DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Disabled & Elderly Health Programs Group

April 25, 2023

Stephanie Stephens
Chief Medicaid and CHIP Services Officer
P.O. Box 13247
4601 W Guadalupe St
Auston, TX 78711-3247

Dear Director Stephens:

This letter and attached report are in reference to a site visit conducted by the Centers for Medicare & Medicaid Services (CMS) from February 13 - 16, 2023. CMS visited several settings in Texas that were identified by the state and/or stakeholders as having the qualities of an institution as outlined at 42 CFR § 441.301(c)(5) and required a CMS-conducted heightened scrutiny review to determine if they comply with the home and community-based services (HCBS) settings criteria at 42 CFR § 441.301(c)(4).

CMS appreciates the efforts of the state to prepare for our visit to Texas. We are asking the state to apply remediation strategies addressing the feedback contained in our report to the specific setting(s) as identified. We note that the HCBS settings criteria identified in the report that are followed by an asterisk require the state to go beyond ensuring that the individual setting has completed the necessary actions identified; specifically, complying with person-centered planning requirements requires further direction to and collaboration with the entities responsible for developing and monitoring the person-centered plans and with the HCBS provider community that is responsible for implementing services and achieving the objectives outlined in the plan. In addition, CMS notes that the state's remediation strategies must be applied to all remaining similarly situated settings you have identified as being presumptively institutional that were not included in CMS' site visit to ensure compliance with the settings criteria at 42 CFR § 441.301(c)(4) by March 17, 2023. Finally, the state should ensure issues identified in this report are addressed in the state's overall assessment process of all providers of HCBS in Texas, to ensure that all providers are being assessed appropriately against the regulatory settings criteria and will implement the necessary remediation to achieve timely compliance.

As described more fully in the attached report, CMS notes below several areas where issues were found to exist across several locations, which raise systemic concerns that must be

addressed by the state. Specifically, the following regulatory criteria located at 42 CFR 441.301(c)(4) were not found to be in practice:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*
- The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Facilitates individual choice regarding services and supports and who provides them.
- The unit or dwelling is a specific physical place that be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities, and protections from eviction that tenants have under the landlord/tenant law of the state, county, city or other designated entity. For settings in which landlord tenant laws to not apply, the state must ensure that a lease, residency agreement or other form or written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- Each individual has privacy in their sleeping or living unit.
- Individuals sharing units have a choice of roommates in that setting.
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- Individuals are able to have visitors of their choosing at any time
- The setting is physically accessible to the individual.
- Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.*
- Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.

Texas' Statewide Transition Plan (STP) must describe strategies to ensure that all providers of Medicaid HCBS have been assessed to meet the regulatory criteria and any needed remediation

has been identified. The state's practice for addressing the observations described in the attached report must align with the processes described in the STP.

CMS requests that the state provide a written response providing updated information describing how the state will remediate both the process for developing and implementing the person-centered service plan and the individual settings to ensure compliance with all of the settings criteria. CMS also requests a written response on how the state will apply this feedback to the ongoing monitoring of person-centered planning functions and settings in the HCBS delivery system as noted above. CMS requests this information be submitted no later than May 23, 2023

Upon review of this feedback, please contact Michele MacKenzie at (410) 786-5929 or michele.mackenzie@cms.hhs.gov if you would like to schedule a follow-up conference call with the CMS team to discuss next steps or request technical assistance.

Thank you for your continued commitment to the state of Texas' successful delivery of Medicaid-funded HCBS.

Sincerely,

Melissa L. Harris, Deputy Director
Disabled & Elderly Health Programs Group

Enclosure

Heightened Scrutiny Site Visit - Texas
Summary Review by Setting
Visit Dates: February 13-16, 2023

Texas Site Visit Team #1- Dallas/Fort Worth:

CMS Representative: Michele MacKenzie
ACL Representative: Jill Jacobs
New Editions: Devon Mayer and Yonda Snyder
Texas: Erica Brown

Introduction:

The Site Visit Team visited one intentional community, one day habilitation/individualized skills and socialization (ISS) setting, and four assisted living (AL) settings in the Dallas/Fort Worth area of Texas. Texas identified AL settings as presumptively institutional and submitted them to the Centers for Medicare & Medicaid Services (CMS) for a heightened scrutiny review as category 3, settings that isolate HCBS members from the larger community. Texas has not submitted intentional communities or individualized skills and socialization settings for heightened scrutiny yet, but anticipates doing so and asked CMS to visit these settings and provide feedback.

Summary of Findings:

Although a distinct review of each setting is included in this report, the table below summarizes the findings for the entirety of the visit to Texas and identifies systemic issues noted through the review. In addition to the findings below, the team also noted that managed care plans routinely included minimal services for individuals, generally assisted living and dental services, and in several settings it was reported that either individuals were not getting the services they needed, or an additional provider was coming into the assisted living setting to provide assistance with activities of daily living (ADLs). CMS encourages the state to ensure their managed care plans are providing contracted services to individuals according to assessed needs.

Rule Citation	Rule Language	Setting Name
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	Lakes Regional Day Center, Masons Personal Care Home, Silver Creek Assisted Living, The Residences at Bridgeport Medical Lodge, 29 Acres, Circle of Helping Hands

Rule Citation	Rule Language	Setting Name
441.301(c)(4)(ii)	The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*	Lakes Regional Day Center, Masons Personal Care Home, Silver Creek Assisted Living, The Residences at Bridgeport Medical Lodge, 29 Acres, Circle of Helping Hands
441.301(c)(4)(iii)	Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	Masons Personal Care Home, Silver Creek Assisted Living, The Residences at Bridgeport Medical Lodge, 29 Acres, Circle of Helping Hands
441.301(c)(4)(iv)	Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.	Lakes Regional Day Center, Masons Personal Care Home, Silver Creek Assisted Living, The Residences at Bridgeport Medical Lodge
441.301(c)(4)(v)	Facilitates individual choice regarding services and supports and who provides them.	Masons Personal Care Home, The Residences at Bridgeport Medical Lodge
441.301(c)(4)(vi)(A)	The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.	Masons Personal Care Home, Silver Creek Assisted Living, Circle of Helping Hands, Residences at Bridgeport
441.301(c)(4)(vi)(B)	Each individual has privacy in their sleeping or living unit	Masons Personal Care Home, Silver Creek Assisted Living, The Residences at Bridgeport Medical Lodge, 29 Acres, Circle of Helping Hands

Rule Citation	Rule Language	Setting Name
441.301(c)(4)(vi)(B)(2)	Individuals sharing units have a choice of roommates in that setting.	Masons Personal Care Home, Circle of Helping Hands
441.301(c)(4)(vi)(C)	Individuals have the freedom to control their own schedules and activities, and have access to food at any time.	Masons Personal Care Home, Silver Creek Assisted Living, The Residences at Bridgeport Medical Lodge
441.301(c)(4)(vi)(D)	Individuals are able to have visitors of their choosing at any time	Masons Personal Care Home, Silver Creek Assisted Living, The Residences at Bridgeport Medical Lodge
441.301(c)(4)(vi)(F)	Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. *	Lakes Regional Day Center, Masons Personal Care Home, Silver Creek Assisted Living, The Residences at Bridgeport Medical Lodge, 29 Acres, Circle of Helping Hands

Additional Provision	Language	Setting Name
State Medicaid Director Letter #19-001[1]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	Lakes Regional Day Center, Masons Personal Care Home, Silver Creek Assisted Living, The Residences at Bridgeport Medical Lodge, 29 Acres, Circle of Helping Hands

Masons Personal Care Home, Assisted Living Facility – Visit February 13, 2023

Facility Description:

The assisted living facility (ALF) setting is a home in a residential neighborhood in Mesquite, TX. The setting is largely indistinguishable as an ALF from the other houses in the neighborhood; it is a single-story brick house, with the backyard fence visible from the street, like all the other homes in the neighborhood. The setting is reported to be licensed as a Type A ALF, although the Owner reported that the setting was licensed as a Type B ALF. Seven people live there, all of whom receive ALF services via a Medicaid HCBS waiver. Upon entry, there is a hallway to the right, and the living room directly in front. The living room was furnished with a line of chairs, all covered with incontinence pads, facing a TV on the left-hand wall. There is a half-wall on the right that separates the living room from the kitchen and dining area. At the back of the living room is a door to the back yard. The hallway on the right leads to two private bedrooms and a closet for towels on the right side of the hall, a shared bathroom and laundry room on the left side and a room shared by two residents at the end of the hallway. The towel closet and the laundry

[1] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

room are kept locked. There is another shared bedroom at the end of the hallway. There is another shared bedroom, for three residents, just off the kitchen and dining area, as well as an administrative office where medications were kept. Most of the interior walls in the common areas – entry way, living room, kitchen – were covered with paper postings, many of them old policy notices. There was an outdoor patio area, with a table and chairs and multiple ashtrays for smokers, and a large backyard. The backyard was entirely fenced with wood privacy fencing (as were many of the homes in the neighborhood) and there was a large 16 passenger van and a wheelchair van in the driveway behind the house. There were cameras in all of the common areas of the house, inside and outside.

Site Visit Review Description:

The team was signed in by facility staff, who conducted temperature screenings as part of COVID-19 protocols and recorded those on the sign-in sheet. The staff person then started the tour by knocking on the door of the first bedroom in the hallway. The resident was eating in the room, but was happy to speak with the team. The second resident responded to the staff person knocking on the door to their room, but was clearly uncomfortable speaking with the team, so the team moved on. The staff person attempted to wake people in the next room to speak with the group; the site visit team asked her to not disturb them. There were people sleeping in the other shared bedroom, and one person sitting in the living room. Staff reports doing all laundry for the residents. Residents' medications were locked in the Owner's office with a tray for each resident. One person returned to the facility after a visit with their family and was very conversational with the team. As described in the Findings, it was unclear which residents were living in the house at the time as one resident indicated that they were temporarily staying at another ALF until the census was up high enough for them to return.

The team reviewed service plans and other documentation on the outdoor patio; the service plans for the residents of this location were scant with person-centered information. The Owner provided the team with large binders that contained the full records of at least three residents, including their residency agreements, as well as a staff training binder, and a large binder of facility policies. The Owner stayed with the team during this time and answered a number of questions from the group about how residents move between the two facilities he owns, the limitations on cigarettes (described below), group activities in the community, residents' pets and house rules. He pointed out how certain policies had been amended due to the settings rule, including locks on doors, access to food, fair housing (lease protections), and visitation rules. He noted that he had remediated the door locks on residents' doors by adding locks to the bedroom doors, and the lease requirement by adding the state's addendum. He indicated that there were house rules and that violation of those rules could result in eviction. Among those rules was the smoking policy.

