The Harris Center for Mental Health and IDD
Audit Committee Meeting
9401 Southwest Freeway Houston, TX 77074
Board Room #109

View Live: https://theharriscentertx.new.swagit.com/views/834/

October 21, 2025
8:30 am

I. **DECLARATION OF QUORUM**

II. **PUBLIC COMMENTS**

III. **MINUTES**

A. Approval of the Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, July 15, 2025
(EXHIBIT A-1)

IV. **REVIEW AND COMMENT**

A. FY25 Fourth Quarter Compliance Audit Activities
(EXHIBIT A-2 Demetria Luckett)

V. **EXECUTIVE SESSION**

*** As authorized by Chapter §551.071 of the Texas Government Code, the Board of Trustees reserves the right to adjourn into Executive Session at any time during the course of this meeting to seek legal advice from its attorney about any matters listed on the agenda.**

VI. **RECONVENE INTO OPEN SESSION**

VII. **CONSIDER AND TAKE ACTION AS A RESULT OF THE EXECUTIVE SESSION**

VIII. **INFORMATION ONLY**

A. FY25 Fourth Quarter Compliance Department Binder
(EXHIBIT A-3)

IX. **ADJOURN**

Veronica Franco

Veronica Franco, Board Liaison
Jim Lykes
Chairperson, Audit Committee
The Harris Center for Mental Health and IDD

EXHIBIT A-1

BOARD OF TRUSTEES
THE HARRIS CENTER *for*
MENTAL HEALTH AND IDD
AUDIT COMMITTEE MEETING
TUESDAY, JULY 15, 2025
MINUTES

Dr. R. Gearing, Board Chair, called the meeting to order at 8:32 a.m. in Room 109, 9401 Southwest Freeway, noting a quorum of the Committee was present.

Committee Members in Attendance: Mr. G. Womack, Dr. J. Lankford, Dr. K. Bacon

Committee Member in Absence: Mr. J. Lykes

Other Board Member Present: Dr. R. Gearing, N. Hurtado-videoconference

I. **DECLARATION OF QUORUM**

Dr. Gearing called the meeting to order at 8:32 a.m. noting that a quorum was present.

II. DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS

III. PUBLIC COMMENTS

There were no requests for Public Comment.

IV. MINUTES

Approval of Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, April 15, 2025.

MOTION: LANKFORD SECOND: WOMACK

THEREFORE, BE IT RESOLVED that the Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, April 15, 2025 as presented under Exhibit A-1, is approved, and recommended to the Full Board for acceptance.

V. REVIEW AND TAKE ACTION

A. FY26 Compliance Work Plan

MOTION: WOMACK SECOND: LANKFORD

THEREFORE, BE IT RESOLVED that the FY26 Compliance Work Plan as presented under Exhibit A-2, is approved, and recommended to the Full Board for acceptance.

B. FY26 Internal Audit Work Plan

MOTION: WOMACK SECOND: LANKFORD

THEREFORE, BE IT RESOLVED that the FY26 Internal Audit Work Plan as presented under Exhibit A-3, is approved, and recommended to the Full Board for acceptance.

VI. REVIEW AND COMMENT

A. **Compliance FY2025 Quarter 3 Activities-** Lisa Walker presented the Compliance FY2025 Quarter 3 Activities to the Audit Committee.
B. Internal Audit Q3-Q4 Reports-David Fotjik presented the Internal Audit FY2025 Q3-Q4 Reports to the Audit Committee.

VII. EXECUTIVE SESSION

There was no Executive Session during the Audit Committee Meeting.

VIII. ADJOURN-

MOTION: WOMACK SECOND: LANKFORD
With unanimous affirmative vote
BE IT RESOLVED The meeting was adjourned at 9:16 a.m.

_____

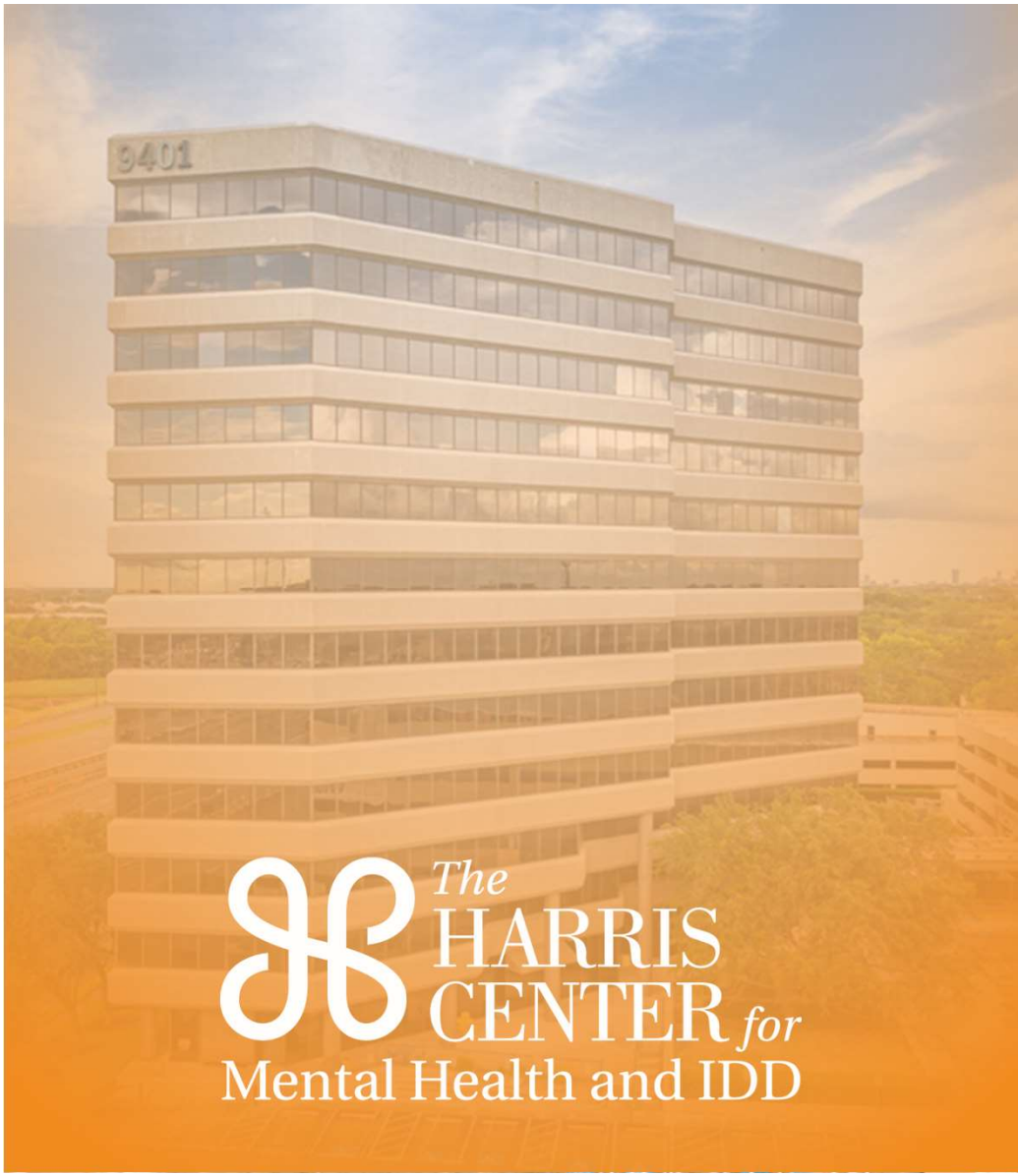
Veronica Franco, Board Liaison
J. Lykes, Chairperson,
Audit Committee
The* HARRIS CENTER *for
Mental Health and IDD

EXHIBIT A-2

Compliance Department

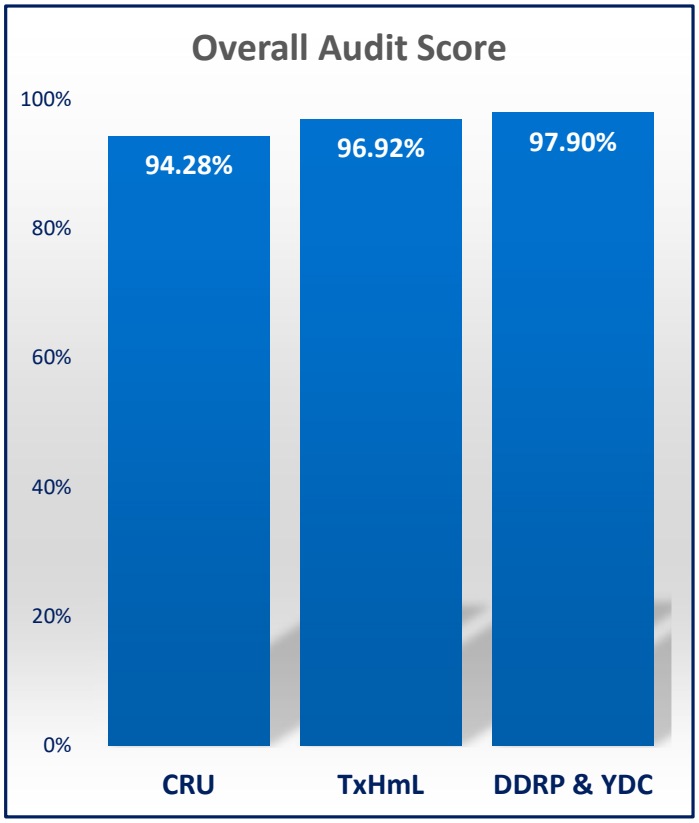
FY 2025 Audit Committee

Fourth Quarter Report



Presented by: Demetria Luckett, Compliance Director
Date 10/2025

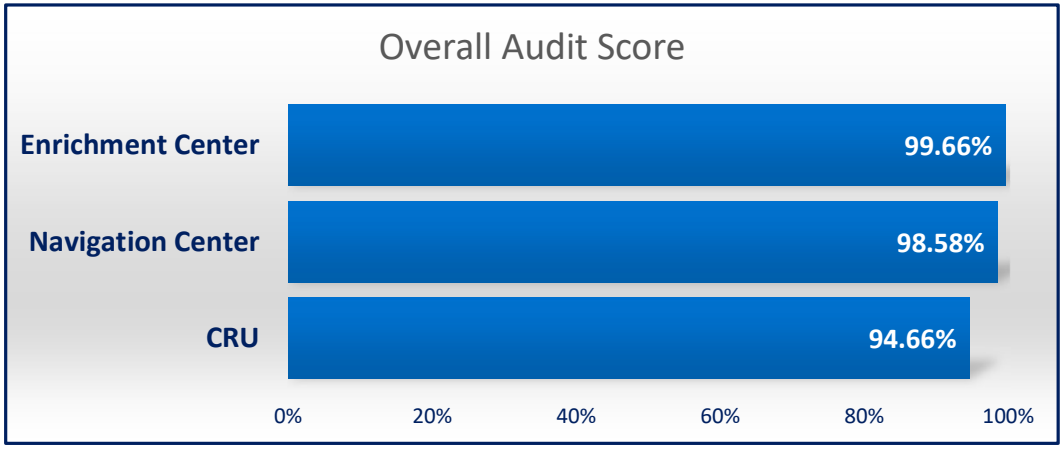
Billing and Coding Focus Audits



Review	Coding & Documentation	Billing & Claim Processes	Overall Score	Summary
Crisis Residential Unit (CRU) Coding Audit	94.28%	N/A	94.28%	CRU had strengths in timely documentation and goals. Gaps identified in consents, plans of care, and note quality. Compliance will follow up in 90 days to monitor improvement activities.
Texas Home Living (TxHmL) Service Coordination Coding/Billing Audit	94.73%	99.12%	96.92%	TxHmL showed strong billing processes, but gaps remain in documentation/coding. Since a Type A encounter must be in place to bill a Type B, consistent completion is important.
Forensic: Dual Diagnosis Residential Program (DDRP) and Youth Diversion Center (YDC) Coding Audit	97.90%	N/A	97.90%	Coding/clinical documentation scored 97.9%, DDRP was fully compliant and YDC showed isolated documentation gaps in consents, progress notes, and CPT coding.

CPEP Division

	Operations	Medical	Environment	Clinical Records	Personnel	Overall
Crisis Residential Unit (CRU) Comprehensive audit	100%	100%	100%	93%	80%	94.66%
The Navigation Center Focus audit	100%	100%	NA	96%	NA	98.58%
The Enrichment Center at the Villas and 811 Properties Focus audit	100%	100%	N/A	99%	N/A	99.66%

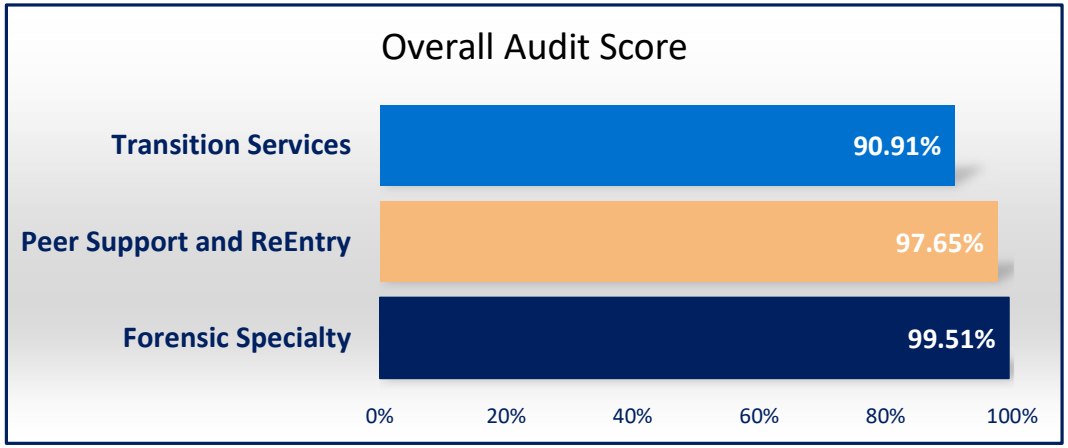


CRU audit showed strong compliance in operations/medical/environment but had gaps in personnel related to staff training, and clinical records related to pain assessments, and rights documentation.

Enrichment and Navigation Centers both scored high. Both centers discontinued services due to funding effective April 30th, 2025. Services were integrated into our Behavioral Health Response Team program.

Forensics Division

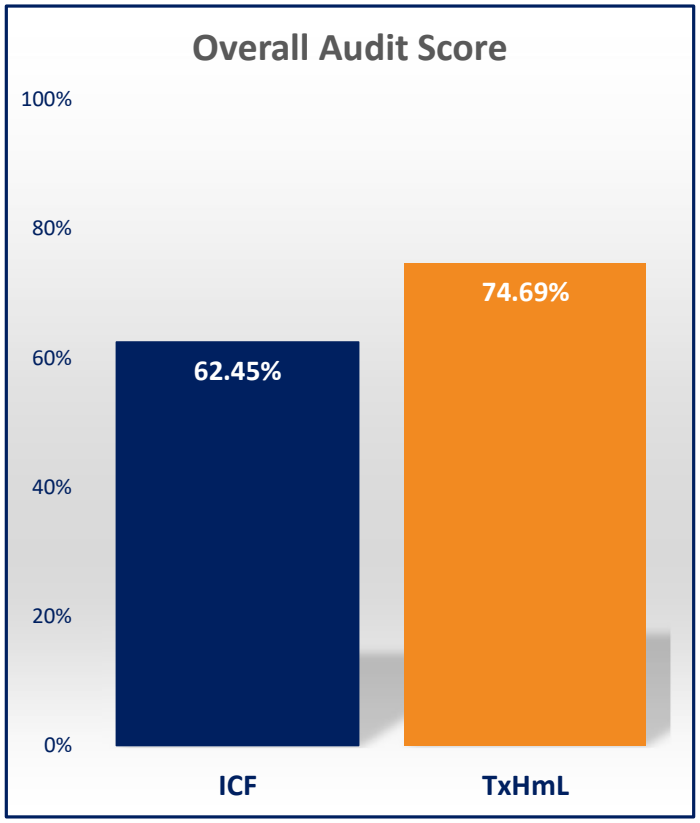
	Operations	Medical	Environment	Clinical Records	Personnel	Overall
Forensic Specialty Comprehensive Audit	100%	100%	100%	100%	97.53%	99.51%
Forensic Peer Support and Re-Entry Services Focus Audit	NA	NA	NA	95.29%	100%	97.65%
Forensic Transition Services Focus Audit	NA	NA	NA	NA	90.91%	90.91%



Forensic Specialty and Peer Support/ReEntry demonstrated performance in their initial audits, only minor gaps in training and documentation.

Forensic Transition Services revealed a higher compliance risk stemming from limited access to contractor records, which restricts effective oversight.

IDD Division



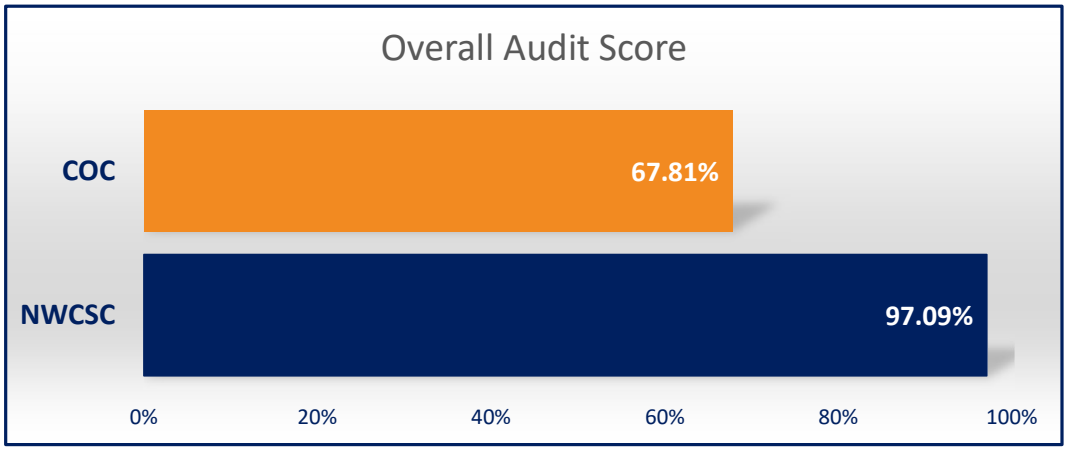
	Operations	Clinical Records	Personnel	Overall
Intermediate Care Facilities (ICF) Comprehensive Audit	100%	34.47%	52.88%	62.45%
Texas Home Living (TxHmL) Service Coordination Focus Audit	NA	74.69%	NA	74.69%

Both ICF and TxHmL audits revealed compliance risks in clinical documentation and person-centered planning. ICF records lacked goals, outcomes, and progress documentation. Paper charts are utilized for ICF facilities, which creates accessibility and organization risks. TxHmL showed gaps in enrollment documentation and timely PDP updates. Both programs require continued oversight: ICF is scheduled for a comprehensive review in FY26 and TxHmL is referred to Performance Improvement for support of their corrective action plan.

Behavioral Health Division

The HARRIS CENTER for Mental Health and IDD

	Operations	Medical	Environment	Clinical Records	Personnel	Overall
Northwest Community Service Center (NWCSC) Comprehensive Audit	100%	100%	100%	87.67%	97.78%	97.09%
Continuity of Care (COC) Comprehensive Audit	50%	NA	NA	61.74%	91.70%	67.81%
Southeast child and adolescent clinic Operational Review						100%
Southwest child and adolescent clinic Operational Review						100%
Northeast child and adolescent clinic Operational Review						100%
Co-Location Clinics Operational Review						100%



NWCSC scored 97.09% with strong operations/medical compliance but gaps were Personal, related to non-compliance with required trainings, supervision documentation, and client records. COC scored 67.81% (first program audit) with deficiencies across domains including lack of policies, incomplete training, and missing required documentation. COC is developing a plan of improvement.

Agency Wide Audit

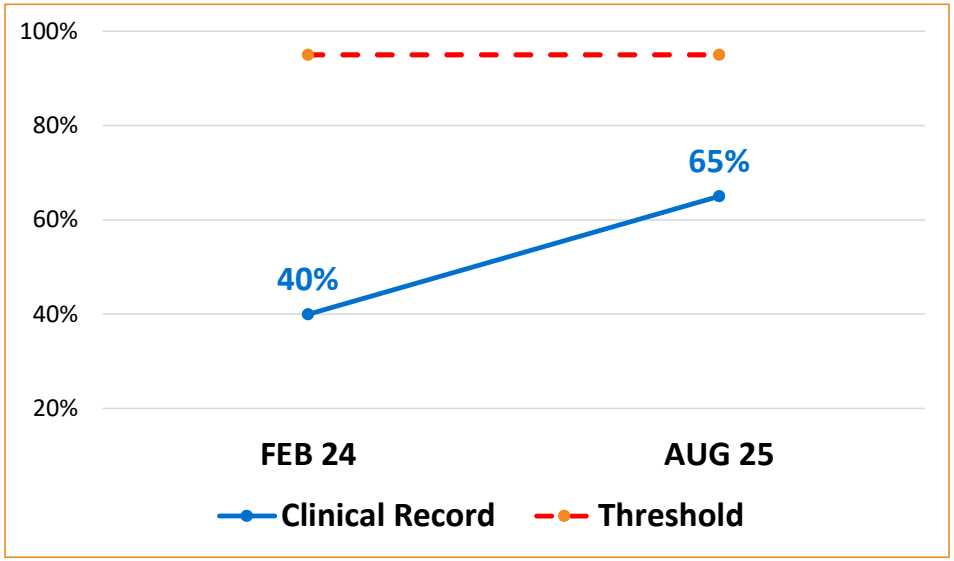
The HARRIS CENTER for Mental Health and IDD

PURPOSE: Identify internal processes surrounding **policy acknowledgements**	
Overall Score	66.93%

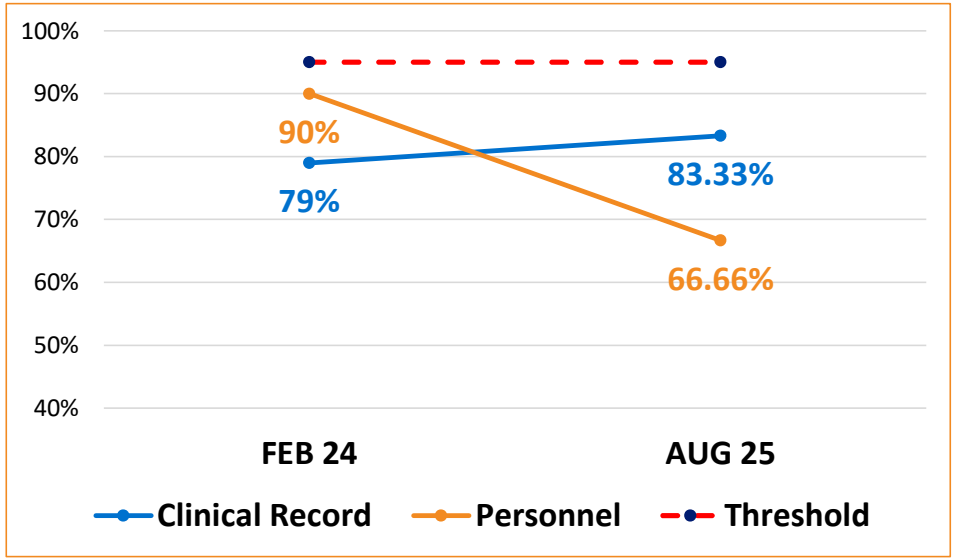
AREAS OF IMPROVEMENT		Action Plan
Policy assigned to employee within Policy Management System	83.92%	Develop a formal Acknowledgement Policy or Procedure outlining requirements for employees to acknowledge key policies at the time of hire and on an annual basis.
Annual Acknowledgement of Policy	52.16%	Compliance will develop an internal process to verify all employees are enrolled in the policy management system during onboarding and provide education to new and existing staff on how to access and use our Policy Management System.
Completed policy acknowledgement since hire	64.71%	

Follow Up Audits - CPEP

Psychiatric Emergency Services (PES)



Homeless Outreach Team (HOT)



PES Highlights

Score rose to 65% (25% improvement), yet compliance gaps in discharge summaries led to referral to Performance Improvement program and staff retraining in progress.

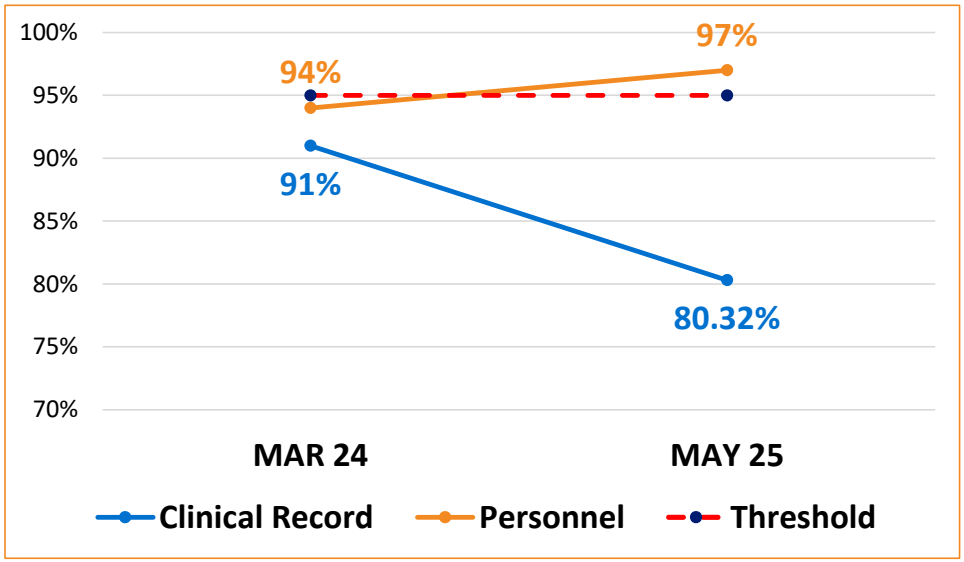
HOT Highlights

Follow up in August 2025 showed slight clinical improvement but risks remain with subjective assessments and a decline in personnel compliance (90% → 66.66%) due to training gaps. Program referred to Performance Improvement.

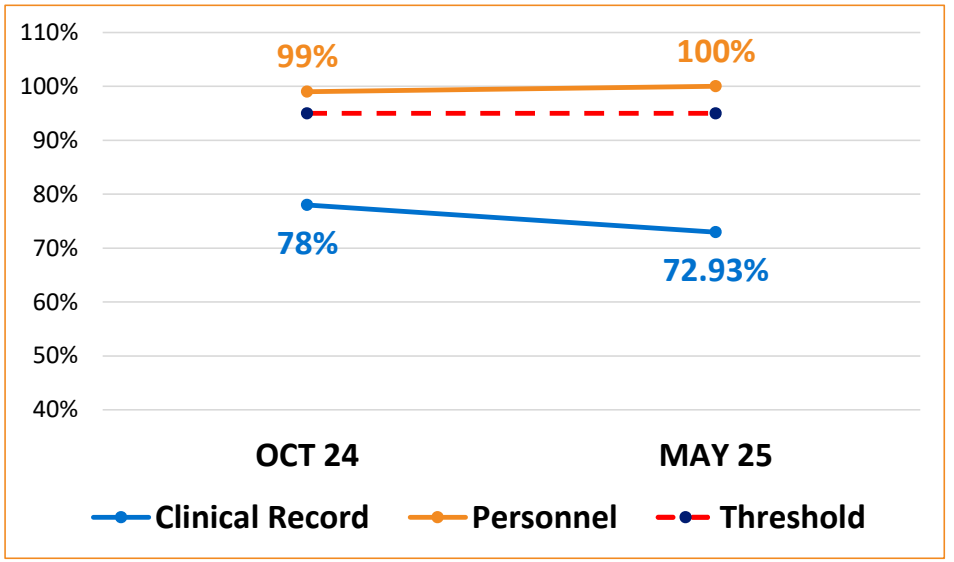
Follow Up Audits – Behavioral Health

The HARRIS CENTER for Mental Health and IDD

Assertive Community Treatment/Forensic Assertive Community Treatment (ACT/FACT)



Assisted Outpatient Therapy (AOT)



ACT/FACT Highlights

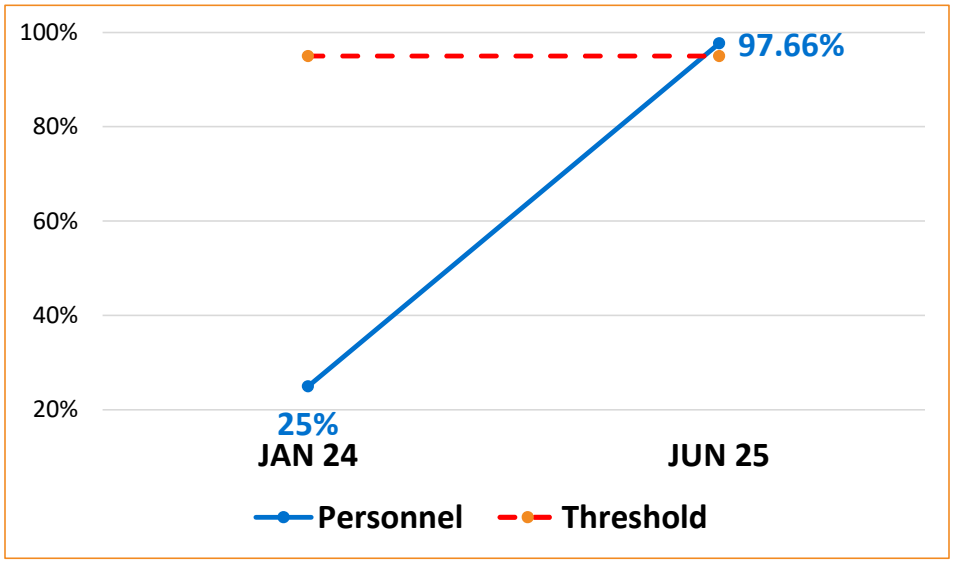
Personnel compliance improved from 94% to 97%. Client records declined from 91% to 80.32% due to missing medication consents and recovery/safety plans. Program was referred to Performance Improvement and are scheduled for a comprehensive audit in FY26.

AOT Highlights

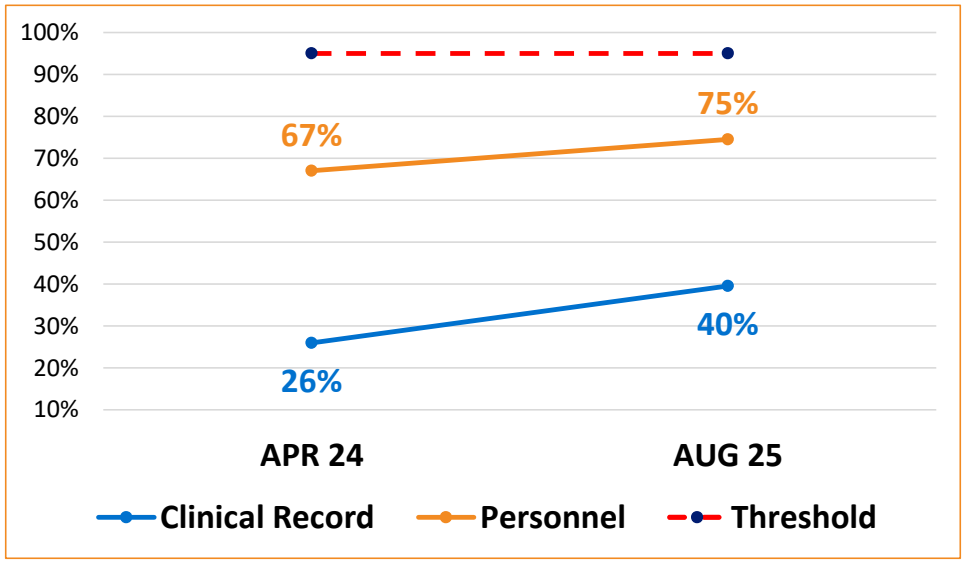
Personnel reached 100% compliance. Client records declined to 72.93% with issues in medication consents, monitoring, recovery plans and documentation. Program referred to Performance Improvement and are scheduled for a Comprehensive audit in FY26.

