2026 Corporate Compliance
Work Plan

2025High Risk Areas:
Cleveland IRA
Community Habilitation
Joslyn Court IRA
Valentine IRA
Chittenango A IRA
Self-Direction

2026 High Risk Areas:
Cleveland IRA
Self-Direction
Children's Services (Comm Hab, HCBS & PSR)

Chittenango B IRA
Sylvan Beach IRA
Worthington IRA

2025 Risk Assessments

The Quality Enhancement Department sent the risk assessment tool to Managers and Directors of AccessCNY programs in December 2026. The results were tabulated with data through November 2025 and are attached. The risk assessment tool measures various types of risk for each program including: staff and management turnover, growth of program, supervision levels, documentation, accidents and injuries, program budget totals, abuse and compliance investigations, internal and external audit issues, HIPAA concerns, availability of current department standards, high risk needs of participants, security and IT concerns, and quality of care and training requirements.

Community Habilitation's risk score was reduced again during 2025 from 16 to 12. While Community Habilitation's risk score did not meet the high-risk threshold in 2025, it remained in that category due to the limited ability to provide close supervision to staff, and the staff utilizing their personal communication devices to complete their documentation. The program had some compliance issues this year; however, they were self-reported and identified quickly by program leadership. The Director of the Program has implemented systems for monitoring compliance with documentation requirements, and this has led to fewer compliance issues and the program being removed from the high-risk list.

Over the past year, the Joslyn Court IRA was successful in lowering its risk score and is no longer identified as a high-risk program for 2026. During 2024 Joslyn Court had multiple reportable incidents involving a participant with unique behavior support needs, which contributed to their higher risk score. During 2025, the number of incidents involving this person significantly decreased. They also had positive state surveys in 2025 with no deficiencies noted. The Valentine IRA had also been designated as high risk during 2025, not due to their risk assessment score, but due to having received two formal statements of deficiency from OPWDD during 2024, one issued in late December of that year. In 2025 Valentine had two OPWDD surveys during which they had no

deficiencies, contributing to the lowering of their risk assessment score from 13 to 5, and resulting in their removal from the high-risk designation.

The Cleveland IRA will remain in the high-risk category with continued concerns related to oversight and staffing. The program experienced another change in the House Coordinator position and has struggled to fill its open slots for Assistants/front line staff. There were two significant incidents at Cleveland during 2025, one resulting in a category 2 substantiated allegation of neglect against staff. In September, the program received an Immediate Jeopardy Statement of Deficiency from OPWDD for fire safety which pointed to additional concerns with program oversight and monitoring. The combination of issues has also led to the Quality Enhancement Department implementing ongoing, monthly unannounced visits to check the physical condition of the house and touch base with the staff.

The Self-Direction program continues to lower its risk score from year to year, falling again from 33 in 2024 to 21 in 2025. While the leadership of the program changed at the end of 2024, beginning of 2025, they have had very few compliance issues and have put solid systems in place to closely monitor adherence to regulatory and billing requirements. The nature of the Self-Direction program, with no direct supervision of staff and minimal documentation requirements, will always present higher risk. As a result, the audit schedule will include routine compliance audits of this program.

The risk assessment score for Children's Services, which includes three programs: HCBS Children's Waiver service, Psychosocial Rehabilitation, and Children's Community Habilitation jumped from 9 in 2024 to 22 in 2025, causing them to fall in the high-risk category for 2026. During the summer, oversight of the Children's Community Habilitation, Psychosocial Rehabilitation, and Children's HCBS services was transitioned from the DD/ABI Department to Children's and Behavioral Services. These programs had several documentation issues, some that led to compliance investigations. There was a general lack of understanding of the regulatory requirements for these programs which contributed to the compliance concerns. There is new leadership over the Children's Community Habilitation, PSR, and the HCBS Children's services which should help stabilize the programs during 2026.

External Audits

The CDPS OMIG Audit from early 2025 is nearing completion. An exit conference was held on 1/16/2026 to review OMIG's findings. The payback amount for this audit will be lower than originally expected; however, we are awaiting the final results.

OMIG conducted a CDPS desk audit of hospital inpatient stays from 8/1/2019 – 12/31/2023. There were some dates identified with overlapping billing for two individuals. The staff involved are no longer working for the agency.

In September 2025, OPWDD's Division of Quality Improvement conducted an Agency Protocol Review. The Agency Review is intended to verify that agencies have procedures and act to facilitate compliance with regulatory requirements, emphasize quality services, and prioritize both compliance and quality organizationally. * The results of the review were positive with very few findings. We received three deficiencies overall, none of which required a written response to OPWDD. The deficiencies were in the following areas:

- Documenting confirmation of applicants' last place of employment
- Ensuring people receiving support have a role in the hiring process
- Completion of DSP Core Competency evaluations and performance appraisals of non-DSP staff
- The agency's Quality Improvement Plan is known to staff, participants, and stakeholders

In response to the Agency Review findings, we will implement actions in the compliance workplan and the Quality Improvement Plan to address the areas of concern.

The agency's compliance plan will be reviewed by the Board during the first quarter of 2026.