Findings of Site Visit:

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	The setting's Administrator does not promote community integration because he thinks people are not "functional" enough. Residents described very limited opportunities to participate in the broader community. Masons Personal Care Home must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community. Establishing partnerships with community resources and leveraging existing community transportation options should be explored. Masons Personal Care Home should develop policies, practices and resources to ensure that individuals have full access to the greater community.
441.301(c)(4)(ii)	The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*	Service plans did not contain information about setting options, including non-disability specific settings and an option for a private unit in a residential setting. The state Medicaid Agency and the entity that is responsible for ensuring the development of the person-centered service plan must ensure that individuals receiving Medicaid-funded HCBS are afforded a choice of setting, in compliance with regulatory requirements, including a choice of non-disability specific settings.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(iii)	Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	The home has cameras in all indoor and outdoor locations. The provider said they are monitored for safety. There are no cameras in the bedrooms. During the tour, staff walked into rooms and tried to wake people up to talk to the team. The team shared that they did not want to disrupt people's schedules. Masons Personal Care Home must ensure their model of service delivery aligns with the regulatory criteria to support participants' right to privacy, dignity, respect and freedom from coercion and restraint. Remote monitoring, when allowed by a state in the delivery of HCBS, should only be used when necessary and ensure the privacy of all residents. Masons Personal Care Home must amend practices that and ensures individuals' rights to privacy, dignity and respect are recognized.
441.301(c)(4)(iv)	Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.	Several doors in the home were locked, including the linen closet that contained bathroom towels, the laundry room, and the food pantry, as well as kitchen cabinets. The laundry room also contained all hygiene supplies, including soap, razors, shaving cream, toothpaste, lotion, and wipes. One of the individuals with whom the team spoke noted they are staying in the other home the provider owns in Dallas because of how many people are living in each home, but they hope to return to this facility. The resident described residents moving back and forth between the two settings due to the total number of people receiving

Rule Citation	Rule Language	Violation Finding Based on Site Visit
		services. The Administrator shared with the team a conversation he had with the father of one of the residents, asking which home the individual should be dropped off at after an appointment. It was unclear to the team whether people were being moved between locations due to the provider's preference and census or if individuals are asking to move back and forth between locations. The Administrator did not provide clear answers to questions about which residents lived in which facility that he owns; it was unclear who lived where or when/why residents moved among or between these two ALFs. Meals are prepared and served at set times. One person had both breakfast and lunch in front of them simultaneously. All individuals in the home who smoke are limited to 6 cigarettes a day and the provider holds the cigarettes and distributes them each morning. When asked if individuals could go buy their own pack, the Administrator said they could, but also noted that none of them are capable of doing so. The Administrator said he did not make the restriction, the primary care physician (PCP) made the restriction because the PCP wants them to reduce their smoking habits. The PCP is the de facto physician for all residents unless their families can drive them to a different provider. The service plans did not indicate a justification for the daily limits on cigarettes. The setting's policy states that residents can use phones for 10 minutes daily at set times.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
		Masons Personal Care Home must ensure their model of service delivery aligns with the regulatory criteria to facilitate independence and community integration, and amend practices to ensure that schedules are not regimented and that individuals have the opportunity to set their own schedules and participate in activities of their choosing. Masons Personal Care Home must ensure their model of service delivery aligns with the regulatory criteria to support participants' autonomy in making choices about daily activities.
441.301(c)(4)(v)	Facilitates individual choice regarding services and supports and who provides them.	The PCP and podiatrist come into the facility and all residents use the same providers. The team asked if individuals could maintain their own providers in the community and the Administrator confirmed they could, but also noted that it would be up to their family members to take them. However, the provider policies indicate that transportation to medical appointments is available within 35 miles. Masons Personal Care Home must ensure their model of service delivery aligns with the regulatory criteria that individuals have access to services and supports that the individual has been assessed to need, and that the individuals have the ability to choose from whom they receive those services and supports.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(A)	The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.	The Administrator shared the remediated lease addendum with the team, however, the addendum had "house rule" restrictions. Masons Personal Care Home must ensure that a lease, residency or other written agreement is in place for each individual and that the agreement provides protections from evictions and appeals processes that are comparable to those in the jurisdiction's landlord tenant laws.
441.301(c)(4)(vi)(B)	Each individual has privacy in their sleeping or living unit	During the tour, staff walked into rooms and tried to wake people up to talk to the team. The team shared that they did not want to disrupt people's schedules. While this may have been done in an attempt to maximize the experience for the review team, care should be taken by staff to respect the privacy of individuals' living spaces. Masons Personal Care Home must ensure that each individual has privacy in their sleeping or living unit.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(B)(1)	Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.	The Administrator told the team that people are not functional enough to have keys. Masons Personal Care Home must ensure that units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. Any modifications on the ability of an individual resident to lock their door must be based on an assessed need and documented in the individual's person-centered service plan.
441.301(c)(4)(vi)(B)(2)	Individuals sharing units have a choice of roommates in that setting.	One individual who spoke with the team noted displeasure with a previous roommate and the resolution was that the Owner made the other individual leave. The team did not see a policy on roommate selection. Masons Personal Care Home must revise its model of service delivery to ensure that individuals sharing units have a choice of roommates.
441.301(c)(4)(vi)(B)(3)	Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.	It was not clear to the team that people had their own living areas due to moves between the Owner's two facilities. One resident described having been brought to the house that day, and referred to 'staying' in the room where we met. There was no décor on the walls, nothing personalized in the space. Masons Personal Care Home must ensure that individuals have the freedom to furnish and decorate their sleeping or living units.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(C)	Individuals have the freedom to control their own schedules and activities, and have access to food at any time.	The food pantry in the kitchen was locked; according to the Administrator this was due to the state requirement to lock up knives. The utensils shown to the team, however, included spoons and tongs. State staff clarified that this is not a state requirement. Masons Personal Care Home must revise its model of service delivery to ensure individuals have access to food at any time, unless there is a documented reason, described in an individual's person-centered service plan, for any restrictions.
441.301(c)(4)(vi)(D)	Individuals are able to have visitors of their choosing at any time	The setting has recommended visiting hours from 8 AM to 8 PM. Masons Personal Care Home must ensure their model of service delivery aligns with the regulatory criteria that participants are able to have visitors of their choosing at any time. Masons Personal Care Home should revise the visitor policy and practice to ensure that individuals can have visitors of their choice at any time.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(F)	Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.*	All individuals in the home who smoke are limited to 6 cigarettes a day and the provider holds the cigarettes and distributes them each morning. When asked if individuals could go buy their own pack, the Administrator said they could, but none of them are capable of doing so. The Administrator said he did not make the restriction, the PCP made the restriction. The service plans did not indicate a justification for the daily limits on cigarettes. The state Medicaid Agency, and the entity that ensures the development of the person-centered service plan should ensure that person-centered service plans that comply with all regulatory requirements are in place for each individual receiving Medicaid-funded HCBS. The entity responsible for the person-centered service plan should ensure that all modifications for a specific individual are incorporated into the plan and Masons Personal Care Home must adhere to the plan. Masons Personal Care Home should ensure that any relevant modifications for a specific individual are incorporated into the plan, and that modifications to the settings criteria are limited only to a specific assessed need as opposed to a blanket modification.

Additional Provision	Language	Violation Finding Based on Site Visit
State Medicaid Director Letter #19-001[2]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	The review team was shown an updated staff training manual to include information on the settings rule, but there was no record of staff being trained on the regulatory information. Masons Personal Care Home should ensure all employees have consistent and reinforced training on the HCBS settings regulatory criteria.

Silver Creek Assisted Living, Assisted Living – Visit February 14, 2023

Facility Description:

Silver Creek Assisted Living is located in Azle, Texas, a largely rural area northwest of Fort Worth. It is a free-standing Type A ALF, a brick single-story "ranch" style building. Upon entry there is a large living room to the right, a dining area and kitchen directly in front, and a hallway to the left. Three people reside in "apartments" with private bathrooms down a small hallway off of the living room, while the other residents live in single bedroom "apartments" with two shared bathrooms off of the hallway to the left of dining area. There is a door to the back yard and an open window to the kitchen off of the dining room. There is a large back porch area and a fenced back yard with a large wooden shed. The back porch had patio furniture down the length of the porch and bird feeders. The facility was clean and well maintained. One resident's door was decorated while the others were undecorated, with only a letter or a sign that indicated the name of the resident who lived there. There are two administrative offices, one at the end of the living room area and one to the left of the entrance, used by other staff. Medications are dispensed from a medication cart in the main residential hallway just outside the communal dining area.

Site Visit Review Description:

The team was greeted by facility staff who conducted COVID screening as the team signed in. The team began reviewing service plans immediately after arrival. The service plans that were reviewed came from the MCOs and had more detail than others the team had reviewed, although they appeared to be service-based rather than person-centered. The team also reviewed the facility policies and lease agreements.

After reviewing plans, the Owner/Administrator of the facility took the team on a tour and introduced the team members to residents in their apartments. The team conducted lengthy conversations with several residents during the tour. A menu and an activity calendar were posted on the wall of the dining area. The activity calendar contained community events that came from the Azle town calendar. Except for two people who were sitting on the back porch, the common areas were mostly empty and quiet during the site visit. When asked, the Owner/Administrator indicated that residents spent most of their time in their rooms. Residents indicated that they were free to use the back porch and could smoke at

[2] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

any time they chose. Residents shared that they have visitors of their choosing. The team observed that rooms were decorated based on individual preference. Several individuals had mini refrigerators in their rooms and could store food. Nearly all conversations with residents occurred in their private living spaces. Near the end of the tour, residents began coming into the dining area for lunch.