Follow Up Audits – Behavioral Health

Integrated Care



Optum Integrated Behavioral Health Home Care (Optum)



Integrated Care Highlights

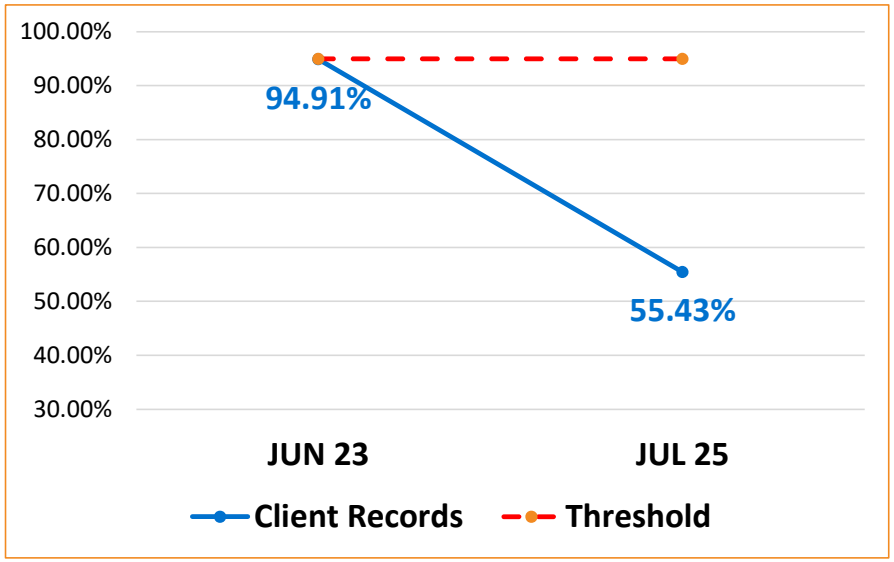
Personnel compliance had a significant improvement from 25% to 97.66%, with only CPR and Handle with Care training below threshold due to scheduling delays. Performance Improvement referral not required.

Optum Highlights

Personnel and Client records improved but remained below threshold. Gaps were noted in enrollment, assessments, administrative reviews, health action plans, and agency training. Program was referred to Performance Improvement for support.

Follow Up Audits – Behavioral Health

Southeast Adult Mental Health (SEAMH)



SEAMH Highlights

Clinical records declined to 55.43% with gaps in measurable treatment plans, progress notes, case management documentation, and co-occurring needs. Program submitted a plan of improvement and is scheduled for a comprehensive review in FY26.

Looking Ahead

FY26 – New 90 day follow up process

Status checks/reports on corrective action plans instead of full audits

Will allow for timely review to verify improvement activities are underway

Continuing to ensure accountability while reducing administrative burden and program disruption

External Audit Activities

Medical Record Requests	
20 Datavant Audit requests	These medical records are requested as part of a required Medicare Risk Adjustment (MRA) program. Datavant requests records on behalf of the insurance provider and the insurance company will review.
14 Additional Medical Record requests from other Managed Care Organizations.	Various MCO's requested records for MRA purposes or to review claims.

Pharmacy audits	
22 Optum Pharmacy Audits	All clinics were audited throughout the quarter to validate claims associated with specific prescription medications. Two are closed out with no errors, no overpayment identified, and no recoupment due. All others are still pending audit results.
2 Texas State Board of Pharmacy Audits	Northwest and Northeast Clinics underwent an inspection by the Texas State Board of Pharmacy. Both clinics passed the audit with no unsatisfactory findings or recommendations.

External Audit Activities Cont.

Follow-Up Review: Corrective Action Plan (CAP) 8/18/25 – 8/25/25

HHS Quality Management team conducted a desk review to confirm completion of actions from prior FY24 comprehensive audit and review monitoring activities. The audit was closed, and The Harris Center successfully completed all actions identified.

Intellectual and Development Disabilities (IDD) Intermediate Care Facilities (ICF)

Multiple Life Safety and Licensure audits were conducted over the course of June 2025 – August 2025 for our Westbury, Pasadena Cottage A/B, and Applewhite locations. Preliminary findings cited licensure deficiencies with a need for a plan of correction. The plan of corrections were submitted and accepted. Follow-up reviews were conducted in August 2025 and Westbury and Pasadena A/B were cleared of all deficiencies. The Applewhite location is still pending a final exit.

Texas Home Living (TxHmL) – Provider

Texas Health and Human Services conducted a recertification and intake inspections for our TxHmL program on 7/8/25 – 7/9/25. No preliminary findings noted. The program received certification for an additional year. A finding was cited post exit conference regarding failure to notify HHSC of an incident. A follow up review was conducted 8/13/25 and no further deficiencies noted; program received certification for an additional year.

Texas General Land Office Community Development and Revitalization (GLO-CDR) Annual Affordability Period Review

An annual review is underway for our Hope Harbor facility to determine compliance with requirements as part of receiving federal benefits through the Affordable Rental Program.

Thank you.

The HARRIS CENTER for Mental Health and IDD

EXHIBIT A-3

The Harris Center for Mental Health and IDD (The Harris Center):
Compliance Department (Compliance) Audit Committee Report

Report Description: This report provides a summary of compliance activities for quarter four of FY25, including internal audit findings, external audit involvement, and ongoing department responsibilities.

Presenter: Demetria Luckett, Compliance Director

Explanation of Auditing Format:

The Compliance department has continued its new auditing format that was introduced earlier this fiscal year. The reviews are grouped into five core areas: Personnel, Operations, Environment, Client Records, and Medical. These areas help us pinpoint risks and improvement areas across our programs and service lines.

This report covers audits completed between March 1st, 2025, and August 31st, 2025, and includes a breakdown by division and type of review: Comprehensive, Focus, and Follow-Up. There will be an overview of each audit completed and corrective action if applicable.

Audit Format Refresher:

- **Personnel:** Training, licensing, certifications, and adherence to staffing requirements.
- **Operations:** Internal processes, documentation practices, and regulatory compliance.
- **Environment:** Safety protocols, emergency preparedness, vehicle compliance, and rights protections.
- **Client Records:** Documentation accuracy, timeliness, integrity, medical necessity, and clinical recordkeeping.
- **Medical:** Medication management practices, consents, clinical services, and patient safety standards.

There were a total of three (3) Billing and Coding Focus Reviews completed for the fourth quarter of FY25. Each billing and coding focus audit consists of two core areas: billing and coding/clinical documentation.

1. **CPEP Division: Crisis Residential Unit (CRU) Focused Coding Audit:**
    a. This audit evaluated coding and clinical documentation practices for compliance with agency policies, service authorization standards, and billing accuracy which resulted in an overall Client Records score of 94.28%. The program demonstrated strong performance in documenting appointment times, service delivery formats, person-specific goals, and timely completion by certified staff. However, areas needing improvement included incomplete consent forms, unsigned or missing plans of care, and documentation quality issues such as copy-paste entries and missing encounter reasons. Billing accuracy also showed minor miscoding risks. Specific findings included provider entering progress notes before the encounter dates and notes lacking justification for services provided. The program has received the findings and compliance will follow up within 90 days to monitor improvements.
2. **IDD Division: Texas Home Living (TxHmL) Service Coordination Coding and Billing Audit:**
    a. Compliance conducted an audit of the Intellectual and Developmental Disability (IDD) Texas Home Living (TxHmL) program, resulting in an overall score of 96.92%. Billing practices were strong, scoring 99.12%, with only one area falling below threshold at 87.72%. Coding documentation scored 94.73%, with deficiencies noted in service authorization and medical necessity (91.23%) and documentation within required timeframe of 24-48 hours (56.14%). Isolated documentation

issues were identified that may impact regulatory compliance and service accuracy. Additionally, service coordinators failed to document required Type A encounters, which are essential to support billing for Type B encounters. Additionally, some progress notes were submitted past the 48-hour deadline, violating documentation timeliness standards.

3. **Forensics Division: Dual Diagnosis Residential Program (DDRP) and Youth Diversion Center (YDC) Focused Coding Audit:**
    a. Compliance conducted a focused coding audit of the Forensic Youth Diversion Center (YDC) and Dual Diagnosis Residential Program (DDRP), resulting in an overall documentation score of 97.90%. While both programs demonstrated strong adherence to coding and clinical documentation standards, two areas fell slightly below the 95% threshold: plan of care documentation and timely service completion by certified QMHPs, each scoring 94.74%. DDRP showed full compliance with no findings requiring corrective action.
    b. In contrast, YDC had isolated documentation issues that may affect regulatory compliance and service authorization. These included unsigned plans of care, late progress notes beyond the 24–48-hour window, missing documentation for at least one encounter, and incorrect CPT code usage. Addressing these issues will strengthen alignment with TAC, CMS, and agency guidelines.

Within the four (4) divisions, Compliance completed a total of five (5) comprehensive, six (6) focus, four (4) operational, and seven (7) follow-up audits. Comprehensive reviews cover the five domains applicable to the program, follow-up reviews cover the domain(s) which previously needed a plan of improvement, operational reviews cover physical requirements of a facility, and focus reviews cover specific domains within a program.

CPEP Comprehensive and Focus Reviews

1. **CPEP - Crisis Residential Unit (CRU) Comprehensive Audit**
    a. A comprehensive audit of the program yielded an overall score of 94.66%, with perfect compliance in operations, medical, and environmental domains. Personnel compliance scored 80.00%, with gaps in required annual training for direct care staff and rights training. Clinical documentation scored 92.82% and key deficiencies included low compliance in pain assessments (13.00%) and missing rights acknowledgment forms (0%). Other clinical areas (crisis planning, care coordination, and discharge planning) fell slightly below our threshold with scores of 93% but still require attention to maintain consistency.
2. **CPEP - The Navigation Center Focus Audit**
    a. The program had an overall score of 98.58%. The program exceeded standards in the operations and medical domains with a 100% score. The program clinical record requirement score was 95.75%, however there were elements within the clinical record component that fell below the 95% threshold score: a recovery plan was not developed for some of the person's served, the provider did not complete a treatment plan review to determine continuation of services, the summary of activities was not documented within the progress note, the treatment plan objective(s) that was the focus of the service was not documented within the progress note, service encounter documentation did not demonstrate progress or the lack of progress in achieving treatment plan goals, and the provider did not complete the appropriate uniform assessment in accordance with the utilization management guidelines resulting in the program having to submit a Plan of Improvement (POI). This program was discontinued April 30th, 2025, and services were integrated into the Behavioral Health Response Team program. In response to the findings, management delivered targeted training in August 2025 and established new workflows to align with updated program operations and ensure compliance.

3. **CPEP - The Enrichment Center at the Villas and 811 Properties Focus Audit**
    a. A focus audit of the Enrichment Center and 811 properties program examined the operations, medical, and clinical service domains and had an overall score of 99.66%. The audit identified 100% compliance in medical and operational domains. The clinical service domain scored 99%. Within the clinical domain, several areas were identified as needing improvement: collaboration with the person served, recovery planning, recovery plan objectives being measurable, treatment plan review completion, and documented progress towards goals. This was the first audit for this program, which discontinued services effective April 30th, 2025. Their functions transitioned to the Behavioral Health Response Team program.

Forensics Comprehensive and Focus Reviews

1. **Forensic Specialty Comprehensive Audit**
    a. Compliance completed a comprehensive audit of the Forensic Specialty Program, with an overall score of 99.51%. All domains were audited, with operations, medical, clinical records, and environment, each scoring 100%. The only area of improvement was in the personnel domain, which scored 97.53% due to a gap in abuse, neglect, and exploitation and Co-occurring Psychiatric and Substance Use Disorder training. Program management addressed the findings at the individual staff level and assigned the training courses for completion as part of their corrective action plan. This was the first time the program had been audited by the Compliance Department.
2. **Peer Support and Re-Entry Services Focus Audit**
    a. The program had an overall audit score of 97.65% and two domains were reviewed: clinical records and personnel. Personnel scored 100% and clinical records scored 95.29%, with one gap (20%) related to documentation of oral communication of rights. Program management stated they will collaborate with the outside contractor facilitating the consent process. This was the first audit for this program.
3. **Forensic Transition Services Focus Audit**
    a. A focus review of the program resulted in a 90.91% score; however, due to limited access, only personnel records were reviewed. The contracted agency, Harris County Juvenile Probation Department, declined to provide client service documentation. This limitation highlights a risk, as oversight of the contractor is not currently accessible to our internal compliance department. There were identified deficiencies in the disclosure of allegation documentation being present and completed Co-occurring Psychiatric and Substance Use Disorder training. Additionally, under the existing agreement, staffing requires two eligibility coordinators and two Transition Care Coordinators; however, program leadership has proposed reallocating positions to better align with the updated requirements. In response to the findings, program leadership has noted that disclosure of allegation documentation is the responsibility of the contract owner and not the agency. Program leadership did confirm that staff will complete their assigned training.

IDD Comprehensive and Focus Reviews

1. **Intermediate Care Facilities (ICF) Comprehensive Audit**
    a. A comprehensive review was conducted for all the ICF locations (Westbury, Applewhite, and Pasadena Cottage A/B). Three domains were audited: operations (100%), clinical records (34.47%), and personnel (52.88%). The program had an overall score of 62.45%. Compliance found that ICF service documentation did not reflect individual goals, outcomes, or progress, and records were maintained only in paper charts at a single location rather than in the agency's electronic system,

which creates accessibility risks. While this was the first comprehensive review, prior audits have occurred from external reviewers. The program will undergo another full comprehensive review for FY26 due to the findings noted.

2. **Texas Home Living (TxHmL) Service Coordination Focus Audit**
    a. This review was conducted to assess compliance with the program's corrective action plan from a previous external audit by Health and Human Services. The program had an overall score of 74.69%. Key findings included missing enrollment documentation, revision of the plan using person-directed planning (PDP), updates to the individuals PDP within required timeframes, and submission of the PDP to program provider. The program was referred to our Performance Improvement department for further guidance on maintaining their plan of improvement.

Behavioral Health Comprehensive and Focus Reviews

1. **Northwest Community Service Center (NWCSC) Comprehensive Audit**
    a. This review had an overall score of 97.09% with compliance noted in operations, medical, and environmental domains. An area of improvement was identified in the personnel domain regarding agency-mandated training courses and documentation of monthly meetings between staff and their supervisor. Client records have identified areas of improvement relating to eligibility and admission, client rights, medication monitoring and consents, recovery plans and reviews, documentation of services, case management and discharge summaries. The program is working to retrain teams to ensure staff are clear on applicable guidelines noted from the audit. Continued education will be provided throughout the year based on self-monitoring audits from the Behavioral Health Clinical Monitoring team.
2. **Continuity of Care (COC) Comprehensive Audit**
    a. A comprehensive audit of the Continuity of Care program examined the operations, clinical service, and personnel records. The program had an overall score of 67.81% with deficiencies noted in all areas. The audit found the program has not developed policies and procedures in accordance with regulatory standards, employees have not completed mandatory annual training courses, and staff are not obtaining the documents indicated in the Continuity of Care Operational Guidelines. The program is currently developing a Plan of Improvement to address the noted deficiencies. This was the first audit for this program.
3. **Four Operational Audits**
    a. The following programs scored 100% on their operational audits in Quarter three of FY25: Southeast Child and Adolescent Services, Southwest Child and Adolescent Services, Northeast Child and Adolescent Services, and our five Co-Location clinics.

Agency Review

1. **Policy Acknowledgement Focus Audit**
    a. Compliance conducted a focused audit over the general policy acknowledgement process, specifically reviewing our Code of Ethics policy. The overall score for the audit was 66.93% and the following areas were measured: the assignment of the code of ethics policy to individual employees within our Policy Management system, annual employee acknowledgement of policy, and acknowledgement of policy at least once since hire. The audit identified key areas where our process can be strengthened through gaps in our onboarding process to assign policies, education surrounding access to the Policy Management system, and low compliance in annual review of the policy. Compliance will develop a formal Policy Acknowledgement Policy or Procedure and

develop an internal process to verify enrollment in our policy acknowledgement system for new and existing employees. Additionally, education will be provided to employees on how to access the system and which policies are required to be acknowledged. This is the first agency wide audit over policy acknowledgements.

Follow-Up Audits

1. **CPEP - Psychiatric Emergency Services (PES) Follow-Up Audit**
    a. A follow-up review was conducted in August 2025 to assess the progress since its February 2024 Plan of Improvement. The program achieved an overall score of 65%, representing a 25% improvement from the previous year's audit. However, it remained below the 95% threshold due to providers not documenting discharge summaries that include all services provided and the individual's response to treatment. As a result, the program has been referred to the Performance Improvement department. Program management committed to retraining staff within 60 days on proper completion of discharge summary notes to ensure compliance and strengthen documentation practices.
2. **CPEP - Homeless Outreach Team (HOT) Follow-Up Audit**
    a. A follow-up audit was completed in August 2025 to assess progress since the original audit in February 2024, focusing on the clinical and personnel domains. Clinical records demonstrated improvement from 79% to 83.33%. The outlier in the clinical records was due to service encounter documentation lacking a subjective assessment of the person served. Personnel scores declined from 90% to 66.66% due to one staff member not being current with required training courses (sample size of two). Program management reported that staff will be reminded to assess and document consumer status in real time during each encounter. The program is being referred to our Performance Improvement department.
3. **Behavioral Health Assertive Community Treatment/Forensic Assertive Community Treatment (ACT/FACT) Follow-Up Audit**
    a. This follow-up audit was conducted to assess the corrective action progress from FY24 quarter three to FY25 quarter four. The audit resulted in an overall score of 88.60% which was a decrease from their previous overall score of 92%. The program was audited over the personnel and client record domains. The program improved personnel compliance from 94% to 97%. The client record score decreased from 91% to 80.32% for this audit. Areas of improvement include informed medication consent must be obtained for each individual medication; new consents obtained if changes in medication occur; and, upon initial contact, the ACT staff member develops a person-centered recovery/safety plan. Personnel gaps were within timely completion of agency mandated training. The program was referred to the Performance Improvement department for further guidance and collaboration.
4. **Behavioral Health Assisted Outpatient Therapy (AOT) Follow Up Audit**
    a. A follow-up audit was completed for Assisted Outpatient Therapy to assess the progress of their plan of improvement implemented in Quarter one of FY2025. The review was completed in Quarter four of FY2025 and personnel and client record domains were audited. The overall score was 86.47% which was a decrease from the previous overall score of 95%. Personnel scored at 100% compliance and client records had a slight decrease to 72.93% from a previous report of 78%. Areas of improvement identified were related to client rights, medication monitoring, medication consents, assessments, recovery plans and reviews, documentation of progress notes, and documentation of medication training and support. The program will be referred to our Performance Improvement department for further collaboration.
5. **Behavioral Health Integrated Care Follow Up Audit**

a. This follow-up audit was conducted to assess the plan of improvement progress from January 2024 to May 2025. Only personnel records were reviewed and there was an improvement from 25% to 97.66%. The program exceeded standards in many of the personnel requirements. There were two areas (CPR and Handle with Care) that did not meet the 95.00% threshold; however, since the employees were unable to schedule these courses sooner than August 2025, a referral to Performance Improvement (PI) was deemed unnecessary.

6. **Behavioral Health Optum Integrated Behavioral Health Home Care (Optum) Follow Up Audit**
    a. The follow-up review assessed the progress over the plan of improvement from FY24 quarter three to FY2025 quarter four. There was an overall audit score of 57.04%, which was an increase from the previous score of 45%. The program's personnel and client records were still under the 95% threshold. Identified areas of improvement included enrollment and assessment, administrative review, and health action plans for clinical records and agency mandated trainings were incomplete for the personnel domain. The program is being referred to the Performance Improvement department for additional assistance on their plan of improvement.
7. **Behavioral Health Southeast Adult Mental Health (SEAMH) Follow Up Audit**
    a. A follow-up audit was conducted to assess the progress of plan of care and progress note documentation from FY2023 Quarter four to FY2025 Quarter four. There was a decrease in the overall clinical record score from 94.91% to 55.43%. Identified areas of improvement were related to progress notes including the treatment plan objective, treatment plan including a description of the presenting problem, treatment plan goals and objectives being measurable using quantifiable criteria, case managers addressing identified needs within case management notes, addressing individuals co-occurring substance use or physical health disorder, and staff not cloning notes. Due to the length of time between the previous review upon which this review is based, Compliance requested, and the Program submitted, a Plan of Improvement (POI) to address these deficiencies.

Other Compliance Activities

1. **Epic Deficiency Monitoring:** Track and communicate ongoing Epic documentation deficiencies to ensure timely resolution.
2. **Policy and Procedure Oversight:** Facilitate and maintain the agency's policy and procedure process using the PolicyStat platform, which includes approvals, updates, and staff communication (ongoing).
3. **Corrective Action Monitoring:** Track and follow up on corrective action plans related to audit findings, including timelines and status updates.
4. **Complaint and Grievance Review:** Support the Rights Office by conducting clinical record reviews related to complaints and grievances.

The following is a list of the external reviews (i.e., Governing Bodies, Managed Care Organizations (MCO), etc.) completed during the review period with involvement or oversight from Compliance:

External Datavant Medical Record Requests:

1. Datavant (on behalf of Aetna) requested records on 5/30/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Aetna members. This is a medical record review and not a claims payment audit. Records were submitted by our Release of Information (ROI) Department.

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2. Datavant (on behalf of Aetna) requested records on 6/2/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Aetna members. This is a medical record review and not a claims payment audit. Records were submitted by our Release of Information Department.
3. Datavant (on behalf of Aetna) requested records on 6/2/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Aetna members. This is a medical record review and not a claims payment audit. Records were submitted by our Release of Information Department.
4. Datavant (on behalf of United Healthcare) requested records on 6/2/25 for the MRA health plan's chart review program. Records were submitted by our ROI department.
5. Datavant (on behalf of Wellpoint) requested records on 6/4/25 for participation in the Medicare risk adjustment (MRA) chart review program. Request included full medical records for review by Wellpoint. Records were submitted by our ROI department.
6. Datavant (on behalf of Wellpoint) requested records on 6/4/25 for participation in the Medicare risk adjustment (MRA) chart review program. Request included full medical records for review by Wellpoint. Records were submitted by our ROI department.
7. Datavant (on behalf of Wellmed) requested records on 7/1/25 for participation in the Medicare risk adjustment (MRA) chart review program. Request included full medical records for review by Wellmed. Records were submitted by our ROI department.
8. Datavant (on behalf of Devoted Health) requested records on 7/1/25 as part of the risk adjustment (MRA) chart review program. Request included full medical records for review by Devoted Health. Records were submitted by our ROI department.
9. Datavant (on behalf of Oscar) requested records on 7/11/25 as part of the Issuer Validation Audit (IVA) which is part of the Risk Adjustment Data Validation (RADV) required by Health and Human Services (HHS). Request included full medical records for review by Oscar. Records were submitted by our ROI department.
10. Datavant (on behalf of Cigna) requested records on 7/17/25 for risk adjustment data reporting to CMS. Request includes complete medical records for identified Cigna members. Records were submitted by our Release of Information Department.
11. Datavant (on behalf of Wellpoint) requested records on 7/22/25 for participation in the Medicare risk adjustment (MRA) chart review program. Request included full medical records for review by Wellpoint. Records were submitted by our ROI department.
12. Datavant (on behalf of Aetna) requested records on 8/6/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Aetna members. This is a medical record review and not a claims payment audit. Records were submitted by our Release of Information Department.
13. Datavant (on behalf of Aetna) requested records on 8/12/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Aetna members. This is a medical record review and not a claims payment audit. Records were submitted by our Release of Information Department.
14. Datavant (on behalf of Devoted Health) requested records on 8/12/25 as part of the risk adjustment (MRA) chart review program. Request included full medical records for review by Devoted Health. Records were submitted by our ROI department.
15. Datavant (on behalf of Devoted Health) requested a second set of records on 8/12/25 as part of the risk adjustment (MRA) chart review program. Request included full medical records for review by Devoted Health. Records were submitted by our ROI department.

16. Datavant (on behalf of Wellpoint) requested records on 8/12/25 for participation in the Medicare risk adjustment (MRA) chart review program. Request included full medical records for review by Wellpoint. Records were submitted by our ROI department.
17. Datavant (on behalf of Wellpoint) requested a second set of records on 8/12/25 for participation in the Medicare risk adjustment (MRA) chart review program. Request included full medical records for review by Wellpoint. Records were submitted by our ROI department.
18. Datavant (on behalf of Wellcare) requested records on 8/12/25 for participation in the Medicare risk adjustment (MRA) chart review program. Request included full medical records for review by Wellcare. Records were submitted by our ROI department.
19. Datavant (on behalf of Wellmed) requested records on 8/12/25 for participation in the Medicare risk adjustment (MRA) chart review program. Request included full medical records for review by Wellmed. Records were submitted by our ROI department.
20. Datavant (on behalf of United Healthcare) requested records on 8/21/25 for the MRA health plan's chart review program. Records were submitted by our ROI department.

Other External Medical Record Requests:

1. AdvantMed (on behalf of Blue Cross Blue Shield) requested records on 6/11/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Blue Cross Blue Shield members. were submitted by our Release of Information (ROI) Department.
2. AdvantMed (on behalf of Blue Cross Blue Shield) requested records on 6/11/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Blue Cross Blue Shield members. were submitted by our Release of Information (ROI) Department.
3. AdvantMed (on behalf of Wellcare) requested records on 7/21/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Wellcare members. were submitted by our Release of Information (ROI) Department.
4. AdvantMed (on behalf of Wellcare by Allwell) requested records on 7/21/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Wellcare by Allwell members. were submitted by our Release of Information (ROI) Department.
5. Vitrix Health, LLC (on behalf of Blue Cross Blue Shield of North Carolina) requested records on 7/22/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS) and HHS. Request includes complete medical records for identified Blue Cross Blue Shield members. Records were submitted by our Release of Information (ROI) Department.
6. Vitrix Health, LLC (on behalf of Anthem) requested records on 7/23/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS) and HHS. Request includes complete medical records for identified Anthem members. Records were submitted by our Release of Information (ROI) Department.
7. Vitrix Health, LLC (on behalf of Blue Cross Blue Shield of North Carolina) requested records on 7/28/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS) and HHS. Request includes complete medical records for identified Blue Cross Blue Shield members. Records were submitted by our Release of Information (ROI) Department.
8. Anthem requested records on 8/5/25 to review member records to meet Affordable Care Act requirements by reporting complete and accurate diagnosis coding to HHS. Request includes complete medical records for identified Anthem members. Records were submitted by our Release of Information (ROI) Department.

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9. Anthem requested records on 8/18/25 to review member records to meet Affordable Care Act requirements by reporting complete and accurate diagnosis coding to HHS. Request includes complete medical records for identified Anthem members. Records were submitted by our Release of Information (ROI) Department.
10. Anthem requested records on 8/19/25 to review member records to meet Affordable Care Act requirements by reporting complete and accurate diagnosis coding to HHS. Request includes complete medical records for identified Anthem members. Records were submitted by our Release of Information (ROI) Department.
11. Humana requested records on 6/24/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Humana members. were submitted by our Release of Information (ROI) Department.
12. Humana requested records on 8/18/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Humana members. were submitted by our Release of Information (ROI) Department.
13. Reveleer (on behalf of Aetna) requested records on 7/17/25 for risk adjustment data reporting to Centers for Medicare and Medicaid Services (CMS). Request includes complete medical records for identified Aetna members. were submitted by our Release of Information (ROI) Department.
14. EXL, on behalf of Texas Children's Health Plan (TCHP), requested records on 8/14/25 to determine if claims were billed and paid in accordance with the Texas Medicaid laws and regulations and contractual terms with TCHP. Our ROI department released records and currently the results are pending.

External Pharmacy Audits:

1. Optum Rx conducted a chart review audit for Southeast Pharmacy on 6/3/25 to validate claims associated with Invega Hafye INJ 1560mg. The requested documentation was submitted by the pharmacy representative on 6/9/25. Audit results are still pending.
2. Optum Rx conducted a chart review audit for Northwest Pharmacy on 6/3/25 to validate claims associated with Invega Trinz INJ 410mg. The requested documentation was submitted by the pharmacy representative on 6/9/25. Audit results are still pending.
3. Optum Rx conducted a chart review audit for Northwest Pharmacy on 6/3/25 to validate claims associated with Invega Trinz INJ 546mg. The requested documentation was submitted by the pharmacy representative on 6/9/25. Audit results are still pending.
4. Optum Rx conducted a chart review audit for Southeast Pharmacy on 6/13/25 to validate claims associated with Uzedy INJ 200mg. The requested documentation was submitted by the pharmacy representative on 6/18/25. On 7/3/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
5. Optum Rx conducted a chart review audit for Northwest Pharmacy on 6/17/25 to validate claims associated with Uzedy INJ 200mg. The requested documentation was submitted by the pharmacy representative on 6/18/25. On 7/3/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
6. Optum Rx conducted a chart review audit for Northeast Pharmacy on 6/18/25 to validate claims associated with Ablify Asim INJ 960mg. The requested documentation was submitted by the pharmacy representative on 6/25/25. Audit results are still pending.
7. Optum Rx conducted a chart review audit for Northwest Pharmacy on 6/25/25 to validate claims associated with Invega Trinz INJ 546mg. The requested documentation was submitted by the pharmacy representative on 7/7/25. Audit results are still pending.

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8. Optum Rx conducted a chart review audit for Northeast Pharmacy on 6/26/25 to validate claims associated with Ablify Asim INJ 960mg. The requested documentation was submitted by the pharmacy representative on 7/11/25. Audit results are still pending.
9. Optum Rx conducted a chart review audit for Northeast Pharmacy on 7/7/25 to validate claims associated with Invega Trinz INJ 410mg. The requested documentation was submitted by the pharmacy representative on 7/14/25. Audit results are still pending.
10. Optum Rx conducted a chart review audit for Northeast Pharmacy on 7/11/25 to validate claims associated with Invega Trinz INJ 819mg. The requested documentation was submitted by the pharmacy representative on 7/23/25. Audit results are still pending.
11. Optum Rx conducted a chart review audit for Northwest Pharmacy on 7/22/25 to validate claims associated with Uzedy INJ 200mg. The requested documentation was submitted by the pharmacy representative on 7/23/25. Audit results are still pending.
12. Optum Rx conducted a chart review audit for Northwest Pharmacy on 7/24/25 to validate claims associated with Invega Trinz INJ 410mg. The requested documentation was submitted by the pharmacy representative on 8/6/25. Audit results are still pending.
13. Optum Rx conducted a chart review audit for Northeast Pharmacy on 8/4/25 to validate claims associated with Invega Trinz INJ 410mg. The requested documentation was submitted by the pharmacy representative on 8/8/25. Audit results are still pending. Optum Rx conducted a chart review audit for Northeast Pharmacy on 8/4/25 to validate claims associated with Invega Trinz INJ 819mg. The requested documentation was submitted by the pharmacy representative on 8/8/25. Audit results are still pending.
14. Optum Rx conducted a chart review audit for Northeast Pharmacy on 8/5/25 to validate claims associated with Concerta Tab 27mg. The requested documentation was submitted by the pharmacy representative on 8/8/25. Audit results are still pending.
15. Optum Rx conducted a chart review audit for Northeast Pharmacy on 8/5/25 to validate claims associated with Vyvanse Cap 20mg. The requested documentation was submitted by the pharmacy representative on 8/8/25. Audit results are still pending.
16. Optum Rx conducted a chart review audit for Southwest Pharmacy on 8/6/25 to validate claims associated with Ablify Asim INJ 960mg. The requested documentation was submitted by the pharmacy representative on 8/6/25. Audit results are still pending.
17. Optum Rx conducted a chart review audit for Southeast Pharmacy on 8/12/25 to validate claims associated with Uzedy INJ 200mg. The requested documentation was submitted by the pharmacy representative on 8/13/25. Audit results are still pending.
18. Optum Rx conducted a chart review audit for Northwest Pharmacy on 8/15/25 to validate claims associated with Uzedy INJ 200mg. The requested documentation was submitted by the pharmacy representative on 8/15/25. Audit results are still pending.
19. Optum Rx conducted a chart review audit for Southwest Pharmacy on 8/19/25 to validate claims associated with Invega Trinz INJ 819mg. The requested documentation was submitted by the pharmacy representative on 8/25/25. Audit results are still pending.
20. Optum Rx conducted a chart review audit for Southwest Pharmacy on 8/20/25 to validate claims associated with Uzedy INJ 250mg. The requested documentation was submitted by the pharmacy representative on 8/25/25. Audit results are still pending.
21. Optum Rx conducted a chart review audit for Southeast Pharmacy on 8/20/25 to validate claims associated with Invega Trinz INJ 819mg. The requested documentation was submitted by the pharmacy representative on 8/25/25. Audit results are still pending.
22. Texas State Board of Pharmacy inspected the Northwest Clinic Pharmacy on 7/9/25 with no unsatisfactory findings or recommendations.

23. Texas State Board of Pharmacy inspected the Northeast Clinic Pharmacy on 8/5/25 with no unsatisfactory findings or recommendations.

