 days of commencement of direct service provision and annually thereafter, employees shall complete training related to:	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. The organization's written policy and procedure for the identification and reporting of child and dependent adult abuse to the department pursuant to 441- Chapters 175 and 176.	Yes	NA	Yes	No
2. Cardiopulmonary resuscitation (CPR) training	Yes	NA	Yes	No
3. A first-aid course	Yes	NA	Yes	No
4. Fire prevention and reaction training	Yes	NA	Yes	No
5. Universal precautions training	Yes	NA	Yes	No
Within the first 6 months of commencement of direct service provision, employees complete the following training requirements:	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. Promotion of a program structure and support for persons served so they can re-learn or re-gain skills for community inclusion and access	Yes	NA	Yes	No
2. Compensatory strategies to assist in managing ADLS (activities of daily living)	Yes	NA	Yes	No
3. Quality of life issues	Yes	NA	Yes	No
4. Behavioral supports and identification of antecedent triggers	Yes	NA	Yes	No
5. Health and medication management	Yes	NA	Yes	No
6. Dietary and nutritional programming	Yes	NA	Yes	No
7. Assistance with identifying and utilizing assistive technology	Yes	NA	Yes	No
8. Substance abuse and addiction issues	Yes	NA	Yes	No
9. Self-management and self-interaction skills	Yes	NA	Yes	No
10. Flexibility in programming to meet members' individual needs	Yes	NA	Yes	No
11. Teaching adaptive and compensatory strategies to address cognitive, behavioral, physical, psychosocial, and medical needs	Yes	NA	Yes	No
12. Community accessibility and safety	Yes	NA	Yes	No
13. Household maintenance	Yes	NA	Yes	No
14. Service support to the member's family or support system related to member's neurobehavioral care	Yes	NA	Yes	No
15. The organization's written policy and procedure for the identification and reporting of child and dependent adult abuse to the department pursuant to 441- Chapters 175 and 176.	Yes	NA	Yes	No
Within the first 12 months of commencement of direct service provision, employees complete:	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. A department-approved, nationally recognized certified brain injury specialist training.	Yes	NA	Yes	No
Review Comments				
Ten personnel files over two houses were reviewed for evidence of the above trainings. Staff in these two locations are sometimes shared as needed. No policy is required for training according to IAC and CNR did not submit policy or procedure related to this topic. The agency maintains certificates of completion for the following trainings/requirements: CPR, first aid, fire prevention and reaction training, and universal precautions. All files reviewed had these trainings completed within the time frames necessary. The agency has maintained a checklist for orientation and additional trainings that they monitor. This checklist has been updated since the last review and there is evidence in the training evidence of adjustments over the years of services. The agency utilizes CE solutions as an online training system. There is evidence of several trainings such as universal precautions, CPR, First-aid, and fire prevention. They also have some of the additional training topics required for direct care staff on CE solutions. The transcript of these trainings was used as evidence. As indicated by the agency, they are still utilizing team meetings for some topics and use agendas and attendance for evidence that individual staff have completed the training. The agency also maintains a form with the staff indicating if the training was missed and made up. CE Solutions has been used for mandatory reporter training. Certificates are maintained on CE Solutions electronically for mandatory reporter training. The mandatory reporter training is an approved curriculum No.335. The agency indicated in the on-site review that they are aware of the changes in mandatory reporter training as required by the state. They will follow the recently changed process and utilize the state training in the future as required.				
CAP Comments				
n/a				