Findings of Site Visit:

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	There was a posted activity calendar but no way for residents to access community activities. The Administrator said the calendar is copied from the town's community activity calendar. Residents noted that the facility doesn't take them to any of the community events in Azle, and that the Owner has not been receptive to the idea of planning group activities outside of Bingo. The facility does not provide transportation, so residents are dependent on friends and family, or Medicaid/Medicare transportation services to go out into the community or to doctors' appointments. Silver Creek must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community. Establishing partnerships with community resources and leveraging existing community transportation options should be explored. Silver Creek should develop policies, practices and resources to ensure that individuals have full access to the greater community.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(ii)	The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*	Service Plans did not contain information about setting options, including non-disability specific settings and an option for a private unit in a residential setting. The state Medicaid Agency and the entity that is responsible for ensuring the development of the person-centered service plan must ensure that individuals receiving Medicaid-funded HCBS are afforded a choice of setting, in compliance with regulatory requirements, including a choice of non-disability specific settings.
441.301(c)(4)(iii)	Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	The team observed an open medication cart with unsecured Medicaid Administration Record binders. There was a Vital Signs binder to the left of the cart. Posted over the cart on the walls were memos containing resident call information. The Administrator opened apartments to show the team when residents were not present to grant access. Silver Creek must ensure their model of service delivery aligns with the regulatory criteria to support participants' right to privacy, dignity, respect and freedom from coercion and restraint. Silver Creek must modify their model of service delivery to protect the privacy of residents' health information.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(iv)	Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.	One resident indicated that a separate provider comes into the building to help him shower two days a week and he is unable to shower if he wants to shower on a different day. Another resident reported relying on assistance from family and friends on the weekends for support with showering. The setting had a posted policy to prohibit alcohol. The lease agreement indicated that alcohol is allowed. The team asked the Owner/Administrator about this conflict and she stated that alcohol was prohibited. Silver Creek must ensure their model of service delivery aligns with the regulatory criteria to facilitate independence and community integration, and amend practices to ensure that schedules are not regimented and that individuals have the opportunity to set their own schedules and participate in activities of their choosing. Silver Creek must ensure their model of service delivery aligns with the regulatory criteria to support participants' autonomy in making choices about daily activities.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(A)	The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.	The Resident Agreement noted that residents were free to leave but that the ALF could not be responsible for their safety which appears to discourage individuals to access the community. The agreement included requirements for visitors signing in and out (which may discourage visitors) and prohibited overnight guests without facility approval. Silver Creek must ensure that a lease, residency or other written agreement is in place for each individual and that the agreement provides protections from evictions and appeals processes that are comparable to those in the jurisdiction’s landlord tenant laws.
441.301(c)(4)(vi)(B)	Each individual has privacy in their sleeping or living unit	The Administrator opened apartments to show the team when residents were not present. While this may have been done in an attempt to maximize the experience for the review team, care should be taken by staff to respect the privacy of individuals’ living spaces. Silver Creek must ensure that each individual has privacy in their sleeping or living unit.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(C)	Individuals have the freedom to control their own schedules and activities, and have access to food at any time.	Residents shared they can get food when they are hungry, however, the team observed that the kitchen door was locked and a sign said the door needs to be locked at all times. Silver Creek must ensure their model of service delivery aligns with the regulatory criteria to support participants' ability to control their schedules and activities. Silver Creek must revise its model of service delivery to ensure individuals have access to food at any time, unless there is a documented reason, described in an individual's person-centered service plan, for any restrictions.
441.301(c)(4)(vi)(D)	Individuals are able to have visitors of their choosing at any time	The setting has "recommended" visiting hours, as well as a prohibition on overnight guests without facility approval and requirements for visitors to sign in and out. Silver Creek must ensure their model of service delivery aligns with the regulatory criteria that participants are able to have visitors of their choosing at any time. Silver Creek should revise the visitor policy and practice to ensure that individuals can have visitors of their choice at any time.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(F)	Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.*	The team observed blanket modifications (access to food was limited by a locked kitchen door, a policy prohibiting alcohol, recommended visitor hours) with no support by a specific assessed need and justification in the PCSP. The state Medicaid Agency, and the entity that ensures the development of the person-centered service plan should ensure that person-centered service plans that comply with all regulatory requirements are in place for each individual receiving Medicaid-funded HCBS. The entity responsible for the person-centered service plan should ensure that all modifications for a specific individual are incorporated into the plan and Silver Creek must adhere to the plan. Silver Creek should ensure that any relevant modifications for a specific individual are incorporated into the plan, and that modifications to the settings criteria are limited only to a specific assessed need as opposed to a blanket modification.

Additional Provision	Language	Violation Finding Based on Site Visit
State Medicaid Director Letter #19-001[3]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	There was no record of staff being trained on HCBS settings criteria. Silver Creek should ensure all employees have consistent and reinforced training on the HCBS settings regulatory criteria.

[3] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

Circle of Helping Hands, Assisted Living Facility – Visit February 16, 2023

Facility Description:

The setting is located in a residential neighborhood and is mostly indistinguishable as an Assisted Living Facility from the rest of the neighborhood. The facility is a Type B ALF and houses 6 residents, five of whom receive Medicaid HCBS. There is capacity for 8 residents. All residents in this ALF are women; the Owner has another building that houses only men. The setting is a brick house with a fenced back yard. To the right of the entryway is a staircase. No residents live on the second floor of the house; the staircase leads to a room for live-in staff. Immediately to the left of the entry is a bedroom for a resident that has glass paned French doors that were standing open. There was a powder room/bathroom just past that bedroom. The bathroom locked but did not contain any hand soap or towels. The entire house smelled strongly of cleaning solution. The house had an open floor plan with living room, kitchen and dining area all open to each other immediately in front of the entryway. There is a length of countertop that separates the kitchen on the left from the living room on the right; the dining room is just past the kitchen area, near the back door of the house. There was a fireplace and a TV along the living room wall, and a series of recliners that lined the short wall for residents to view the TV. Two resident bedrooms and the laundry room are to the right of the living room. There is a shared bathroom on that hall, with a second door that opens to the living room. To the left of the TV and fireplace is a large room that is shared by two residents. There is a third bathroom and a large walk-in closet just past the bedroom. The back door leads to a fenced backyard. No pets are allowed in the house.

Site Visit Review Description:

The team gathered at the dining room table to review service plans. There was a binder from the facility for each resident as well as the plan documents that were gathered by the state from the MCOs. Unfortunately, the state was provided with plans for the company's other facility; the team only had one service plan to review for a resident of the building. The Administrator of the building indicated that he had never been provided with a service plan from the MCOs for the residents of the facility. The binders contained very little information. Most of the binders contained a plan of care document for the resident but these were all older documents, completed in 2019 or 2020. Sugar check and medication records were current but there was no other documentation in the binders. When asked if he was familiar with the Medicaid HCBS settings rule, the Administrator indicated that he was and explained his understanding that was largely accurate. The Administrator informed the team that one resident attends a day program but that attendance was in abeyance due to the recent ice storm.

During the course of the visit, the team conversed with at least four residents and the one staff member who was onsite during the visit. One resident indicated that she smoked and that she kept her own cigarettes and could go outside whenever she wanted to smoke. One resident showed her room to the team. The staff person lived in the house, in the upstairs room. She stated that she looked after the residents' needs and did whatever they needed, whenever they needed it. The staff person stated that she cooked and cleaned and that she would prepare snacks or meals if someone wanted something different to eat or wanted to eat at different times. The staff person indicated the residents were free to walk to the park but that she could not accompany them if they needed assistance because she could not leave the other residents alone. The staff person took a team member on a tour and was going to open a resident's door to see if she was sleeping, but the team member asked her not to disturb that person.

Findings of Site Visit:

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	One individual shared examples of the types of community activities that they would like to do, but reportedly the provider is not facilitating access to any of these activities. Individual shared that there are no planned activities at this residence. Circle of Helping Hands must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community. Establishing partnerships with community resources and leveraging existing community transportation options should be explored. Circle of Helping Hands should develop policies, practices and resources to ensure that individuals have full access to the greater community.
441.301(c)(4)(ii)	The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*	Service plans did not contain information about setting options, including non-disability specific settings and an option for a private unit in a residential setting. The state Medicaid Agency and the entity that is responsible for ensuring the development of the person-centered service plan must ensure that individuals receiving Medicaid-funded HCBS are afforded a choice of setting, in compliance with regulatory requirements, including a choice of non-disability specific settings.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(iii)	Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	The team observed that tape was placed over the lock to the shared bathroom that was in a shared bedroom so that the door cannot be locked for privacy. One individual's room had a hasp lock on the outside of the door. One individual said they could show their room to the site visit team member if it was ok and seemed to question whether it was allowable without staff permission. There were cameras in the public areas of the house. The Administrator informed the team that these were for "accident observation" and that he was the only person who had access to the recordings. Circle of Helping Hands must ensure their model of service delivery aligns with the regulatory criteria to support participants' right to privacy, dignity, respect and freedom from coercion and restraint. Circle of Helping Hands should amend their model of service delivery to ensure individuals' rights to privacy such that individuals have privacy in bathing. This includes facilitating privacy in the shared bedroom. Remote monitoring, when allowed by a state in the delivery of HCBS, should only be used when necessary and ensure the privacy of all residents.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(A)	The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.	The remediated lease agreement includes eviction language but the document does not clearly spell out what is included in the lease; it is unclear that the lease comports with what is allowable under the jurisdiction's local landlord tenant laws and if individuals are afforded the same rights as individuals not receiving Medicaid HCBS. The document had not been updated for current residents yet. Circle of Helping Hands must ensure that a lease, residency or other written agreement is in place for each individual and that the agreement provides protections from evictions and appeals processes that are comparable to those in the jurisdiction's landlord tenant laws.
441.301(c)(4)(vi)(B)	Each individual has privacy in their sleeping or living unit	A shared bedroom had a lock, but an individual reported they did not have a key. The team observed that tape was placed over the lock to the shared bathroom that was in a shared bedroom so that the door cannot be locked for privacy. Circle of Helping Hands must ensure that each individual has privacy in their sleeping or living unit.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(B)(1)	Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.	The team observed a hasp lock on the exterior of the front bedroom door. Another bedroom was observed to have a lock, but one of the two residents who shared the room did not have a key to the lock. Circle of Helping Hands must ensure that units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. Any modifications on the ability of an individual resident to lock their door must be based on an assessed need and documented in the person-centered service plan.
441.301(c)(4)(vi)(B)(2)	Individuals sharing units have a choice of roommates in that setting.	An individual with a roommate did not know of a process for changing roommates. Circle of Helping Hands must revise its model of service delivery to ensure that individuals sharing units have a choice of roommates.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(F)	Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.*	There was no justification provided for the bathroom door with a taped-over lock or why the individual did not have a key for their room. The state Medicaid Agency, and the entity that ensures the development of the person-centered service plan should ensure that person-centered service plans that comply with all regulatory requirements are in place for each individual receiving Medicaid-funded HCBS. The entity responsible for the person-centered service plan should ensure that all modifications for a specific individual are incorporated into the plan and Circle of Helping Hands must adhere to the plan. Circle of Helping Hands should ensure that any relevant modifications for a specific individual are incorporated into the plan, and that modifications to the settings criteria are limited only to a specific assessed need as opposed to a blanket modification.

Additional Provision	Language	Violation Finding Based on Site Visit
State Medicaid Director Letter #19-001[4]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	The Administrator was conversant on the rule, but there was no record of direct support staff being trained on HCBS settings criteria. Circle of Helping Hands should ensure all employees have consistent and reinforced training on the HCBS settings regulatory criteria.