External Program Specific Audits

1. **Health and Human Services (HHS), Behavioral Health Services (BHS), Quality Management Follow Up Review**
    a. HHS accepted a corrective action plan resulting from a previous comprehensive FY24 Audit. This audit was a follow-up to ensure implementation of the corrective action plans. The review requested evidence of monitoring activities and conducted a desk follow-up review on 8/18/25-8/25/25. The review results showed that The Harris Center for Mental Health and IDD completed all the actions identified in the Corrective Action Plan from the previous Comprehensive on-site review.
2. **Texas General Land Office Community Development and Revitalization (GLO-CDR) Annual Affordability Period Review of Affordable Rental Program**
    a. The GLO-CDR notified The Harris Center for Mental Health and IDD it will conduct an annual review of our Hope Harbor facility. The notice was submitted 6/16/25 and documentation was requested by 7/7/25. Currently, the review is ongoing, and no formal response has been received.
3. **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) - IDD Division**
    a. Texas Health and Human Services Commission (HHSC) conducted an onsite Full Book Survey for recertification of our Applewhite location between 6/24/2025 – 6/27/25. Based on an interview and record review, the governing body failed to ensure specific requirements were met for 6 of 6 individuals reviewed. It was determined the program would need a follow-up review within 60 days. A plan of correction was submitted on 7/23/2025 by the Program Director.
    b. A Life Safety Code Survey was conducted for the Applewhite facility on 7/2/25 which resulted in deficiencies that would require a plan of correction. A plan of correction was submitted by the facility to HHSC on 7/25/25. HHSC conducted a Life Safety Code follow-up review for Applewhite facility on 8/20/2025 to determine if the facility complies with state licensure requirements and federal participation requirements for ICF/IID facilities in Medicare or Medicaid programs. The survey found that the facility meets state licensure requirements and is in substantial compliance with federal participation requirements.
    c. Licensing and Life Safety Code surveys for Westbury were conducted by HHSC between 7/10/25 – 7/11/25. The survey concluded with cited deficiencies that did not meet licensure or state requirements. A plan of corrective was required and the program director submitted on 8/4/25. Plan of corrective was accepted by HHSC on 8/05/25. A follow-up visit for Life Safety was conducted 8/20/25 and the program was cleared of any deficiencies.
    d. HHSC conducted an unannounced onsite survey for Pasadena Cottage A between 6/26/25 – 6/27/25. Preliminary findings found deficiencies with life safety codes. Fire drills were identified as potential noncompliance with federal and state requirements. A plan of correction was submitted 7/23/25 and accepted by HHSC on 7/25/25. A follow-up review was conducted by HHSC following up on the previous deficiencies cited between 8/5/25 – 8/11/25. The survey resulted in meeting all licensure requirements, state standards for participation, no health deficiencies, and no licensure violations.
    e. An onsite full book survey for Pasadena Cottage B was conducted by HHSC on 2/28/25. A follow-up survey took place 8/21/25 – 8/22/25 to determine if the program met all licensing standards. The survey found that the facility meets state licensure requirements and is in substantial compliance

with federal participation requirements. Pasadena Cottage B was cleared of all deficiencies on 8/22/25.

f. An unannounced survey for Pasadena Cottage B was conducted by HHSC to investigate an incident between 8/19/25 – 8/28/25. The allegation was found to be unsubstantiated. An unrelated standard level deficiency was assigned regarding facility staffing. The program will provide training to staff on professional conduct with consumers and provide reminders to review the employee handbook.

4. **Texas Home Living (TxHmL) Recertification by Health and Human Services**
   a. A recertification audit was completed 7/8/25 – 7/9/25 to determine if the contract followed the certification principles for the TxHmL program. Based on the visit, a quality assurance finding regarding failure to notify, was cited. A Follow-Up desk survey was conducted on 8/13/25 and it was noted no new areas of noncompliance were discovered. The program received certification for an additional year.

COMPREHENSIVE, FOCUS, AND FOLLOW-UP AUDIT EXECUTIVE SUMMARIES

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Focused Coding Review
Review Dates: July 14, 2025 – July 25, 2025

I. Audit Type:
Focused Billing and Coding Review

II. Purpose:
The purpose of this audit was to evaluate the accuracy, completeness, and compliance of clinical documentation and coding practices within the Crisis Residential Unit (CRU). The review focused on ensuring alignment with Texas Administrative Code (TAC), Centers for Medicare & Medicaid Services (CMS) regulations and guidelines, and internal agency policies and procedures. The audit also examined the 2025 Current Procedural Terminology (CPT) guidelines, TEX. ADMIN. CODE 26 §301.351 Crisis Services, TEX. ADMIN. CODE 26 §301.329 Medical Records System, TEX. ADMIN. CODE 26 §320. 26 TEX. ADMIN. CODE §306.277; Telemedicine and Telehealth Benefits and Limitations; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361; HIM.EHR.A.6; Telehealth & Telemedicine Procedure MED.B.6; Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Financial Assessment ACC.A.11, Writing Off Self Pay Balances FM.B.10, Charity Care Procedures FM.B.11, and Telehealth & Telemedicine Procedure MED.B.6. The audit aimed to identify strengths and areas for improvement to support high-quality care and ensure regulatory compliance.

III. Audit Method:
Active records were randomly selected from the Affiliated Harris Center Encounter Data IP Service Detail Auditing report in the EPIC (EHR) system for persons served during the 3rd quarter of FY 2024 (March 1, 2025 – May 31, 2025). Compliance reviewed forty-two (42) client encounters containing qualified mental health care provider documentation. The above-mentioned sample size was obtained on 07/17/2025. This desk review was conducted using the Compliance Coding tool and clinical documentation requirements (client records).

IV. Audit Findings/History:
Overall Audit Score (CRU Program) – 94.28%
The audit identified a few isolated documentation issues that, although not widespread, offer opportunities to better follow agency policies and standards. These issues include missing a valid Plan of Care documentation with no specified service or frequency, a Plan of Care that is completed but not signed by the client, indicating missing consent, progress notes that do not fully align with TAC and agency requirements, and visits documented before the actual date of service, which could impact the accuracy of care timelines. Additionally, the date of service recorded by one provider in the EPIC Electronic Medical Record (EMR) differed from the date documented by another provider. This inconsistency may affect the accuracy of the client record and should be resolved to maintain uniformity across all documentation.

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V. Recommendations:
It is recommended that the program leadership of the CPEP Division and the Program Director of the Crisis Residential Program review the findings and collaborate with the appropriate personnel to assess and ensure that physician and other QMHP services are properly documented, accurate, and aligned with TAC, CPT, CMS guidelines, and Agency P&P. Compliance will re-evaluate provider documentation and coding in the next 180 days to confirm that the program has implemented its plan of improvement (POI) related to documentation accuracy and service authorization. Compliance will also continue to support the CPEP Division and the CRU team regarding service documentation, including review of clinical documentation from a credentialed professional coder. The leadership of both the CPEP Division and the CRU program director must return a signed copy acknowledging receipt of this report to Compliance within seven (7) business days.

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Intellectual Developmental Disability (IDD) Division
Texas Home Living (TxHmL)Program
Focused Billing & Coding Review
Review Dates: August 27, 2025 – September 22, 2025

I. Audit Type:
Focused Billing and Coding Review

II. Purpose:
This review was performed to assist the Intellectual Developmental Disability (IDD) program and Revenue Management division in evaluating Targeted Case Management (IDDTCM) Service's clinical documentation, coding, and billing practices for compliance with the 2025 regulations and guidance from the Center for Medicare and Medicaid Services (CMS), the 2025 Current Procedural Terminology (CPT) guidelines, Healthcare Common Procedure Coding System (HCPCS) guidelines, the Behavioral Health & Case Management Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 December 2024, the Texas Administrative Code (TAC) Targeted Case Management (TCM) 1 26 TAC §331.21, MH Case Management Medicaid Reimbursement 26 TEX. ADMIN. CODE §306.277, Telemedicine and Telehealth Benefits and Limitations, Documentation of Service Provision 26 TAC §354.1432, 26 Tex. Admin. Code § 301.361 - Documentation of Service Provision, HIM.EHR.A.6, Telehealth & Telemedicine Procedure MED.B.6, Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Financial Assessment ACC.A.11, Writing Off Self Pay Balances FM.B.10, Charity Care Procedures FM.B.11, Telehealth & Telemedicine Procedure MED.B.6.

III. Audit Method:
Active records were randomly selected by generating the Compliance PB Transaction Report in the EPIC (EHR) system for individuals served during the 4th quarter of FY 2025 (June 1, 2025 – August 31, 2025). Compliance reviewed fifty-seven (57) client encounters containing qualified service coordination provider documentation for the Intellectual Developmental Disability TCM Code T1017. The specified sample size was obtained on 08/27/2025. This desk review was conducted using the Compliance Coding & Billing Audit Review Tool. It included two components: Medical Billing & Coding requirements and Clinical Documentation requirements.

IV. Audit Findings and History
Compliance has identified a small number of isolated documentation issues that could impact regulatory compliance, service authorization, and the accuracy of clinical records for the Intellectual and Developmental Disability (IDD) Texas Home Living (TxHmL) program. During the review, it was observed that Service coordinators neither documented nor provided any Type A encounters, even though Type A services are essential and required to support the billing of Type B encounters. The absence of Type A documentation creates a compliance risk, as reimbursement for Type B encounters cannot be supported without evidence of the corresponding Type A services. Late Documentation: Service progress notes were submitted after the 48-hour deadline, failing to meet documentation timeliness requirements. The overall score for this audit was 96.92%.

V. Recommendations
It is recommended that the program leadership of the Intellectual Developmental Disability (IDD) Division review the findings and collaborate with the appropriate personnel to evaluate and ensure Service Coordination services are clinically documented, accurate, and aligned with the provided services. Clinical documentation and progress notes should conform to TAC, CPT, CMS guidelines, and Agency Policies and Procedures. Compliance will continue to support the program leadership and Revenue Management team regarding their documentation of services, including review of clinical documentation by a credentialed coder. The program leaders of the Forensic Division must return a signed copy acknowledging receipt of this report to Compliance by 09/26/2025

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Forensic Division Focused Coding Review
Review Dates: May 16, 2025 – May 27, 2025

I. Audit Type:

Focused Billing and Coding Review

II. Purpose:

This focused audit was conducted to assess the Forensic DDRP and YDC program's compliance with clinical documentation and coding standards, in alignment with internal policies and applicable regulatory requirements. Compliance with the 2024 Center for Medicare and Medicaid Services (CMS) Regulations and Guidance, the 2024 Current Procedural Terminology (CPT) guidelines, Behavioral Health & Case Management Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 December 2024; the Texas Administrative Code (TEX. ADMIN. CODE) Documentation of Service Provision 26 TEX, ADMIN. CODE §301.361, HIM.EHR.A.6, Telehealth & Telemedicine Procedure MED.B.6, Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Financial Assessment ACC.A.11, Writing Off Self Pay Balances FM.B.10, Charity Care Procedures FM.B.11, Telehealth & Telemedicine Procedure MED.B.6.

III. Audit Method:

Active records were randomly selected by generating the Compliance PB Transaction Report in the EPIC (EHR) system for persons served during the 4th quarter of FY 2025 (May 1, 2025 – May 31, 2025). Compliance reviewed forty-eight (48) client encounters containing qualified mental health care provider documentation. The sample size mentioned above was obtained on 05/16/2025. This desk review was conducted using the Compliance Coding & Billing Audit Review Tool. It consisted of two components: Medical Billing & Coding requirements (Operations) and Clinical Documentation requirements (Client records).

IV. Audit Findings/History:

Overall Audit Score (AMH Program) – 97.90%
Compliance has identified a small number of isolated documentation issues that may affect regulatory compliance, service authorization, and the accuracy of clinical records for the Forensic DDRP and YDC programs. These include the patient's signature being pending on the Plan of Care, indicating incomplete documentation and a possible gap in the established patient agreement with treatment goals. Progress notes were submitted beyond the required 24–48-hour deadline. For at least one encounter, there is no progress note available to support it. A review of the clinical document revealed that the CPT code used did not match the service documented.

V. Recommendations

It is recommended that the program leadership of the Forensic Division review the findings and collaborate with the appropriate personnel to assess and ensure physician and other QMHP services are clinically documented, accurate and aligned with the service provided. Clinical documentation and progress notes should align with Texas Admin. Code, CPT, CMS guidelines, and agency Policy and procedure. Compliance will continue to provide essential support to Division and Revenue Management team regarding their documentation of services, including review of clinical documentation from a credential professional coder.

The Harris Center for Mental Health and IDD:
The Compliance Department
4th Quarter (Qtr.) of Fiscal Year (FY) 2025
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Crisis Residential Unit (CRU)
Comprehensive Review
Review Date: July 14, 2025, to July 25, 2025

I. Audit Type:
Comprehensive Review.

II. Purpose:
The purpose of this review was to assess Crisis Residential Unit (CRU) Bristow and Southmore Operation Guidelines, Medical Requirements, Environmental Requirements, Personnel Requirements, and Clinical Record Requirements for compliance with Health and Human Service (HHS) Information Item V for *Crisis Residential Services* and Texas Administrative Code (TEX. ADMIN. CODE) *26 §301.355 Utilization Management, TEX. ADMIN. CODE 26 §320.75 Monitoring Compliance with Policies and Procedures, TEX. ADMIN. CODE 26 §301.323 Environment of Care and Safety, TEX. ADMIN. CODE 26 §301.359 Telemedicine Services, TEX. ADMIN. CODE 26 §301.351 Crisis Services, TEX. ADMIN. CODE 26 §301.329 Medical Records System, TEX. ADMIN. CODE 26 §320.25 Communication of Rights to Individuals Receiving Mental Health Services, TEX. ADMIN. CODE 26 §320.59 Documentation of Informed Consent.*

III. Audit Method:
Active records were randomly selected from *the Affiliated Harris Center Encounter Data IP Service Detail Auditing* report in the Electronic Health Record (EHR) for person's served during the 3rd Qtr. of FY 2025 (March 1, 2025, to May 31, 2025), and the *Organizational Development Staff Training Roster Report*. Compliance conducted a desk review, sampling Fifteen (15) consumer records and seven (7) personnel records using a modified version of the STATE Review Tool. Detailed data for this review is presented below.

IV. Audit Findings and History:
Overall Program Score: 94.6%
Detailed finding(s) is presented below.
Identified program strengths were in Operational Requirements (100%), Medical Requirements (100%), and Environmental Requirements (100%).

The program has elements within the Personnel Requirements and the Clinical Record Requirements that fail below the threshold score of 95% which requires a POI: Staff must be current with the training identifying the causes of aggressive or threatening behaviors of individuals who need mental health services *TAC 320.29 (1) (3) 67%,* All employees shall receive instruction for maintaining annual rights training *TAC §320.113 (b) (1-2) (c) (2) 33%.* The initial evaluation for physical health must be performed and at a minimum a pain assessment must be completed. *Information Item V: V.D.3.b.v.(3)(e) 13%.* The communication of rights to the individual receiving mental health services shall be documented on a form bearing the date and signature of the individual and/or legal authorized representative (LAR) and the staff member who explained the rights. *Information Item V: V.D.3.b.vi. (2-4) 0%.* Every individual admitted to services must participate in the development of a crisis treatment plan. *Information Item V: V.D.4.b.i.ii.iii 93%.* Coordination of services and continuity of care must be provided for every individual. *Information Item V: V.D.5.b.i.ii 93%.* Discharge planning must be initiated at the time of an individual's admission. *Information Item V: V.D.5.c. (1-4) 93%.*

History

No previous review of this type has been conducted.

V. Recommendations:
Compliance recommends that the Crisis Residential Unit (CRU) program review the findings and continue to assess its processes to ensure all required standards are completed in accordance with *TEX. ADMIN. CODE Staff Member Training Requirements, Communication of Rights to Individuals Receiving Mental Health Services, and Information Item V for Crisis Residential Services.* The CRU program is required to submit a Plan of Improvement (POI) focusing on the elements in Personnel Requirements and the Clinical Record Requirements. The Vice President (VP) of CPEP Division and the Program Manager/Director must sign and return the report with management response along with the POI to Compliance within seven business days.

The Harris Center for Mental Health and IDD:
The Compliance Department
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
The Navigation Center: Harris Center Support Team
Focus Review
Review Date: May 22, 2025, to May 30, 2025

I. Audit Type:
Focus Review.

II. Purpose:
The purpose of this review was to assess The Navigation Center: Harris Center Support Team Operation Guidelines, Medical Requirements and Clinical Record Requirements for compliance with Texas Administrative Code (TEX. ADMIN. CODE) *26 §301.355 Utilization Management, TEX. ADMIN. CODE 26 §320.75 Monitoring Compliance with Policies and Procedures, TEX. ADMIN. CODE 26 §301.353 Provider Responsibilities for Treatment Planning and Service Authorization, TEX. ADMIN. CODE 26 §301.359 Telemedicine Services, TEX. ADMIN. CODE 26 §301.361 Documentation of Service Provision, TEX. ADMIN. CODE 26 §301.329 Medical Records System, TEX. ADMIN. CODE 25 §320.25 Communication of Rights to Individuals Receiving Mental Health Services, TEX. ADMIN. CODE 25 §320.59 Documentation of Informed Consent, and The Navigation Center Operational Guidelines.*

III. Audit Method:
Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 2nd Qtr. of FY 2025 (December 1, 2024, to February 28, 2025), Compliance conducted a desk review, sampling fifteen (15) consumer records using a modified version of the STATE Review Tool. Detailed data for this review is presented below.

IV. Audit Findings and History: Overall Program Score: 98.6%
Detailed finding(s) is presented below.
Identified program strengths were in Operational Requirements (100%), Medical Requirements (100%), and Clinical Record Requirements (95%)
.
The program has elements within the Clinical Record Requirements that fell below the threshold score of 95% which requires a plan of improvement: The local mental health authority (LMHA) or local behavior health authority (LBHA) will develop a recovery plan for every person served (67%). Each provider must complete a treatment plan review to determine continuation of services (*0%).* The summary of activities must be documented within the progress note (*75%).* The treatment plan objective that was the focus of the service must be documented in the progress note (*63%).* Service encounter documentation must show how the person served demonstrated progress or the lack of progress in achieving treatment plan goals (63%). Prior to providing services the provider must complete the appropriate uniform assessment (90%).

History

No previous review of this type has been conducted.

V. Recommendations:
Compliance recommends that The Navigation Center program review the findings in the Plan of Improvement (POI) and continue to assess its processes to ensure all required standards are completed in accordance with *TEX. ADMIN. CODE Provider Responsibilities for Treatment Planning and Service Authorization, Documentation of Service Provision, and The Program Operational, Guidelines.* The Navigation Center program is required to submit a POI focusing on Clinical Record Requirements. The Vice President (VP) of CPEP Division and the Program Manager/Director must sign and return the report with management response along with the POI to Compliance within seven days.

The Harris Center for Mental Health and IDD:
The Compliance Department
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
The Enrichment Center at the Villas and 811 Properties
Focus Review
Review Date: June 2, 2025, to June 12, 2025

I. Audit Type:
Focus Review.

II. Purpose:
The purpose of this review was to assess The Enrichment Center and 811 Properties Operation Guidelines, Medical Requirements and Clinical Record Requirements for compliance with Texas Administrative Code (TEX. ADMIN. CODE) *26 §301.355 Utilization Management, TEX. ADMIN. CODE 26 §320.75 Monitoring Compliance with Policies and Procedures, TEX. ADMIN. CODE 26 §301.353 Provider Responsibilities for Treatment Planning and Service Authorization, TEX. ADMIN. CODE 26 §301.359 Telemedicine Services, TEX. ADMIN. CODE 26 §301.361 Documentation of Service Provision, TEX. ADMIN. CODE 26 §301.329 Medical Records System, TEX. ADMIN. CODE 25 §320.25 Communication of Rights to Individuals Receiving Mental Health Services, TEX. ADMIN. CODE 25 §320.59 Documentation of Informed Consent, and The Enrichment Center Operational Guidelines.*

III. Audit Method:
Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for person's served during the 3rd Qtr. of FY 2025 (December 1, 2024, to February 28, 2025), Compliance conducted a desk review, sampling fifteen (15) consumer records using a modified version of the STATE Review Tool. Detailed data for this review is presented below.

IV. Audit Findings and History: Overall Program Score: 99.6%
Detailed finding(s) is presented below.
The program's strength was Operation Requirements 100%, Medical Requirements 100%, and Clinical Record Requirements 99%.
The program has elements within the Clinical Record Requirements that fail below the threshold score of 95% which requires a POI: In collaboration with the person's served and their legal authorized representative (LAR) the local mental health authority (LMHA) or local behavior health authority (LBHA) will develop a recovery plan. *TEX. ADMIN. CODE 26 §301.353 (d)(1) (c) 86%,* The recovery plan objectives should be measurable using quantifiable criteria. *TEX. ADMIN. CODE 26 §301.353 (e)(2)(D) 92%.* Each provider must complete a treatment plan review to determine continuation of services. *TEX. ADMIN. CODE 26 §301.353 (f)(1)(A) 91%.* Service encounter documentation must show how the person served demonstrated progress or the lack of progress in achieving treatment plan goals. *TEX. ADMIN. CODE 26 §*301.361 (a) (12) 75%, and Progress notes must be made and entered into the record within two (2) business days after each encounter. *TEX. ADMIN. CODE 26 §*301.361 (b) 92%,

History

No previous review of this type has been conducted.

V. Recommendations:
Compliance recommends that The Enrichment Center program review the findings in the Plan of Improvement (POI) and continue to assess its processes to ensure all required standards are completed in accordance with *TEX. ADMIN. CODE Provider Responsibilities for Treatment Planning and Service Authorization and Documentation of Service Provision.* The Enrichment Center program is require to submit a POI focusing on Clinical Record Requirements. The Vice President (VP) of CPEP Division and the Program Manager/Director must sign and return the report with management response along with the POI to Compliance within seven business days.

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Forensic Specialty Comprehensive Review
Review Date: May 8, 2025, to May 12, 2025

I. Audit Type:
Comprehensive Review

II. Purpose:
This review was conducted to determine if the Forensic Specialty Program complies with the Texas Administrative Code (TEX. ADMIN. CODE), Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. CODE § 320.75(a)(1-3); Medication Services 26 TEX. ADMIN. CODE § 301.355(b)8)(A)(B)(C)(D)(E); General Principles 26 TEX. ADMIN. CODE § 320.207(i)(1-4); Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323(a)(4)(A-E); Community Centers: Actions Taken Upon the Death of an Individual Served 26 TEX. ADMIN. CODE § 301.407 (b)(c); Community Centers: Administrative Death Review Determination 26 TEX. ADMIN. CODE § 301.411(a)(1-4)(b)(c); Community Centers: Clinical Death Review Determination 26 TEX. ADMIN. CODE § 301.413(b)(1-3)(c(1-5); Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331(h)(1-4), § 301.331(a)(3(iv),§ 301.331(C)(viii); Staff Member Training 26 TEX. ADMIN. CODE § 320.113(c)(2); Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353; Documentation of Service Provision §301.361; Interlocal Agreement; Forensic Front Door Program Description; and Adult Forensic Operational Guidelines Manual.

III. Audit Method:
A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024- February 28, 2025) was obtained through the function of the Electronic Health Record database (i.e., Epic). Ten (10) clients from the Forensic Specialty and twelve (12) clinical staff were selected from the roster provided by the program leadership. The review used an audit tool developed by Compliance.

IV. Audit Findings and History:
The overall score is 99.51%. The program's strengths were 100% Medical requirements, 100% Clinical Records requirements, 100% Operations Requirements, and 100% Environment Requirements, and Handle with Care II (identifying the causes of aggressive or threatening behaviors of individuals who need mental health services, including behavior that may be related to an individual's non-psychiatric medical condition (100%). The area of improvement was Personnel Requirements 97.53%: Identifying, preventing, and reporting abuse, neglect, and exploitation (88.89%); Co-occurring psychiatric and substance use disorders (COPSD) (88.89%). The program description lacked clarity. According to the Program Director, this was intentional as the program's structure changes daily at the jail. To avoid constant updates, the description was written in a more general format. Compliance has not previously reviewed the Forensic Specialty Program.

V. Recommendations
The Forensic Specialty program should continue to review client documentation and staff records for compliance with regulatory standards, Interlocal Agreement, and the Adult Forensic Operational Guidelines Manual, and collaborate with Human Resources to ensure staff records are updated. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a follow up of the monitoring plan within 90 days. The Vice President of the Forensic Division and the Forensic Front Door Program Director must sign and return this report to Compliance within seven (7) business days.

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Forensic Peer Support and Re-Entry Services Focus Review
Review Date: July 17, 2025, to July 24, 2025

I. Audit Type:
Comprehensive Review

II. Purpose:
This review was conducted to determine if the Forensic Peer Support and Re-Entry Services Program complies with the Texas Administrative Code (TEX. ADMIN. CODE), Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331(h)(1-4), § 301.331(a)(3)(A)(iv),§ 301.331(C)(vii);General Principles 26 TEX. ADMIN. CODE § 320.207(c)(2); Supervision of Peer Specialist 1TEX. ADMIN. CODE § 354.3103(d)(b)(1-2); Peer Specialist Certification 1TEX. ADMIN. CODE § 354.3207(a); Minimum Qualifications 1TEX. ADMIN. CODE § 354.3051(a)(1-6); Peer Specialist Certification Renewal Training 1TEX. ADMIN. CODE § 354.3161(a)(b)(c) (d)(1-3)(e), § 354.3163(a),§ 354. 3211(a) FY24-25 PCN A.I.C.3.13; Eligibility to Receive Service 1TEX. ADMIN. CODE § 354.3011(1)(3); Services Provided 1TEX. ADMIN. CODE § 354.3013(a)(b)(1-3)(c)(d); Communication of Rights to Individuals Receiving Mental Health Service 26 TEX. ADMIN.CODE §320.25(a)(b); Documentation of Service Provision §301.361; Interlocal Agreement; Forensic Peer Support and Re-Entry Description; and Adult Forensic Operational Guidelines Manual.

III. Audit Method:
A client roster for persons served during the 3rd Qtr. FY 2025 (March 1, 2025- May 31, 2025) was obtained through the function of the Electronic Health Record database (i.e., Epic). Ten (10) clients from the Forensic Peer Support and Re-Entry Services Program and six (6) staff were selected from the roster provided by the program leadership. The review used an audit tool developed by Compliance

IV. Audit Findings and History:

The overall score is 97.65%. The program's strengths were 100%; A current, signed job description for each staff member; 100% • Criminal background checks; 100% The Harris Center informed its employees in writing, in the predominant language of the workforce; of employee whistleblower rights and protections; 100% Peer Specialist Minimum Qualifications; 100% Identifying, preventing, and reporting abuse, neglect, and exploitation Training; 100% Co-Occurring Psychiatric and Substance Use Disorder (COPSD) Training; 100% Drug Testing; 100% Health Insurance Portability and Accountability Act Training; 100% Identifying the causes of aggressive or threatening behaviors of individuals who need mental health services, including behavior that may be related to an individual's non-psychiatric medical condition; 100% Documented, periodic performance reviews; 100 % Core Training: a plan to provide training for at least one of the following: (A) peer specialists; 100% Copies of Current training (i.e., Agency-mandated training); 100% Peer specialist certification must be renewed every two years; : Clinical Records: 100% Eligibility to Receive Service : A recipient must be an adult and have a mental health condition or substance use disorder, or both; 100%; 100% Target Population: Patients are screened by Peer staff to determine criteria for the program to include motivation for participation, charges, and participation in other programs; 100% Documentation of Service provision; Area of Improvement: 20% Oral communication of rights shall be documented on a form bearing the date and signatures of the individual and/or the parent, conservator, or guardian, and the staff member who explained the rights. The form should be filed in the individual's Electronic Health Record. One staff member's drug testing result was not found; however, Human Resources (HR) provided a copy of a check indicating that drug testing was conducted. The checklist was signed by the staff but was missing the HR Generalist's signature. Compliance has not previously reviewed the Forensic Peer Support and Re-Entry Services program. One staff member was not assigned the agency-mandated Office Safety training in Absorb.

V. Recommendations
The Forensic Peer Support and Re-Entry Services program should continue to review client documentation and staff records for compliance with regulatory standards and the Interlocal Agreement, Adult Forensic Operational Guidelines Manual, and collaborate with Human Resources (HR) to ensure staff records are updated as required. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the Forensic Division, Senior Director of Adult and Juvenile Justice Services, and the Forensic Peer Support and Re-Entry Services Program Director must sign and return this report to Compliance within three (3) business days.

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Forensic Transition Services Focus Review
Review Date: August 13, 2025, to August 20, 2025

I. Audit Type:
Focus Review

II. Purpose:
This review was conducted to determine if the Forensic Transition Services Program complies with the Texas Administrative *Code (TEX. ADMIN. CODE), Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331(h)(1,2,4); Staff Training in Rights of Individual Receiving Mental Health Services 26 TEX. ADMIN. CODE § 320.29(1)(3); Access to Services for Co-Occurring Psychiatric and Substance Use Disorders 26 TEX. ADMIN. CODE § 564.906 (a)(1-4)(b)(c); Agency Policy and Procedures HR.B.35.5; Communication of Rights to Individuals Receiving Mental Health Service 26 TEX. ADMIN.CODE §320.25(a)(b); Interlocal Agreement Between Harris County Juvenile Board and The Harris Center for Mental Health and IDD; Transition Services Unit 2024 Program Descriptions; Agency Mandated training, and Transition Services Program Overview.*

III. Audit Method:
A client roster for persons served during the 3rd Qtr. FY 2025 (March 1, 2025- May 31, 2025) was retrieved from the Electronic Health Record (Epic). Ten (10) clients enrolled in the Transition Services Program were selected, along with the three (3) staff members identified by program leadership. Education and Development provided staff training records, and personnel data were obtained from Human Resources (HR). The review was conducted using an audit tool developed by Compliance, consisting of one component: Personnel requirements.

IV. Audit Findings and History:
The program achieved a compliance score of 90.91%, with full adherence in all core areas, including staff documentation and mandatory agency training.

Two key deficiencies were identified: missing DFPS abuse/neglect history checks and signed staff disclosures, both required under contract, and a lack of documented training in Co-Occurring Psychiatric and Substance Use Disorders (COPSD).

Performance data, provided by the contracted agency (Harris County Juvenile Probation Department), showed strong outcomes: 97.3% of youth were referred to services, 100% of screened youths received mental health support, 87% of referred families were provided follow-up services, and 80% will provide positive feedback on services received.

The program is operating under the prior year's contract, as the FY2025 agreement has not yet been issued. A staffing proposal is in place to reallocate roles to better meet service needs. Due to access restrictions from HCJPD, only personnel records were reviewed. This was the program's first compliance audit.

V. Recommendations

The Forensic Transition Services program should continue to review staff records for compliance with regulatory standards and the Interlocal Agreement, Adult Forensic Operational Guidelines Manual, and collaborate with Human Resources (HR) to ensure staff records are updated as required. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the Forensic Division, Senior Director of Adult and Juvenile Justice Services, and the Forensic Front Door Program Director must sign and return this report to Compliance within three (3) business days.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Intellectual and Developmental Disabilities (IDD) Division
Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IDD)
Review Dates: February 14, 2025- May 13, 2025

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if client records complied with the Texas Health and Human Services Commission's standard for ICF/IID facilities. Compliance conducted this review to assess ICF/IID for compliance with *Texas Administrative Code (TEX. ADMIN. CODE) Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IDD) Program 261 §419.239, §330.7, §261.236, §261.237, §261.238, §261.239, §261.240, §261.242, §261.243 §261.244*

III. Audit Method:
A client roster for people served during 2nd Qtr. FY 2025 (December 1, 2024 - February 28, 2025) was obtained from records onsite. A staff training transcript was provided by the Organizational Development Staff Training Roster Report. A sample size of fifteen (15) client records for ICF program. The review was conducted using a state audit tool modified by Compliance. Detailed data for this review is presented below.