III. Outcome-Based Standards				
Providers of CNRS should ensure processes are in place to promote ethical, respectful, and safe service delivery which achieves positive outcomes for members.				
A. Member Rights				
	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. Rights and responsibilities are presented in language that is understandable to the member	NA	Yes	Yes	No
2. A written copy of the members' rights and responsibilities is prominently posted in a location that is available to all members	NA	Yes	Yes	No
3. Within five days after admission a statement was signed by the member, or the member's responsible party, indicating an understanding of rights and responsibilities	NA	Yes	Yes	No
4. Members are advised within 30 days following changes made in the statement of residents' rights and responsibilities	NA	Yes	Yes	No
The agency's policies and procedures related to rights and responsibilities ensure:	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. That each member is fully informed of the rights and responsibilities and of all rules governing member conduct and responsibilities	NA	Yes	Yes	No
2. That members are valued	NA	Yes	Yes	No
3. That abuse is prohibited and that members receive kind and considerate care at all times and are free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury	NA	Yes	Yes	No
4. That members receive assistance with accessing financial management services as needed	NA	Yes	Yes	No
5. That members receive individualized services	NA	Yes	Yes	No
6. That members receiving assistance with obtaining preventative, appropriate, and timely medical and dental care	NA	Yes	Yes	No
7. That the member's desire for intimacy is respected and supported	NA	Yes	Yes	No
8. That the living environment is reasonably safe and located in the community	NA	Yes	Yes	No
Review Comments:				
Michele Baughn, HCBS specialist with the QIO team, toured the homes in Coralville on December 10, 2019 as a supplement to the on-site review on December 13, 2019. Rights and responsibilities are posted within the two homes toured as a part of this review. Both homes had the postings in shared living spaces. Member files reviewed along with service documentation served as evidence that the agency is meeting all requirements of the rights and responsibilities. Members receive notice of their rights at the time of intake. The agency responds to requests, needs, and preferences as indicated in service plans and quality improvement practices. Service documentation and service goals indicated that members receive financial management assistance when needed such as going to the bank, depositing funds, and budgeting. Members' dental needs and appointments are indicated in the progress reports with medical appointments. Services are individualized by member needs and directly related to the Mayo-Portland Assessment. Both houses are located in residential areas in their communities. They appear to be safe and accessible.				
CAP Comments:				
n/a				
Appeals and Grievances	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. The policies and procedures for member grievances and appeals and provided to the member at the commencement of services and annually thereafter	Yes	Yes	Yes	No
Review Comments:				
Ten member files were reviewed for the process of appeals and grievances. The agency submitted CNR Policy P2: Participant and Family Grievance Process. This policy is the same for all homes and services under CNR. This policy notes fair consideration and timely resolution of complaints made by or on behalf of participants. This policy also states that throughout the grievance process, the participant shall be protected from any form of reprisal or intimidation. CNR reported that the grievance process is explained to all participants and family/support systems at time of admission and as needed during his/her rehabilitative stay. The procedure is also noted in the client bill of rights and reviewed annually. All homes have the policy to report concerns to accrediting bodies posted in the main living spaces in addition to the client bill of rights.				
CAP Comments:				
n/a				
Confidentiality	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. Members provide consent regarding which personal information is shared and with whom	NA	NA	Yes	No
Review Comments:				
CNR provides a document in the member file of a HIPAA acknowledgement and in this signed form, note that their privacy practices are online for members to access and/or print. They noted that this privacy notice indicates who they will share information with. Records of staff training on HIPAA and confidentiality topics are in transcripts maintained online. The agency produced releases for all ten members reviewed. There was no indication in service documentation that an information was exchanged prior to these releases. CNR's releases contain the specific entity to release to and date of expiration, which is one year from signing. Upon review of these ten member files, it was evident that the releases have been somewhat changed over time, but still maintain needed information.				
CAP Comments:				
n/a				