[4] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

Residences at Bridgeport, Assisted Living – Visit February 14, 2023

Facility Description:

The Residences at Bridgeport Medical Lodge is a Type B Assisted Living Facility in Bridgeport TX, co-located with a skilled nursing facility. The entry is under a covered walkway, with resident post office boxes immediately adjacent to the front door. Once inside, the Administrator's office is immediately to the left of the front door and guests find themselves facing a communal dining room that is elevated with a rail around the sides. There were many people in the dining area when the team arrived. The team was told that this was for the facility's Valentine's Day party. Past the dining area and a short hallway is the residential area, which stretches down a hallway in both directions. Resident apartment doors line both sides of this hallway. The hallway to the right extends to a righthand "ell" that leads to 3 or 4 additional apartments. The hallway on the left extends to an "ell" that leads to a communal library area and a door to the breezeway between the assisted living facility and the skilled nursing facility. Many residents had decorated their doorways with seasonal or other decorations. Rooms were a mix of studio, one bedroom and two-bedroom apartments. The information submitted by the state for the CMS heightened scrutiny review states that the facility has 27 residents and 16 residents receive Medicaid HCBS. The site visit team did not observe an outdoor area. Residents have access to a smoking area but if they want to use a communal outdoor area, they have to walk around the outside of the building through the parking lot.

Site Visit Review Description:

The site visit team was began to review service plans. Two members of the team went to go speak with residents at the Valentine's Day party. They spoke with several residents as they engaged in the Valentine's party and played Bingo. Individuals shared that meals and alternate food is available and that individuals can eat in the dining room or in their rooms. Individuals shared they had keys to their apartments and the team observed deadbolt locks on doors and observed one individual unlock their apartment using a key. When they returned, the group continued to review policy and training documents as well as participant service plans. During the service plan review, the team noted that a number of plans were dated that day and a number of plans were signed more than one year ago. The policy binder contained numerous policies that came from commercially available nursing facility policy manuals, and that included nursing facility references and "f tag" ("federal tag" referencing federal nursing facility deficiencies) information.

On a tour, the team observed a sign in the hallway about electronic monitoring and asked about this. The Director informed that group that the signage related to "nanny-cams" in resident apartments, but that no one currently had a camera in their apartment. During the tour, one resident was available for additional conversation, including a number of questions about what the team was doing and the settings rule. Following the tour, the team had a conversation with a direct care staff person. The staff person told the team that she saw her work as largely "meals and pills".

Findings of Site Visit:

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	Individuals shared that the trips organized for Medicaid HCBS waiver participants (monthly trip to Walmart) are more limited than the trips for private pay residents. One individual shared that requests for transportation to a different location were turned down and they weren't offered support to locate alternate transportation options. One service plan noted that the resident frequently felt lonely and isolated, but that they were not doing anything in the community; another noted that the resident wanted to spend more time with their son, but that scheduling was a barrier. Residences at Bridgeport must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community. Establishing partnerships with community resources and leveraging existing community transportation options should be explored. Residences at Bridgeport should develop policies, practices and resources to ensure that individuals have full access to the greater community.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(ii)	The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*	Service plans did not contain information about setting options, including non-disability specific settings and an option for a private unit in a residential setting. The state Medicaid Agency and the entity that is responsible for ensuring the development of the person-centered service plan must ensure that individuals receiving Medicaid-funded HCBS are afforded a choice of setting, in compliance with regulatory requirements, including a choice of non-disability specific settings.
441.301(c)(4)(iii)	Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	The team observed a staff member knocking on resident doors and entering without waiting to be invited in to announce that dinner was being served. Individuals shared that they have asked for permission multiple times, including in writing, to use the locked staff restroom that is located next to the communal dining room due to medical conditions. The individuals asked that the request be kept in their file, but there was nothing in the file. Staff denied the request. They cannot eat in their room because there is an extra charge for it, which they cannot afford. Residences at Bridgeport must ensure their model of service delivery aligns with the regulatory criteria to support participants' right to privacy, dignity, respect and freedom from coercion and restraint.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(iv)	Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.	Individuals shared that there are not many activities at the setting, but there is a new activity coordinator and they were hopeful that there would be more activities in the future. Residences at Bridgeport must ensure their model of service delivery aligns with the regulatory criteria to facilitate independence and community integration, and amend practices to ensure that schedules are not regimented and that individuals have the opportunity to set their own schedules and participate in activities of their choosing.
441.301(c)(4)(v)	Facilitates individual choice regarding services and supports and who provides them.	One individual shared that some people have the level of support they need and that others do not. They shared that the provider seems to prefer only providing meals and medication assistance. Residences at Bridgeport must ensure their model of service delivery aligns with the regulatory criteria that individuals have access to services and supports that the individual has been assessed to need, and that the individuals have the ability to choose from whom they receive those services and supports.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(A)	The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.	The service agreements did not contain protections from eviction. Residences at Bridgeport should revise the existing lease agreement to ensure it is a legally enforceable agreement that provides comparable protections against eviction as those provided under landlord/tenant law.
441.301(c)(4)(vi)(B)	Each individual has privacy in their sleeping or living unit	The team observed staff knocking and entering rooms (without waiting to be let in) to notify people of meal time. Residences at Bridgeport must ensure that each individual has privacy in their sleeping or living unit.
441.301(c)(4)(vi)(C)	Individuals have the freedom to control their own schedules and activities.	The setting has a policy that individuals can only smoke at designated times and the provider holds individuals' cigarettes and lighters in a lock box. Staff shared this is a condition of the lease. Residences at Bridgeport must ensure their model of service delivery aligns with the regulatory criteria to support participants' ability to control their schedules and activities.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(D)	Individuals are able to have visitors of their choosing at any time	Individuals shared that visitors are not allowed at night. A bullet point in the resident packet includes “reasonable hours” language. Residences at Bridgeport must ensure their model of service delivery aligns with the regulatory criteria that participants are able to have visitors of their choosing at any time. Residences at Bridgeport should revise the visitor policy and practice to ensure that individuals can have visitors of their choice at any time.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(F)	Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.*	The team observed blanket modifications (smoking hours and access to cigarettes, prohibition on overnight visitors) with no support by a specific assessed need and justification in the PCSP. The state Medicaid Agency, and the entity that ensures the development of the person-centered service plan should ensure that person-centered service plans that comply with all regulatory requirements are in place for each individual receiving Medicaid-funded HCBS. The entity responsible for the person-centered service plan should ensure that all modifications for a specific individual are incorporated into the plan and Residences at Bridgeport must adhere to the plan. Residences at Bridgeport should ensure that any relevant modifications for a specific individual are incorporated into the plan, and that modifications to the settings criteria are limited only to a specific assessed need as opposed to a blanket modification.

Additional Provision	Language	Violation Finding Based on Site Visit
State Medicaid Director Letter #19-001[5]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	There was no record of staff being trained on HCBS settings criteria. Residences at Bridgeport should ensure all employees have consistent and reinforced training on the HCBS settings regulatory criteria.

[5] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

Lakes Regional Day Center, Day Habilitation/Potential Individualized Skills and Socialization (ISS) setting – Visit February 13, 2023

Facility Description:

Lakes Regional Day Center is located on the grounds of Terrell State Hospital, in Terrell, TX. The setting is separated from the state hospital by a fence and a creek and cannot be entered from the state hospital grounds. The setting resembles a single-family home, on both the exterior and interior. Upon entry, the dining room and kitchen are to the right and the living room is to the left. There is a hallway to the left that leads to an arts and crafts room, and two rooms that are equipped to use for employment skills training (one of which doubles as a quiet room). There is an administrative office at the end of the hall, and a storage closet in the middle of the hall. There are multiple bathrooms in the building, one of which is reserved for staff use and one which is equipped to support people who need assistance with toileting changes. There was some general health information posted, but nothing with individual, identifying information. Outside there is a large, grassy area where people can spend time. 22 people participate in services at this setting, 20 of whom are receiving Medicaid-funded day habilitation.

Site Visit Review Description:

Upon arrival the team was given a tour of the setting. The team then gathered in the dining room to review service plans. The team observed a monthly activities calendar that included primarily group activities but asked about people being able to do things different from this calendar or on their own. The team was told that two people were in the community at this time, one to get her nails done in preparation for Valentine's Day and the other shopping for the holiday. While the team was there, some people participated in arts and crafts. A Lakes Regional staff member came to the center and spent time with at least one participant. The team was told that her job was to prepare people for employment.

Over the course of the morning, many of the people who were at the center drifted into the dining room to observe the site visit team. The team observed individuals helping themselves to snacks from a basket on the kitchen counter, others engaged in activities such as knitting and puzzles. One man began playing music in the dining room and an impromptu dance party took place. While this was occurring, some people stayed in the living room area to watch TV or listen to music on headphones. Eventually people started moving on to other things, including getting their lunch bags and starting to eat their lunches. The settings team spoke with several people receiving services during the course of the visit. The atmosphere of the building was relaxed and unstructured.

The team observed that service plans were not detailed or individualized. Most of the plans included goal and preference language that was applicable to specific services that were available, rather than individualized to the person's preferences. For example, nearly all participants had dental services and a goal around having a healthy mouth. One person's plan indicated interests in doing and learning new things, but this was not reflected in that person's goals for day habilitation, which were focused on the person learning how to use their phone.
One individual reported living with family and another reported living in a group home owned by the same provider. Individuals report that they can participate in activities or stay behind, they are not required to go on group outings. There were no assigned seats and individuals were observed to be free to come and go about the setting, to go outside, and to decide how to spend their leisure time. The Director shared examples of individual activities that people engage in (visit to the hair salon and getting nails done). One individual shared about their romantic relationship and gave an example of an off-site date. Individuals bring food from home, they can eat when they are hungry, and there is not a strict schedule for meal or snack times. Individuals were observed getting food as they desired and they were not limited to eating in the common area, nor were they required to remain seated while eating. The setting was observed to be accessible. Staff reported that individuals can use the kitchen and

people were observed going in and out. The bathroom doors had locks on them to allow privacy. At least some of the individuals in the setting receive service coordination from the local DD authority who also provide the residential and day services. The facility's Code of Conduct policy included restrictions on phone contents, including pictures and ringtones and prohibited the use of headphones unless recommended.

Findings of Site Visit:

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	While the Day Center has a relationship with other Lakes Regional entities to provide employment-focused services, at least one participant indicated clearly to a site visit team member that his goal was to resume employment. The availability of these employment supports should be increased. Lakes Regional Day Center must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community. Establishing partnerships with community resources and leveraging existing community transportation options should be explored. Lakes Regional Day Center should develop policies, practices and resources to ensure that individuals have full access to the greater community. Additionally, the setting should ensure that individuals are informed of their choices for competitive, integrated employment.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(ii)	The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*	The service plans did not contain information about how setting was selected or that individuals had options to receive services in non-disability specific settings. The state Medicaid Agency and the entity that is responsible for ensuring the development of the person-centered service plan must ensure that individuals receiving Medicaid-funded HCBS are afforded a choice of setting, in compliance with regulatory requirements, including a choice of non-disability specific settings.
441.301(c)(4)(iv)	Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.	The facility Code of Conduct includes restrictions on phone content, including pictures and ringtones and notes that headphones are not permitted unless recommended by the team. Lakes Regional Day Center must ensure their model of service delivery aligns with the regulatory criteria to facilitate independence and community integration, and amend practices to ensure that schedules are not regimented and that individuals have the opportunity to set their own schedules and participate in activities of their choosing.