IV. Audit Findings/History:
The Overall score for this comprehensive audit was 62.45%. This review of the ICF/IID program revealed adherence to some regulatory requirements, particularly in areas related to Level of Care (LOC) and Level of Need (LON) assessments. The program demonstrated 100% compliance across multiple areas, including proper completion of ID/RC Assessments, active treatment documentation, and team-based evaluations. These strengths affirm the program's commitment to delivering structured, supervised residential care aligned with state and federal standards. However, several areas of improvement were identified that require immediate attention to ensure full regulatory compliance and optimal service delivery. Key deficiencies include Missing or outdated records such as unsigned ID/RC forms, Plans of Care (POC), HIPAA forms, Social Security cards, immunization records, and medical histories. Plans lacked measurable goals, outcomes, timeframes, and participant signatures. No documented consumer agreement or review history was found. ICAP assessments were expired, and procedures for renewing LOC/LON were not followed. Financial assessments and Medicaid eligibility documentation were incomplete. Progress notes did not reflect individual goals or outcomes and lacked time alignment with services billed. Several staff members did not complete the required annual training courses. Records were not integrated into the agency's electronic system. Service documentation failed to align with individual goals and lacked evidence of progress. Additionally, record storage practices hindered accessibility and compliance tracking. Compliance discovered that the service documentation did not address the individual's goals, objectives or outcomes as identified in the individual's Plan of Care. The length of the notes did not reflect the time as identified. The summarization of the individual's activities did not reference any of the goals, objectives or outcomes from the services provided. There was no mention of progress or lack of progress towards meeting goals, objectives or outcomes. Compliance also noted that records were being stored at one location and were not in the agency's electronic system. Compliance had not previously conducted a comprehensive review of the ICF.IID Program. The ICF/IID program, however, was audited on 2/27/2025 and 2/28/2025 and were cited for failure to ensure sanitary practices were promoted for 6 of 6 individuals. ICF/IID program submitted a Corrective Action Plan (CAP)TP Health and Human Service Commission (HHSC) which was accepted. Compliance followed up on the CAP and was able to observe that ICF/IID staff were utilizing sanitary practices by utilizing hand washing and there were notifications posted as reminders to wash hands to ensure sanitary practices are being used.

V. Recommendations:
The Program should continue to assess its processes and review documentation ensuring all required standards are completed in accordance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow up Review in 180 days. The Vice President (VP) of IDD Division and the Program Manager/Director must sign and return this report and the completed POI management response along with the POI to Compliance by the close of business.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Intellectual and Developmental Disabilities (IDD) Division
Texas Home Living (TxHmL) Focus Review
Review Dates: May 1, 2025-July 31, 2025

I. Audit Type:
Focus Review

II. Purpose:
Compliance conducted this review to follow up on the previous corrective action plan from the state, as well as included a coding/billing review compliance with Texas Administrative Code (TEX. ADMIN. CODE) for TXHML - Service Coordination (SC). A Local Intellectual Developmental Disabilities Authority LIDDA Role and Responsibilities 26 §330.7, TEX. ADMIN. The Texas Home Living (TxHmL) ELIGIBILITY, ENROLLMENT, AND REVIEW §262.103(t) §262.701 (f) §331.11(a) §331.5 (33)(B)&(C) §331.7(a)(1) HB 4000 LIDDA's Responsibilities §331.11(c)(1)&(2) LIDDA Requirements for Providing Service Coordination in the TxHmL Program §262.701(k) and (l) §262.701(h)(3) §331.11(b)(1)(A), §331.11(d)(1-2), §262.701 (h)(4) §331.21 (a)(3) §262.701(j)(8) §262.501(a) §262.701(m).

III. Audit Method:
A client roster for persons served during the fourth quarter of FY 2025 (May 1, 2025, to July 31, 2025) was obtained from the IDD SC programs Texas Home Living. A sample size of twenty (20) client records each for TxHmL. The review was conducted using a state audit tool modified by Compliance. Detailed data for this review are presented below.

IV. Audit Findings/History:
Compliance had not previously conducted a Focus review of the TxHmL - Service Coordination Program. TxHmL Service Coordination program was audited by Health and Human Services Commission (HHSC) previously and submitted a Corrective Action Plan (CAP) in response to the findings. Compliance followed up on the CAP and was able to observe that Enrollment packets are not being consistently sent to the Program Provider and the Financial Management Services Agency (FMSA), before the Individual Plan of Care (IPC) begin date. Enrollment packets are not being consistently sent to the Program Provider and the Financial Management Services Agency (FMSA), as required by policy. Staff facilitating the Person-Directed Plan (PDP) are not consistently asking consumers if they desire to work, which is a key component of person-centered planning. The Service Coordination Form is not being completed, which may impact on the coordination and quality of services provided. Updates to the PDP are not being documented when changes occur, resulting in discrepancies between actual services and recorded plans. Enrollment packets are not being uploaded to the agency's electronic system, leading to incomplete digital records and potential audit risks. The overall score for this audit is 74.69%.

V. Recommendations:
The Program should continue to assess its processes and review documentation ensuring all required standards are completed in accordance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow up Review in 180 days. The Vice President (VP) of IDD Division and the Program Manager/Director must sign and return this report and the completed POI management response along with the POI to Compliance by the close of business.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division Northwest Adult Mental Health (NWAMH) Comprehensive Review
Review Dates: May 8, 2025-June 18, 2025

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if the NWAMH program was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Responsibilities of Local Authorities, Community Centers, and Contractors 25 TEX. ADMIN CODE § 414.554*; *Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323*; *Medical Records System 26 TEX. ADMIN. CODE § 301.329*; *Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331*; *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353*; *Medication Services § 301.355*; *Telemedicine 26 TEX. ADMIN. CODE § 301.359*; *Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361*; *Supervision 26 TEX. ADMIN. CODE §301.363; Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275*; *Medication Training and Support Services § 306.315*; *Rights Handbooks for Individuals Receiving Mental Health Services at Health and Human Services Commission Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 26 TEX. ADMIN. CODE § 320.21*; *Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals Not Operated by a Community Center 26 TEX. ADMIN. CODE § 320.23*; *Communication of Rights to Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25*; *Rights Protection Officer at Health and Human Services Commission Facilities and Community Centers 26 TEX. ADMIN. CODE § 320.27*; *Staff Training in Rights of Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE § 320.29*; *Documentation of Informed Consent 26 TEX. ADMIN. CODE § 320.59*; *Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. Code § 320.75*; *General Principles 26 TEX. ADMIN. CODE § 320.207*; *Medication Monitoring 26 TEX. ADMIN. CODE § 320.217*; the Texas Health and Human Services Commission's (HHSC) *Performance Contract Notebook (PCN) FY 24-25*; the Harris Center's MH Division's *AMH Procedures Manual*; and Harris Center policies and procedures *ACC.B.8 Referral, Transfer, and Discharge*; *ACC.B.14 Declaration for Mental Health Treatment; HIM.EHR.B.5 Content of Patient/Individual Records*; *HIM.EHR.B.9 Patient/Individual Records Administration*; *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure*; *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and *RR.B.2 Assurance of Individual Rights*.

III. Audit Method:
Client rosters for persons served during the 2nd and 3rd Qtrs. FY 2025 (December 1, 2024-May 31, 2025) were obtained through the Find Episodes report (to obtain a sample of admissions and discharges) of the Electronic Health Record database (i.e., Epic), and an employee roster was provided by program leadership. The review period was expanded to ensure a robust sample of recently enrolled or discharged clients. Twenty (20) clients and eight (8) employees from the NWAMH Program were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance. random number list. The review used an audit tool developed by Compliance.

IV. Audit Findings/History:
The overall score for this audit was 97.09%. Compliance noted that agency staff are not fulfilling annual training requirements; are not receiving monthly supervision meetings; are not accurately completing consent and client rights documentation; are not completing quarterly Abnormal Involuntary Movement Scales (AIMS); are not including all required elements of plans of care; not including all required elements of case management note and progress note documentation; and are not providing services listed within the plan of care (e.g., medication training and support services). Compliance has not previously conducted a comprehensive review of the NWAMH Program.

V. Recommendations:
The NWAMH program should continue to review client documentation and employee training requirements for compliance with regulatory standards. A Plan of Improvement (POI) is required to address deficiencies noted in this review.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division Continuity of Care (COC) Comprehensive Review
Review Dates: July 9, 2025-July 30, 2025

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if the COC program was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Competency and Credentialing 26 TEX. ADMIN. CODE §§ 301.331 (a)(3)(A)(iii), (a)(3)(A)(v), (a)(3)(A)(viii), (a)(3)(A)(x), (a)(3)(B)(i)-(iii), (a)(3)(B)(v), and (h)(1)-(2) and (4)*; *Supervision 26 TEX. ADMIN. CODE §301.363 (a)(2)*; *Local Mental Health Authority, Local Behavioral Health Authority, and Continuity of Care Liaison Responsibilities 26 TEX. ADMIN. CODE §306.155*; *Most Appropriate and Available Treatment Options TEX. ADMIN. CODE § 306.163 (b)(6)*; *Discharge Planning 26 TEX. ADMIN. CODE § 306.201 (c)(3)*; *Staff Training in Rights of Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE § 320.29 (1) and (3)*; *the Texas Health and Human Services Commission's (HHSC) Performance Contract Notebook (PCN) FY 2024-2025 and Information Item J*; *and the Harris Center's policies and procedures HIM.EHR.B.5 Content of Patient/Individual Records*; *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure*; *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and the *Private Beds (HCPC) COC Process Operational Guidelines.*

III. Audit Method:
A client roster for persons served during the 3rd Qtr. FY 2025 and an employee roster were provided by COC program leadership. Twenty (20) clients and five (5) employees were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

IV. Audit Findings/History:
The overall score for this audit was 67.81%. Compliance noted that agency staff did not complete all required online training courses, did not participate in discharge planning, and did not obtain or complete documents as stipulated in the program's Operational Guidelines. Additionally, the program had not developed policies and procedures in accordance with the Texas Administrative Code. Compliance has not previously audited the COC program.

V. Recommendations:
The program should continue to review employee training records for compliance with regulatory standards and Harris Center policies, employee documentation for adherence to regulatory standards and internal policy, develop policies and procedures as outlined in the Texas Administrative Code, and develop a contingency plan for the integration of Information Item J when it is incorporated into the FY 2025-2026 PCN. A Plan of Improvement (POI) is required to address the deficiencies noted in this report.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Agency Wide Policy Acknowledgement Audit
Review Dates: August 18, 2025 – September 26, 2025

I. Audit Type:
Focus

II. Purpose:
The purpose of this focused audit was to evaluate the effectiveness of the organization's policy management system as it relates to employee acknowledgement of the Code of Ethics. Specifically, this audit sought to determine the following:

- Whether the Code of Ethics is consistently assigned to all applicable employees within our policy platform.
- The extent to which employees are completing acknowledgements on an annual basis.
- To identify any gaps in our process or system configuration.

By assessing these areas, the audit aims to provide leadership with assurance on the adequacy of current workflows and highlight risks where acknowledgements are incomplete or inconsistent. CARF standards reference the need for written documentation when policies, procedures, and staff accountability are involved. Formalizing acknowledgement procedures provides the organization with evidence of compliance during survey review.

III. Audit Method:

A random sample size of 10% of all active employees was selected for review. All divisions were represented including relief staff.

IV. Audit Findings/History:
The audit identified several areas where the current process for policy assignment and acknowledgement can be strengthened. Approximately 16.08% of employees in the sample had not claimed their policy management system account, which is required to begin receiving assigned policies. Access is provided via email at time of hire, but without activation, employees do not appear in the system and cannot be assigned policies such as the Code of Ethics.

Among all employees sampled, 52.16% had acknowledged the Code of Ethics policy within the past 12 months which indicates that an annual review is not consistently monitored or enforced. While 64.71% of employees have acknowledged the policy at once since hire, this still leaves a portion of staff without any documented acknowledgement. Additionally, no formal procedure currently exists requiring acknowledgement of the Code of Ethics or other critical policies, which contributes to a gap in our policy acknowledgement process.

V. Recommendations:

To strengthen the agency's approach to policy acknowledgements, the Compliance Department will take ownership of implementing the following improvements.

Compliance will work with Human Resources and leadership to develop a formal Policy Acknowledgement Policy or Procedure. It will outline the requirements for employees to acknowledge key policies, including the Code of Ethics, at the time of hire and on an annual basis.

Compliance will develop an internal process to verify all employees are enrolled in the policy management system during onboarding. In addition, compliance will provide education to new and existing staff on how to access and use our Policy Management System, ensuring employees can complete acknowledgements in a timely manner.

The Harris Center for Mental Health and IDD:
The Compliance Department
4th Quarter (Qtr.) of Fiscal Year (FY) 2025
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Psychiatric Emergency Services (PES)
Plan of Improvement (POI) Follow-Up
Review Date: August 20, 2025, to August 25, 2025

I. Audit Type:
POI Follow-up Review.

II. Purpose:
The purpose of this review was to assess the PES program for implementation of its POI to ensure compliance with the Texas Administrative Code (TEX. ADMIN. CODE) *26 §301.353 Provider Responsibilities for Treatment Planning and Service Authorization and Agency Policy and Procedure ACC.B.8 Referral, Transfer and Discharge.*

III. Audit Method:
Active records were randomly selected from *the Affiliated Harris Center Encounter Data IP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 3rd Qtr. of FY 2025 (May 1, 2025, to May 31, 2025), Compliance conducted a desk review, sampling twenty (20) consumer records using a modified version of the Compliance Service Encounter Review Tool. Detailed data for this review is presented below.

IV. Audit Findings and History:
Overall Program Score: 65%
Detailed finding(s) is presented below.
The program's Clinical Record Requirement that fell below the threshold score of 95%: Whether planned or unplanned, the provider must document in the person's served record a summary of all the services provided and their response to treatment and any relevant treatment information (65%).

History

A previous review was conducted 2nd Qtr. FY 2024.

V. Recommendations:
The Program should continue to monitor its processes to ensure all required standards are completed in accordance with *TEX. ADMIN. CODE Provider Responsibilities for Treatment Planning and Service Authorization and Agency P&P for Referral, Transfer and Discharge.* The PES program will continue to follow the current POI and is required to collaborate with Performance Improvement (PI) for essential support. The Vice President (VP) of CPEP Division and the Program Manager/Director must sign and return this report with management response to Compliance within seven business days.

The Harris Center for Mental Health and IDD:
The Compliance Department
4th Quarter (Qtr.) of Fiscal Year (FY) 2025
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Homeless Outreach Team (HOT)
Plan of Improvement (POI) Follow-Up
Review Date: August 20, 2025, to August 25, 2025

I. Audit Type:
POI Follow-up Review.

II. Purpose:
The purpose of this review was to assess the HOT program for implementation of its POI to ensure compliance with the Texas Administrative Code (TEX. ADMIN. CODE) *26 §301.361 Documentation of Service Provision, HOT Initiative Memorandum of Unentertaining, HOT Operational Guidelines, and Agency Policy and Procedure HR.A.16 Organizational Development.*

III. Audit Method:
Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for person's served during the 3rd Qtr. of FY 2025 (March 1, 2025, to May 31, 2025), Compliance conducted a desk review, sampling twenty (20) consumer records using a modified version of the Compliance Service Encounter Review Tool. Detailed data for this review is presented below.

IV. Audit Findings and History:
Overall Program Score: 75%
Detailed finding(s) is presented below.
The program's strength in the Clinical Record Requirements was service encounter documentation included the type of service provided, service encounter documentation documented the location where the service was provided, and each person served was linked to services, resulting in all elements scoring 100%.

The program had Personnel Requirement and Clinical Record Requirements that fell below the recommended threshold score of 95%: staff job duties that involve direct care responsibilities must be current with required trainings (66.66%) and service encounter documentation must include a subjective assessment of each person's served (33.33%).

History

A previous review was conducted 2nd Qtr. FY 2024.

V. Recommendations:
The Program should continue to monitor its processes to ensure all required standards are completed in accordance with *TEX. ADMIN. CODE Documentation of Service Provision, HOT MOU: Linking the Individual to Social Services, HOT Operational Guidelines: Documenting Subjective Assessment in the Service Encounter Note, and Agency P&P Organizational Development.* The HOT program will continue to follow the current POI and is required to collaborate with Performance Improvement (PI) for essential support. The Vice President (VP) of CPEP Division and the Program Manager/Director must sign and return this report with management response to Compliance within seven business days.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division Northwest/Southeast Assertive Community Treatment/Forensic Assertive Community Treatment (NW/SE ACT/FACT) Plan of Improvement (POI) Follow-up Review
Review Dates: May 8, 2025-June 6, 2025

I. Audit Type:
POI Follow-up

II. Purpose:
This review was conducted to determine if the NW/SE ACT/FACT programs were compliant with the Texas Administrative Code (TEX. ADMIN. CODE) D*ocumentation of Informed Consent 26 TEX. ADMIN. CODE § 320.59*; the Harris Center's procedures *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure* and *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and the *ACT Operational Guidelines (2022)*.

III. Audit Method:
Client rosters for persons served during the 2nd and 3rd Qtrs. FY 2025 (December 1, 2024-May 30, 2025) were obtained through the Encounter Data Service Details report (to review Consent to Treatment with Medication documents) and the Find Episodes report (to review the completion of Safety Plans) of the Electronic Health Record database (i.e., Epic), and an employee roster was provided by program leadership. The review period was expanded due to recent training (i.e., within the 3rd Qtr.) in the medical department on completing Consents to Treatment with Medication documents and to ensure a robust sample of recently enrolled clients. Sixty (60) clients (30 from the Encounter Data Service Details report and 30 from the Find Episodes report) and ten (10) employees (five from NWACT and five from SEACT) from the NW/SE ACT/FACT Programs were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

IV. Audit Findings/History:
The overall score for this audit is 88.60%. Compliance noted that agency staff are not fulfilling annual training requirements; are not consistently signing Consent to Treatment with Medication documents or having the client sign the document; are not completing new Consent to Treatment with Medication documents when a different medication is prescribed; and are not completing safety plans upon initial contact with the client. Compliance has not previously conducted a comprehensive review of the Co-locations Program.

V. Recommendations:
The NW/SE ACT/FACT programs should continue to review client documentation and employee training requirements for compliance with regulatory standards. A POI is not required to address the deficiencies noted in this review; however, the program was referred to Performance Improvement to resolve these ongoing deficiencies.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division Assisted Outpatient Treatment (AOT) Plan of Improvement (POI) Follow-up Review
Review Dates: May 21, 2025-June 12, 2025

I. Audit Type:
POI Follow-up

II. Purpose:
This review was conducted to determine if the AOT program were compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Competency and Credentialing 26 TEX. ADMIN. CODE 301.331*; *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353*; *Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361*; *Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275*; *Medication Training and Support Services § 306.315*; *Services to Individuals with COPSD 26 TEX. ADMIN. CODE § 306.7*; *Rights Handbooks for Individuals Receiving Mental Health Services at Health and Human Services Commission Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 26 TEX. ADMIN. CODE § 320.21*; *Communication of Rights to Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25*; *Documentation of Informed Consent 26 TEX. ADMIN. CODE § 320.59*; *General Principles 26 TEX. ADMIN. CODE § 320.207*; *Medication Monitoring 26 TEX. ADMIN. CODE § 320.217*; the Texas Health and Human Services Commission's (HHSC) *Performance Contract Notebook (PCN) FY 24-25*; the Harris Center's *Assisted Outpatient Treatment Project Narrative Submission;* and the Harris Center's procedures *ACC.B.8 Referral, Transfer, and Discharge*; *ACC.B.14 Declaration of Mental Health Treatment*; *HIM.EHR.B.9 Patient/Individual Records Administration*; *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure*; *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and *RR.B.2 Assurance of Individual Rights;* and if the POI implemented by the program had resolved deficiencies identified during the comprehensive review conducted during the 1st Qtr. FY 2025.

III. Audit Method:
Client rosters for persons served during the 2nd and 3rd Qtrs. FY 2025 (December 1, 2024-May 31, 2025) were obtained through the Find Episodes report (to obtain a sample of admissions and discharges) of the Electronic Health Record database (i.e., Epic), and an employee roster was provided by program leadership. The review period was expanded to ensure a robust sample of recently enrolled or discharged clients. 20 persons served and five (5) employees were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

IV. Audit Findings/History:
The overall audit score for this follow-up was 86.47%. Compliance noted that agency staff are not offering persons served a Declaration for Mental Health Treatment document; are not providing medication training and support services in accordance with what is indicated on the plan of care; are not completing Abnormal Involuntary Movement Scales (AIMS) in accordance with regulatory standards; are not completing the Columbia-Suicide Severity Rating Scale (C-SSRS), the Adult Needs and Strengths Assessment (ANSA), the Fagerstrom Tobacco Use Assessment, the Brief Negative Symptom Assessment(BNSA)/Positive Symptom Rating Scale (PSRS), or the Brief Bipolar Symptom Scale (BDSS)/Quick Inventory of Depressive Symptomology-Clinician Rated (QIDS-C) in accordance with program guidelines; are not including all required elements when developing plans of care; and are not including all required elements when entering progress notes. Compliance conducted a comprehensive review of the AOT Program during the 1st Qtr. FY 2025.

IV. Recommendations:
The program should continue to review client documentation for compliance with regulatory standards and provide periodic targeted training based on self-monitoring results. A Plan of Improvement (POI) was not required to address the noted deficiencies; however, the program should continue with their current POI and consult with the Performance Improvement (PI) Department to identify additional opportunities to resolve these deficiencies.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division Integrated Care Plan of Improvement (POI) Follow-up Review
Review Dates: May 27, 2025-July 24, 2025

I. Audit Type:
POI Follow-up

II. Purpose:
This review was conducted to determine if the Integrated Care program had completed its Plan of Improvement and was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) Competency and Credentialing 26 TEX. ADMIN. CODE *§§ 301.331 (a)(3)(A)(iii)*, *(a)(3)(A)(v)*, *(a)(3)(A)(viii)*, *(a)(3)(A)(x)*, *(a)(3)(B)(i)-(iii)*, and *(a)(3)(B)(v)*; the *Certified Community Behavioral Health Clinic Improvement and Advancement Grant Criteria Checklist (CCBHC)*; and the Harris Center's procedures *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure* and *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*.

III. Audit Method:
An employee roster was obtained through a request made to program leadership. Eight (8) employees were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

IV. Audit Findings/History:
The overall score for this audit is 97.66% and it is based on the personnel domain. Compliance noted that agency staff completed all required online training courses and did not complete two in-person training courses; however, the two employees who did not complete these courses have scheduled them for August 2025. Compliance previously audited the program during the second quarter FY 2024.

V. Recommendations:
The program should continue to review employee training records for compliance with regulatory standards and Harris Center policies. A Plan of Improvement (POI) is not required to address the deficiencies noted in this report due to the employees having scheduled the missing in-person training courses.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division Optum Integrated Behavioral Health Home Care (Optum) Plan of Improvement (POI)
Follow-up Review
Review Dates: July 18, 2025-September 3, 2025

I. Audit Type:
POI Follow-up

II. Purpose:
This review was conducted to determine if the Optum program had completed its Plan of Improvement and was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Competency and Credentialing 26 TEX. ADMIN. CODE §§ 301.331 (a)(3)(A)(iii)*, *(a)(3)(A)(v)*, *(a)(3)(A)(viii)*, *(a)(3)(A)(x)*, *(a)(3)(B)(i)-(iii)*, and *(a)(3)(B)(v)*; the *Integrated Behavioral Health Home (IBHH) Incentive Program Contract* and *Addendum;* and the Harris Center's procedures *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure* and *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*.

III. Audit Method:
A client and employee roster were obtained through a request made to program leadership. Twenty (20) clients were randomly selected using an Excel formula to generate a random number list. The ten (10) employee records of the program were also reviewed. The review used an audit tool developed by Compliance.

IV. Audit Findings/History:
The overall score for this audit is 57.04%. Compliance noted that agency staff did not complete all required online or in-person training courses and did not complete two in-person training courses. Compliance also noted the program was not meeting deadlines stipulated in their contract; was not completing comprehensive assessments, health action plans (HAP), or supporting health promotion through education and referrals; was not including measurable short- and long-term goals on the HAP; was not completing crisis plans within 30 days of enrollment; and an LPHA was not signing the HAP. Compliance previously audited the program during the third quarter FY 2024.

V. Recommendations:
The program should continue to review employee training records for compliance with regulatory standards and Harris Center policies. A Plan of Improvement (POI) is not required to address the deficiencies noted in this report; however, the program should continue with the previous POI and consult with Performance Improvement (PI) to identify processes to resolve these deficiencies.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division Southeast Community Service Center (SECSC)Adult Mental Health Plan of Improvement (POI) Follow-up Review
Review Dates: July 1, 2025-July 10, 2025

I. Audit Type:
POI Follow-up

II. Purpose:
This review was conducted to determine if the SECSC program was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE §§ 301.353 (e)(1)(A)*, *(e)(1)(F)*, *(e)(2)(B)*, and *(e)(2)(D)*; *Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361 (a)(11)*; *MH Case Management Services Standards 26 TEX. ADMIN. CODE § 306.263 (b)(3)*; and the Harris Center's procedures *HIM.EHR.B.5 Content of Patient/Individual Records* and *HIM.EHR.B.9 Patient/Individual Records Administration*.

III. Audit Method:
A client roster for persons served during the 3rd Qtr. FY 2025 (March 1, 2025-May 31, 2025) was obtained through the Encounter Data Service Details of the Electronic Health Record (EHR) database (i.e., Epic). Forty (40) clients were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

IV. Audit Findings/History:
The overall audit score is 55.43% and is based on the client record domain. Compliance noted that agency staff are including the expected date by which treatment plan goals will be achieved; but are consistently including the treatment plan goal that was the objective of the service when entering progress; are not consistently identifying the strengths, service needs, and assistance required to address identified needs when entering case management notes; are not consistently including a description of the presenting problem, specifically addressing the individual's co-occurring substance use or physical health disorder, or creating treatment plan goals and objectives that are objective and measurable using quantifiable criteria when developing treatment plans; and are not entering unique documentation into the EHR. Compliance previously audited the program during the fourth quarter FY 2023.

V. Recommendations:
The program should continue to review client documentation for compliance with regulatory standards and Harris Center policies, and provide periodic targeted training based on self-monitoring results. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days.

EXTERNAL AUDITS

DATAVANT MEDICAL RECORD REQUESTS

[redacted] 17

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical records	Date:	5/30/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here: https://datavant.com/provider/setup or use the following for a one-time response: https://datavant.com/provider/upload with credentials

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	6/2/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please cal[redacted] with any questions.

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Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here: https://datavant.com/provider/setup or use the following for a one-time response: https://datavant.com/provider/upload with credentials

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
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Send secure faxes t[redacted]

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JUN 09 2025

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	6/2/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

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- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

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> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

JUN 0 2 2025

RECEIVED

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	6/2/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here: https://datavant.com/provider/setup or use the following for a one-time response: https://datavant.com/provider/upload with credentials

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

JUN 03 2025

VERIFICATION OF RECEIPT OF FAX:
RECEIVED

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Unknown	Date:	6/4/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

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- Username: [redacted]
- Password: [redacted]

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Send secure faxes to [redacted]

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JUN 05 2025

RECEIVED

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Unknown	Date:	6/4/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

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- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
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datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Unknown	Date:	7/1/2025
Fax Number:		Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
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- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
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datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Unknown	Date:	7/1/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

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- Username: [redacted]
- Password: [redacted]

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datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Unknown	Date:	7/11/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

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- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
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To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

JUL 14 2025

RECEIVED

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Unknown	Date:	7/17/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

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- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
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> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

JUL 18 2025
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To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	7/22/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
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- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
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3. Onsite Chart Retrieval:
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4.Fax:
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5. Mail:
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> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

JUL 28 2025

RECEIVED

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	MEDICAL RECORDS	Date:	8/6/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here: https://datavant.com/provider/setup or use the following for a one-time response: https://datavant.com/provider/upload with credentials

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
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3. Onsite Chart Retrieval:
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Send secure faxes to [redacted]

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> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

AUG 07 2025
RECEIVED

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	8/12/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

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1. Provider Portal:
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- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
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AUG 13 2025

RECEIVED

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	medical records	Date:	8/12/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

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- Username: [redacted]
- Password: [redacted]

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AUG 13 2025

RECEIVED

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Unknown	Date:	8/12/2025
Fax Number:		Phone Number:	([redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

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- [redacted]
- [redacted]

2. Remote EMR Retrieval:
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datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	medical records	Date:	8/12/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please cal[redacted] with any questions.

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[redacted]

2. Remote EMR Retrieval:
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4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:

[redacted]

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[illegible] 13 2025

RECEIVED

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	UNK	Date:	8/12/2025
Fax Number:		Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

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- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
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[illegible]

RECEIVED

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	8/12/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 15 days of receipt of this request.

Datavant has been contracted to obtain the medical record information for a select list of members included in the attached pull list. Please review the attached request letter for more information and a list of components required for these records.

Medical records can be submitted through the following options:

1. PROVIDER PORTAL:

Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here: https://datavant.com/provider/setup or use the following for a one-time response: https://datavant.com/provider/upload with [redacted]

- Password: [redacted]

2. REMOTE EMR Retrieval:

Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates. contacting

3. ONSITE Chart Retrieval:

Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant Contact

4.FAX:

Send secure faxes to [redacted]

5. MAIL:

Mark "Confidential" on the envelope and mail the medical records to:

[redacted]

When submitting via Fax or Mail, please notate on the pull list for each record as Pull or CNA (chart not available) by marking the associated circle. If CNA, please provide a reason in the notes section. Please place the pull list with the markings first or on top when sending.

If you want to set up Remote EMR or Onsite Retrieval or have any issues with the Provider Portal, contact Datavant at and please reference your Outreach ID at the top of the page.

We appreciate your efforts to complete this chart review for the requester. Our goal is to make the retrieval process as easy as possible for you. Thank you in advance for your assistance with this important endeavor.

Datavant

[redacted]

RECEIVED

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	unk	Date:	8/12/2025
Fax Number:		Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

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- Username: [redacted]
- Password: [redacted]

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4.Fax:
Send secure faxes to [redacted]

5. Mail:
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datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	8/21/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call [redacted] with any questions.

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- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
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Contact

4.Fax:
Send secure faxes to [redacted]

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Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

AUG 22 2025

RECEIVED

EXTERNAL AUDITS

OTHER MEDICAL RECORD REQUESTS

BlueCross BlueShield of Texas

Advantmed

MEDICAL RECORD REQUEST

1st MR Request Sent Date: June 11, 2025

Provider ID: [redacted]

TO: THE HARRIS CENTER FOR MENTAL HEALTH AND IDD

Attention To: Medical Records
Address: [redacted]
City, State Zip: Houston, TX 77074
Phone: [redacted]
Fax: [redacted]

FROM: ADVANTMED

Address: [redacted]
City, State Zip: Irvine, CA 92614
Phone: [redacted]
Fax: [redacted]
Email: [redacted]
Website: https://www.advantmed.com

DUE DATE: June 18, 2025

Dear Physician Or Office Administrator

Blue Cross and Blue Shield of Texas has partnered with Advantmed to collect and review medical records Risk Adjustment Data Collection & Reporting.

Advantmed offers multiple methods to submit records in response to this request. Please consider uploading records through our "SECURE UPLOAD PORTAL" to expedite the process.

Upload
Most Convenient and Secure Method:
To upload records securely visit
https://www.advantmed.com/uploadrecords

Fax
To fax records toll free, use our secure fax lines:
[redacted]

Email
To email records to our secure server:
[redacted]

Mail
To mail records, please send to:
[redacted]
Irvine, CA 92614

Please use link for sharing your feedback: 'https://secure1.advantmed.com/ClientPortals/SurveyForm'

JUN 18 2025

RECEIVED

[redacted] [redacted]

BlueCross BlueShield of Texas

Advantmed

MEDICAL RECORD REQUEST

1st MR Request Sent Date: June 11, 2025

Provider ID: [redacted]

TO: [redacted]	FROM: ADVANTMED
Attention To: Medical Records	Address: [redacted]
Address: [redacted]	City, State Zip: Irvine, CA 92614
City, State Zip: [redacted] 7074	Phone: [redacted]
Phone: [redacted]	Fax: [redacted]
Fax: [redacted]	Email: [redacted]
	Website: https://www.advantmed.com

DUE DATE: June 18, 2025

Dear Physician Or Office Administrator

Blue Cross and Blue Shield of Texas has partnered with Advantmed to collect and review medical records Risk Adjustment Data Collection & Reporting.

Advantmed offers multiple methods to submit records in response to this request. Please consider uploading records through our "SECURE UPLOAD PORTAL" to expedite the process.

Upload
Most Convenient and Secure Method:
To upload records securely visit
https://www.advantmed.com/uploadrecords

Fax
To fax records toll free, use our secure fax lines:
[redacted]

Email
To email records to our secure server:
[redacted]

Mail
To mail records, please send to:
[redacted]

Please use link for sharing your feedback: 'https://secure1.advantmed.com/ClientPortals/SurveyForm'

JUL 12 2025

RECEIVED

[redacted] Advantmed

REQUEST FOR MEDICAL RECORDS

Request Send Date: July 21, 2025

Provider ID: [redacted]

ATTENTION TO: Medical Records

TO:	FROM: ADVANTMED
THE HARRIS CENTER FOR MENTAL HEALTH AND IDD	[redacted]
[redacted]	Irvine, CA 92614
[redacted]	[redacted]
[redacted]	[redacted]
	[redacted]
	https://www.advantmed.com/

Dear Physician or Office Administrator:

Wellcare has partnered with Advantmed to collect medical records for Risk Adjustment Data Collection & Reporting.