B. Restrictive Interventions				
The agency has written policies related to the use of restraints and restrictive interventions which:	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. Defines the uses of physical restraints	NA	NA	NA	No
2. Designates the administrator or designee as the person who may authorize their use	NA	NA	NA	No
3. Establishes a mechanism for monitoring and controlling their use	NA	NA	NA	No
4. Ensures and defines that staff receive a department-approved training program by qualified professionals on physical restraint techniques	NA	NA	NA	No
Interventions are implemented in accordance with 481-subrule 63.12(4), rule 481-63.27(135C), and rule 481-63.28(135C).	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. Rationale for the restraint	NA	NA	NA	No
2. Authorization for the use of physical restraints prior to or immediately after application of the restraint	NA	NA	NA	No
3. Evidence from the responsible staff person which clearly indicates staff actions and procedures used to protect the member's rights and to ensure safety	NA	NA	NA	No
4. The agency should keep record of this training with attendance and only those who have completed the training use or take part in restraint techniques	NA	NA	NA	No
5. Evidence of notification about the use of the restraint to the member's primary care provider, the interdisciplinary team, and the member's responsible party (as applicable)	NA	NA	NA	No
Review Comments:				
CNR reported at the time of the on-site review that the agency does not use restraints. There was no evidence in member files that restraints were used. The agency does not have a policy on this, but reported at the time of the exit interview that they educate their staff on not using restraints when they talk about behavioral interventions with their Personal Intervention Plan (PIP) trainings. They have continued to do this since the last review and this is true for all staff hires. Technical assistance was provided on site regarding the possible development of a policy, as the agency is considering different ways of documenting this for evidence. It is recommended that the agency have policy and procedure to support this practice and ensure consistency across sites.				
CAP Comments:				
n/a				
C. Treatment Planning				
Treatment Planning	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. The member's treatment team mutually develops an individualized treatment plan	Yes	Yes	Yes	No
2. The plan takes into account member's individual strengths, barriers, and interests	Yes	Yes	Yes	No
3. The plan goals are based on the member's need for services	Yes	Yes	Yes	No
4. The plan includes neurobehavioral challenges and environmental needs as identified in the member's individual standardized comprehensive functional neurobehavioral assessment	Yes	Yes	Yes	No
5. The member and the member's treatment team evaluate the member's progress towards treatment goals regularly and no less than quarterly	Yes	Yes	Yes	No
6. Plans are revised as the member's stats or needs change to reflect the member's progress and response to treatment	Yes	Yes	Yes	No
7. The member's initial treatment plan is submitted to Iowa Medicaid Enterprise (IME) within 30 days of admission for approval	Yes	Yes	Yes	No
8. The member's treatment plan does not exceed 180 days	Yes	Yes	Yes	No
Review Comments:				
CNR used the thirty-day progress report as evidence of the plan for initial authorization. This progress report contains the goals approved at the time of authorization. The progress report is completed within the first 30 days to review goals worked on. The agency develops initial goals based on the Mayo-Portland Assessment and these are used for their electronic service documentation. The agency submitted evidence of quarterly progress reports for all ten members reviewed across the two houses. Barriers are noted in the narrative of the progress report. Progress reports are signed by members and guardians. These reports serve as the service plans and indicate validation of the goals for the past three months or approximately 90 days. On the first review with the agency, when asked how they demonstrates changes in goals as needed, administrators were able to provide examples of specific member goals changing in their electronic service record. This is true for all members still. Based on recommendations from the previous on-site review, the agency developed a process for summarizing the individual planning meetings to update the service plans and goals. In these summaries, the agency notes the review of goals and any changes made. Not all goals are listed, but modifications are indicated. It notes that all remaining goals without changes indicated are maintained. This also addresses other concerns with items such as requested increase in support or specific issues to the member that have arisen in the past reporting period. The agency also addresses discharge planning in these summaries. This document indicates that this summary has been provided to the member and/or legal representative, though it is not signed. The current process is a retro-active review of goals. The agency is encouraged to continue to explore ways that they can set an initial service plan and continue its development rather than summarize the past months for evidence in this section. Service plans should indicate the plan going forward and not just the review of the past service period. This recommendation was discussed at the time of the on-site review and has continued to be a recommendation from the previous review. There is no corrective action needed at this time.				
CAP Comments:				
n/a				

IV. General CNRS Provider Requirements				
Service Documentation includes:	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. The specific location, date, and times of service provision	Yes	Yes	Yes	No
2. The service(s) provided	Yes	Yes	Yes	No
3. The member's first and last name	Yes	Yes	Yes	No
4. The staff providing service(s), including first and last name, signature and professional credentials (if any)	Yes	Yes	Yes	No
5. The specific interventions	Yes	Yes	Yes	No
6. The name, dosage, and route of medications administered	Yes	Yes	Yes	No
7. Any supplies dispensed as part of the service	Yes	Yes	Yes	No
8. The member's response to staff interventions	Yes	Yes	Yes	No
9. The service provided and corresponding documentation substantiates the units of service billed for payment	Yes	Yes	Yes	No
10. The provider maintains clinical and fiscal records during the time the member is receiving services from the provider and for a minimum of five years from the date of the last claim for services.	Yes	Yes	Yes	No
Review Comments				
<p>Ten member files were reviewed for evidence that IAC is met in practice with service documentation. All IAC indicators are present in the service documentation. The agency utilizes E-doc for electronic service documentation. Providers document on goal work and then have a separate narrative to indicate other supports and services provided in the course of the shift or day of services. The additional narrative to accompany goal work is useful to indicate the level of care, progress, and care provided as a 24-hour service. At the time of the initial review for the Des Moines location, the agency was able to produce evidence of the billing claim from the first month of service with corresponding service documentation for that month. This member was served in the Des Moines location. They did not submit a policy on the maintenance of records, but indicated in their self-assessment that they are aware of and are practicing the maintenance of records within the guidelines of IAC.</p>				
CAP Comments				
n/a				
Incident Report:	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. The agency has established definitions of incidents and outlines reporting procedures in accordance with IAC 481-50	Yes	Yes	Yes	No
2. Incidents are reported according to the definitions	NA	NA	Yes	No
3. Incidents are reported timely	NA	NA	Yes	No
4. The agency maintains a centralized location for filing of incident reports	Yes	Yes	Yes	No
5. The occurrence of an incident and completions of an incident report is noted in the member's record	NA	NA	Yes	No
6. The agency has a mechanism for tracking and trending incidents	Yes	Yes	Yes	No
Review Comments				
<p>CNR submitted policy indicative of the incident reporting criteria for their level of care and facility. They used Policy C10: Notification and Reporting of At-Risk Behaviors and Major Injuries for evidence of this. CNR noted in the review process that incident reports are reviewed at varying levels on a daily, weekly, quarterly, and annual basis. Incidents were noted in the member file in service documentation. None of the 10 files contained examples of incidents. The agency uses a form in E-doc to document and track incidents. This serves as their centralized file. These are then trended in quarterly data in the quality improvement plan under staff and member safety indicators. The board agenda indicated review of incidents and quarterly trending data. There was one incident noted in this information, but staff confirmed that the incident occurred at the Des Moines location and was, therefore, not reviewed as a part of this data.</p>				
CAP Comments				
n/a				