441.301(c)(4)(vi)(F)	Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.*	The team observed that the behavioral plans that were part of the service plans included boilerplate language that was identical for multiple people and included instances where gender pronouns were incorrect, so it appeared to be copied and pasted rather than developed individually. One behavioral support plan included goals and consequences around "gossiping" and having "unnecessary opinions" which appeared to be directed by the provider, not the individual. Another behavior support plan was for an individual who was staying up late and sleeping in late which caused the individual to miss the day program. The plan noted that in instances when the individual overslept and missed the bus to the day program, the individual would have to go to another group home operated by the provider, rather than staying in their own home. One plan noted that an individual had a "rights restriction" on smoking due to "possible COPD" but the plan did not address other interventions that were attempted, how the individual participated in or was informed about the restriction, or how that restriction would be regularly reviewed. The state Medicaid Agency, and the entity that ensures the development of the person-centered service plan should ensure that person-centered service plans that comply with all regulatory requirements are in place for each individual receiving Medicaid-funded HCBS. The entity responsible for the person-centered service plan should ensure that all modifications for a specific individual are incorporated into the plan and Lakes Regional Day Center must adhere to the plan.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
		Lakes Regional Day Center should ensure that any relevant modifications for a specific individual are incorporated into the plan, and that modifications to the settings criteria are limited only to a specific assessed need as opposed to a blanket modification.

Additional Provision	Language	Violation Finding Based on Site Visit
State Medicaid Director Letter #19-001[6]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	The Director shared information with the team about plans for upcoming staff training, as well as training for individuals receiving services and their families, related to the settings rule. Lakes Regional Day Center should ensure all employees have consistent and reinforced training on the HCBS settings regulatory criteria.

29 Acres, Intentional Community – Visit February 15, 2023

Facility Description:

29 Acres is an intentional community located in Cross Roads, TX, just east of Denton. The setting consists of ten houses, a community center with entertainment facilities and a pool, and an area for animals and outdoor recreation. The houses are one or two story and house 4-6 residents. The entrance to the property was fenced with automated gates; the entrance gate is left open until 11pm at night. The community is clean and modern; houses are landscaped and decorated. One four-bedroom house, the 200 House, is certified as a Medicaid provider of residential support services on the HCBS waiver. There are two bedrooms on either side of the entry way, with doors that face each other in an alcove. Each room has a private bathroom. At the front of the house, to the left of the entryway, there is a cubby area for residents' personal belongings – bags, shoes, and a central room that is locked for medication storage. There is a laundry room that is locked, but residents can use it to do their own laundry with supports. Past the bedrooms and the central storage room is a common kitchen, dining, and sitting area. There is a screened porch off of the dining area. The room was decorated with art by residents, comfortable chairs, and a TV. The kitchen has a counter/breakfast bar that stretches across the front of the room with food preparation appliances across the back. One resident was sitting at the breakfast bar having his breakfast during the visit, at about 10am. There is a pantry just off the kitchen where residents store their food; the pantry is not locked. The front door and back door to the porch were not locked and there were no key pads to control entrance or egress by residents.

[6] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

Site Visit Review Description:

The site visit team was greeted by the property manager who provided a thermometer for COVID temperature checks while the group signed in. After stepping into the building, the team was greeted by the Founder and Director of 29 Acres and the Chief Operations Officer (COO). While certain features of the property were pointed out by the Director and COO, the group did not do a full tour of the 29 Acres campus. The group received a tour of the only house on the campus certified to provide Medicaid HCBS. Three of the four residents of this house receive Medicaid HCBS. The group toured the home and had limited conversation with the people who were home. The group observed a camera dock in the kitchen and were told that cameras were in one resident's room at the request of that resident's parents, with a docking station for viewing in the kitchen. There were cameras in common areas of the home.

Following the visit to the home, the group walked back to the 29 Acres community center to begin reviewing service plans and policies. The team was given a binder for each HCBS recipient and the facility's policy and procedure manual, as well as a copy of the Settings Rule training that was provided to staff (no date given for this). The policy manual explicitly states that residents have choice of service provider. The Director shared there are 11 vans and cars for transportation and reported that there is public transportation and ride sharing available in the area. Individuals meal prep and go shopping with staff. The Director shared that the entrance criteria would exclude people with a primary psychiatric diagnosis because the setting does not have services to support them and it wouldn't be safe.

The Director brought in copies of the Activities calendars for November and February as well as a copy of an activities survey that is distributed each month to residents and their families. Copies of residential agreements were included as part of each resident's binder that also included the service plan and behavior support plan. There was evidence in the binder for the resident with the cameras, that the facility engaged in an effort to mitigate camera use, and to train staff on how to respect the privacy of residents with a camera in use. The team later had a discussion with the Director about the use of cameras as a modification of the conditions of the rule, subject to a specific assessed need of the resident, not the resident's parents or legally authorized representative. The residential agreement and policy manual both documented that residents had a choice of service provider for their residential support services. The residential agreement contained a clear eviction policy, separation of rent and services, clear language about who was responsible for what, and a fee structure.

The plans included goals for community-based activities as well as goals for behavior modifications. The team noted there were several goals on behavior plans that were marked as completed and the goal was ended. When asked about employment, the team was told that the parents of the three people that use Medicaid HCBS are not interested in employment for their adult children. Other residents of the campus work in community-based jobs and the facility provides transportation or helps people learn how to navigate the public transportation system. The gate is closed after 11pm, but residents have key fobs to open the gate. If guests arrive late, the team was told that they can buzz the person that they are visiting in order to be allowed on campus. The provider shared that each of the homes choose housemates and make their own house rules based on the preferences of the residents in that home, including rules related to overnight visitors and alcohol use. The provider shared the lease and community policies do not prohibit guests or alcohol. Smoking is discouraged, but allowed in designated areas.

Findings of Site Visit:

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	The site visit team was told that the parents of the three people that use Medicaid HCBS are not interested in employment for their adult children. There was no evidence to support individuals were provided the opportunity to seek employment and work in competitive integrated settings. 29 Acres must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community, including opportunities to seek employment and work in competitive integrated settings. Additionally, the setting should ensure that individuals are informed of their choices for competitive, integrated employment.
441.301(c)(4)(ii)	The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*	Service plans did not contain information about setting options, including non-disability specific settings and an option for a private unit in a residential setting. The state Medicaid Agency and the entity that is responsible for ensuring the development of the person-centered service plan must ensure that individuals receiving Medicaid-funded HCBS are afforded a choice of setting, in compliance with regulatory requirements, including a choice of non-disability specific settings.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(iii)	Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	The team observed cameras in bedrooms which the provider shared were placed there at the parents' request. The team observed cameras in common areas. The team observed that individuals had personal, locked mailboxes with the keys hanging next to the mailboxes. 29 Acres must ensure their model of service delivery aligns with the regulatory criteria to support participants' right to privacy, dignity, respect and freedom from coercion and restraint. Remote monitoring, when allowed by a state in the delivery of HCBS, should only be used when necessary and ensure the privacy of all residents.
441.301(c)(4)(vi)(B)	Each individual has privacy in their sleeping or living unit	The team observed cameras in bedrooms which the provider shared were placed there at the parents' request. 29 Acres must ensure that each individual has privacy in their sleeping or living unit.

Rule Citation	Rule Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(F)	Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.*	Individuals with cameras in their rooms had information in their service plans regarding camera use, but it appeared to be for the parents' comfort level, not based on a specific assessed need and justified in the plan. The state Medicaid Agency, and the entity that ensures the development of the person-centered service plan should ensure that person-centered service plans that comply with all regulatory requirements are in place for each individual receiving Medicaid-funded HCBS. The entity responsible for the person-centered service plan should ensure that all modifications for a specific individual are incorporated into the plan and 29 Acres must adhere to the plan. 29 Acres should ensure that any relevant modifications for a specific individual are incorporated into the plan, and that modifications to the settings criteria are limited only to a specific assessed need as opposed to a blanket modification.

Texas Site Visit Team #2- Houston/Waco/Austin/San Antonio:

CMS Representative: Ryan Shannahan
ACL Representative: Erica McFadden
New Editions: Vicky Wheeler, Amy Coey

Introduction:

The Site Visit Team visited six settings in Texas. All six were Assisted Living Facilities (ALFs): Grandview of Westover Hills, Brookdale North Austin, Austin Senior Care, Brookdale Lake Brazos, Brookdale Lakeshore, and Brookdale Champion Oaks. These settings were located in the eastern to central regions of Texas (Houston, Waco, Austin, and San Antonio). Each setting was identified by the state as presumptively

institutional and submitted to CMS for a heightened scrutiny review. Brookdale is the largest provider in Texas with the most settings. Stakeholders noted feedback in general about Brookdale settings. As such, a variety of Brookdale settings were chosen for the site visit team to visit.

Promising Practices:

The state helped develop a residency agreement template with Brookdale for all their locations. These residency agreements provide the participants protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. The Brookdale settings have added an addendum to their residency agreement that includes their commitment to assist individuals with the opportunity to seek employment and work in competitive integrated settings. Also, many of the ALFs visited were pet-friendly; this is something that is not typically or consistently seen across states.

Summary of Findings:

Although a distinct review of each setting is included in this report, the table below summarizes the findings for the entirety of the visit to the eastern and central regions of Texas and identifies systemic issues noted through the review.