REQUESTOR: Wellcare

DUE DATE: August 04, 2025

Advantmed offers multiple methods to submit records in response to this request. Please consider uploading records through our "**SECURE UPLOAD PORTAL**" to expedite the process.

Please use link for sharing your feedback: 'https://secure1.advantmed.com/ClientPortals/SurveyForm'

Most Convenient and Secure Method:
To upload records securely visit https://www.advantmed.com/uploadrecords
OR email records to our secure server at [redacted]

To begin set up for remote EMR download by Advantmed's trained Medical Record Technicians, email necessary forms to [redacted] Please provide a point of contact and number for further communication.

To fax records toll free, use our secure fax lines:
[redacted]

To mail records, please send to:
[redacted]

To schedule an onsite appointment, please contact us at [redacted]

JUL 29 2025

RECEIVED

Advantmed

REQUEST FOR MEDICAL RECORDS

Request Send Date: July 21, 2025

Provider ID: [redacted]

TO:	FROM: ADVANTMED
THE HARRIS CENTER FOR MENTAL HEALTH AND IDD	[redacted] Irvine, CA 92614
[redacted]	[redacted]
[redacted]	[redacted]
	[redacted]
	https://www.advantmed.com/

Dear Physician or Office Administrator:

Wellcare By Allwell has partnered with Advantmed to collect medical records for Risk Adjustment Data Collection & Reporting.

REQUESTOR: Wellcare By Allwell

DUE DATE: August 04, 2025

Advantmed offers multiple methods to submit records in response to this request. Please consider uploading records through our **"SECURE UPLOAD PORTAL"** to expedite the process.

Please use link for sharing your feedback: 'https://secure1.advantmed.com/ClientPortals/SurveyForm'

Most Convenient and Secure Method:
To upload records securely visit https://www.advantmed.com/uploadrecords
OR email records to our secure server at [redacted]

To begin set up for remote EMR download by Advantmed's trained Medical Record Technicians, email necessary forms to [redacted]. Please provide a point of contact and number for further communication.

To fax records toll free, use our secure fax lines:
[redacted]

To mail records, please send to:
[redacted] Irvine, CA 92614

To schedule an onsite appointment, please contact us at [redacted]

Medical Records Request

Purpose: 2025 MRA

On Behalf of: BCBSA- BCBS of North Carolina

To: Medical records
Date: 7/22/2025

Fax Number: [redacted]
Provider Group: The Harris Center For Ment

Due Date: 08/04/2025
Work Group ID: [redacted]
Location ID:

Delivery Options

Provider Portal [redacted]

- Username:
- Password:

Secure Fax [redacted]

Mail

Plano, TX 75024

Thank you for addressing this important request for medical records in a timely manner. Our goal at Virtix Health is to minimize any disruption to your practice and we are available to assist at any time.

- Please review all the contents in this packet, particularly:
  - The letter from BCBSA- BCBS of North Carolina explaining the purpose of this request as well as the desired medical record components and date range.
  - The Member List, which provides the patient name, date of birth (DOB), provider and date of service (DOS) information for each record being requested.
- Please return the records using one of the three Delivery Options provided above.
  - We recommend using our secure, easy to use Provider Portal at https://cclinxportal.virtixhealth.com. From the portal you can view an electronic version of the Record List, securely upload images and monitor real-time status at a record level.
  - When sending Records via secure fax or mail, please ensure that you include the Medical Records Request cover sheet with the Records.
- Should you have any questions or require assistance, please contact the Virtix Support line at [redacted] and reference your Work Group ID [redacted]

Sincerely,

[redacted]

JUL 23 2025

RECEIVED

Medical Records Request

Purpose: 2025 ACA
On Behalf of: Anthem

To: medical records
Date: 7/23/2025

Fax Number: [redacted]
Provider Group:

Due Date: 08/06/2025
Work Group ID: [redacted]
Location ID:

Delivery Options

Provider Portal [redacted]

- Username: [redacted]
- Password: [redacted]

Secure Fax [redacted]
Mail [redacted]

Thank you for addressing this important request for medical records in a timely manner. Our goal at Virtix Health is to minimize any disruption to your practice and we are available to assist at any time.

- Please review all the contents in this packet, particularly:
  - The letter from Anthem explaining the purpose of this request as well as the desired medical record components and date range.
  - The Member List, which provides the patient name, date of birth (DOB), provider and date of service (DOS) information for each record being requested.
- Please return the records using one of the three Delivery Options provided above.
  - We recommend using our secure, easy to use Provider Portal at https://cclinxportal.virtixhealth.com. From the portal you can view an electronic version of the Record List, securely upload images and monitor real-time status at a record level.
  - When sending Records via secure fax or mail, please ensure that you include the Medical Records Request cover sheet with the Records.
- Should you have any questions or require assistance, please contact the Virtix Support line at [redacted] and reference your Work Group ID [redacted].

Sincerely,

[redacted]

JUL 29 2025

RECEIVED

Medical Records Request

Purpose: 2025 MRA

On Behalf of: BCBSA- BCBS of North Carolina

To: Medical records
Date: 7/28/2025

Fax Number: [redacted]
Provider Group: The Harris Center For Ment

Due Date: 08/04/2025
Work Group ID: [redacted]
Location ID:

Delivery Options

[redacted]

Plano, TX 75024

Thank you for addressing this important request for medical records in a timely manner. Our goal at Virtix Health is to minimize any disruption to your practice and we are available to assist at any time.

- Please review all the contents in this packet, particularly:
  - The letter from BCBSA- BCBS of North Carolina explaining the purpose of this request as well as the desired medical record components and date range.
  - The Member List, which provides the patient name, date of birth (DOB), provider and date of service (DOS) information for each record being requested.
- Please return the records using one of the three Delivery Options provided above.
  - We recommend using our secure, easy to use Provider Portal at https://cclinxportal.virtixhealth.com. From the portal you can view an electronic version of the Record List, securely upload images and monitor real-time status at a record level.
  - When sending Records via secure fax or mail, please ensure that you include the Medical Records Request cover sheet with the Records.
- Should you have any questions or require assistance, please contact the Virtix Support line at [redacted] and reference your Work Group ID [redacted].

Sincerely,

[redacted]

[redacted]

Anthem.

MEDICAL RECORDS MEMBER LIST

8/5/2025

Site Information

Site ID:	[redacted]
Site Name:	Harris Center for Mental Health & IDD
Site Address:	[redacted]
Site Phone:	[redacted]

Time-sensitive request for medical records from 01/01/2025 – Present
Please send a copy of all requested records within 14 business days of receipt of this request

Action Required, please return a copy of the following:

- All documentation for face-to-face encounters between the patient and the provider
- All documentation for telehealth encounters between the patient and the provider
- History and Physical Notes
- Consultation Letters & Reports
- Physician Orders
- Emergency & Urgent care visit notes
- Diagnostic test reports
- Operative & Pathology Reports
- Medication lists
- Inpatient hospital notes, including the discharge summary

PLEASE DO NOT SEND THIS REQUEST TO ANY PRINTING/COPY SERVICES

Records can be sent by:

1. Uploading the record image to Cotiviti's secure portal at www.submitrecords.com, enter your Client identifier: [redacted]; Please name each medical record file with only the individual member's corresponding Request ID listed below, if possible.
2. Secure fax to [redacted] or
3. US Postal Service [redacted]

If you are unable to process in house, please utilize one of the following methods:

4. Remote EMR Downloading
   - Please call [redacted] for remote EMR set up or any questions regarding remote EMR retrieval services
5. Onsite Scanning Technician
   - Please call [redacted] to set up Onsite Scanning Services or for any questions regarding Onsite Scanning

If you have any questions regarding this medical record request please contact Cotiviti directly at [redacted].

Site ID: [redacted]

Member Name	Date of Birth	Effective Dates	Request ID	No Patient/ No Record
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Anthem.

MEDICAL RECORDS MEMBER LIST

8/18/2025

Site Information

Site ID:	[redacted]
Site Name:	Harris Center for Mental Health & IDD
Site Address:	[redacted]
Site Phone:	[redacted]

Time-sensitive request for medical records from 01/01/2025 – Present
Please send a copy of all requested records within 14 business days of receipt of this request

Action Required, please return a copy of the following:

- All documentation for face-to-face encounters between the patient and the provider
- All documentation for telehealth encounters between the patient and the provider
- History and Physical Notes
- Consultation Letters & Reports
- Physician Orders
- Emergency & Urgent care visit notes
- Diagnostic test reports
- Operative & Pathology Reports
- Medication lists
- Inpatient hospital notes, including the discharge summary

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2. Secure fax to [redacted]; or
3. US Postal Service [redacted]

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5. Onsite Scanning Technician
   - Please call [redacted] to set up Onsite Scanning Services or for any questions regarding Onsite Scanning

If you have any questions regarding this medical record request please contact Cotiviti directly at [redacted].

Site ID: [redacted]

Member Name	Date of Birth	Effective Dates	Request ID	No Patient/ No Record
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Anthem.

MEDICAL RECORDS MEMBER LIST

8/19/2025

Site Information

Site ID:	[redacted]
Site Name:	Harris Center for Mental Health & IDD
Site Address:	[redacted]
Site Phone:	[redacted]

Time-sensitive request for medical records from 01/01/2025 – Present
Please send a copy of all requested records within 14 business days of receipt of this request

Action Required, please return a copy of the following:

- All documentation for face-to-face encounters between the patient and the provider
- All documentation for telehealth encounters between the patient and the provider
- History and Physical Notes
- Consultation Letters & Reports
- Physician Orders
- Emergency & Urgent care visit notes
- Diagnostic test reports
- Operative & Pathology Reports
- Medication lists
- Inpatient hospital notes, including the discharge summary

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2. Secure fax to [redacted] or
3. US Postal Service [redacted]

If you are unable to process in house, please utilize one of the following methods:

4. Remote EMR Downloading
   - Please call [redacted] for remote EMR set up or any questions regarding remote EMR retrieval services
5. Onsite Scanning Technician
   - Please call [redacted] to set up Onsite Scanning Services or for any questions regarding Onsite Scanning

If you have any questions regarding this medical record request please contact Cotiviti directly at [redacted]

Member Name	Date of Birth	Effective Dates	Request ID	Site ID: No Patient/ No Record
[redacted]	[redacted]	[redacted]	[redacted]	☑

Humana.

6/24/2025

THE HARRIS CENTER FOR MENTAL HEALTH AND IDD

[redacted]

RE: Please submit requested medical record(s) for your Humana-covered patient(s)

Dear physician or office administrator:

Humana reviews medical records for our members in an effort to report complete and accurate diagnosis coding to the Centers for Medicare & Medicaid Services (CMS) for our Medicare Advantage members and to the U.S. Department of Health and Human Services for our commercial members.

Please return the medical record(s) for the time period(s) requested, with the enclosed patient information form, for the patient(s) listed. Return in one of the following ways:

- Upload records to the secure provider upload portal at www.submitrecords.com/humana (instructions enclosed).
- Send via secure fax to [redacted]
- Send via mail using the enclosed self-addressed, prepaid trackable postage label(s). A new prepaid label is being used. Please discard old labels.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule states in the Safeguards Principle that individually identifiable health information should be protected with reasonable administrative, technical and physical safeguards to ensure its confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure. **Please submit all electronic and hard-copy medical records via a HIPAA-compliant method.**

Please ensure each record includes the section with the physician's or healthcare provider's signature. Do not submit original medical records. Please include the following:

If a physician record (including telehealth visits):		
Discharge summary	Consult notes	Demographics sheet
	Diagnostic testing reporting (commercial patients only)	Dialysis (commercial patients only)
History and physical	Infusion testing and reporting (commercial patients only)	Operative reports
Physician or healthcare provider signature and credentials (electronic or handwritten)	Problem list	Progress notes
Signature log*	SOAP notes (subjective, objective, assessment, plan)	Telehealth visits progress notes

If a hospital record (including telehealth visits):		
Admit notes (commercial patients only)	Demographics sheet	Coding summary (if not on face sheet)
Consult notes		Diagnostic testing reports
Discharge summary	Emergency department records	Face sheet
History and physical	Infusion testing and reporting (commercial patients only)	Lab results/pathology reports
Operative reports	Physician orders	Physician or healthcare provider signature and credentials (electronic or handwritten)
Problem list	Progress notes	Signature log*
SOAP notes (subjective, objective, assessment, plan)	Telehealth visits progress notes	

***Note:** Signature logs are not accepted in place of the physician's or healthcare provider's electronic or handwritten signature. Signature logs are used to identify a provider's name if the signature is illegible.

JUN 25 2025

[redacted]

RECEIVED

Humana®

8/18/2025

THE HARRIS CENTER FOR MENTAL HEALTH AND IDD

[redacted]

[redacted]

RE: Please submit requested medical record(s) for your Humana-covered patient(s)

Dear physician or office administrator:

Humana reviews medical records for our members in an effort to report complete and accurate diagnosis coding to the Centers for Medicare & Medicaid Services (CMS) for our Medicare Advantage members and to the U.S. Department of Health and Human Services for our commercial members.

Please return the medical record(s) for the time period(s) requested, with the enclosed patient information form, for the patient(s) listed. Return in one of the following ways:

- Upload records to the secure provider upload portal at www.submitrecords.com/humana (instructions enclosed).
- Send via secure fax to [redacted]
- Send via mail using the enclosed self-addressed, prepaid trackable postage label(s). A new prepaid label is being used. Please discard old labels.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule states in the Safeguards Principle that individually identifiable health information should be protected with reasonable administrative, technical and physical safeguards to ensure its confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure. **Please submit all electronic and hard-copy medical records via a HIPAA-compliant method.**

Please ensure each record includes the section with the physician's or healthcare provider's signature. Do not submit original medical records. Please include the following:

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Discharge summary	Consult notes	Demographics sheet
	Diagnostic testing reporting (commercial patients only)	Dialysis (commercial patients only)
History and physical	Infusion testing and reporting (commercial patients only)	Operative reports
Physician or healthcare provider signature and credentials (electronic or handwritten)	Problem list	Progress notes
Signature log*	SOAP notes (subjective, objective, assessment, plan)	Telehealth visits progress notes

If a hospital record (including telehealth visits):		
Admit notes (commercial patients only)	Demographics sheet	Coding summary (if not on face sheet)
Consult notes		Diagnostic testing reports
Discharge summary	Emergency department records	Face sheet
History and physical	Infusion testing and reporting (commercial patients only)	Lab results/pathology reports
Operative reports	Physician orders	Physician or healthcare provider signature and credentials (electronic or handwritten)
Problem list	Progress notes	Signature log*
SOAP notes (subjective, objective, assessment, plan)	Telehealth visits progress notes	

***Note:** Signature logs are not accepted in place of the physician's or healthcare provider's electronic or handwritten signature. Signature logs are used to identify a provider's name if the signature is illegible.

[redacted]

RECEIVED

reveleer

Today's Date: 07/21/2025
Due Date: 07/17/2025

To		**From**	Aetna IVA
Provider Name	[redacted]	**Requester**	[redacted]
Provider Fax	[redacted]	**Requester Phone**	

REQUEST FOR MEDICAL RECORDS

Department of Health and Human Services & Centers for Medicare and Medicaid Services Risk Adjustment Data Validation – Initial Validation Audit (HRADV-IVA)

January 1, 2024, through December 31, 2024

Reveleer is contacting you to request medical record documentation as listed below as soon as possible. To give you adequate time to prepare the necessary information, Reveleer is providing you with retrieval details and a specific list of plan members that are part of this review.

Aetna is requesting your cooperation by providing specific patient medical records from your office to facilitate the medical record review. As you may know, Risk Adjustment is the payment methodology used by (CMS) Centers for Medicare and Medicaid Services for Affordable Care Act (ACA) members based on the patient health status. To assess your medical record documentation of the patient health conditions, it is necessary to perform ongoing chart reviews to evaluate the accuracy and completeness of your medical record documentation.

Reveleer has entered into a Business Associate Agreement with Aetna and, as such, is bound by applicable federal and state privacy and confidentiality requirements in conducting this activity on Aetna's behalf. Any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding the confidentiality of patient records, including current HIPAA requirements.

Reveleer requests documentation for dates of service within January 1, 2024, through December 31, 2024.

Please refer to the Member Pull list for specific dates of service and the IVA Documentation Check List. Please note- To avoid follow up calls to your office, please ensure the attached attestation form is completed.

Thank you for your participation. Please send your records using one of the following options:

1. Provider Gateway – A portal with unique pin to upload charts securely to Reveleer Platform [redacted]

Pin located on Member Pull List page (see attached)

2. Remote Download – For secure access EMR set up; email us at [redacted]

RECEIVED

3. Secure Fax [redacted]

4. Traceable Mail - See address below. For mail inquiries, contact us at [redacted]

5. 3rd Party Copy Vendor/Invoices - For locations that utilize a Copy Service or need to submit an Invoice with associated fees, please contact us for submittal instructions at Reveleer Provider Relations at [redacted]

All documents sent to us must be in PDF Format only. Please note, we require the actual medical record for audit purposes. Use of CCD files (Continuity of Care Document) are not acceptable for this review.

Due to the time sensitive nature of this review, we kindly request that you please verify that the patients on the enclosed list have been seen at your office during the indicated review period and submit records within seven (7) business days of receiving this notice.

For your convenience, our fax number and address are listed below. Since we are the authorized collection agent for the corresponding Health Plans (see following pages), we ask that you contact us directly with your questions by calling: Reveleer Provider Relations at [redacted] with the Reference ID (AID) and Health Plan located at the lower left of the page. If you have received this communication in error, immediately contact us at the number above.

Faxing Records, please fax to [redacted]

Mailing Records (paper, CD's, Flash Drives, etc.) please send to:

IVA - Aetna

[redacted]

Privacy Notice

THIS REQUEST CONTAINS PATIENT INFORMATION PROTECTED BY PRIVACY LAWS. DO NOT SHARE WITH OR TRANSMIT THIS REQUEST OR ANY PART OF IT ELECTRONICALLY, IN PRINT, OR VERBALLY EXCEPT WITH AUTHORIZED PERSONNEL AT YOUR OFFICE.

This message is intended only for use by the individual or entity to which it is addressed and contain information that is privileged, confidential, or exempt from disclosure under applicable federal and state law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

EXL
111 Ryan Court, Suite 300
Pittsburgh, PA 15205

MEDICAL RECORDS TRANSMITTAL

Facility: THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
Patient Name: [redacted]
Patient Account No.: [redacted]
Date of Birth: [redacted]

Audit ID	Claim No.	Claim Line No.	Revenue Code	CPT Code	Billed HCPCS	Dates of Service
[redacted]		1			[redacted]	08/02/2024 - 08/02/2024

RECORDS TO SEND (PHYSICIAN):	• Medication Administration Records (MAR)/Flow Sheets • Medication Wastage Documentation showing discarded amount(s) and reason for wastage • Treatment/Progress Notes, or any other specific records to support the medications given for this time frame • Authorization for treatment (if applicable) • Physician Order/Prescription and any other specific records to support medications given • CMS-1500 • UB-04
RECORDS TO SEND (PHARMACY OR INFUSION PROVIDERS):	• Physician Order/Prescription and any other specific records to support medications given • Medication Wastage Documentation showing discarded amount(s) and reason for wastage • Pharmacy Distribution Record/Compounding Record with NDC number • Pharmacy Assessment/Care Plan • Authorization for treatment (if applicable) • Itemized Delivery Ticket/Confirmation of Delivery to member • Nursing Notes/Visits

PLEASE RETURN THIS FORM WITH THE MEDICAL RECORDS WITHIN 30 DAYS.

Medical Records should be uploaded via the EXL Provider Portal for review. For any support or submission of medical records, please visit our provider portal. The portal also has many other self-service features, along with FAQs and a User Guide: https://exlhealthproviderportal.exlservice.com

[redacted]

EXTERNAL AUDITS

PHARMACY AUDITS

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM [redacted] SEClinicPharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em

# of Pages: 8 (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: June 3, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				INVEGA HAFYE INJ 1560MG	

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[X] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate).

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO_____
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____ [redacted]

_____
Pharmacy Manager / Representative Signature

[redacted]

Optum Rx

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM [redacted] NW Clinic Pharmacy **TO: EXL Service**

(Sender's Name)

Secure Fax: [redacted]

Encrypted Em

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY

NABP #: [redacted]

Date: June 3, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				INVEGA TRINZ INJ 410MG	Claim Reversed on 6/3/25

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[X] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate).

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO_____
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

Pharmacy Manager / Representative Signature

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM [redacted] NWClinicPharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY
NABP #: [redacted]
Date: June 6, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				INVEGA TRINZ INJ 546MG	

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[X] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate).

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO_____
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____ [redacted]

_____
Pharmacy Manager / Representative Signature

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Southeast Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: June 13, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				UZEDY INJ 200MG	

Please Remember to:

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Pharmacy Manager / Representative PRINT [redacted]

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Northwest Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY
NABP #: [redacted]
Date: June 17, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				UZEDY INJ 200MG	

Please Remember to:

1. **Add Comments above, if needed.**
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*Specify details in the Comments for each Rx number [redacted]

Pharmacy Manager / Representative PF [redacted]

_____

Pharmacy Manager / Representative Signature [redacted] Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: Rebecca Fox/Northeast Clinic Pharmacy **TO:** EXL Service
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em

# of Pages: 8 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: June 18, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				ABILIFY ASIM INJ 960MG	

Please Remember to:

1. **Add Comments above, if needed.**
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*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____ [redacted]

_____
Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Northwest Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY
NABP #: [redacted]
Date: June 25, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				INVEGA TRINZ INJ 546MG	

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
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Pharmacy Manager / Representative PRINT [redacted]

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Northeast Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY
NABP [redacted]
Date: June 26, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				ABILIFY ASIM INJ 960MG	

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
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Pharmacy Manager / Representative PRINT [redacted]

Pharmacy Manager / Representative Signature Date

[redacted]

07/07/2025 10:50:52 AM CLOUDFAX PAGE 4 OF 4

Optum Rx

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Northeast Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: July 7, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				INVEGA TRINZ INJ 410MG	

Please Remember to:

1. **Add Comments above, if needed.**
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*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Northeast Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em: [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: July 11, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				INVEGA TRINZ INJ 819MG	

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
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*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

_____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted]/Northwest Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax:
Encrypted Em [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY
NABP # [redacted]
Date: July 22, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				UZEDY INJ 200MG	claim was reversed and returned to stock/never picked up

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
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Pharmacy Manager / Representative PRINT [redacted]

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted]/ Northwest Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted En

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY
NABP #: [redacted]
Date: July 24, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				INVEGA TRINZ INJ 410MG	

Please Remember to:

1. **Add Comments above, if needed.**
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Pharmacy Manager / Representative PRINT [redacted]

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted]/Northeast Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em [redacted]

# of Pages: 13 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: August 4, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				INVEGA TRINZ INJ 410MG	
				INVEGA TRINZ INJ 819MG	

Please Remember to:

1. **Add Comments above, if needed.**
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Pharmacy Manager / Representative PRINT [redacted]

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Northeast Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em [redacted]

# of Pages: 14 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: August 5, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				CONCERTA TAB 27MG	
				VYVANSE CAP 20MG	

Please Remember to:

1. **Add Comments above, if needed.**
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Pharmacy Manager / Representative PRINT_____ [redacted]

_____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Southwest Clinic Pharmacy **TO: EXL Service**

(Sender's Name)

Secure Fax: [redacted]
Encrypted Em [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHWEST CLINIC PHARMACY 3
NABP #: [redacted]
Date: August 6, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				ABILIFY ASIM INJ 960MG	

Please Remember to:

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Pharmacy Manager / Representative PRINT_____ [redacted]

Pharmacy Manager / Representative Signature Date

[redacted]

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EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted]/Southeast Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Ema [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: August 12, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				UZEDY INJ 200MG	

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Pharmacy Manager / Representative PRINT [redacted]

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted]/Northwest Clinic Pharmacy **TO: EXL Service**

(Sender's Name)

Secure Fax: [redacted]
Encrypted Em [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY
NABP #: [redacted]
Date: August 15, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				UZEDY INJ 200MG	

Please Remember to:

1. **Add Comments above, if needed.**
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Pharmacy Manager / Representative PRINT_____ [redacted]

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Southwest Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Em

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHWEST CLINIC PHARMACY 3
NABP # [redacted]
Date: August 19, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				INVEGA TRINZ INJ 819MG	

Please Remember to:

1. **Add Comments above, if needed.**
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Pharmacy Manager / Representative PRINT [redacted]

_____
Pharmacy Manager / Representative Signature Date

[redacted]

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EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] /Southwest Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted En

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHWEST CLINIC PHARMACY 3
NABP #: [redacted]
Date: August 20, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				UZEDY INJ 250MG	claim reversed never picked up

Please Remember to:

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Pharmacy Manager / Representative PRINT_____ [redacted]

_____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM [redacted] Southeast Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax:
Encrypted Em [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: August 20, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]				INVEGA TRINZ INJ 819MG	

Please Remember to:

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Pharmacy Manager / Representative PRINT_____ [redacted]

_____
Pharmacy Manager / Representative Signature Date

[redacted]

Texas State Board of Pharmacy

[redacted]

Austin, TX 78701

[redacted]

Inspection Report

Facility Information

Name: *NORTHWEST CLINIC PHARMACY* **License Number**: [redacted]

Class of License: *A*

Inspection Information

Type: *Compliance* **Purpose**: *Routine*

Date: *07/09/2025* **Arrival Time**: *2:30 PM* **Departure Time**: *4:30 PM*

Action Taken: *Inspection*

General Comments:

Licenses/Registration

Verify personnel have active licenses & address with PIC/RPh if necessary	*Satisfactory*
01. Required licenses posted	*Satisfactory*
09. Active licenses/certifications	*Satisfactory*
62. No aiding and abetting	*Satisfactory*
65. Proper registration procedures	*Satisfactory*
79. Identification badges	*Satisfactory*

Inventory Records

15. Change of PIC inventory	*Satisfactory*

Comment

Change of PIC inventory completed on: 05/09/2025.

17. Meets inventory requirements	*Satisfactory*
59. Proper drug destruction	*Satisfactory*
68. Change of ownership controlled substance inventory	*Not Applicable*
69. Annual controlled substance inventory	*Satisfactory*

Comment

Annual controlled substance inventory completed on: 02/28/2025 at 8am.

Notifications

31. Closed pharmacy (Is pharmacy engaged in the business described in application for licensure?) *Satisfactory*

34. Notifications *Satisfactory*

76. PIC (Does the pharmacy have a pharmacist-in-charge?) *Satisfactory*

Environment/Equipment/Security

03. Orderly/Clean *Satisfactory*

291.33(b)(1)(A).
The pharmacy shall be arranged in an orderly fashion and kept clean. All required equipment shall be clean and in good operating condition.

Comment

Advised to clean all areas of the pharmacy, including equipment and supplies. AC vent is a source of concern. Repair/replace ceiling tiles which is a source of contamination.

04. Balance inspection *Satisfactory*

Comment

Number of balances: zero balance.

05. Equipment Inspection *Satisfactory*

07. Security *Satisfactory*

08. Environment *Satisfactory*

48. Drugs (procurement, temperature, security, out-of-date, samples) *Satisfactory*

90. TSBP complaint notification *Satisfactory*

Controlled Substances

10. Prescriptions separated *Satisfactory*

24. Theft/Loss *Satisfactory*

Comment

No theft or loss has occurred.

26. Controlled substance prescription compliance *Satisfactory*

30. Controlled substance invoices dated/initialed by pharmacist *Satisfactory*

35. Controlled substance invoices separated *Satisfactory*

46. Drug distribution *Not Applicable*

53. Possession of controlled substances *Satisfactory*

Corresponding responsibility (Does the pharmacist exercise sound professional judgment with respect to the accuracy or authenticity of a prescription drug order?)	*Satisfactory*

Labeling/Prepackaging

32. Prescription label (Is prescription label complete?)	*Satisfactory*
45. Proper dispensing/labeling	*Satisfactory*
54. Proper prepackaging procedures	*Not Applicable*

Library

06. Required Library	*Satisfactory*

Training

60. Documentation of required training	*Satisfactory*
61. Supervision of supportive personnel	*Satisfactory*

Patient/Computer/Dispensing Records

18. Records available	*Satisfactory*
22. Data processing system compliance	*Satisfactory*
25. Prescriptions (complete, retrievable, auto-refills, accelerated refills)	*Satisfactory*
37. Legal dispensing (Are valid prescriptions being dispensed by a pharmacist?)	*Satisfactory*
56. Prescription transfers	*Satisfactory*
67. Written drug information provided	*Satisfactory*
80. Patient counseling	*Satisfactory*
82. Patient Medication Records	*Satisfactory*
84. Drug regimen review	*Satisfactory*
86. Absence of pharmacist records	*Satisfactory*

Policies & Procedures/SOPs

70. Required policies & procedures/SOPs	*Satisfactory*
92. Automated dispensing policy & procedures/SOPs	*Satisfactory*

Non-Sterile Compounding

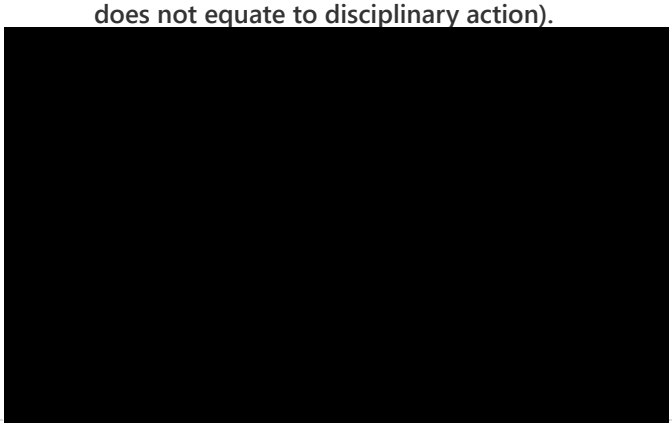
03. Orderly/Clean/Hand Hygiene	*Not Applicable*
04. Balance inspection (for non-sterile compounding)	*Not Applicable*
05. Equipment Inspection	*Not Applicable*

06. Non-sterile Library	*Not Applicable*
32. Non-sterile compound label (Is label complete?)	*Not Applicable*
38. Area/Environment for non-sterile compounding	*Not Applicable*
43. Records for non-sterile compounding	*Not Applicable*
60. Documentation of non-sterile required training	*Not Applicable*
70. Required policies & procedures/SOPs	*Not Applicable*
87. Quality Control/Assurance	*Not Applicable*

Signatures

An agent of the Texas State Board of Pharmacy has inspected your pharmacy. The results of this inspection have been noted.

- **Items designated as "Refer to Legal" must be rectified immediately. In addition, the matter discovered during the inspection and deemed to be a serious violation by the inspector will be referred to the Legal Division for review and possible disciplinary action; and**
- **Items designated as "Warning Notice" must be corrected by the deadline noted to ensure compliance with the laws and rules governing the practice of pharmacy (Note: A "Warning Notice" is issued for a minor violation, and does not equate to disciplinary action).**



Texas State Board of Pharmacy

[redacted]

Austin, TX 78701

[redacted]

Inspection Report

Facility Information

Name: *NORTHEAST CLINIC PHARMACY* **License Number:** [redacted]

Class of License: *A*

Inspection Information

Type: *Compliance* **Purpose:** *Routine*

Date: *08/05/2025* **Arrival Time:** *2:30 PM* **Departure Time:** *4:00 PM*

Action Taken: *Inspection*

General Comments: *Pharmacy currently does not engage in Non-Sterile compounding.*

Licenses/Registration

Verify personnel have active licenses & address with PIC/RPh if necessary	*Satisfactory*
01. Required licenses posted	*Satisfactory*
09. Active licenses/certifications	*Satisfactory*
62. No aiding and abetting	*Satisfactory*
65. Proper registration procedures	*Satisfactory*
79. Identification badges	*Satisfactory*

Inventory Records

15. Change of PIC inventory	*Satisfactory*

Comment

Change of PIC inventory completed on: 05/08/2025.

17. Meets inventory requirements	*Satisfactory*
59. Proper drug destruction	*Satisfactory*
68. Change of ownership controlled substance inventory	*Not Applicable*
69. Annual controlled substance inventory	*Satisfactory*

Comment

Annual controlled substance inventory completed on: 09/03/2024 at 7:30am.

Notifications

31. Closed pharmacy (Is pharmacy engaged in the business described in application for licensure?) *Satisfactory*

34. Notifications *Satisfactory*

76. PIC (Does the pharmacy have a pharmacist-in-charge?) *Satisfactory*

Environment/Equipment/Security

03. Orderly/Clean *Satisfactory*

291.33(b)(1)(A).
The pharmacy shall be arranged in an orderly fashion and kept clean. All required equipment shall be clean and in good operating condition.

Comment

Advised to clean all areas of the pharmacy.
Repair/replace ceiling tiles.