V. Quality Improvement				
Quality Improvement	SA Response	Included in Policy	Evidence Submitted	CAP Required
1. The organization has in place an outcome management system which measures the efficiency and effectiveness of service provision. The system includes:	Yes	NA	Yes	No
a. Members' preadmission location of service.	Yes	NA	Yes	No
b. Length of stay.	Yes	NA	Yes	No
c. Discharge location.	Yes	NA	Yes	No
d. Reason for discharge.	Yes	NA	Yes	No
e. Member and stakeholder satisfaction.	Yes	NA	Yes	No
f. Access to services	Yes	NA	Yes	No
2. The organization measures and analyzes organizational activities and services quarterly	Yes	NA	Yes	No
3. The organization conducts satisfaction surveys with members, family members, employees, and stakeholders, and share the information with the public.	Yes	NA	Yes	No
4. The organization conducts internal review of member service records at regular intervals.	Yes	NA	Yes	No
5. The organization tracks major and minor incident data according to subrule 77.37(8) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof; and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.	Yes	NA	Yes	No
6. The organization continuously identify areas in need of improvement.	Yes	NA	Yes	No
7. The organization develops a plan to address the identified areas in need of improvement.	Yes	NA	Yes	No
8. The organization implements the plan, document the results, and report to the governing body annually.	Yes	NA	Yes	No
Review Comments				
<p>CNR reports that they have a Performance Improvement Committee (PIC) to monitor and improve the quality of care provided to participants across all locations, while ensuring that the organization maintains the highest level of program integrity. Through PIC, which CNR notes in review materials meets on a regular basis to include quarterly meetings with members of the Board of Directors, CNR measures a number of data points and performance indicators to include, but not limited to, incident report trending, satisfaction surveys, and staff training. PIC utilizes information and activities from several other committees when completing its analysis to include the Environmental Cares Committee, Infection Control Committee, and Grievance Committee. CNR's reports in submission materials, "Performance Indicators were chosen to support a participant-focused and comprehensive philosophy of excellence in the delivery of CNR's services to participants, personnel, and outside stakeholders while maintaining a competitive and financially solvent program." The agency maintains a Performance Improvement Committee Report each quarter with indicators identified. Each indicator contains the following: target goals, measures, data points, quarter comparisons, and a section on discussion and action steps. This included data from personnel and member file audits, incidents, satisfaction surveys, and budget items. They also maintain an annual "Outcome Validation Study," where they focus on the first area in these criteria from IAC. This report is completed annually, but is also comprehensive of years served since 2010. This report meets IAC requirements. The agency indicates in this report how these statistics impact their approach to service delivery.</p>				
CAP Comments				
n/a				

PROVIDER ACKNOWLEDGEMENT

Community Neuro Rehab of Iowa certifies that it has received the review report which notes the results of the HCBS/CNRS QIO Services review conducted on December 13, 2019. Community Neuro Rehab of Iowa assures that it will actively work to correct the areas noted in the review report. Implementation of the required corrective actions will begin within 30 days of the date of the review report unless other timelines have been established in the review report. Follow-up review by the HCBS/CNRS QIO Services Specialist, either in writing or onsite, will be required to assure implementation of corrective actions.

Thomas Wayne Brown

PRINT NAME of Chief Administrative Officer or Executive Officer

[Signature]

SIGNATURE of Chief Administrative Officer or Executive Officer

1/29/2020
Date

Steven Polkow

PRINT NAME of President or Chairperson of the governing body

2/10/20

[Signature]

SIGNATURE of President or Chairperson of the governing body

2/10/20
Date