Regulation Citation	Regulation Language	Setting Name
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	Grandview of Westover Hills, Brookdale North Austin, Austin Senior Care, Brookdale Lake Brazos, Brookdale Lakeshore, Brookdale Champion Oaks
441.301(c)(4)(ii)	The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*	Grandview of Westover Hills, Brookdale North Austin, Austin Senior Care
441.301(c)(4)(iii)	The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	Grandview of Westover Hills, Brookdale North Austin, Austin Senior Care, Brookdale Lake Brazos
441.301(c)(4)(iv)	The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.	Brookdale North Austin, Austin Senior Care, Brookdale Lakeshore

Regulation Citation	Regulation Language	Setting Name
441.301(c)(4)(vi)(B)	Each individual has privacy in their sleeping or living unit	Grandview of Westover Hills, Brookdale North Austin, Austin Senior Care
441.301(c)(4)(vi)(C)	Individuals have the freedom to control their own schedules and activities, and have access to food at any time.	Grandview of Westover Hills, Brookdale North Austin
441.301(c)(4)(vi)(D)	Individuals are able to have visitors of their choosing at any time	Grandview of Westover Hills, Brookdale North Austin, Austin Senior Care, Brookdale Lake Brazos, Brookdale Lakeshore, Brookdale Champion Oaks
441.301(c)(4)(vi)(E)	The setting is physically accessible to the individual.	Grandview of Westover Hills, Austin Senior Care, Brookdale Lake Brazos, Brookdale Champion Oaks

Additional Provision	Language	Setting Name
State Medicaid Director Letter #19-001[7]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	Grandview of Westover Hills, Brookdale North Austin, Austin Senior Care, Brookdale Lake Brazos, Brookdale Lakeshore, Brookdale Champion Oaks

Grandview of Westover Hills - Visit February 16, 2023

Facility Description:

Grandview of Westover Hills is an ALF with a memory care unit located in San Antonio, Texas. At the time of the visit, there were 53 total residents, including six HCBS participants. There are no HCBS participants in the memory care unit. The Administrator mentioned that another ALF closed and those HCBS residents moved to this setting. All the HCBS participants had shared rooms. Most non-Medicaid HCBS residents had private rooms. Rooms have a sink, refrigerator, and a microwave in them. Some of the amenities on site included a patio, library, beauty salon, fitness room, and movie theater. This setting is pet-friendly and some residents had their own dog or cat, as well as their own car.

Site Visit Review Description:

The site visit team first sat in the library and spoke to the Administrator. The lead Administrator indicated to the team that she was not aware of what the HCBS settings rule was and claimed the first time she had heard of it was when the state reached out a week before the visit. However, it

[7] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

should be noted the Administrator was new to the setting, and the state representatives in attendance for the site visit noted there had been HCBS training provided to the setting, along with an onsite state-conducted heightened scrutiny review. This setting does not have the Managed Care Organization (MCO)-developed service plans on site. Both administration/staff and residents noted they were unaware of any MCO case managers visiting the setting or residents. The team went on a tour of the setting, including the memory care unit, with the settings' marketing salesperson. After the tour, the team went back to the library and reviewed the setting's service plans and the residency agreement. The team split up and interviewed three HCBS participants. During those interviews, the site visit team learned that one of the HCBS residents had received phone calls that morning from their MCO that the setting is no longer going to serve HCBS participants and that they had 60 days to find a new home. Another resident interviewed said a different MCO was ending the contract soon. There are three MCOs for HCBS at this setting, but the specific MCO plan was not noted by the resident or administration. Administrative staff noted that they had talked with other providers and were considering not being an HCBS provider due to concerns with becoming compliant with the criteria in the HCBS settings rule. However, as of the date of the site visit, they had not officially notified the state or participants of this decision. The provider stated they did reach out to inform the MCOs that the setting will not likely continue servicing HCBS participants and inquired about what was needed to terminate the contract for services. In response, the MCOs prematurely notified the residents that they would need to find an alternative residential placement. The notifications to the participants occurred on the day of the site visit. The state representatives in attendance for the site visit provided their contact information to the residents to assure they are provided with options when choosing a new setting, and also followed up with the settings' administration regarding the setting selection process.

Findings of Site Visit:

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	Grandview of Westover Hills did not have the MCO-developed service plans on site and did not know of any case managers. The setting's service plans do not reflect personal interests in activities, whether setting-based or community-based. The activity calendar did not have any outside community outings at all. Although the setting staff noted there was transportation guidance at the front desk for residents to access, the residents interviewed reported receiving very little access to transportation by the facility. Residents also mentioned the need, as well as desire, to get out in the community more. According to the residents, the facility does not help them access other transportation options. Grandview of Westover Hills must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community.

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
		Establishing partnerships with community resources and leveraging existing community transportation options should be explored. Grandview of Westover Hills should develop policies, practices and resources to ensure that individuals have full access to the greater community, including routine engagement with residents regarding opportunities for community activities and transportation needs.
441.301(c)(4)(ii)	The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*	The HCBS participants said they did not have much of an option to move to Grandview of Westover Hills, and that their needs were not being met by the facility. The HCBS participants' previous residence closed and they were relocated to Grandview of Westover Hill. They know they can move at any time, and at the time of the site visit were looking to relocate, especially given that a few of the residents were informed by MCOs that the facility was discontinuing its HCBS contracts. The facility seemed to be confused by the HCBS contracts ending. They stated they made an inquiry to one of the MCOs about next steps if they decided to terminate the contract. The setting Administrator thought that the call to the MCOs resulted in the termination of the contract. Residents were starting to be notified by the MCO the day of the site visit. There was no notification given by the facility to residents. The state Medicaid Agency and the entity that is responsible for ensuring the development of the person-centered service plan must ensure that individuals receiving Medicaid-funded HCBS are afforded a choice of setting, in compliance with regulatory requirements, including a choice of non-disability specific settings.

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
441.301(c)(4)(iii)	The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	The residents interviewed felt that they are not able to receive the same services as others and feel discriminated against. When they call for assistance, they regularly have to wait for hours for a staff person to respond. In one instance, the resident had to lay in their soiled diaper for hours before they assisted them. They feel they are being treated differently from the other, non-Medicaid, residents. Residents also reported hearing staff talk badly about them to each other in the hallways and ignoring call lights when one of the residents wanted to get out of bed. They said this happens frequently. One resident, who was ambulatory, stated they felt they always had to be there in the apartment, to ensure their roommate was being taken care of, and that they were safe and not stuck in bed all day. Grandview of Westover Hills must ensure their model of service delivery aligns with the regulatory criteria to support participants' right to privacy, dignity, respect and freedom from coercion and restraint.
441.301(c)(4)(vi)(B)	Each individual has privacy in their sleeping or living unit.	The residents interviewed stated that the staff enter into resident' apartments without permission on a regular basis. It was witnessed by the site visit team while there. Grandview of Westover Hills must ensure their model of service delivery aligns with the regulatory criteria to support participants' right to privacy in their living area.
441.301(c)(4)(vi)(C)	Individuals have the freedom to control their own schedules and activities, and have access to food at any time.	Lunch came during the resident interview, and this resident does not like the gravy, and always asks to leave it off. When the meal came, the gravy was on the chicken fried steak, against the resident's preferences. They said that it is a constant issue, and often it is not corrected. On this occasion, when the site visit team was present, it was corrected.

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
		Grandview of Westover Hills should revise their method of service delivery to ensure that individuals can control their schedules and activities and have access to food at any time. Grandview of Westover Hills should revise their current practice to ensure that residents have options in meal choices and flexibility in mealtimes.
441.301(c)(4)(vi)(D)	Individuals are able to have visitors of their choosing at any time.	There are posted community hours on the front door from 9am-5pm. Individuals entering the facility have to ring a bell after that time and this serves as a deterrent to come and go as residents please and for residents to have visitors outside of those times. According to staff, residents need permission for overnight guests and it can only be family members. Residents do not have keys to the outside doors of the facility. A staff member shared that they rarely see outside visitors in the evenings. The resident interviewed said if you left in the evening, you risk not being able to get back in, because the staff may or may not let you in. Grandview of Westover Hills must ensure their model of service delivery aligns with the regulatory criteria that participants are able to have visitors of their choosing at any time. The setting should revise the visitor practice of requested to ensure that individuals understand that they can have visitors of their choice at any time.
441.301(c)(4)(vi)(E)	The setting is physically accessible to the individual.	The doors to the outside patio area could not be accessed by wheelchair users without assistance. Grandview of Westover Hills should ensure that all parts of the setting, including the outdoor amenities, are accessible to all individuals.

Additional Provision	Language	Violation Finding Based on Site Visit
State Medicaid Director Letter #19-001[8]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	When the site visit team arrived and spoke to the Administrator, she was not aware of what the HCBS settings rule was and claims that the first time she had heard of it was when the state reached out a week before the visit. Grandview of Westover Hills should ensure all employees have consistent and reinforced training on the HCBS settings regulatory criteria

Brookdale North Austin - Visit February 15, 2023

Facility Description:

Brookdale North Austin is an ALF with a memory care unit located in Austin, Texas. At the time of the visit, there were 65 total residents, including one HCBS participant. The staff here received training on the regulation days before our visit. The HCBS participant resides in the ALF, but Administrators from the facility noted that HCBS participants can move to the memory care unit if needed.

Site Visit Review Description:

The site visit team reviewed the HCBS participant's service plan, interviewed direct support staff who provided services to the HCBS participant and other residents of the ALF. One site visit team member was invited to the HCBS participant's apartment for a tour. It was noted the apartment was decorated by the participant, with family pictures and personal items. During the interview, the participant noted being a long-time resident of the ALF, placed there with the assistance of their mother, and wanting to continue residing at Brookdale. They indicated having some difficulties with other residents, but those issues were resolved when the other resident moved.

Findings of Site Visit:

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the	A resident the team spoke to said the activities are not geared towards them or their interests. They also mentioned they want to go out in the community more and to the public library and have mentioned it multiple times to staff, but has not been taken. In addition, they stated that since COVID-19, there was no transportation for the

[8] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
	community, to the same degree of access as individuals not receiving Medicaid HCBS.	residents to engage in activities in the community. They stay in the facility all day, but they would like to get out more. They cannot afford Lyft or Uber and said the facility has not offered any other options. Brookdale North Austin must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community. Establishing partnerships with community resources and leveraging existing community transportation options should be explored. Brookdale North Austin should develop policies, practices and resources to ensure that individuals have full access to the greater community.
441.301(c)(4)(ii)	The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*	The resident interviewed does not feel that they have much of a choice over where they can live. Where they came from was worse and they are unaware of any other options. If they move, the resident was concerned they would be placed with a roommate and they do not want that. The state Medicaid Agency and the entity that is responsible for ensuring the development of the person-centered service plan must ensure that individuals receiving Medicaid-funded HCBS are afforded a choice of setting, in compliance with regulatory requirements, including a choice of non-disability specific settings
441.301(c)(4)(iii)	The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	The resident interviewed stated that staff just walk in their rooms. On one occasion a staff was standing inside their apartment without announcing themselves. The resident is visually impaired, so was unable to see who it was. They reported it, but staff still walk into their room unannounced. It was such a problem and a violation of their privacy, that their family paid to have an alarm put on their door to let them know when someone is entering.