04. Balance inspection *Satisfactory*

Comment

Number of balances: zero balance.

05. Equipment Inspection *Satisfactory*

07. Security *Satisfactory*

08. Environment *Satisfactory*

48. Drugs (procurement, temperature, security, out-of-date, samples) *Satisfactory*

90. TSBP complaint notification *Satisfactory*

Comment

Advised to notify patients of complaint information.

Controlled Substances

10. Prescriptions separated *Satisfactory*

24. Theft/Loss *Satisfactory*

Comment

No theft or loss has occurred.

26. Controlled substance prescription compliance *Satisfactory*

30. Controlled substance invoices dated/initialed by pharmacist *Satisfactory*

35. Controlled substance invoices separated *Satisfactory*

46. Drug distribution *Not Applicable*

53. Possession of controlled substances	*Satisfactory*
Corresponding responsibility (Does the pharmacist exercise sound professional judgment with respect to the accuracy or authenticity of a prescription drug order?)	*Satisfactory*

Labeling/Prepackaging

32. Prescription label (Is prescription label complete?)	*Satisfactory*
45. Proper dispensing/labeling	*Satisfactory*
54. Proper prepackaging procedures	*Not Applicable*

Library

06. Required Library	*Satisfactory*

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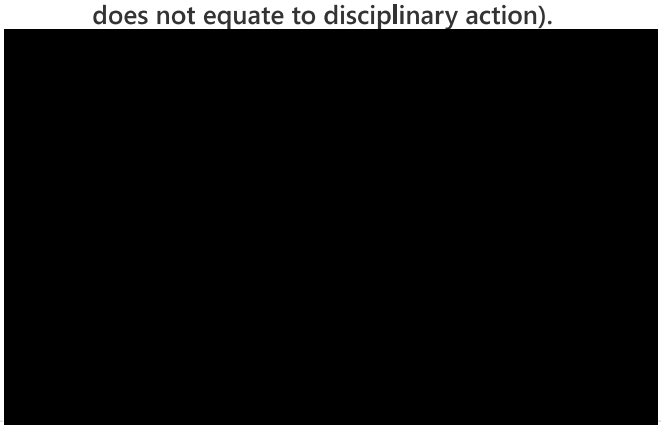

EXTERNAL AUDITS

PROGRAM AUDITS

Health and Human Services Commission
Behavioral Health Services
Quality Management

Harris Center for Mental Health and IDD
Document Request List
Follow-up Review

The following items are requested for your Quality Management review by your Quality Management Lead Reviewer, [redacted].

The items listed must be submitted to the SharePoint server link provided by the Quality Management Lead Reviewer by the close of business on August 18, 2025.

If you have any questions regarding this request, please email the QM Lead Reviewer at [redacted].

Documents Requested
Comprehensive Review Report
CAP Summary Tab, Operations, Row 84 A copy of the FY2025 Form S, including the PASRR fax line number
CAP Summary Tab, Medical, Rows 68 and 80 A copy of the amended Procedure ID 16688628 that includes: • The CEO submits the reporting form to HHSC upon determination of the need to conduct an administrative death review • The CMO submits the committee recommendations following an administrative death review Annual audit results for FY2025
CAP Summary Tab, Clinical Record, Row 14 Tracking documentation verifying adults receiving TANF transfer XX are individuals living with a minor under 18 for FY25 Q3 (March, April, May)
CAP Summary Tab, Clinical Record, Row 148 Audit results for OCR KPI Screeners used to ensure discharge planning was included in the discharge summary for FY25 Q3 (March, April, May)
CAP Summary Tab, Clinical Record, Rows 170, 171,172,173, and 176 Monthly review documentation of the PASRR MI program manager confirming completion of: • IDT meetings within the timeframe • 1041 with documentation of refusal or ineligibility • Annual IDT meetings within the timeframe • Documentation of F30, 60, 90-day follow-ups • 1014, including documentation of signatures for FY25 Q3 (March, April, May)

Document Request List

Documents Requested
CAP Summary Tab, ResD Crisis Facility, Row 80 • Schedule a Teams video walkthrough to view the shower rod • Audit of duty checklist, ensuring rounding is accounted for and at least hourly for FY25 Q3 (May)
Diversion Center Review Report
CAP Summary Tab, Personnel Requirements, Row 15 • Jail Diversion staff members' training documentation for new hires or annual FY25 Q2 and Q3 updates • Practice manager's training audit report for FY25 Q3 (March, April, May)
State Hospital Step-down
CAP Summary Tab, Personnel Requirements, Rows 19 and 29 • A Copy of the form entitled "Step Down Staff Orientation Checklist-Clinicians" • The Step-Down Program Manager's tracking log that demonstrates all staff members within 24-48 hours of new hire on-site orientation/training attesting to the tour for FY25 Q3 (March, April, May)

TEXAS GENERAL LAND OFFICE
COMMISSIONER DAWN BUCKINGHAM, M.D.

6/16/25
Hope Harbor
C/O Center Hope Harbor
[redacted]

Re: ANNUAL Affordability Period Review of Affordable Rental Program

To whom it may concern:
The Texas General Land Office Community Development and Revitalization (GLO-CDR) division is reaching out to remind you of the requirements agreed to as part of receiving federal benefits through the Affordable Rental Program (ARP) under contract [redacted].

As GLO-CDR begins to review and verify your obligation to meet these requirements, we ask you to provide documentation to support that you continue to meet ARP eligibility requirements and commitments. We would appreciate your staff's assistance in providing the items outlined below by the end of business on Monday July 7th, 2025.

1. Compliance Unit Report (Race/ethnicity information on LMI & Market Rate units is mandatory)
2. Rent Schedule & Income Limits used by property
3. Housing Unit Inspections (please most recent annual inspections for units with move-ins and recertifications effective during OCTOBER and any work orders generated due to deficiencies)
4. Certificate of Continued Compliance (self-certified form completed, signed, and dated)
5. Utility Allowance schedule, source (vendor, PHA, etc.), and effective date.
6. Insurance documentation (Declarations Pages and/or Policies) to demonstrate compliance with grant requirements to maintain Property, Wind, and Flood Insurance (as applicable).
7. Property Budget
8. Tenant Selection Plan (include amendments if applicable)

GLO-CDR appreciates your ongoing recovery efforts for the citizens of Texas impacted by Hurricane Ike. If you have any questions or concerns, please contact me at [redacted] or [redacted].

Sincerely,

[redacted]

Affordable Rental Program
Community Development and Revitalization

[redacted]

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]
Executive Commissioner

July 14, 2025

Electronic Mail

[redacted]
CEO
Applewhite
[redacted]

Provider ID #: [redacted]
Facility ID #: [redacted]
Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID)

Dear [redacted]:

The Texas Health and Human Services Commission (HHSC) visited the above referenced facility on June 27, 2025. HHSC staff recorded a number of deficiencies and violations that form the basis for the proposed action against the facility's certification and Medicaid provider agreement as described in this letter. The Statement of Deficiencies and Plan of Correction (Form CMS-2567) and the Statement of Licensing Violations and Plan of Correction and the State Standards for Participation (HHSC Form 3724) are enclosed for your reference. You will receive a separate notice if HHSC proposes any action against the licensure of Applewhite. The notice will describe any appeal rights associated with the licensure action.

Purpose of Visit: Recertification Survey; Licensing Inspection; SSP Inspection
Action: Decertification effective: September 25, 2025.

Deficiencies causing the action:

__xx_ Deficiencies that jeopardize resident health and safety and/or limit the facility's capacity to render adequate care:**[W102/W104, W318/W323/W352]**.
__xx___Deficiencies in the provision of active treatment: [W158/W159, W195/W196/W255]].

Plans of Correction

In accordance with Chapter 2, §2728, of the State Operations Manual (SOM), you must submit an acceptable Plan of Correction (PoC) by the **tenth calendar day** after you receive the enclosed Form CMS-2567. You must prepare a PoC for each deficiency on the Form CMS-2567 and submit the PoC(s) to the HHSC regional office at the address stated below within **ten calendar days** after you receive this letter.

In accordance with Texas Administrative Code (TAC), Title 26, §551.192(f), you must submit an acceptable POC within **ten working days** after you receive the enclosed HHSC Form 3724. You must prepare a PoC for each violation identified on the HHSC Form 3724 and submit the PoC(s) to the HHSC regional office at the address stated below within **ten working days** after you receive this letter.

The POCs serve as your representation that you are in compliance with applicable federal standards of participation (SoPs), federal conditions of participation (CoPs), and state rules. HHSC staff will

conduct one revisit to determine if the facility has achieved compliance with the SoPs, CoPs, and rules. If the facility fails to achieve compliance with those SoPs, CoPs, and rules within **45 calendar days** after you receive this letter HHSC will recommend termination of your Medicaid provider agreement effective (90 days after exit).

In accordance with SOM, Chapter 3, §3006.5(C)(1) (a-e), an acceptable PoC must include:

- how the corrective action for the deficient practice will be accomplished for individuals found to have been affected by the deficient practice;
- how the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations;
- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur;
- how the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur (i.e., what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent); and
- when the facility will accomplish corrective action. (Note: The date corrective action will be accomplished must be reasonable for the deficient practice cited). **The PoC for each deficiency must include a completion date.**

You must sign all originals when you enter your PoC on each set of Form CMS-2567. The Form CMS-2567 and HHSC Form 3724 are subject to public disclosure. Therefore, do not use proper names in any PoC that you submit. The facility's administrator or other authorized official must sign and date each PoC.

You must e-mail, fax, or mail the **original,** signed and completed Form CMS-2567 and HHSC Form 3724 to [redacted] MHCM, ICF Program Manager at the address below.

[redacted] MHCM, ICF Program Manager
[redacted]
Houston, TX 77023
fax: [redacted]
email: [redacted]

Informal Dispute Resolution Reconsideration (IDR)

In accordance with 1 TAC, §393.1, if issues were not resolved during the exit conference for the visit date of June 27, 2025, you may request an IDR to contest cited deficiencies and/or violations. To request an IDR, complete an IDR Request Form and submit the form to the Health and Human Services Commission (HHSC) within **ten calendar days** after you received the statement of deficiencies and/or violations.

The guidelines and procedures for requesting an IDR as well as the IDR Request Form are available at the following HHSC website:
https://hhs.texas.gov/doing-business-hhs/vendor-contractor-information/informal-dispute-resolution-process.

[redacted]
07/14/2025
Page 3

Submit the IDR Request form in accordance with the instructions provided on that website.

If you have any questions about the information in this letter, please contact [redacted] MHCM, ICF Program Manager at [redacted] by email at [redacted]

Sincerely,

[redacted]
[redacted]
Regional Coordinator, Region 06
Regulatory Services

bcv

Enclosure

cc: Manager of Provider Licensing Enforcement, Regulatory Services

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 07/14/2025 2:15:51PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 060	26 TAC §261.212; §551.42(f) Governing Body 26 TAC §261.212 A program provider must comply with the entire: 1) Subchapter C (relating to Standards for Licensure); 2) Subchapter D (relating to General Requirements for Facility Construction); 3) Subchapter F (relating to Inspection, Surveys, and Visits). 26 TAC §551.42(f) (f) Governing body and management. A facility must establish a governing body and the governing body must adopt, implement, and enforce the facility's policies and procedures. The governing body must review and update the facility policies and procedures at least annually. This Requirement is not met as evidenced by: Based on interview and record review, the governing body failed implement and enforce the facility policies and procedures for 6 of 6 individuals reviewed for governing body (Individual #1, Individual #2, Individual #3, Individual #4, Individual #5, and Individual #6). The governing body failed specifically to: Develop, monitor, and revise, as necessary, policies and operating directions which ensure that all assessments and individuals annual support planning meetings were up to date, completed, and scheduled for all residents.?	S 060	S 060 **CORRECTIVE ACTION TAKEN FOR AFFECTED CLIENTS** Governing body will ensure specific management requirements are met by ensuring the QIDP monitors the active treatment programming for affected individuals by August 4th, 2025 and at least yearly following to include Annual Staffing, Comprehensive Functional Assessments, and IPP program data sheets. The QIDP will ensure that nursing services are obtained for preventive and recommended health care services. Individual #1's Annual Staffing to be completed by 8/4/2025. Individual #1's IPP Program Data Sheet to be completed and revised by 8/4/2025 Individual #1's Annual Dental Consultation to be completed on 8/15/2015 Individual #2's Annual Staffing to be completed by 8/4/2025. Individual #2's IPP Program Data Sheet to be completed and revised by 8/4/2025 Individual #2's Annual Hearing Consultation to be completed on 9/29/2025	8/4/2025

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER [redacted] SIGNATURE [redacted] TITLE Program Director (X6) DATE 7/23/2025

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 07/14/2025 2:15:54PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	**06/27/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

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S 060	Continued From page 1 The Governing body develops, monitors, and revises, as necessary, policies and operating directions which ensure the clients have updated and current individual program plans with active treatment. This failure resulted in services not rendered, delayed, and monitored. [redacted]	S 060	cont. S 060 [redacted]	

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

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	[redacted]	A. BUILDING: _____ B. WING _____	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

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S 060	Continued From page 2 [redacted]	S 060	Cont. S 060 **IDENTIFICATION OF OTHER CLIENTS AT RISK** [redacted] **SYSTEMATIC CHANGES TO PREVENT REOCCURRENCE** IDT team, inclusive of PD, QIDP, Nursing, Dietary, LAR/Guardian and client will review client's treatment plan quarterly. QIDP and Nursing will review client's healthcare appointments monthly and address any concerns. The Program Assistant and Nursing staff will schedule healthcare appointments weekly. QIDP will implement tracking system and monitor due dates of Annual Staffing, IPP Program data sheets, Comprehensive Functional Assessments, Dental/Vision/Hearing/Healthcare consultations. **QA MONITORING SYSTEMS** The Program Director will conduct a monthly review of the QIDP's caseload to verify compliance with regulatory timelines. Audit findings will be reviewed during monthly administrative meetings and corrective actions will be implemented immediately if deficiencies are found. The governing body will receive quarterly reports on compliance status and trend	

[redacted]

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

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	[redacted]	A. BUILDING: _____ B. WING _____	**06/27/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 060	Continued From page 3 [redacted]	S 060		

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

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S 060	Continued From page 4 [redacted] Interview with the QIDP on 6/27/2025 at 1:20 pm revealed that she had been in the position for the past three months but has worked at the organization for about four years. She was aware that the annual staffing, ISP, and IPP for all individuals had not been updated. The QIDP stated that she, in conjunction with family members, guardians, and the PD were in the process to align their conflicting schedules to have the outdated documentation and assessments scheduled and completed within the next two weeks. Interview with the Program Director on 6/27/2025	S 060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 060	Continued From page 5 at 1:05 pm revealed that she had been in the position for the past three months and was aware that the annual staffing, ISP, and IPP for all individuals had not been updated. She added that the QIDP who was also new in her position, though with the company for many years was aware of the deficient practice. The PD stated that she, in conjunction with family members, guardians, and the QIDP were in the process to align their conflicting schedules to have the outdated documentation and assessments scheduled and completed within the next two weeks. Interview with the Day Hab Supervisor (DHS) on 06/27/2025 at 10:15 am revealed that he was aware that individuals Individual Support Plans and Individual Program Plan were not up to date and that individuals were still working on objectives from the year before. The DHS stated the QIDP completes yearly assessments and schedules ISP meetings and during the meeting the DHS and the QIDP on the collaborative effort determine the IPP objective and goals the individuals will be working on throughout the year. The DHS acknowledged that the 2025 assessments and annual planning meeting had not been scheduled. He stated that he would not use the word "regress" but acknowledged the fact that not having updated ISPs and IPPs could have a negative impact on the individual's progression or skill acquisition. Interview with the Direct Support Professional A (DSP A) on 06/27/2025 at 10:59 am revealed that individuals were still working on Individual Program Plans dated from the year before. Though they used to be changed every six months, the individual IPP's had not yet been updated. Interview with the Direct Support Professional B (DSP B) on 06/27/2025 at 11:15 am revealed that	S 060		

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 07/14/2025 2:15:54PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ [redacted] _____	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 060	Continued From page 6 individuals were still working on Individual Program Plans dated from the year before. Though they used to be changed yearly, the individual IPP's had not yet been updated. [redacted]	S 060		
[redacted] 062	26 TAC §261.212; §551.42(h) Facility Staffing 26 TAC §261.212 A program provider must comply with the entire: 1) Subchapter C (relating to Standards for Licensure); 2) Subchapter D (relating to General Requirements for Facility Construction); 3) Subchapter F (relating to Inspection, Surveys, and Visits). 26 TAC §551.42(h) (h) Facility staffing. A facility must ensure a	S 062	**S 062** **CORRECTIVE ACTION TAKEN FOR AFFECTED CLIENTS** QIDP will ensure specific management requirements are met by ensuring the active treatment programming for affected individuals by August 4th, 2025 and at least yearly following to include Annual Staffing, Comprehensive Functional Assessments, and IPP program data sheets. Ensuring nursing services obtained preventive and recommended health care services.	8/4/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	**06/27/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 062	Continued From page 7 resident receives professional and non-professional program services needed to implement the active treatment program defined by a resident's IPP. This Requirement is not met as evidenced by: [redacted] This deficient practice could affect the rights of the individuals and cause a delay in their potential growth towards becoming independent and delay all their active treatment services.	S 062	Cont. S 062 [redacted]	

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 07/14/2025 2:15:54PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 062	Continued From page 8 [redacted]	S 062	cont. S062 **IDENTIFICATION OF OTHER CLIENTS AT RISK** [redacted] **SYSTEMATIC CHANGES TO PREVENT REOCCURRENCE** IDT team, inclusive of PD, QIDP, Nursing, Dietary, LAR/Guardian and client will review client's treatment plan quarterly. QIDP and Nursing will review client's healthcare appointments monthly and address any concerns. The Program Assistant and Nursing staff will schedule healthcare appointments weekly. QIDP will implement tracking system and monitor due dates of Annual Staffing, IPP Program data sheets, Comprehensive Functional Assessments, Dental/ Vision/Hearing/Healthcare consultations. **QA MONITORING SYSTEMS** The Program Director will conduct a monthly review of the QIDP's caseload to verify compliance with regulatory timelines. Audit findings will be reviewed during monthly administrative meetings and corrective actions will be implemented immediately if deficiencies are found. The governing body will receive quarterly reports on compliance status and trend	

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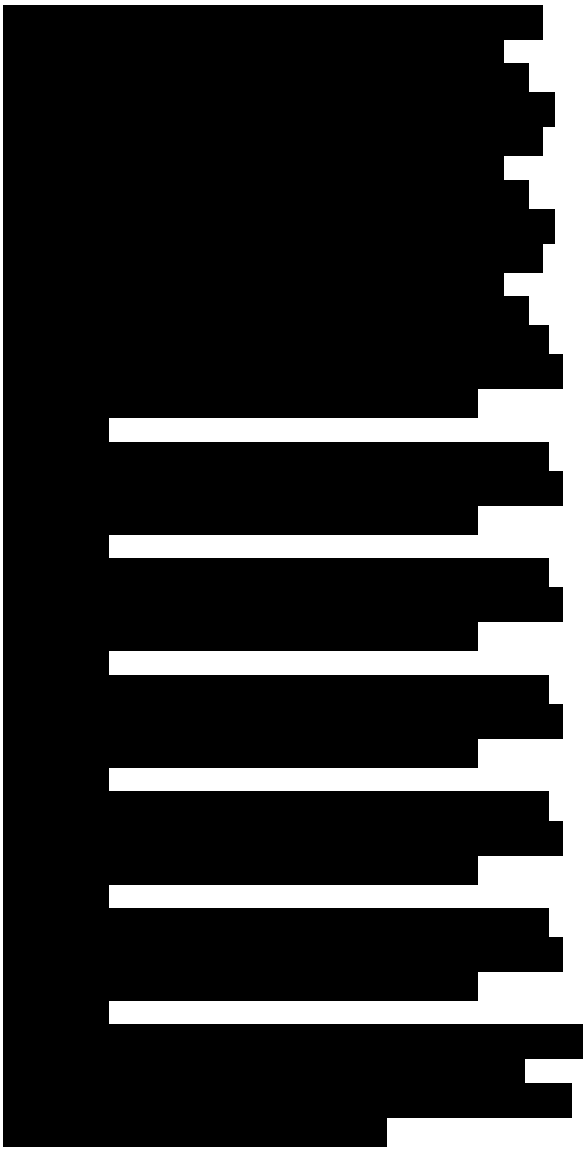
S 062	Continued From page 9	S 062		



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S 062	Continued From page 10 [redacted]	S 062		

Texas Health and Human Services Commission

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S 062	Continued From page 11 [redacted] Interview with the Program Director on 6/27/2025 at 1:05 pm revealed that she had been in the position for the past three months and was aware that the annual staffing, ISP, and IPP for all individuals had not been updated. She added that the QIDP who was also new in her position, though with the company for many years was aware of the deficient practice. The PD stated that she, in conjunction with family members, guardians, and the QIDP were in the process to align their conflicting schedules to have the outdated documentation and assessments scheduled and completed within the next two weeks. Interview with the Day Hab Supervisor (DHS) on 06/27/2025 at 10:15 am revealed that he was aware that individuals Individual Support Plans and Individual Program Plan were not up to date and that individuals were still working on objectives from the year before. The DHS stated the QIDP completes yearly assessments and schedules ISP meetings and during the meeting the DHS and the QIDP on the collaborative effort determine the IPP objective and goals the individuals will be working on throughout the year.	S 062		

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S 062	Continued From page 12 The DHS acknowledged that the 2025 assessments and annual planning meeting had not been scheduled. He stated that he would not use the word "regress" but acknowledged the fact that not having updated ISPs and IPPs could have a negative impact on the individual's progression or skill acquisition. Interview with the Direct Support Professional A (DSP A) on 06/27/2025 at 10:59 am revealed that individuals were still working on Individual Program Plans dated from the year before. Though they used to be changed every six months, the individual IPP's had not yet been updated. Interview with the Direct Support Professional B (DSP B) on 06/27/2025 at 11:15 am revealed that individuals were still working on Individual Program Plans dated from the year before. Though they used to be changed yearly, the individual IPP's had not yet been updated.	S 062		
S 063	26 TAC §261.212; §551.42(i) Active Treatment 26 TAC §261.212 A program provider must comply with the entire: 1) Subchapter C (relating to Standards for Licensure); 2) Subchapter D (relating to General Requirements for Facility Construction); 3) Subchapter F (relating to Inspection, Surveys, and Visits). 26 TAC §551.42(i) (i) Active treatment services. A facility must ensure a resident receives a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services in the IPP created	S 063	**S 063** **CORRECTIVE ACTION TAKEN FOR AFFECTED CLIENTS** IDT will ensure specific management requirements are met by ensuring the QIDP monitors the active treatment programming for affected individuals by August 4th, 2025 and at least yearly following to include Annual Staffing, Comprehensive Functional Assessments, and IPP program data sheets. The QIDP will ensuring nursing services obtained preventive and recommended health care services.	8/4/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 063	Continued From page 13 by the IDT. [redacted] This deficient practice could affect the rights of the individuals and cause a delay in their potential growth towards becoming independent and delay all their active treatment services. Findings: [redacted]	S 063	Cont S 063 [redacted]	

Texas Health and Human Services Commission

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 063	Continued From page 14 [redacted]	S 063	Cont S 063 **IDENTIFICATION OF OTHER CLIENTS AT RISK** [redacted] **SYSTEMATIC CHANGES TO PREVENT REOCCURRENCE** IDT team, inclusive of PD, QIDP, Nursing, Dietary, LAR/Guardian and client will review client's treatment plan quarterly. QIDP and Nursing will review client's healthcare appointments monthly and address any concerns. The Program Assistant and Nursing staff will schedule healthcare appointments weekly. QIDP will implement tracking system and monitor due dates of Annual Staffing, IPP Program data sheets, Comprehensive Functional Assessments, Dental/Vision/Hearing/Healthcare consultations. **QA MONITORING SYSTEMS** The Program Director will conduct a monthly review of the QIDP's caseload to verify compliance with regulatory timelines. Audit findings will be reviewed during monthly administrative meetings and corrective actions will be implemented immediately if deficiencies are found. The governing body will receive quarterly reports on compliance status and trend.	

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S 063	Continued From page 15	S 063		

[redacted]

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S 063	Continued From page 16	S 063		

[redacted]

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S 063	Continued From page 17 process to align their conflicting schedules to have the outdated documentation and assessments scheduled and completed within the next two weeks. Interview with the Program Director on 6/27/2025 at 1:05 pm revealed that she had been in the position for the past three months and was aware that the annual staffing, ISP, and IPP for all individuals had not been updated. She added that the QIDP who was also new in her position, though with the company for many years was aware of the deficient practice. The PD stated that she, in conjunction with family members, guardians, and the QIDP were in the process to align their conflicting schedules to have the outdated documentation and assessments scheduled and completed within the next two weeks. Interview with the Day Hab Supervisor (DHS) on 06/27/2025 at 10:15 am revealed that he was aware that individuals Individual Support Plans and Individual Program Plan were not up to date and that individuals were still working on objectives from the year before. The DHS stated the QIDP completes yearly assessments and schedules ISP meetings and during the meeting the DHS and the QIDP on the collaborative effort determine the IPP objective and goals the individuals will be working on throughout the year. The DHS acknowledged that the 2025 assessments and annual planning meeting had not been scheduled. He stated that he would not use the word "regress" but acknowledged the fact that not having updated ISPs and IPPs could have a negative impact on the individual's progression or skill acquisition. Interview with the Direct Support Professional A (DSP A) on 06/27/2025 at 10:59 am revealed that individuals were still working on Individual Program Plans dated from the year before.	S 063		

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S 063	Continued From page 18 Though they used to be changed every six months, the individual IPP's had not yet been updated. Interview with the Direct Support Professional B (DSP B) on 06/27/2025 at 11:15 am revealed that individuals were still working on Individual Program Plans dated from the year before. Though they used to be changed yearly, the individual IPP's had not yet been updated.	S 063		
S 065	26 TAC §261.212; §551.42(k) Health Care Services 26 TAC §261.212 A program provider must comply with the entire: 1) Subchapter C (relating to Standards for Licensure); 2) Subchapter D (relating to General Requirements for Facility Construction); 3) Subchapter F (relating to Inspection, Surveys, and Visits). 26 TAC §551.42(k) (k) Health care services. A facility must provide or obtain preventative and general medical care for a resident and ensure a resident receives nursing services in accordance with the resident's needs. This Requirement is not met as evidenced by: [redacted]	S 065	S 065 **CORRECTIVE ACTION TAKEN FOR AFFECTED CLIENTS** Governing body will ensure specific management requirements are met by ensuring the QIDP monitors the active treatment programming for affected individuals by August 4th, 2025 and at least yearly following to include Annual Staffing, Comprehensive Functional Assessments, and IPP program data sheets. The QIDP will ensure that nursing services are obtained for preventive and recommended health care services. Individual #1's Annual Dental Consultation to be completed on 8/15/2015 Individual #2's Annual Hearing Consultation to be completed on 9/29/2025 Individual #3s Annual Dental Consultation to be completed on 8/8/2025 Individual #4s Annual Dental Consultation to be completed on 8/8/2025.	8/4/2025

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	[redacted]	A. BUILDING: _____ B. WING [redacted]	[redacted]27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

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S 065	Continued From page 19 [redacted]	S 065	Cont. S 065 **IDENTIFICATION OF OTHER CLIENTS AT RISK** [redacted] **SYSTEMATIC CHANGES TO PREVENT REOCCURRENCE** IDT team, inclusive of PD, QIDP, Nursing, Dietary, LAR/Guardian and client will review client's treatment plan quarterly. QIDP and Nursing will review client's healthcare appointments monthly and address any concerns. The Program Assistant and Nursing staff will schedule healthcare appointments weekly. QIDP will implement tracking system and monitor due dates of Annual Staffing, IPP Program data sheets, Comprehensive Functional Assessments, Dental/Vision/Hearing/Healthcare consultations. **QA MONITORING SYSTEMS** The Program Director will conduct a monthly review of the QIDP's caseload to verify compliance with regulatory timelines. Audit findings will be reviewed during monthly administrative meetings and corrective actions will be implemented immediately if deficiencies are found. The governing body will receive quarterly reports on compliance status and trend.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 065	Continued From page 20 Some procedures are intolerable to individuals and require anesthesia which would involve getting consents. At times guardians are not in agreement with the sedation procedure for medical appointments and assessments.	S 065		

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]
Executive Commissioner

July 14, 2025

Electronic Mail

[redacted]
CEO
Applewhite
[redacted]

Provider ID #: [redacted]
Facility ID #: [redacted]
Intermediate Care Facility for Individuals with Intellectual Disability (ICFs/IID)

Dear [redacted]

Enclosed you will find documents relating to the Life Safety Code Survey conducted at the above referenced facility dated July 2, 2025. Attached are the set(s) of documents which include(s) the Centers for Medicare and Medicaid Services (CMS) Statement of Deficiencies and Plan of Correction (Form CMS-2567) and the Texas Health and Human Services Commission (HHSC) Statement of Licensing Violations and Plan of Correction (HHSC Form 3724).

26 Texas Administrative Code (TAC) §551.192(f) requires a facility to submit an acceptable PoC by the **tenth working day** from receipt of this notice letter. Please prepare a PoC for each violation on the HHSC Form 3724 and submit it to the address listed below no later than **ten working days** from receipt of this letter.

Please take note of the event identification number in the center of the bottom of each set of forms; this identification number is specific to each event. For any exactly duplicated tag on the various sets of documents, you must write a PoC **for each tag on each set of forms**. You must sign all originals when you enter your plans of correction **on each set of forms**.

You may e-mail, fax or mail these **<u>original</u>** signed and completed forms to the address listed below.

[redacted], Program Manager
Texas Health and Human Services Commission
Region 06
[redacted]

State Operations Manual §3006.5(C)(1)(a-e) requires that an acceptable PoC must include:

- how the corrective action for the deficient practice will be accomplished for individuals found to have been affected by the deficient practice;
- how the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations;
- what measures will be put into place or what systemic changes will be made to ensure that the

deficient practice will not recur;
- how the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent; and
- when the facility will accomplish corrective action. (Note: The completion date must be reasonable for the deficient practice cited. **If you reference the content of the PoC for another tag, you must give a completion date for each tag.)**

Since the HHSC-3724 and CMS-2567 forms are subject to public disclosure, do not use proper names in the PoC. In addition to the above elements, the facility's administrator or other authorized official must sign and date the PoC.

INFORMAL DISPUTE RESOLUTION

You have the opportunity to dispute the cited deficiencies/violations through the IDR process in accordance with Texas Government Code Section 531.058 and Texas Administrative Code, Title 1 Part 15, Chapter 393. If you would like to dispute the deficiencies/violations through the IDR process, you must submit an IDR Request Form within 10 calendar days after receiving the Forms 2567/3724 via email to [redacted] The IDR Request Form and instructions regarding submitting IDR supporting documentation can be found on the IDR website at:
https://www.hhs.texas.gov/business/contracting-hhs/informal-dispute-resolution-process.

Please let me know if you have any questions or need additional information. I can be reached by phone at [redacted] or by e-mail at [redacted].

Sincerely,

[redacted]
Regional Coordinator, Region 06
Regulatory Services

bcv

Enclosure

Texas Health and Human Services

Report of Contact
Intermediate Care Facilities for Individuals with Intellectual Disabilities

Form 3614-A
Dec 2019

Region: 06	Life Safety Code Visit	Entrance Date: 07-02-2025 8:30 AM	Exit Date: 07-02-2025

Facility Name APPLEWHITE	Telephone [redacted]	FAX
Address – Street (physical location) [redacted] RIVE [redacted]	TULIP Facility ID: [redacted] County: Harris	

PURPOSE OF CONTACT:

LICENSING INSPECTION;SSP INSPECTION;STANDARD SURVEY/RE-SURVEY

Follow Up Visit (original exit date) – SURVEY/INVESTIGATION

Intakes Number(s) Investigated

IID Capacity: 6	IID Census:

LTCR STAFF REPORTING

Name	Title
[redacted]	Safety Offcr II

REGULATORY DECISIONS AND SANCTIONS RECOMMENDED

DOES NOT MEET STANDARDS OF PARTICIPATION; SSP-VIOLATIONS CITED; FOLLOW UP WITH POC.