Updates On Action Steps for 2025:

- Continue implementing Billing Builder in the IRAs and in SEMP.
- Rolled out program-specific, billing requirement compliance training in multiple programs.
- Implemented pre-billing audits at Crystal House. Will do so with new programs funded by Medicaid as they open.
- Quality audits were completed in some Residential programs. On hold for some time due to open positions in QE.
- New Compliance Officer hired and trained.
- Completed medical audits in Residential programs.
- Determined at this time adding restrictions to clock in/out procedures related to EVV in Self-Direction and Community Hab will not be effective.
- Hired an Administrator of IT and Analytics to increase system administrator capabilities for EHRs.
- Human Resources implemented personnel file audits.
- Workplans were created in high-risk programs to address specific risk areas. Progress on the plans was monitored and reported on during quarterly compliance meetings. Annually (ongoing)
- Compliance policies, including the Compliance Committee Charter, were updated, posted on SharePoint and the agency's website. Annually (ongoing)
- Regular IT training and testing will be conducted/continued to address risk areas. This was partially implemented during 2025 and will continue in the 2026 workplan.

- Sent surveys to employees to determine the effectiveness of the compliance program. The results of the survey were shared in agency and department compliance meetings. Results were used to develop new agency-wide compliance training. Annually (ongoing)
- Board training for corporate compliance and incident reporting completed. Annually (ongoing)
- Held monthly or bi-monthly department compliance meetings to address standing items (i.e. updated regulations, trends, etc.) and new issues as they arose. Ongoing
- Provided quarterly compliance reports to the Board of Directors. Ongoing
- The self-assessment of the agency's compliance program is being completed during the first quarter of 2026.

2026 Strategies and Action Steps

AccessCNY opened several new programs in 2025 which will continue to be monitored carefully throughout this year, although some of them will be funded through state grants rather than Medicaid. As appropriate, the QE department will implement pre-billing audits of those programs.

During the second half of 2025 AccessCNY began the process of acquiring four certified residential programs operated by the Kelberman Center. Over the past year and a half, these programs were issued a combination of Statements of Deficiency and 45-day letters by OPWDD, identifying significant health and safety concerns and multiple systemic issues related to various aspects of programming. As a result, the Chittenango A and B IRAs, Sylvan Beach IRA, and the Worthington IRA will be placed in the high-risk category for 2026.

The Corporate Compliance Committee will continue its quarterly review of the findings of all departmental internal and external audits as well as monitor the progress of each of the high-risk category programs.

- The Quality Enhancement department will implement billing audits across programs based on risk assessment scores, results of internal and external audits, and where compliance issues arise.
- The QE department will continue conducting quality assurance audits in Residential programs. The audit schedule will also include Day Habilitation and MH Residential programming during 2026.
- The QE department will implement a schedule of Life Plan, caseload, and admission audits during 2026.
- The QE department will work with programs to develop a system for timely completion, tracking, and monitoring of Staff Action Plans to reduce the number of compliance issues in this area.
- Audit tools will be developed for new programs opening or beginning to provide services in 2026.

- Centralize agency policies, develop a master table of content, and implement department review schedules.
- Create workplans in high-risk programs to address specific risk areas. Progress on the plans will be monitored and reported at quarterly compliance meetings. Annually (ongoing)
- Review/update compliance policies, including the Compliance Committee Charter. Annually (ongoing)
- Regular IT training and testing will be conducted/continued to address risk areas. Ongoing
- Human Resources will implement quality improvement measures to address compliance with DSP Core Competency Evaluations.
- Send a survey to employees to determine the effectiveness of the compliance program. Results will be used to inform training and workplan changes as needed. Annually (ongoing)
- Conduct Board training for corporate compliance and incident reporting. Annually (ongoing)
- Continue to hold monthly or bi-monthly department compliance meetings to address standing items (i.e. updated regulations, trends, etc.) and new issues as they arose. Ongoing
- Provide quarterly compliance reports to the Board of Directors. Ongoing

Department Management will:

- Ensure response forms to internal audits are completed and returned to Quality Enhancement within the required timeframe.
- Ensure staff are following standards.
- Continue to ensure EHRs are implemented fully and populated with quality data.
- Ensure new staff are completing required training and are observed to ensure that they understand and appropriately apply the material.
- Self-monitor activities outside of QE monitoring activities.
- Identify trends and areas of concern and implement corrective actions.
- Work with the QE Department to minimize risk areas identified in each risk assessment.

Chief Executive Director and Executive Team will:

- Continue to hold Program Managers and Directors accountable for repeat deficiencies in audits.
- Continue to hold Program Managers and Directors accountable for completing internal audit corrective actions in a timely manner, which includes developing a monitoring system to prevent reoccurrence of issues.
- Continue to update standards and policies.

Calendar of Events for 2026

January – Corporate Compliance Committee will review and approve 2026 compliance workplan and audit schedule.

February – Board of Directors annual training
April - Corporate Compliance Officer will update all necessary policies and send them to the committee for review and approval. This will include the committee's charter.
2nd Quarter – Compliance survey will be sent to all staff to assess knowledge and understanding of the compliance program.
4th Quarter – Complete a self-assessment of the compliance plan.
November – Send out 2026 risk assessments for completion.
December – Identify high risk programs for 2027.

Respectfully submitted:

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Compliance Committee Chair

**From the OPWDD Provider's Manual*