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
		In addition, the resident interviewed stated she had a physical confrontation with another resident where that resident pushed her, and she often felt bullied. She reported it to the staff, but she didn't think they believed her, and they didn't do anything about it. She tries to keep to herself as a result. When asked if she knew who to call to report issues anonymously, she didn't know. While that information is shared at admission, the resident had been there for years and didn't receive that information again in a format accessible to her. Brookdale North Austin must ensure their model of service delivery aligns with the regulatory criteria to support participants' right to privacy, dignity and respect, and that residents are free from coercion and restraint.
441.301(c)(4)(iv)	The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.	The resident interviewed stated that there was a choice of activities, but the choices are limited. Activity staff said they could take residents out on Tuesdays or Thursdays if the residents let them know. The resident we interviewed did not seem to know that. In addition, the resident said they felt forced to eat in the dining room and didn't like their tablemate. They would have to pay to eat in their room for a delivery charge they cannot afford. Brookdale North Austin must ensure their model of service delivery aligns with the regulatory criteria to facilitate independence and community integration, and amend practices to ensure that schedules are not regimented and that individuals have the opportunity to set their own schedules and participate in activities of their choosing.
441.301(c)(4)(vi)(B)	Each individual has privacy in their sleeping or living unit.	Even though staff said they knock before coming in the residents' rooms, residents interviewed said that is not the case. It was witnessed that staff just walk in without knocking first as happened when the site visit team was in the resident's room speaking with them. A resident

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
		mentioned that items from their room have gone missing. Staff have come in without announcing they are there. The resident's family put an electronic monitoring system on the door so it notifies the individual when someone comes in the room. Brookdale North Austin must ensure their model of service delivery aligns with the regulatory criteria to support participants' privacy in their living area.
441.301(c)(4)(vi)(B)(3)	Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.	Residents are allowed to bring in their own furnishings, but a resident reported that a staff member had an issue with the position of some of the furniture in their apartment, and they moved it. Housekeeping continued to move their furniture when they cleaned, even though they are visually impaired and need everything in one place, so they know how to navigate their apartment safely. Staff also put decorations on their door without permission and took their decorations down without their permission – not allowing them to hang what they want. Brookdale North Austin must ensure that individuals have the freedom to furnish and decorate their sleeping or living units.
441.301(c)(4)(vi)(C)	Individuals have the freedom to control their own schedules and activities, and have access to food at any time.	There is an additional charge to bring your meal to your room. The resident and staff interviewed said when residents want an alternative meal, the option is typically limited to a peanut butter and jelly sandwich. The only other option they have is usually limited to Cheerios even though they would prefer the option of fruit. Brookdale North Austin must ensure their model of service delivery aligns with the regulatory criteria to support participants' ability to control their schedules and activities. Brookdale North Austin should revise their current practice

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
		to ensure that residents have options in meal choices and flexibility in mealtimes.
441.301(c)(4)(vi)(D)	Individuals are able to have visitors of their choosing at any time.	While everyone stated that residents can have visitors at any time, the front doors lock at 8:00pm. A resident interviewed said it makes it very difficult to go out and come back after the doors lock, having to wait for staff to come unlock the door. Brookdale North Austin must ensure their model of service delivery aligns with the regulatory criteria that participants are able to have visitors of their choosing at any time. The setting should revise the visitor practice to ensure that individuals understand that they can have visitors of their choice at any time.

Additional Provision	Language	Violation Finding Based on Site Visit
State Medicaid Director Letter #19-001[9]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	There was no evidence through discussions with staff that they were aware of any of the rule's criteria. Brookdale North Austin should ensure all employees have consistent and reinforced training on the HCBS settings regulatory criteria

Austin Senior Care - Visit February 15, 2023

Facility Description:

Austin Senior Care is an ALF located in Austin, Texas. At the time of the visit, there were three total residents, including two HCBS participants, all females. This is a single-family home in a residential neighborhood. There are four bedrooms, but one of them is for the Owner of the house who is also the only staff person. There is one shared bathroom. When the Owner of the house needs to leave for any reason, the Owner's family members provide the care. Two of the residents share a bedroom. When you walk in the house, there is an open room to the left that serves as an office and has a prominent camera monitor display. The staff person said the cameras are only in the public areas of the house, and that video surveillance was monitored via the large screens in the office, iPad, and phone. As you walk down the hall, there is a living room, kitchen, and dining room. When the site visit team was there, all residents were laying in their beds and the team did not witness any social interaction.

[9] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

Individuals are not allowed to enter the kitchen and the team was told by the Owner that since COVID-19, no one eats in the dining room. They all like to eat in their rooms instead.

Site Visit Review Description:
The site visit team arrived and reviewed service plans in the dining room. All the residents were in their rooms the whole time the site visit team was there. There was only one HCBS participant there, the other was in the hospital. The team conducted an interview with the HCBS participant in the dining room with the Owner present. It was obvious the individual was uncomfortable and did not want the team to visit their room or residence, so the team promptly ended the interview. The Owner gave the team a tour of the setting, with the exception of the HCBS participant's bedroom. As the staff gave a tour, they opened the doors to bedrooms without residents' permission, and the site visit team observed a resident lying in bed. The Owner noted that residents spend most of their time in their rooms, without a lot of opportunity for social activities or community integration. The site visit team ended the visit shorter than planned so as not to make any of the residents uncomfortable.

Findings of Site Visit:

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	There are no community outings. There is only one staff person (who is the Owner of the home) and they do not go out as a group. Individuals can come and go as they please. There is a facility vehicle available for transportation. Additionally, there is a van that occasionally takes residents out to medical appointments and other errands. Based on observations by the team, it is not apparent that residents are supported to engage in any activities. Austin Senior Care must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community. Establishing partnerships with community resources and leveraging existing community transportation options should be explored. Austin Senior Care should develop policies, practices and resources to ensure that individuals have full access to the greater community.
441.301(c)(4)(ii)	The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered	It is unclear if residents had any choices before moving here. The Owner/Administrator said one potential resident had nowhere else to go.

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
	service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.*	The state Medicaid Agency and the entity that is responsible for ensuring the development of the person-centered service plan must ensure that individuals receiving Medicaid-funded HCBS are afforded a choice of setting, in compliance with regulatory requirements, including a choice of non-disability specific settings.
441.301(c)(4)(iii)	The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	The Owner stated the residents could lock their doors, but the site visit team witnessed the Owner knocking on residents' doors, and then walking in without permission. In one instance, the resident was in bed sleeping and did not appear fully clothed, but the Owner entered anyway and left the door open so the team members could see the room, without asking permission from the resident. Although cameras were not used in bedrooms, there were cameras all throughout common spaces of the house, including outside the front doors and on the back patio. It is unclear whether the residents wanted them or not, and there was not any signage reminding residents of the cameras. One of the residents appeared to be coerced by the Owner into talking to the site visit team. They were very distressed and uneasy when they came out of their room to talk to the five team members and said after a few minutes that they really did not want to do the interview. They were very uncomfortable. Austin Senior Care must ensure their model of service delivery aligns with the regulatory criteria to support participants' right to privacy, dignity, respect and freedom from coercion and restraint.
441.301(c)(4)(iv)	The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to,	The Owner stated they selected who lived there; and then the housemates would make the final decision. If they were the type of residents who were social and always wanted to

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
	daily activities, physical environment, and with whom to interact.	be out and bring people over, they would not be selected to live there. If a resident started bringing dates over, the Owner said they'd have to have a conversation, inferring that having people over would need to stop. The Owner said the residents can access the common area and outside of the house whenever they wanted. One of the residents does a lot of walking. However, interaction in the house did not seem to be encouraged. The only activities that are offered to bring people together are running errands in the van. Residents said they usually get their dinner in the kitchen and take it back to their bedrooms to eat, and they keep to themselves. On the day of the visit, everyone was in their rooms. Austin Senior Care must ensure their model of service delivery aligns with the regulatory criteria to facilitate independence and community integration, and amend practices to ensure that schedules are not regimented and that individuals have the opportunity to set their own schedules and participate in activities of their choosing.
441.301(c)(4)(vi)(B)	Each individual has privacy in their sleeping or living unit.	Residents do not have privacy. There are cameras in the living unit, and as stated previously, the Owner does not obtain permission before entering people's rooms. Austin Senior Care must ensure their model of service delivery aligns with the regulatory criteria to support participants' right to privacy in their living area.
441.301(c)(4)(vi)(B)(1)	Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.	None of the doors have locks that residents can lock from the outside. They can lock the doors when they are inside the room only. The resident that was interviewed indicated they would like a key to their room but was told they could not have one due to a fire safety concern.

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
		Austin Senior Care must ensure that units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. Doors should be lockable from the outside by the individual.
441.301(c)(4)(vi)(D)	Individuals are able to have visitors of their choosing at any time.	While the Owner said visitors could come at any time, there are no overnight guests allowed. Additionally, the Owner stated dates were not allowed in the residence. It appears that the Owner makes the decision over who is allowed to visit. Austin Senior Care must ensure their model of service delivery aligns with the regulatory criteria that participants are able to have visitors of their choosing at any time. The setting should revise the visitor practice to ensure that individuals understand that they can have visitors of their choice at any time.
441.301(c)(4)(vi)(E)	The setting is physically accessible to the individual.	Most of the setting seemed accessible with ramps installed at the entrance and the back patio; however, the hallways appeared very narrow for an oversized or electric wheelchair to access. In addition, there is a small lip when entering the roll-in shower that could be a trip hazard for some of the residents or make it difficult for some wheelchair users to enter. When these issues were raised, the Owner stated it was not an issue for the residents. Austin Senior Care should ensure the setting is accessible to all individuals.

Additional Provision	Language	Violation Finding Based on Site Visit
State Medicaid Director Letter #19-001[10]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in	There was no evidence through discussions with staff that they were aware of any of the rule's criteria.

[10] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

	community training policies and procedures established by the state.	Austin Senior Care should ensure all employees have consistent and reinforced training on the HCBS settings regulatory criteria

Brookdale Lake Brazos - Visit February 14, 2023
Facility Description:
Brookdale Lake Brazos is an ALF with a memory care unit located in Waco, Texas. At the time of the visit, there were 47 total residents, including 3 HCBS participants. One of the HCBS participants was located in the memory care unit. The setting is a multi-story building. There is an unaffiliated nursing facility next door. There is a patio with a grassy area on the banks of the Brazos River. There are studios, one-bedroom, and two-bedroom units. Some residents have roommates of their choice, but most have their own private room. On the ALF side, individuals mostly have private rooms, while on the memory care side, most have shared rooms. Rooms were furnished and decorated to the residents' liking and all rooms have at least one bathroom and a kitchenette. Each room has a refrigerator and microwave. This setting is pet-friendly, and some residents had their own dog or cat.