REFERRALS

ADMINISTRATIVE

ACO ID: [redacted]

NARRATIVE

[redacted] Program Assistant
[redacted] Manager of Residential Services
[redacted] Maintenance Technician
Health Narrative attached: No; LSC Narrative attached: No

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 07/14/2025 1:41:00PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**07/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Purpose of visit: Licensure Inspection Date of Entry: 7/2/25 Census: 6 Abbreviations/Acronyms used: S/S = Scope and Severity NFPA = National Fire Protection Association p.m. = post meridiem a.m. = ante meridiem # = number symbol	S 000		
S 169	26 TAC §261.212; §551.62(a)(5) MeetLicStd: S & G/ Maintenance 26 TAC §261.212 A program provider must comply with the entire: 1) Subchapter C (relating to Standards for Licensure); 2) Subchapter D (relating to General Requirements for Facility Construction); 3) Subchapter F (relating to Inspection, Surveys, and Visits). 26 TAC §551.62(a)(5) (5) All outside areas, grounds, adjacent buildings, etc., on the site shall be maintained in good condition and kept free of rubbish, garbage, untended growth, and other conditions which may constitute a fire or health hazard. This Requirement is not met as evidenced by: S/S = F Based on observation and interview, the facility	S 169		08/11/25

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE Program Director ICF and ISS (X6) DATE 7/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**07/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 169	Continued From page 1 failed to maintain 1 of 2 outside areas (the backyard) in good condition and not a condition which may constitute a health hazard. The facility failed to ensure an outside area was in good condition and not a condition which may constitute for a health hazard, by allowing standing water in a mop bucket, a plastic bin, and on a plastic lid to develop algae-like growth and a breeding site for water-borne insects and larvae. This deficient practice of not ensuring an outside area was in good condition affected the Individuals that participate in outdoor activities, decreasing the quality of life by being outdoors, and exposure to flying insect bites. Finding included: Observation on 7/2/25 at 9:55 a.m. of the facility's backyard area revealed a square plastic bin, a mop bucket, and the top of a plastic bin's lid filled with standing water that had turned dark green with algae-like growth, located behind a wooden fence area next to the main wooden fence gate to the front yard of the facility and against the facility wall. Further observation revealed standing waters were a breeding site for water-borne insects and larvae. Many flying biting insects flew around the area when surveyor had gotten closer and was bitten. In an interview on 7/2/25 at 11:26 a.m. with the Program Assistant at the exit conference, when asked if she was aware of the standing water in plastic bins and that they were a breeding site for water-borne insects and larvae, she stated no. She further stated she will let Maintenance know immediately so they could take care of that. When asked how long do you think the standing	S 169	**S169** **CORRECTIVE ACTION TAKEN** The facility will perform monthly environmental checks of all outside areas, grounds, adjacent buildings, and on the site. Maintaining good condition and kept free of rubbish, garbage, untended growth, and other conditions for affected individuals by August 11, 2025. **IDENTIFICATION OF OTHERS AT RISK** All residents were at risk due to the deficient practice, with 6 out of 6 residents directly affected. This facility failure could put all individuals at risk for exposure to water-borne insects and larvae, preventing outdoor activities, and decreasing the quality of life by outside exposed to flying insect bites. **SYSTEMATIC CHANGES TO PREVENT REOCCURRENCE** Residential Services staff (inclusive of QIDP, PA, and DSPs) will receive initial training upon hire, followed by annual and as-needed training on environment safety checks and inputting upkeep ticket to have facilities address any issues. PA will reinforce these practices through monthly compliance checks. **QA MONITORING SYSTEM** The QIDP will oversee the compliance of the PA ensuring one environmental safety check is done each month. The PA will oversee the compliance of the DSP staff ensuring the any required environmental issues are submitted with an upkeep ticket. The PD will monitor the performance and compliance on a quarterly cadence.	

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 07/14/2025 1:41:00PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**07/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 169	Continued From page 2 waters had been present, she stated she could not tell. When asked who would be responsible for environmental checks, she stated it should be herself, but she was not told to do so. When asked had a check been conducted in the outside area, she stated she had never been inside that fenced area. When asked what the potential outcome would be, she stated this could potentially affect staff and Individuals by mosquito attacks. She further stated the facility will quickly take care of this to get the staff and Individuals out of risk. When asked how many Individuals would be affected, she stated all 6 Individuals.	S 169		

Texas Health and Human Services Commission

Form 3630 - ICF
July 2024

Intermediate Care Facility
Survey/Inspection Summary Report

The Texas Health and Human Services Commission Regulatory Services division conducted a survey or inspection on 07/02/2025

Facility Name	Type of Facility
Applewhite	Intermediate Care Facility for Individuals with Intellectual Disabilities
Street Address [redacted]	City, State, ZIP Code [redacted]

The items on the following charts represent areas that the survey team surveyed or inspected for compliance with state and/or federal requirements. Only the items checked Yes or No are applicable to this report; other deficiencies in areas not checked may still be pending and not reflected on this current report. You may obtain a copy of the complete report, including outstanding deficiencies, from the facility administration.

Life Safety Code Survey or Inspection

	Compliance			Compliance			Compliance	
	Yes	No		Yes	No		Yes	No
1. Fire Alarm System	x		3. Emergency Electrical System	x		5. Other: See CMS Form 2567		
2. Sprinkler System	x		4. Physical Plant and Environment		x	6. Other:		

Health Survey or Inspection (ICF/IID)

1. Governing Body and Management			5. Client Behavior and Facility Practices			9. State Standards for Participation		
2. Client Protections			6. Health Care Services			10. Licensure:		
3. Facility Staffing			7. Physical Environment					
4. Active Treatment			8. Dietetic Services					

If you need further information, you may call the HHSC regional office at [redacted]

The Survey/Inspection Summary Report must be posted in an area of the facility that is readily available to residents, clients, employees and visitors in accordance with the facility's appropriate licensure regulations at Texas Administrative Code, Title 26, Part 1, Chapter 551, §551.326.

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]
Executive Commissioner

August 20, 2025

Administrator
Applewhite
[redacted]

Provider #: [redacted]
[redacted]
Type: ICF/IID

Dear Administrator:

On August 20, 2025, the Texas Health and Human Services Commission (HHSC) conducted a Life Safety Code non-onsite follow-up, to determine if your facility complies with state licensure requirements and federal participation requirements for ICF/IID facilities in the Medicare or Medicaid (or both) programs. The survey found that your facility **meets** state licensure requirements and **is in substantial compliance** with federal participation requirements.

If you have any questions, please contact [redacted] Life Safety Code Program Manager at [redacted]

Sincerely,

[redacted]
[redacted], Life Safety Code Program Manager
Regulatory Services Division, Region 06

[redacted]

[redacted]

Texas Health and Human Services | Report of Contact
Intermediate Care Facilities for Individuals with Intellectual Disabilities | Form 3614-A
Dec 2019

Region: 06	Life Safety Code Visit	Entrance Date: 08-20-2025 9:00 AM	Exit Date: 08-20-2025

Facility Name APPLEWHITE	Telephone [redacted]	FAX
[redacted]dress – Street (physical location) [redacted]	TULIP Facility ID: [redacted] County: Harris	

PURPOSE OF CONTACT:

FOLLOW-UP TO LICENSURE INSPECTION;NON-ONSITE FOLLOW-UP

Follow Up Visit (original exit date) – SURVEY/INVESTIGATION 07-02-2025

Intakes Number(s) Investigated

IID Capacity: 6	IID Census:

LTCR STAFF REPORTING

Name	Title
[redacted]	LIFE SAFETY CODE PROGRAM MANAGER

REGULATORY DECISIONS AND SANCTIONS RECOMMENDED

MEETS LICENSURE REQUIREMENTS (LSC);NO DEFICIENCIES CITED (LSC);NO LICENSURE VIOLATIONS CITED (LSC)

REFERRALS

ADMINISTRATIVE

ACO ID: [redacted]

NARRATIVE

Date Printed: 08/20/2025 10:56:50AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	R 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments Purpose of Visit: Non-Onsite Follow-Up No deficiencies cited.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Date Printed: 08/20/2025 10:56:39AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING **01 - MAIN BUILDING** B. WING _____	R **08/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Purpose of Visit: Non-Onsite Follow-Up No deficiencies cited.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 08/20/2025 10:56:27AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Initial Comments Purpose of Visit: Non-Onsite Follow-Up No violations cited.	{S 000}		

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]
Executive Commissioner

July 24, 2025

ELECTRONIC MAIL

[redacted]
CEO
Westbury House
[redacted]

Provider ID #: [redacted]
Facility ID #: [redacted]
Intermediate Care Facility for Individuals with Intellectual Disability (ICFs/IID)

Dear [redacted]:

Enclosed you will find documents relating to the standad survey conducted at the above referenced facility dated 7/10/25 and 7/11/25. Attached are the set(s) of documents which include(s) the Centers for Medicare and Medicaid Services (CMS) Statement of Deficiencies and Plan of Correction (Form CMS-2567) and the Texas Health and Human Services Commission (HHSC) Statement of Licensing Violations and Plan of Correction (HHSC Form 3724).

42 Code of Federal Regulations (CFR) §488.110(k) requires a facility to submit an acceptable Plan of Correction (PoC) by the **tenth calendar day** from receipt of this notice letter. Please prepare a PoC for each deficiency on the Form CMS-2567 and submit the PoC to the address listed below no later than **ten calendar days** from receipt of this letter.

26 Texas Administrative Code (TAC) §551.192(f) requires a facility to submit an acceptable PoC by the **tenth working day** from receipt of this notice letter. Please prepare a PoC for each violation on the HHSC Form 3724 and submit it to the address listed below no later than **ten working days** from receipt of this letter.

Please take note of the event identification number in the center of the bottom of each set of forms; this identification number is specific to each event. For any exactly duplicated tag on the various sets of documents, you must write a PoC **for each tag on each set of forms**. You must sign all originals when you enter your plans of correction **on each set of forms**.

You may e-mail, fax or mail these <u>original</u> signed and completed forms for the Health Survey to the address listed below.

[redacted]

You may e-mail, fax or mail these <u>original</u> signed and completed forms for the Life Safety Code tags to the address listed below.

[redacted]

[redacted]
07/24/2025
Page 2

[redacted]
fax: [redacted]
email: [redacted]

State Operations Manual §3006.5(C)(1)(a-e) requires that an acceptable PoC must include:

- how the corrective action for the deficient practice will be accomplished for individuals found to have been affected by the deficient practice;
- how the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations;
- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur;
- how the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent; and
- when the facility will accomplish corrective action. (Note: The completion date must be reasonable for the deficient practice cited. **If you reference the content of the PoC for another tag, you must give a completion date for each tag.)**

Since the HHSC-3724 and CMS-2567 forms are subject to public disclosure, do not use proper names in the PoC. In addition to the above elements, the facility's administrator or other authorized official must sign and date the PoC.

INFORMAL DISPUTE RESOLUTION

You have the opportunity to dispute the cited deficiencies/violations through the IDR process in accordance with Texas Government Code Section 531.058 and Texas Administrative Code, Title 1 Part 15, Chapter 393. If you would like to dispute the deficiencies/violations through the IDR process, you must submit an IDR Request Form within 10 calendar days after receiving the Forms 2567/3724 via email to IDR@hhsc.state.tx.us. The IDR Request Form and instructions regarding submitting IDR supporting documentation can be found on the IDR website at:
https://www.hhs.texas.gov/business/contracting-hhs/informal-dispute-resolution-process.

If you have any questions about the information in this letter or need additional information regarding the Health Survey, please contact [redacted] MHCM, ICF Program Manager at [redacted] or by email at [redacted]
Please let me know if you have any questions or need additional information regarding the Life Safety Code Survey. I can be reached by phone at [redacted] or by e-mail at [redacted]

Sincerely,

Texas Health and Human Services

Report of Contact
Intermediate Care Facilities for Individuals with Intellectual Disabilities

Form 3614-A
Dec 2019

Region: 06	Life Safety Code Visit	Entrance Date: 07-10-2025 8:45 AM	Exit Date: 07-10-2025

Facility Name WESTBURY HOUSE	Telephone [redacted]	FAX
Address – Street (physical location) [redacted]	TULIP Facility ID: [redacted] County: Harris	

PURPOSE OF CONTACT:

LICENSING INSPECTION;STANDARD SURVEY/RE-SURVEY

Follow Up Visit (original exit date) – SURVEY/INVESTIGATION

Intakes Number(s) Investigated

IID Capacity: 6	IID Census:

LTCR STAFF REPORTING

Name	Title
[redacted]	Safety Offcr II

REGULATORY DECISIONS AND SANCTIONS RECOMMENDED

DEFICIENCIES CITED (LSC);DOES NOT MEET LICENSURE REQUIREMENTS (LSC);LICENSURE VIOLATIONS CITED (LSC); FOLLOW UP WITH POC

REFERRALS

ADMINISTRATIVE

ACO ID: [redacted]

NARRATIVE

Texas Health and Human Services Commission

Form 3630 - ICF
July 2024

Intermediate Care Facility
Survey/Inspection Summary Report

The Texas Health and Human Services Commission Regulatory Services division conducted a survey or inspection on 07/10/2025

Facility Name	Type of Facility
Westbury House	Intermediate Care Facility for Individuals with Intellectual Disabilities
Street Address	City, State, ZIP Code
[redacted]	[redacted]

The items on the following charts represent areas that the survey team surveyed or inspected for compliance with state and/or federal requirements. Only the items checked Yes or No are applicable to this report; other deficiencies in areas not checked may still be pending and not reflected on this current report. You may obtain a copy of the complete report, including outstanding deficiencies, from the facility administration.

Life Safety Code Survey or Inspection

	Compliance			Compliance			Compliance	
	Yes	No		Yes	No		Yes	No
1. Fire Alarm System	X		3. Emergency Electrical System			5. Other: See CMS Form 2567		X
2. Sprinkler System			4. Physical Plant and Environment	X		6. Other:		

Health Survey or Inspection (ICF/IID)

1. Governing Body and Management			5. Client Behavior and Facility Practices			9. State Standards for Participation		
2. Client Protections			6. Health Care Services			10. Licensure:		
3. Facility Staffing			7. Physical Environment					
4. Active Treatment			8. Dietetic Services					

If you need further information, you may call the HHSC regional office at [redacted]

The Survey/Inspection Summary Report must be posted in an area of the facility that is readily available to residents, clients, employees and visitors in accordance with the facility's appropriate licensure regulations at Texas Administrative Code, Title 26, Part 1, Chapter 551, §551.326.

Texas Health and Human Services Commission

Form 3630 - ICF
July 2024

Intermediate Care Facility
Survey/Inspection Summary Report

The Texas Health and Human Services Commission Regulatory Services division conducted a survey or inspection on 07/11/2025 WESTBURY

Facility Name	Type of Facility
Westbury House	Intermediate Care Facility for Individuals with Intellectual Disabilities
Street Address	**City, State, ZIP Code**
[redacted]	[redacted] [redacted]

The items on the following charts represent areas that the survey team surveyed or inspected for compliance with state and/or federal requirements. Only the items checked Yes or No are applicable to this report; other deficiencies in areas not checked may still be pending and not reflected on this current report. You may obtain a copy of the complete report, including outstanding deficiencies, from the facility administration.

Life Safety Code Survey or Inspection

	Compliance			Compliance			Compliance	
	Yes	No		Yes	No		Yes	No
1. Fire Alarm System			3. Emergency Electrical System			5. Other: See CMS Form 2567		
2. Sprinkler System			4. Physical Plant and Environment			6. Other:		

Health Survey or Inspection (ICF/IID)

1. Governing Body and Management	X		5. Client Behavior and Facility Practices	X		9. State Standards for Participation		
2. Client Protections	X		6. Health Care Services	X		10. Licensure:		
3. Facility Staffing	X		7. Physical Environment		X			
4. Active Treatment	X		8. Dietetic Services	X				

If you need further information, you may call the HHSC regional office at [redacted]

The Survey/Inspection Summary Report must be posted in an area of the facility that is readily available to residents, clients, employees and visitors in accordance with the facility's appropriate licensure regulations at Texas Administrative Code, Title 26, Part 1, Chapter 551, §551.326.

Date Printed: 07/24/2025 10:44:42AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Purpose of Visit: Standard Survey/ Resurvey Date of Entry: 7/10/25 Census: 5 42 CFR Part 483.73 Requirements for Long Term Care Facilities Abbreviations used: NFPA- National Fire Protection Association Westbury House is in substantial compliance with 42 CFR Part 483.73 Requirements for Emergency Preparedness, no deficiencies were cited.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] [redacted] | TITLE: Program Director ICF and ISS | (X6) DATE: 8/4/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Date Printed: 07/24/2025 10:59:03AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS 07/08/2025 Purpose of visit: Focus Fundamental Survey Entrance Date: July 08, 2025 Facility Census: 5 ABBREVIATIONS: PD Program Director QIDP Qualified Intellectual Disability Professional DHS Day Habilitation Supervisor RN Registered Nurse RD Registered Dietician AM Morning DSP Direct Support Professional PM Afternoon BSP Behavior Support Plan IDT Interdisciplinary Team ANE Abuse, Neglect, And Exploitation HM House Manager DHC Day Habilitation Supervisor IDD Intellectual and Developmental Disablity	W 000		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to complete fire drill reports at expected and unexpected times under varying conditions, at least quarterly on each shift during one of four quarters (the fourth quarter of 2024). for 5 of 5 individual reviewed for Physical Environment. (Individuals #1, Individuals #2,	W 440		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] | TITLE: Program Director ICF and ISS | (X6) DATE: 7/25/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Date Printed: 07/24/2025 10:59:03AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 440	Continued From page 1 Individuals #3, Individuals #4 and individual #5). The Facility failed specifically to: There were no fire drills reports for the 1st shift, 2nd shift, and 3rd shift during the 4th quarter of 2024. This failure could affect the safety of residents, in the event of a fire and the staff are unaware of their responsibilities and duties and unprepared to evacuate residents at any time in case of a fire emergency, exposing residents to smoke inhalation and fire related bodily injuries. [redacted]	W 440	**W 440** **CORRECTIVE ACTION TAKEN** All Residential staff, inclusive of QIDP, PA, and DSP will be trained on Fire Drill protocol by 8/11/2025 inclusive of all shifts learning evacuation routes, designated meeting area and documentation requirements. **IDENTIFICATION OF OTHERS AT RISK** All residents were at risk due to the deficient practice, with 5 out of 5 residents directly affected. This facility failure could put all individuals at risk for smoke inhalation if staff and individuals are not trained over the fire drill procedures, potentially causing a delay in evacuation during a fire. **SYSTEMATIC CHANGES TO PREVENT REOCCURRENCE** Residential Services staff (inclusive of QIDP, PA, and DSPs) will receive initial training upon hire, followed by annual and as-needed training on fire drill protocol by PA. PA will reinforce these practices through monthly compliance checks. **QA MONITORING SYSTEM** The QIDP will oversee the compliance of the PA ensuring one fire drill per shift each calendar quarter as required, met with evidence. The PA will oversee the compliance of the DSP staff ensuring the required one fire drill per shift each calendar quarter is met with evidence. The PD will monitor the performance and compliance on a quarterly cadence.	08/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 440	Continued From page 2	W 440		

[redacted]

[redacted]

Record review of the Facility Fire Drill Reports revealed that fire drills were conducted at the house regularly from 01/09/2025 at 06:05 p.m. to 06/30/2025 at 12:30 p.m. but fire drills for the 1st shift, 2nd shift, and 3rd shift during the 4th quarter of 2024 were missing.

Interview with the RN on 7/11/2025 at 1:30 pm revealed that she had been in the position for the past 11 months. She stated that she was not aware that individuals were missing fire drills and E-Scores. The RN stated that individual was located to a different home during the Beryl Storm but was not aware they had missing Fire Drills and E-Scores. The RN stated that individual not being able to escape could lead to injury or death. Individual not knowing how to escape could delay their escape and further put them in harm ways.

Interview with the Program Director on 7/11/2025 at 02:06 pm revealed that she had been in the position for the past three months and She stated that she was not aware that individuals were missing fire drills and E-Scores. The PD stated that the Fire Drills are entered electronically to a system, with incident management. The PD stated that moving forward the PD and QIDP would be included in the emails chains to make sure it happens as scheduled and that a backup

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 440	Continued From page 3	W 440		

copy is maintained. The PD stated that individual was located to a different home during the Beryl Storm but was not aware they had missing Fire Drills and E-Scores. The PD stated that individual not being able to escape could lead to injury or death. Individual not knowing how to escape could delay their escape and further put them in harm ways.

Interview with the QIDP on 7/11/2025 at 02:15 pm revealed that she had been in the position for the past three months and She stated that she was not aware that home was missing fire drills and E-Scores. The QIDP stated that individuals were located to a different home during the Beryl Storm but was not aware they had missing Fire Drills and E-Scores. The QIDP stated that the Fire Drills are entered electronically to a system, with incident management. The PD stated that moving forward the PD and QIDP would be included in the emails chains to make sure it happens as scheduled and that a backup copy is maintained. The QIDP stated Fire Drills, and E-Score would be part of the documents she gets from the Home every month. The QIDP stated that individual not being able to escape could lead to injury or death. Individual not knowing how to escape could delay their escape and put their life and safety at risk.

Policy: Dated 04/28/2025 and Titled: Individualized Skills and Socialization Quarterly Fire Drill Policy

Stated as follows:

Onsite Fire Drills are conducted and documented Quarterly.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 440	Continued From page 4	W 440		

1-Purpose

-Fire drill is a practice of the emergency procedure to be used in a case of a real fire
-A fire drill is a method of practicing how a building would be evacuated in the event of a real fire or other emergencies
-A fire drill is an organized evacuation
-The purpose of a fire drill is to test and evaluate the efficiency the knowledge and the response of the personnel implementing the facility fire emergency plan
-The purpose of a fire drill is to familiarize and or reinforce proper evacuation routes and practices
-The goal is to have the proper actions be an automatic
-Behaving correctly during a fire drill will train everyone to respond calmly and safely in the unlikely event of the real fire

2-Benefit

-Simulated fire drills, help everyone including staff, prepared to respond to a real fire, emergency quickly, calmly, and safely
-Simulated fire drills are important requirements that serve to prepare and educate staff in the event of the real fire. All staff are expected to participate in a fire drills.
-Participation in fire drills, help ensure that all staff respond quickly inappropriately
-Simulated fire drills what to do in an emergency is the goal of any fire or other drills?

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]
Executive Commissioner

NOTICE OF ACCEPTED PLAN OF CORRECTION

This fax/e-mail consists of one page only.

To:	[redacted]
Facility Name:	Westbury House
Facility ID Number:	[redacted]
Telephone Number:	[redacted]
Fax Number:	
From:	ICF/IID Manager/Superintendent/Director/Representative
Program:	HHSC Regulatory Services, 06 Regional Office
Phone Number:	[redacted]
Fax Number:	[redacted]
Mail Code:	[redacted]
Address:	[redacted]

We accepted your plan of correction for the following visit(s):

X **Health** ☐ **LSC** **Exit Date:** *07/11/2025*

Follow-up Visit Information (Select only the statements that apply)**:**

X **A follow-up visit may be scheduled to determine compliance for violations or deficiencies cited**. (Select this statement after the original visit and first on-site follow-up visit.)

☐ **An additional follow-up visit, if authorized, may be scheduled to determine compliance for violations or deficiencies cited**. (Select this statement after the second on-site follow-up visit.)

☐ **The plan of correction (PoC) or evidence of correction or both may be accepted as determination of correction in lieu of conducting an on-site follow-up visit for violations or deficiencies cited.** (Select this statement when violations or deficiencies will be followed-up by a desk review.)

Evidence Request (Select the following statement only when requesting evidence of correction for violations or deficiencies cited on the exit date referenced above):

As described in the preceding paragraph, **evidence** may be requested and accepted as verification of correction in lieu of conducting an on-site follow-up visit.

X **Submit evidence showing how the facility attained and maintains corrective action for the violation(s) or deficiency(ies) listed below:**

_____

_____

_____

Evidence must be received at the HHSC Regional Office listed above by: _____

Clearly identify which violation or deficiency each piece of evidence corresponds to. Examples of acceptable evidence include the following:

☐ An invoice or receipt verifying that purchases were made, repairs were completed, etc.

☐ Sign-in sheets verifying staff attendance at an in-service training.

☐ Copies of interviews with more than one training participant about an in-service training.

***If, during a future visit, violations or deficiencies that were corrected through PoC or evidence are again cited, HHSC may recommend enforcement actions, including immediate imposition of remedies.** If you have further questions or wish to revise your PoC completion date, please contact the program manager at the telephone number or address provided above.

Signed: [redacted] **Date**: *08/05/2025*

[redacted]

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]
Executive Commissioner

August 20, 2025

Administrator
Westbury House
[redacted]

Provider #: [redacted]
Facility ID #: [redacted]
Type: ICF/IID

Dear Administrator:

On August 20, 2025, the Texas Health and Human Services Commission (HHSC) conducted a Life Safety Code non-onsite follow-up, to determine if your facility complies with state licensure requirements and federal participation requirements for ICF/IID facilities in the Medicare or Medicaid (or both) programs. The survey found that your facility **meets** state licensure requirements and **is in substantial compliance** with federal participation requirements.

If you have any questions, please contact [redacted], Life Safety Code Program Manager at [redacted]

Sincerely,

[redacted]
[redacted], Life Safety Code Program Manager
Regulatory Services Division, Region 06

[redacted]

Texas Health and Human Services | Report of Contact
Intermediate Care Facilities for Individuals with Intellectual Disabilities | Form 3614-A
Dec 2019

Region: 06	Life Safety Code Visit	Entrance Date: 08-20-2025 11:00 AM	Exit Date: 08-20-2025

Facility Name WESTBURY HOUSE	Telephone [redacted]	FAX
Address – Street (physical location) [redacted]	TULIP Facility ID: [redacted] County: Harris	

PURPOSE OF CONTACT:

FOLLOW-UP TO LICENSURE INSPECTION;NON-ONSITE FOLLOW-UP

Follow Up Visit (original exit date) – SURVEY/INVESTIGATION 07-10-2025

Intakes Number(s) Investigated

IID Capacity: 6	IID Census:

LTCR STAFF REPORTING

Name	Title
[redacted]ITH	LSC PROGRAM MANAGER

REGULATORY DECISIONS AND SANCTIONS RECOMMENDED

MEETS LICENSURE REQUIREMENTS (LSC);NO DEFICIENCIES CITED (LSC);NO LICENSURE VIOLATIONS CITED (LSC)

REFERRALS

ADMINISTRATIVE

ACO ID: [redacted]

NARRATIVE

Date Printed: 08/20/2025 11:32:16AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	R 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments Purpose of Visit: Non-onsite Follow Up No deficiencies cited.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Date Printed: 08/20/2025 11:32:05AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING **01 - MAIN-BUILDING** B. WING _____	R **08/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Purpose of Visit: Non-onsite Follow Up No deficiencies cited.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 08/20/2025 11:31:55AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: **01 - MAIN-BUILDING** B. WING _____	R **08/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	Initial Comments Purpose of Visit: Non-onsite Follow Up No violations cited.	{M 000}		

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]
Executive Commissioner

July 14, 2025

Electronic Mail

[redacted]
CEO
Pasadena Cottage
[redacted]
[redacted]

Provider ID #: [redacted]
Facility ID #: [redacted]
Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID)

Dear [redacted]:

The Texas Health and Human Services Commission (HHSC) visited the above referenced facility on June 27, 2025. HHSC staff recorded a number of deficiencies and violations that form the basis for the proposed action against the facility's certification and Medicaid provider agreement as described in this letter. The Statement of Deficiencies and Plan of Correction (Form CMS-2567) and the Statement of Licensing Violations and Plan of Correction and the State Standards for Participation (HHSC Form 3724) are enclosed for your reference. You will receive a separate notice if HHSC proposes any action against the licensure of Pasadena Cottage. The notice will describe any appeal rights associated with the licensure action.

Purpose of Visit: Re-certification Health survey; Fundamental Survey; SSP Inspection
Action: Decertification effective: September 25, 2025.

Deficiencies causing the action:

__xx_ Deficiencies that jeopardize resident health and safety and/or limit the facility's capacity to render adequate care: [(W102/W104, W158/W159, W318/W331)].

Plans of Correction

In accordance with Chapter 2, §2728, of the State Operations Manual (SOM), you must submit an acceptable Plan of Correction (PoC) by the **tenth calendar day** after you receive the enclosed Form CMS-2567. You must prepare a PoC for each deficiency on the Form CMS-2567 and submit the PoC(s) to the HHSC regional office at the address stated below within **ten calendar days** after you receive this letter.

In accordance with Texas Administrative Code (TAC), Title 26, §551.192(f), you must submit an acceptable POC within **ten working days** after you receive the enclosed HHSC Form 3724. You must prepare a PoC for each violation identified on the HHSC Form 3724 and submit the PoC(s) to the HHSC regional office at the address stated below within **ten working days** after you receive this letter.

The POCs serve as your representation that you are in compliance with applicable federal standards of participation (SoPs), federal conditions of participation (CoPs), and state rules. HHSC staff will

conduct one revisit to determine if the facility has achieved compliance with the SoPs, CoPs, and rules. If the facility fails to achieve compliance with those SoPs, CoPs, and rules within **45 calendar days** after you receive this letter HHSC will recommend termination of your Medicaid provider agreement effective (90 days after exit).

In accordance with SOM, Chapter 3, §3006.5(C)(1) (a-e), an acceptable PoC must include:

- how the corrective action for the deficient practice will be accomplished for individuals found to have been affected by the deficient practice;
- how the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations;
- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur;
- how the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur (i.e., what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent); and
- when the facility will accomplish corrective action. (Note: The date corrective action will be accomplished must be reasonable for the deficient practice cited). **The PoC for each deficiency must include a completion date.**

You must sign all originals when you enter your PoC on each set of Form CMS-2567. The Form CMS-2567 and HHSC Form 3724 are subject to public disclosure. Therefore, do not use proper names in any PoC that you submit. The facility's administrator or other authorized official must sign and date each PoC.

You must e-mail, fax, or mail the **original,** signed and completed Form CMS-2567 and HHSC Form 3724 to [redacted], MHCM, ICF Program Manager at the address below.

[redacted] MHCM, ICF Program Manager
[redacted]
[redacted]
fax: [redacted]
email: [redacted]

Informal Dispute Resolution Reconsideration (IDR)

In accordance with 1 TAC, §393.1, if issues were not resolved during the exit conference for the visit date of June 27, 2025, you may request an IDR to contest cited deficiencies and/or violations. To request an IDR, complete an IDR Request Form and submit the form to the Health and Human Services Commission (HHSC) within **ten calendar days** after you received the statement of deficiencies and/or violations.

The guidelines and procedures for requesting an IDR as well as the IDR Request Form are available at the following HHSC website:
https://hhs.texas.gov/doing-business-hhs/vendor-contractor-information/informal-dispute-resolution-process.

[redacted]
07/14/2025
Page 3

Submit the IDR Request form in accordance with the instructions provided on that website.

If you have any questions about the information in this letter, please contact [redacted], MHCM, ICF Program Manager at [redacted] or by email at [redacted].

Sincerely,

[redacted]
Regional Coordinator, Region 06
Regulatory Services

bcv

Enclosure

cc: Manager of Provider Licensing Enforcement, Regulatory Services

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]
Executive Commissioner

July 14, 2025

Electronic Mail

[redacted]
CEO
Pasadena Cottage
[redacted]

Provider ID #: [redacted]
Facility ID #: [redacted]
Intermediate Care Facility for Individuals with Intellectual Disability (ICFs/IID)

Dear [redacted]:

Enclosed you will find documents relating to the Life Safety Code Recertification/ Re-Licensure survey conducted at the above referenced facility dated June 26, 2025. Attached are [*number*] set(s) of documents which include(s) the Centers for Medicare and Medicaid Services (CMS) Statement of Deficiencies and Plan of Correction (Form CMS-2567) and the Texas Health and Human Services Commission (HHSC) Statement of Licensing Violations and Plan of Correction (HHSC Form 3724).

42 Code of Federal Regulations (CFR) §488.110(k) requires a facility to submit an acceptable Plan of Correction (PoC) by the **tenth calendar day** from receipt of this notice letter. Please prepare a PoC for each deficiency on the Form CMS-2567 and submit the PoC to the address listed below no later than **ten calendar days** from receipt of this letter.

26 Texas Administrative Code (TAC) §551.192(f) requires a facility to submit an acceptable PoC by the **tenth working day** from receipt of this notice letter. Please prepare a PoC for each violation on the HHSC Form 3724 and submit it to the address listed below no later than **ten working days** from receipt of this letter.

Please take note of the event identification number in the center of the bottom of each set of forms; this identification number is specific to each event. For any exactly duplicated tag on the various sets of documents, you must write a PoC **for each tag on each set of forms**. You must sign all originals when you enter your plans of correction **on each set of forms**.

You may e-mail, fax or mail these **<u>original</u>** signed and completed forms to the address listed below.

[redacted], Program Manager
Texas Health and Human Services Commission
Region 06
[redacted]

[redacted]

[redacted]
07/14/2025
Page 2

State Operations Manual §3006.5(C)(1)(a-e) requires that an acceptable PoC must include:

- how the corrective action for the deficient practice will be accomplished for individuals found to have been affected by the deficient practice;
- how the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations;
- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur;
- how the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent; and
- when the facility will accomplish corrective action. (Note: The completion date must be reasonable for the deficient practice cited. **If you reference the content of the PoC for another tag, you must give a completion date for each tag.)**

Since the HHSC-3724 and CMS-2567 forms are subject to public disclosure, do not use proper names in the PoC. In addition to the above elements, the facility's administrator or other authorized official must sign and date the PoC.

INFORMAL DISPUTE RESOLUTION

You have the opportunity to dispute the cited deficiencies/violations through the IDR process in accordance with Texas Government Code Section 531.058 and Texas Administrative Code, Title 1 Part 15, Chapter 393. If you would like to dispute the deficiencies/violations through the IDR process, you must submit an IDR Request Form within 10 calendar days after receiving the Forms 2567/3724 via email to IDR@hhsc.state.tx.us. The IDR Request Form and instructions regarding submitting IDR supporting documentation can be found on the IDR website at:
https://www.hhs.texas.gov/business/contracting-hhs/informal-dispute-resolution-process.

Please let me know if you have any questions or need additional information. I can be reached by phone at [redacted] or by e-mail at [redacted].

Sincerely,

[redacted]
Regional Coordinator, Region 06
Regulatory Services

bcv

Enclosure

Texas Health and Human Services | Report of Contact
Intermediate Care Facilities for Individuals with Intellectual Disabilities | Form 3614-A
Dec 2019

Region: 06	Life Safety Code Visit	Entrance Date: 06-26-2025 8:45 AM	Exit Date: 06-26-2025

Facility Name PASADENA COTTAGE	Telephone [redacted]	FAX
Address – Street (physical location) [redacted]	TULIP Facility ID: [redacted] County: Harris	

PURPOSE OF CONTACT:

LICENSING INSPECTION;STANDARD SURVEY/RE-SURVEY

Follow Up Visit (original exit date) – SURVEY/INVESTIGATION

Intakes Number(s) Investigated

IID Capacity: 6	IID Census:

LTCR STAFF REPORTING

Name	Title
[redacted]	Engineer V

REGULATORY DECISIONS AND SANCTIONS RECOMMENDED

DEFICIENCIES CITED (LSC);DOES NOT MEET LICENSURE REQUIREMENTS (LSC);LICENSURE VIOLATIONS CITED (LSC)

REFERRALS

ADMINISTRATIVE

ACO ID: [redacted]

NARRATIVE

[redacted] Program Assistant

Date Printed: 07/14/2025 12:17:49PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Purpose of visit: Standard Survey/Re-survey Entrance date: 6/26/25 Facility census: 5 Pasadena Cottage was in substantial compliance with 42 CFR Part 483.475 Emergency Preparedness Requirements for Intermediate Care Facilities for Persons with Intellectual Disabilities. Abbreviations used: CFR - Code of Federal Regulations	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Date Printed: 07/14/2025 12:19:02PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING **01 - MAIN-BUILDING** B. WING _____	**06/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Purpose of Visit: Standard Survey/Re-survey. Entrance date: 06/25/25 Facility census: 5 42 CFR Part 483.470(j) Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. Abbreviations used: CFR - Code of Federal Regulations NFPA - National Fire Protection Association.	K 000		
K0352	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals 2012 EXISTING (Prompt) Where a required automatic sprinkler system is installed, supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility, when sprinkler operation is impaired. An automatic sprinkler system in accordance with NFPA 13D would not require water flow alarms where a facility has smoke alarms or smoke detectors in accordance with NFPA 72. 9.7.2.1, 7.6 (NFPA 13D), NFPA 72 This STANDARD is not met as evidenced by: References: NFPA 101, Life Safety Code, 2012 Edition Chapter 9 Building Service and Fire Protection Equipment	K0352		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0352	Continued From page 1 9.7.2 Supervision. 9.7.2.1 Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition. Chapter 17 Initiating Devices 17.16 Supervisory Signal-Initiating Devices. 17.16.1 Control Valve Supervisory Signal-Initiating Device. 17.16.1.1 Two separate and distinct signals shall be initiated: one indicating movement of the valve from its normal position (off-normal), and the other indicating restoration of the valve to its normal position. 17.16.1.2 The off-normal signal shall be initiated during the first two revolutions of the handwheel or during one-fifth of the travel distance of the valve control apparatus from its normal position. 17.16.1.3 The off-normal signal shall not be restored at any valve position except normal. 17.16.1.4 An initiating device for supervising the position of a control valve shall not interfere with the operation of the valve, obstruct the view of its indicator, or prevent access for valve maintenance. Based on observation and interview, the facility	K0352		

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K0352	Continued From page 2 failed to ensure 1 of 2 supervisory devices or tamper switch for the fire sprinkler system control valves was installed and monitored the system according to NFPA 72, 17.16.1.1, 17.16.1.2, 17.16.1.3, and 17.16.1.4 as referred to by NFPA 101, 9.7.2.1. The facility did not ensure 1 of 2 control valves for the sprinkler system transmitted a local or remote alarm to the fire alarm control panel. This deficient practice could place individuals at risk of smoke inhalation or fire related injuries resulting from fire water supply being potentially interrupted and going undetected due to control valve supervision not being verified by a distinctive signal being emitted at the fire alarm control panel. Finding included: Observation on 06/26/25 at 10:02 a.m. revealed there was not a supervisory signal transmitted to the fire alarm control panel when closing the lower water control valve of the fire alarm system. In an interview on 06/26/25 at 11:35 a.m. with the Program Assistant, he acknowledged there was no supervisory signal transmitted to the fire alarm control panel when closing the lower control valve on the riser. He said he was not aware of this issue. He said he just started working here for two weeks. When asked if it could affect the individuals, he said "yes". When asked how it could affect the individuals, he said if someone turns off the valve, and there was no signal to alarm. He said he was responsible for the tamper switch.	K0352		

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K0353	Continued From page 3	K0353		
K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3).	K0353		

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K0353	Continued From page 4 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Reference: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition.	K0353		

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K0353	Continued From page 5 Chapter 5 Sprinkler Systems 5.2 Inspection. 5.2.1 Sprinklers. 5.2.1.1.1 Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). Based on observation and interview, the facility failed to ensure 1 of 10 fire sprinkler heads were maintained free of physical damage according to NFPA 25, 5.2.1.1.1. A fire sprinkler head was physically damaged and missing an escutcheon. This deficient practice could cause a delay in the activation of the sprinkler system during a fire, allow a fire to progress, and expose staff and residents in the facility to smoke inhalation and other fire-related bodily injuries. Finding included: Observation on 06/26/25 at 10:26 a.m. revealed the sprinkler head, in Bedroom 2, was physically damaged and did not have an escutcheon. In an interview on 06/26/25 at 11:35 a.m. with the Program Assistant at the exit conference, he acknowledged missing escutcheon in Bedroom 2. He said he was not aware of missing the escutcheon. When asked if the individuals could affect because of missing the escutcheon in Bedroom 2, he said "maybe". When asked how it could affect the individuals, he said, it could malfunction. He said he was responsible for the missing escutcheon.	K0353		

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K0712	Fire Drills CFR(s): NFPA 101 Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted and filed 3 of 4 quarters (first and third shifts in the first quarter, first and third shift in the third quarter, and third shift in the fourth quarter) quarterly during the last 12 months. The facility failed to ensure fire drills were conducted and filed each shift quarterly during the last 12 months.	K0712		

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K0712	Continued From page 7 Failure to ensure fire drills were conducted each shift quarterly could affect individuals. This deficient practice could result in staff not knowing the fire procedures, which could cause fire related injuries to individuals. Findings included: Record review of the fire drill reports reflected there were no records of fire drills for the first and the third shift in the first quarter (Jan, Feb, and Mar) of 2025. Record review of the fire drill reports reflected there were no records of fire drills for the first and the third shift in the third quarter (Jul, Aug, and Sep) of 2024. Record review of the fire drill reports reflected there were no records of fire drills for the third shift in the fourth quarter (Oct, Nov, and Dec) of 2024. In an interview on 06/26/25 at 11:35 a.m., the Program Assistant said he was not aware of the missing fire drills. He said he just started working at the facility for two weeks. When asked if he could find any other fire drills, he said all of them were in the binder. When asked if missing fire drills could affect the individuals, he said "yes". When asked how they could affect, he said the individuals might forget to evacuate in an emergency. He said he was responsible for the fire drills.	K0712		

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M 000	Initial Comments Purpose of Visit: Standard Survey/Re-survey. Entrance date: 02/29/24 Facility census: 6 Abbreviations used: NFPA - National Fire Protection Association.	M 000		
M 376	§551.61(b)(2)(A)(i) Impractical Rating/ Per Shift Each Quarter (A) Impractical rating. (i) The facility must have one fire drill per shift each calendar quarter (minimum of 12 drills per year). This Requirement is not met as evidenced by: S/S=F Based on record review and interview, the facility failed to ensure fire drills were conducted and filed in 3 of 4 quarters (first and third shifts in the first quarter, first and third shift in the third quarter, and third shift in the fourth quarter) quarterly during the last 12 months. The facility failed to ensure fire drills were conducted and filed each shift quarterly during the last 12 months. Failure to ensure fire drills were conducted each shift quarterly could affect individuals. This deficient practice could result in staff not knowing the fire procedures, which could cause fire related injuries to individuals. Findings included: Record review of the fire drill reports reflected there were no records of fire drills for the first and	M 376		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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M 376	Continued From page 1 the third shift in the first quarter (Jan, Feb, and Mar) of 2025. Record review of the fire drill reports reflected there were no records of fire drills for the first and the third shift in the third quarter (Jul, Aug, and Sep) of 2024. Record review of the fire drill reports reflected there were no records of fire drills for the third shift in the fourth quarter (Oct, Nov, and Dec) of 2024. In an interview on 06/26/25 at 11:35 a.m., the Program Assistant said he was not aware of the missing fire drills. He said he just started working at the facility for two weeks. When asked if he could find any other fire drills, he said all of them were in the binder. When asked if missing fire drills could affect the individuals, he said "yes". When asked how they could affect, he said the individuals might forget to evacuate in an emergency. He said he was responsible for the fire drills.	M 376		
M 490	§551.61(e)(2) Gen. Req./ Building etc., Good Repair (2) The building, grounds and equipment must be maintained in good repair, operational, sanitary, and free of hazards. This Requirement is not met as evidenced by: S/S=C Based on observation and interview, the 1 of 1 facility failed to maintain the building in good repair. The door handle in Bedroom 6 was loose.	M 490		

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M 490	Continued From page 2 A 2-in by 6-in unpatched hole in wall in Bedroom 3. These deficient practices could place individuals at risk by exposure to a diminished quality of life and health. Findings included: Observation on 06/26/25 at 10:19 a.m. revealed the door handle in Bedroom 6 was loose. In an interview on 06/26/25 at 11:35 a.m. with the Program Assistant, he acknowledged the loose door handle. He said he was not aware of the loose door handle. He did not know when that happened. When asked if it could affect the individuals, he said it was difficult to open and close the door. He said he was responsible for fixing the loose door handle. Observation on 06/26/25 at 10:19 a.m. revealed there was a 2-inch by 6-inch unpatched hole in the wall in Bedroom 3. In an interview on 06/26/25 at 11:35 a.m. with the Program Assistant, he acknowledged the unpatched hole. He said he was not aware of the unpatched hole. He did not know when that happened. When asked if it could affect the individuals, he said it may affect if there were insects from the unpatched hole. He said he was responsible for fixing the wall.	M 490		
M 592	§551.65(a) FA-SS/ General (a) General. Fire alarms, detection systems, and sprinkler systems must be as required by NFPA	M 592		

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M 592	Continued From page 3 101, NFPA 72, NFPA 13, NFPA 13R, or NFPA 13D, as specified in NFPA 101, Chapter 32, New Residential Board and Care Occupancies and Chapter 33, Existing Residential Board and Care Occupancies, and as modified in this section. This Requirement is not met as evidenced by: S/S=F References: NFPA 101, Life Safety Code, 2012 Edition Chapter 9 Building Service and Fire Protection Equipment 9.7.2 Supervision. 9.7.2.1 Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition. Chapter 17 Initiating Devices 17.16 Supervisory Signal-Initiating Devices. 17.16.1 Control Valve Supervisory Signal-Initiating Device. 17.16.1.1 Two separate and distinct signals shall be initiated: one indicating movement of the valve from its normal position (off-normal), and the other indicating restoration of the valve to its normal position. 17.16.1.2 The off-normal signal shall be initiated	M 592		

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M 592	Continued From page 4 during the first two revolutions of the handwheel or during one-fifth of the travel distance of the valve control apparatus from its normal position. 17.16.1.3 The off-normal signal shall not be restored at any valve position except normal. 17.16.1.4 An initiating device for supervising the position of a control valve shall not interfere with the operation of the valve, obstruct the view of its indicator, or prevent access for valve maintenance. Based on observation and interview, the facility failed to ensure 1 of 2 supervisory devices or tamper switch for the fire sprinkler system control valves was installed and monitored the system according to NFPA 72, 17.16.1.1, 17.16.1.2, 17.16.1.3, and 17.16.1.4 as referred to by NFPA 101, 9.7.2.1. The facility did not ensure 1 of 2 control valves for the sprinkler system transmitted a local or remote alarm to the fire alarm control panel. This deficient practice could place individuals at risk of smoke inhalation or fire related injuries resulting from fire water supply being potentially interrupted and going undetected due to control valve supervision not being verified by a distinctive signal being emitted at the fire alarm control panel. Finding included: Observation on 06/26/25 at 10:02 a.m. revealed there was not a supervisory signal transmitted to the fire alarm control panel when closing the lower water control valve of the fire alarm system. In an interview on 06/26/25 at 11:35 a.m. with the Program Assistant, he acknowledged there was	M 592		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 592	Continued From page 5 no supervisory signal transmitted to the fire alarm control panel when closing the lower control valve on the riser. He said he was not aware of this issue. He said he just started working here for two weeks. When asked if it could affect the individuals, he said "yes". When asked how it could affect the individuals, he said if someone turns off the valve, and there was no signal to alarm. He said he was responsible for the tamper switch.	M 592		
M 967	§551.74(b)(6) Safety Operations/ Sprinkler System (6) The facility must ensure that individual sprinkler heads are inspected and maintained in accordance with NFPA 13, NFPA 13D or NFPA 13R and in accordance with NFPA 25. This Requirement is not met as evidenced by: S/S=F Reference: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. Chapter 5 Sprinkler Systems 5.2 Inspection. 5.2.1 Sprinklers. 5.2.1.1.1 Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). Based on observation and interview, the facility failed to ensure 1 of 10 fire sprinkler heads were maintained free of physical damage according to	M 967		

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: **01 - MAIN-BUILDING** B. WING _____	**06/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 967	Continued From page 6 NFPA 25, 5.2.1.1.1. A fire sprinkler head was physically damaged and missing an escutcheon. This deficient practice could cause a delay in the activation of the sprinkler system during a fire, allow a fire to progress, and expose staff and residents in the facility to smoke inhalation and other fire-related bodily injuries. Finding included: Observation on 06/26/25 at 10:26 a.m. revealed the sprinkler head, in Bedroom 2, was physically damaged and did not have an escutcheon. In an interview on 06/26/25 at 11:35 a.m. with the Program Assistant at the exit conference, he acknowledged missing escutcheon in Bedroom 2. He said he was not aware of missing the escutcheon. When asked if the individuals could affect because of missing the escutcheon in Bedroom 2, he said "maybe". When asked how it could affect the individuals, he said, it could malfunction. He said he was responsible for the missing escutcheon.	M 967		

HHSC Notice of Accepted Plan of Correction (10/07)

Texas Health and Human Services Commission
Notice of Accepted Plan of Correction

(Note: Acceptance of a plan of correction does not preclude HHSC from taking enforcement action.)

To:			
Facility Name Pasadena Cottage			Survey Date 06/26/2025
Address [redacted]			Provider Type ICF/IID
City [redacted]	State [redacted]	Zip Code [redacted]	Facility ID # 007807
Telephone Number: (713)472-3470 Fax Number:			Provider # 45G980

From:			
Name: [redacted]			Position: Life Safety Code Program Manager
Program: HHSC Region 06 - Unit 21 (icf/mr) Regional Office			Telephone Number: [redacted]
Address: [redacted]			Fax Number: [redacted]
City: [redacted]	State: [redacted]	Zip Code: [redacted]	Mail Code: [redacted]

Your plan of correction has been accepted for:

___ Health Survey - Federal Deficiencies
___ Health Survey - State Violations
_X_ Life Safety Code Survey - Federal Deficiencies
_X_ Life Safety Code Survey - State Violations

ALF, ADC, and HCSSA Follow-up Visit Information: ***HHSC*** *will not accept submission of documentation demonstrating correction of the violations/deficiencies cited as the sole indication by the licensee of compliance with the rules or regulations. HHSC will verify compliance with the rules or regulations through an on-site inspection.*

NF Follow-up Visit Information: (Select only the statements that apply.)

___ A first on-site revisit may be scheduled to determine compliance for violations/deficiencies cited.

___ A second on-site revisit may be scheduled to determine compliance for violations/deficiencies cited.

___ A third on-site revisit, if authorized, may be scheduled to determine compliance for violations/deficiencies cited.

_X_ The plan of correction and/or evidence of compliance may be accepted as determination of correction in lieu of conducting an on-site follow-up visit. A desk review may be performed. If, during a future visit, violations or deficiencies that were considered corrected through a desk review are discovered not to have been corrected, enforcement actions may be recommended.

___ We request evidence showing how the facility attained and maintains corrective action for the following violation(s)/deficiency(ies) cited on the exit date referenced above: ___

This evidence must be received at the HHSC regional office listed above by ___ . The evidence must clearly identify to which violation/deficiency it corresponds.

Examples of acceptable evidence of compliance include the following:

- An invoice or receipt verifying purchases were made, repairs were completed, etc.
- A photo of a corrected environmental issue.
- A policy and procedure reflecting compliance and how compliance will be monitored and maintained.
- A resident's care plan addressing the compliance issue.

If you have questions, p[redacted]	
[redacted]	Date: 08/13/2025

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]
Executive Commissioner

August 20, 2025

Administrator
Pasadena Cottage
[redacted]

Provider #: [redacted]
Facility ID #: [redacted]
Type: ICF/IID

Dear Administrator:

On August 20, 2025, the Texas Health and Human Services Commission (HHSC) conducted a Life Safety Code non-onsite follow-up, to determine if your facility complies with state licensure requirements and federal participation requirements for ICF/IID facilities in the Medicare or Medicaid (or both) programs. The survey found that your facility **meets** state licensure requirements and **is in substantial compliance** with federal participation requirements.

If you have any questions, please contact [redacted] Life Safety Code Program Manager at [redacted]

Sincerely,

[redacted]

[redacted], Life Safety Code Program Manager
Regulatory Services Division, Region 06

[redacted]

[redacted]

Texas Health and Human Services | Report of Contact
Intermediate Care Facilities for Individuals with Intellectual Disabilities | Form 3614-A
Dec 2019

Region: 06	Life Safety Code Visit	Entrance Date:08-20-2025 10:00 AM	Exit Date: 08-20-2025

Facility Name PASADENA COTTAGE	Telephone [redacted]	FAX
Address – Street (physical location) [redacted]	TULIP Facility ID: [redacted] County: Harris	

PURPOSE OF CONTACT:

FOLLOW-UP TO LICENSURE INSPECTION;NON-ONSITE FOLLOW-UP

Follow Up Visit (original exit date) – SURVEY/INVESTIGATION 06-26-2025

Intakes Number(s) Investigated

IID Capacity: 6	IID Census:

LTCR STAFF REPORTING

Name	Title
[redacted]	LSC PROGRAM MANAGER

REGULATORY DECISIONS AND SANCTIONS RECOMMENDED

MEETS LICENSURE REQUIREMENTS (LSC);NO DEFICIENCIES CITED (LSC);NO LICENSURE VIOLATIONS CITED (LSC)

REFERRALS

ADMINISTRATIVE

ACO ID: [redacted]

NARRATIVE

Date Printed: 08/20/2025 11:14:11AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	R 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments Purpose of visit: Non-onsite follow up No Deficiencies Cited	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 08/18/2025 9:09:38AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	R **08/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Initial Comments All deficiencies cleared for follow up from exit 6-27-25	{S 000}		

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Date Printed: 08/18/2025 9:09:06AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	R 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS All deficiencies cleared Follow up from exit 6-27-25	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]
Executive Commissioner

August 20, 2025

Administrator
Pasadena Cottage
[redacted]

Provider [redacted]
Facility ID #[redacted]
Type: ICF/IID

Dear Administrator:

On August 20, 2025, the Texas Health and Human Services Commission (HHSC) conducted a Life Safety Code non-onsite follow-up, to determine if your facility complies with state licensure requirements and federal participation requirements for ICF/IID facilities in the Medicare or Medicaid (or both) programs. The survey found that your facility **meets** state licensure requirements and **is in substantial compliance** with federal participation requirements.

[redacted]

[redacted]

[redacted] Life Safety Code Program Manager
Regulatory Services Division, Region 06

[redacted]

[redacted]

Texas Health and Human Services

Report of Contact
Intermediate Care Facilities for Individuals with Intellectual Disabilities

Form 3614-A
Dec 2019

Region: 06	Life Safety Code Visit	Entrance Date:08-20-2025 10:00 AM	Exit Date: 08-20-2025

Facility Name PASADENA COTTAGE	Telephone [redacted]	FAX
Address – Street (physical location) [redacted]	TULIP Facility ID: [redacted] County: [redacted]	

PURPOSE OF CONTACT:

FOLLOW-UP TO LICENSURE INSPECTION;NON-ONSITE FOLLOW-UP

Follow Up Visit (original exit date) – SURVEY/INVESTIGATION 06-26-2025

Intakes Number(s) Investigated

IID Capacity: 6	IID Census:

LTCR STAFF REPORTING

Name	Title
[redacted]	LSC PROGRAM MANAGER

REGULATORY DECISIONS AND SANCTIONS RECOMMENDED

MEETS LICENSURE REQUIREMENTS (LSC);NO DEFICIENCIES CITED (LSC);NO LICENSURE VIOLATIONS CITED (LSC)

REFERRALS

ADMINISTRATIVE

ACO ID: [redacted]

NARRATIVE

Date Printed: 08/20/2025 11:14:11AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	R 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments Purpose of visit: Non-onsite follow up No Deficiencies Cited	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Date Printed: 08/20/2025 11:14:01AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING **01 - MAIN-BUILDING** B. WING _____	R **08/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Purpose of visit: Non-onsite follow up No Deficiencies Cited	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 08/20/2025 11:13:50AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: **01 - MAIN-BUILDING** B. WING _____	R **08/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	Initial Comments Purpose of visit: Non-onsite follow up No Violations Cited	{M 000}		

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

TEXAS Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

August 26, 2025

[redacted]
QIDP
Pasadena Cottage B
[redacted]
[redacted]

Provider ID #: [redacted]
Facility ID #: [redacted]
Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICFs/IID)

Dear [redacted]:

Enclosed you will find documents relating to the *Health Survey* conducted at the above referenced facility dated August 22, 2025. **It is no longer necessary for you to sign and date all the No Deficiencies/No Violations forms enclosed** or return the forms to the Region 06 Regulatory Services office.

The following forms are enclosed for your records:

___X___ FORM CMS-2567

___X___ Form DADS 3724 STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Should you have any questions or issues, please feel free to contact me or my designee. I can be reached by phone at [redacted] or by e-mail at [redacted]

Sincerely,

[redacted]
ICF/IID Program Manager, Region 06
Regulatory Services
06
[redacted]

Enclosure

[redacted]

Texas Health and Human Services

Report of Contact
Intermediate Care Facilities for Individuals with Intellectual Disabilities

Form 3614-A
Dec 2019

Region: 06	Health Visit	Entrance Date: 08-21-2025 11:59 AM	Exit Date: 08-22-2025

Facility Name PASADENA COTTAGE B	Telephone [redacted]	FAX
Address – Street (physical location) [redacted]	TULIP Facility ID: [redacted] County: Harris	

PURPOSE OF CONTACT:

FOLLOW-UP TO SURVEY

Follow Up Visit (original exit date) – SURVEY/INVESTIGATION

Intakes Number(s) Investigated

IID Capacity: 6	IID Census: 6

LTCR STAFF REPORTING

Name	Title
[redacted]	Soc Svcs Surveyor (ICF-MR)

REGULATORY DECISIONS AND SANCTIONS RECOMMENDED

MEETS STATE STANDARDS FOR PARTICIPATION; NO DEFICIENCIES CITED (HEALTH); SUBSTANTIAL COMPLIANCE (HEALTH); SSP-NO VIOLATIONS CITED; NO FOLLOW-UP REQUIRED.

REFERRALS

ADMINISTRATIVE

ACO ID:[redacted]
Facility Staff –[redacted] QIDP

NARRATIVE

Health Narrative attached: No; LSC Narrative attached: No

Texas Health and Human Services Commission

Form 3630 - ICF
July 2024

Intermediate Care Facility
Survey/Inspection Summary Report

The Texas Health and Human Services Commission Regulatory Services division conducted a survey or inspection on 08/21/2025

Facility Name	Type of Facility
Pasadena Cottage B	Intermediate Care Facility for Individuals with Intellectual Disabilities
Street Address [redacted]	City, State, ZIP Code [redacted]

The items on the following charts represent areas that the survey team surveyed or inspected for compliance with state and/or federal requirements. Only the items checked Yes or No are applicable to this report; other deficiencies in areas not checked may still be pending and not reflected on this current report. You may obtain a copy of the complete report, including outstanding deficiencies, from the facility administration.

Life Safety Code Survey or Inspection

	Compliance			Compliance			Compliance	
	Yes	No		Yes	No		Yes	No
1. Fire Alarm System			3. Emergency Electrical System			5. Other: See CMS Form 2567		
2. Sprinkler System			4. Physical Plant and Environment			6. Other:		

Health Survey or Inspection (ICF/IID)

1. Governing Body and Management	X		5. Client Behavior and Facility Practices	X		9. State Standards for Participation	X	
2. Client Protections	X		6. Health Care Services	X		10. Licensure:	X	
3. Facility Staffing	X		7. Physical Environment	X				
4. Active Treatment	X		8. Dietetic Services	X				

If you need further information, you may call the HHSC regional office at [redacted]

The Survey/Inspection Summary Report must be posted in an area of the facility that is readily available to residents, clients, employees and visitors in accordance with the facility's appropriate licensure regulations at Texas Administrative Code, Title 26, Part 1, Chapter 551, §551.326.

Date Printed: 08/26/2025 9:01:06AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	R 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE B	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS Purpose of visit: Follow-up to Full book survey and complaint intake # 554997 Date of entrance: 08/21/2025 Census: 6 Cleared all deficiencies. The facility is in substantial compliance.	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 08/26/2025 9:01:44AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	R 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA COTTAGE B	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Purpose of visit: Follow-up to Full book survey and complaint intake # 554997 Date of entrance: 08/21/2025 Census: 6 Cleared all deficiencies. The facility is in substantial compliance.	S 000		

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

[redacted]

TEXAS
Health and Human Services

LTCR 3701
March 2024

Preliminary Findings Based on Survey, Inspection, or Investigation

Facility/Agency/Program Provider Name:	Entrance Date:	Exit Date:
Pasadena Cottage B	08/19/2025	08/28/2025

Physical Street Address:	Purpose of Visit:
[redacted]	☐Survey ☒Investigation ☐Other:

City:	Zip Code:	County:
Pasadena	77502	Harris

Facility/Agency/Program Provider Type	Facility ID/Vendor Number
☐ALF ☐DAHS ☐HCSSA ☒ICF ☐NF ☐PPECC ☐DAHS with ISS (traditional DAHS services and ISS) ☐DAHS – ISS only (only provides ISS services)	[redacted]

Administrator/Manager/Program Director Name: [redacted]

This list contains preliminary areas of potential noncompliance with federal and/or state requirements, based on findings from the entrance and exit dates listed above. Note: If the visit was to an assisted living facility, refer to the attached checklists.

State	Federal	Brief Description of Noncompliance
☐	☐	Complaint#1022116-Allegation Abuse (Physical)- AP Esperanza Martinez-
☐	☐	Unsubstantiated and Allegation Rights- Unsubstantiated
☐	☐	
☐	☐	Incident Intake#1032192-Allegation Abuse- AP Esperanza Martinez - Unsubstantiated
☐	☐	
☐	☐	Unrelated standard level deficiencies in the area (s) of :
☒	☒	Facility Staffing
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Signature – Administrator/Program Director or Designee	Date
[redacted]	08/28/2025

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]

July 23, 2025

Mhmr Authority Of Harris County
[redacted]

Contract# [redacted]
Home and Community-based Services

Dear Provider:

On July 9, 2025, the Texas Health and Human Services Commission (HHSC) conducted a survey to determine if your contract was in compliance with the certification principles for the: Texas Home Living (TxHmL) program.

Based on this visit, we determined that violations exist. HHSC Form 3724: Statement of Violations is enclosed.

Your PoC must contain the following information:

1.How the program provider will accomplish corrective action for those individuals affected by the violation(s).
2.How the program provider will identify other individuals with the potential to be affected by the same violations(s).
3.The measures the program provider will put into place or the systemic changes the program provider will make to ensure the violation(s) will not recur.
4.How the program provider will monitor its corrective actions to ensure the violation(s) are being corrected and will not recur.
5.When the corrective action will be completed.

Return HHSC Form 3724 with your PoCs via email, fax, or postal mail to:

[redacted]

Informal Dispute Resolution (IDR)

You can contest cited violations through the IDR process in accordance with the certification principles for HCS (26 TAC, Section 565.49(f)), TxHmL (Section 566.23 (f)), and 1 TAC, Section 393.3 for HHSC Informal Dispute Resolution for TxHmL and HCS Providers.

[redacted]

If you would like to contest cited violations through the IDR process, you must submit a fully executed IDR Request Form to the HHSC IDR Department within 10 calendar days after receipt of the official statement of violations. Forms must be emailed to [redacted] The form is available at

https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/vendor-contract-information/idr/idr-request-form-hcs-txhml.pdf.

Providers must then submit a rebuttal letter and supporting documentation to Michigan Peer Review Organization (MPRO). The rebuttal letter and supporting documentation must be received by MPRO no later than the fifth calendar day after submitting the IDR Request Form to HHSC.

Supporting documentation can be submitted by either:

•Uploading the documents to MPRO's IDR Portal: [redacted]
•Mailing the documents: MPRO - IDR Department. [redacted]
Farmington Hills, MI 48335

Additional information and procedures for requesting an IDR are available at hhs.texas.gov/doing-business-hhs/contracting-hhs. Click on Informal Dispute Resolution Process under For Current Vendors.

You will be notified of the IDR results within 30 days of receipt of the IDR Request Form. If you have questions about the IDR process, please contact the HHSC IDR Department at [redacted]

If you have any questions, please contact [redacted] Assistant Regional Director [redacted]

Sincerely,

[redacted]

HHSC Regulatory Services Division 06
oc [redacted]

[redacted]

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 08/14/2025 8:37:55AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	R **08/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MHMR AUTHORITY OF HARRIS COUNTY	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{3 000}	Initial Comments Purpose of Visit: To conduct Post 45 Day Follow-Up Desk Review for all violations cited during recertification survey with exit date of 7/9/25. No new areas of noncompliance were discovered. The program provider is in compliance with all certification principles. Date of Entrance: 7/8/25. Census: 15	{3 000}		

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

TEXAS Health and Human Services

Texas Health and Human Services Commission

[redacted]

August 14, 2025

The Harris Center For Mh And Idd
[redacted]

Re: Contract Number [redacted]

Dear Provider:

The TxHmL contract held by The Harris Center For Mh And Idd was surveyed by Health and Human Services (HHS) Long-Term Care Regulation from 07/08/2025 to 07/09/2025. The purpose of this visit was to conduct a recertification survey to determine compliance with the TxHmL the contract is in compliance with the certification principles in the TAC, Title 26, Part 1, Chapter 566, Subchapter N for Texas Home Living (TxHmL) Program and Community First Choice.

As a result of the recertification survey, Plan of Correction, and follow-up visit(s) as applicable, it has been determined that the provider is in compliance and is certified from 07/09/2025 to 07/08/2026.

Please keep a copy of the form(s) enclosed for your records.

Sincerely,

[redacted]

HHS LTCR HCS and TxHmL Program, Region 06
oc Enclosures