Site Visit Review Description:
The site visit team arrived at the setting and convened in a room to review service plans and the residency agreement. The team spoke to several direct support staff, and the Administrator took the team on a tour of the facility. Two of the site visit team members went on a tour of the memory care unit and spoke to the HCBS participant. During the tour with the Administrator, the team spoke to a few residents and were invited into their apartments. Each apartment was a studio, one-bedroom, or two-bedroom unit that was decorated by the resident(s). Meals are served in the dining room; however, residents could bring meals back to their apartment if they wished.

Findings of Site Visit:

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	The activity calendar consisted of in-house activities. The setting had a document called an "Engagement Profile" that the Activity Director has access to, but the direct support staff are unaware of them and do not receive a copy. There was little evidence of residents being supported to access the greater community. Brookdale Lake Brazos must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community. Establishing partnerships with community resources and leveraging existing community transportation options

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
		should be explored. The setting should develop policies, practices and resources to ensure that individuals have full access to the greater community.
441.301(c)(4)(iii)	The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	The resident interviewed said if there were any issues or problems she had, she would talk to a staff member or her daughter; however, she was unclear who to go to if she had to report anonymously. While that information is shared at admission, the resident had been there for years and didn't receive that information again in a format accessible to her. Brookdale must ensure their model of service delivery aligns with the regulatory criteria to support participants' right to privacy, dignity, respect and freedom from coercion and restraint.
441.301(c)(4)(vi)(B)(2)	Individuals sharing units have a choice of roommates in that setting.	The semi-private rooms in the facility were in the memory care unit. Staff reported that the residents were matched as roommates by the facility if they had similar interests and routines. Residents could change if they wanted to, but ultimately the initial choice seemed to be made by the facility. Brookdale Lake Brazos must revise its model of service delivery to ensure that individuals sharing units have a choice of roommates.
441.301(c)(4)(vi)(D)	Individuals are able to have visitors of their choosing at any time.	There was confusion among staff if there could be overnight visitors. Policy indicated that guests should leave by 10pm; however, a resident reported that she did have a family member spend the night, but that was due to a death in the family. Brookdale Lake Brazos must ensure their model of service delivery aligns with the regulatory criteria that participants are able to have visitors of their choosing at any time and

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
		should provide training to staff and residents to understand the policy around individuals' ability to have visitors at any time.
441.301(c)(4)(vi)(E)	The setting is physically accessible to the individual.	The doors to the outside courtyard area could not be accessed by wheelchair users without assistance. Brookdale Lake Brazos should ensure that all parts of the setting, including the outdoor amenities, are accessible to all individuals.
441.301(c)(4)(vi)(F)	Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.	There was a resident living in memory care with no lock on his door, no key, and no ability to leave memory care to access activities outside of the memory car unit. He was a resident receiving HCBS, yet his service plan did not show any modifications or conditions that suggested the need for restrictions. The state Medicaid Agency, and the entity that ensures the development of the person-centered service plan should ensure that person-centered service plans that comply with all regulatory requirements are in place for each individual receiving Medicaid-funded HCBS. The entity responsible for the person-centered service plan should ensure that all modifications for a specific individual are incorporated into the plan and Brookdale Lake Brazos must adhere to the plan. Brookdale Lake Brazos should ensure that any relevant modifications for a specific individual are incorporated into the plan, and that modifications to the settings criteria are limited only to a specific assessed need as opposed to a blanket modification.

Additional Provision	Language	Violation Finding Based on Site Visit
State Medicaid Director Letter #19-001[11]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	During staff interviews, it was unclear if staff were trained on the HCBS settings rule. There was no evidence through discussions with staff that they were aware of any of the rule criteria. Brookdale Lake Brazos should ensure all employees have consistent and reinforced training on the HCBS settings regulatory criteria

Brookdale Lakeshore - Visit February 14, 2023
Facility Description:
Brookdale Lakeshore is an ALF located in Waco, Texas. At the time of the visit, there were 30 total residents, including three HCBS participants. The setting was newly remodeled. There is a theater area, as well as a common area where residents can gather for activities. During the site visit, the facility staff were celebrating Valentine's Day and were giving out candy and had activities planned for the day. Staff noted the night prior, there was a dinner and party for all the residents, with family and friends invited to attend. Apartment units include a living space, kitchen, bathroom, and bedroom with walk-in closet.

Site Visit Review Description:
The site visit team gathered in an empty apartment unit and reviewed service plans for the HCBS participants who reside in the facility. The team also interviewed direct support staff and residents of the setting. It was noted that participants were able to come and go as they choose, decorate their apartments, choose to participant in activities within the setting, and access food at any time, either through the facility dining services or by shopping and keeping snacks/food in their apartment. Residents have the option of sharing an apartment, but all units are designed for single occupancy.

Findings of Site Visit:

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the	The activity calendar consisted of in-house activities. The setting had a document called an "Engagement Profile" that the Administrator said was kept with the medical charts, but the direct support staff were unaware of them and do not receive a copy. Staff stated that very few of the residents leave on their own because of safety concerns. A resident

[11] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
	community, to the same degree of access as individuals not receiving Medicaid HCBS.	that was interviewed said when they left the facility, they had to ask permission to do so. They also stated they really would like to have a volunteer job of playing music outside in the community, but they had never been asked by the facility of their interest to do so. Brookdale Lakeshore must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community. Establishing partnerships with community resources and leveraging existing community transportation options should be explored. Brookdale Lakeshore should develop policies, practices and resources to ensure that individuals have full access to the greater community.
441.301(c)(4)(iv)	The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.	The resident interviewed said they were told to be back to the facility at a certain time so that the staff could get their work done. They said they could stay up if they asked staff first. Residents do not have keys to the outside doors and have to request to enter and exit the building at all times of day. Brookdale Lakeshore must ensure their model of service delivery aligns with the regulatory criteria to facilitate independence and community integration, and amend practices to ensure that schedules are not regimented and that individuals have the opportunity to set their own schedules and participate in activities of their choosing.
441.301(c)(4)(v)	The setting facilitates individual choice regarding services and supports and who provides them.	The Administrator stated that if a resident started to have memory care issues and was no longer safe in their facility, they would transfer the resident to their sister facility with a memory care unit. This suggested that an individual's and family's choice could be limited if that should happen.

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
		Brookdale Lakeshore must ensure their model of service delivery aligns with the regulatory criteria that individuals have access to services and supports that the individual has been assessed to need, and that the individuals have the ability to choose from whom they receive those services and supports.
441.301(c)(4)(vi)(D)	Individuals are able to have visitors of their choosing at any time.	The front doors of the facility are locked at all times and individuals have to ring a bell to get in. The door is not staffed 24 hours and once individuals ring the bell, staff get a notification on their pagers or on their phones. Brookdale Lakeshore must ensure their model of service delivery aligns with the regulatory criteria that participants are able to have visitors of their choosing at any time. Brookdale Lakeshore should revise the visitor practice of requested visitation hours to ensure that individuals feel that they can have visitors of their choice at any time.

Additional Provision	Language	Violation Finding Based on Site Visit
State Medicaid Director Letter #19-001[12]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	There was a PowerPoint staff training document on the HCBS settings rule with signatures from staff, dated a week before our site visit. During staff interviews, both staff members did not recall taking the training. Brookdale Lakeshore should ensure all employees have consistent and reinforced training on the HCBS settings regulatory criteria

Brookdale Champion Oaks - Visit February 13, 2023

Facility Description:

Brookdale Champion Oaks is an ALF located in Houston, Texas serving the aging population. At the time of the visit, there were 39 total residents, including 11 HCBS participants. The setting is a one-story stand-alone facility that is shaped like a square with a beautiful courtyard and a garden in the middle. The doors to the courtyard are all unlocked and usable to residents, except that residents who use wheelchairs need to

[12] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10

get staff assistance to help them outside. There is an exercise/fitness room and a billiards table. Some residents have roommates of their choice, but most have their own private room. When rooms are shared, they have a choice of putting a partition in the room. Rooms were furnished and decorated to the residents' liking and all rooms have one bathroom. This setting is pet-friendly, and some residents had their own dog or cat.

Site Visit Review Description:
The site visit team arrived at the setting and convened in a room that is usually set up with coffee and snacks for individuals to review service plans. Direct support staff were also available at this time for interviews. After service plans and the residency agreement were reviewed, the Administrator took the team on a tour of the facility. During the tour, the team spoke to a few residents who invited us into their apartments. Each apartment was a studio with a bathroom and had either one bed or two, if shared; apartments were decorated by the resident(s). Although staff indicated visitors were welcome at any time, there were requested visiting hours in the admission paperwork. Meals are served in the dining room; however, residents could bring them back to their apartment if they wished. Menus are developed based on resident input and other options are provided if the resident would like something other than what is being served. There were snacks available 24 hours per day. The team reviewed a sample template residency agreement and were told the state helped develop the template.

Findings of Site Visit:

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
441.301(c)(4)(i)	The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	Service plans do not reflect personal interests in activities, whether setting based or community based. The activity calendar consisted of in-house activities. All outings outside of the facility are planned as a group – not facilitated individually. The plans, and staff conversations, did not reference or show any residents involved or engaged in the local community. Brookdale Champion Oaks must ensure their model of service delivery aligns with the regulatory criteria to support participants' full access to the greater community. Establishing partnerships with community resources and leveraging existing community transportation options should be explored. Brookdale Champion Oaks should develop policies, practices and resources to ensure that individuals have full access to the greater community.

Regulation Citation	Regulation Language	Violation Finding Based on Site Visit
441.301(c)(4)(vi)(D)	Individuals are able to have visitors of their choosing at any time.	While reading admission documentation, it was noted that there were requested visiting hours and residents have to notify the facility if they wish to have an overnight guest. Brookdale Champion Oaks must ensure their model of service delivery aligns with the regulatory criteria that participants are able to have visitors of their choosing at any time. The setting should revise the visitor practice of requested visitation hours to ensure that individuals understand that they can have visitors of their choice at any time.
441.301(c)(4)(vi)(E)	The setting is physically accessible to the individual.	There is a very nice courtyard with a gazebo that is not accessible to wheelchair users. The doors to the courtyard do not have a method to open for wheelchair users and the gazebo has steps to enter and not a ramp. Brookdale Champion Oaks should ensure that all parts of the setting, including the outdoor amenities, are accessible to all individuals.

Additional Provision	Language	Violation Finding Based on Site Visit
State Medicaid Director Letter #19-001[13]	Description of how staff are trained and monitored on their understanding of the settings criteria and the role of person-centered planning, consistent with state standards as described in the waiver or in community training policies and procedures established by the state.	During staff interviews, it was unclear if staff were trained on the HCBS settings rule. There was no evidence through discussions with staff that they were aware of any of the rule's criteria. Brookdale Champion Oaks should ensure all employees have consistent and reinforced training on the HCBS settings regulatory criteria

[13] Heightened Scrutiny SMD-SMDL Final (medicaid.gov); see question 10