



## Office for People With Developmental Disabilities

**ANDREW M. CUOMO**  
Governor

**KERRY A. DELANEY**  
Acting Commissioner

# DQI Site Review Protocol Resource October 3<sup>rd</sup>, 2016

Applicable to all non-ICF certified sites, Implementation date: 10/03/2016



## SITE REVIEW OVERVIEW

This document is a resource regarding the implementation of the OPWDD Division of Quality Improvement Site Review Protocol, effective 10/03/2016. It should be used as a reference and will be helpful when access to the DQIA Protocol application is unavailable. It will also support understanding of standards applicable to specific program types; the standards that require verification of the requirements for one (1) or more specific person(s) selected to sample; and tasks DQI shares with OFPC.

The Site Protocol Manual, is comprised of three (3) Sections:

1. **Program Specific Guidance Charts-**

- There is a chart for each program type or grouped program types.
- The tables identify each standard determined to be routinely applicable to the program type; and standards applicable to the program type based on a qualifier question. (Note: In the IT application, only the applicable standards will be present.)
- The tables include the page numbers where guidance for each standard may be found in the **Full Protocol with Guidance** (Section 3).
- The tables identify the standards that require targeted sampling\* (i.e. verification for at least one person).

2. **Quick Reference Protocol** - This document has the same content as the fill-in Site Review Protocol (available on the Intranet, for your use as desired). It identifies all information gathering, documentation requests, and standards on the protocol but lacks instruction on which standards apply to different program types. Please use Section 1 as needed.

- **Full Protocol with Guidance** - This document identifies:
- All information gathering, documentation requests, and standards on the protocol;
- For each standard:
- The program types for which it should be reviewed;
- The applicable regulatory reference, requirement or whether it is a quality indicator
- Guidance for evaluation of the standard, including reasoned decision making for whether the standard is *Met* or *Not Met*.
- Activities and review content included in the protocol have been determined to be necessary components of the on-site review.

## **ADDITIONAL GUIDANCE:**

Every non-ICF certified facility is expected to receive a **Full Site Review** using the **Site Review Protocol** to meet obligations to assess for compliance, focus on safeguards, and adhere to Mental Hygiene Law.

**\*Regarding sampling:** It has been determined that for the specific standards noted on the protocol and in Section 1, a compliance decision can only be determined based on review of the circumstances for a person receiving supports from the certified program. This begins through review of that standard(s) for one person selected by the surveyor. In many cases, this is sufficient. Based on observation, discussion, previous and current findings in the program DQI staff may make decisions whether sample expansion is needed. As needed, the DQI Area Director should be consulted.

Note: Section 10 – Specialized Risk Areas, requires that you identify the specific individual(s) sampled.

### **Section 8 – Fire Safety:**

- This section must be completed as follows:
  - All Non-Life Safety Code certified residences:
    - **DQI staff** will review all standards in Section 8 for all FULL Reviews
  - All Day Programs (no residential purpose):
    - **DQI staff** will review all standards in Section 8 for all FULL Reviews
  - All LSC Residences:
    - OFPC Annual LSC Reviews: **OFPC** will review all standards in Section 8
    - OFPC Validation Visits: **OFPC** will review only for the standards for which correction is being verified.
    - DQI will NOT routinely review Section 8 in LSC residences. **DQI staff** is required to review previous survey findings, incidents; and complete on-site information gathering, discussion, observation, documentation review associated with mandatory survey activities. If through these activities, DQI staff becomes aware of conditions related to fire safety that may put individuals at risk, DQI will review Section 8 partially or wholly, as determined necessary.

Note: The activities in the Site Review protocol are only one part of DQI's overall assessment of agency performance and quality service delivery. Person Centered and Agency reviews will provide additional assessment of service delivery and agency operations during the survey cycles.



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# **Section 1**

## **Guidance Charts**

(Which identify the applicable standards and the page where standard guidance can be found, as well as when targeted sampling (i.e. verification for at least one person), is required.)



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**The following 9 charts provide guidance for the identified program types:**

1. Clinic Treatment
2. Day Habilitation
3. Day Training
4. Day Treatment
5. Free Standing Respite
6. Residences (IRAs, CRs, Apts)
7. Certified Prevoc Site
8. Private School
9. Specialty Hospital

**(See bookmarks on the left-side panel)\***

# CLINIC TREATMENT

QNO.	Program Class & Type STANDARD	Decision	Targeted Sample	Pg. No.
Standard #	STANDARD:	DECISION:	Verify for 1 Individual min.	Site Guidance Page Number
<b>SECTION 2: HEALTH SUPPORT &amp; MEDICATIONS</b>				
2-1	There is a written plan detailing how the facility will deal with life-threatening emergencies.	Met / Not Met	NO	20
2-2	Staff working know actions to take in the event of a medical emergency.	Met / Not Met	NO	21
Qualifier Question	The site provides nursing and/or delegated nursing services such as medication administration.	Y/N		22
2a-3	Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA or MD administers medications and/or prescribed treatments to individuals.	Met / Not Met	NO	27-28
2a-4	Individual's medications and treatments have been correctly administered per physicians' orders and his/her needs.	Met / Not Met	YES if QQ is Yes	29-31

2a-5	Medication Administration Records (MARs) are legible, correctly identify the current physician's orders/prescriptions and required documentation of administration.	Met / Not Met	YES if QQ is Yes	32-33
2a-6	Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.	Met / Not Met	YES if QQ is Yes	34-36
2a-7	Medications and treatments are stored securely as required, including the security of keys or codes to access medications.	Met / Not Met	NO	37-39
2a-8	Medication that is discontinued or outdated is not retained at the site.	Met / Not Met	YES if QQ is Yes	40-41
2a-9	Used needles and syringes are disposed in puncture resistant containers.	Met / Not Met	NO	42
<b>SECTION 4: GENERAL OPERATIONS FOR : INDIVIDUALIZE CHOICE, AUTONOMY &amp; SATISFACTION</b>				
4-3	The site has a mechanism to assess individuals' satisfaction with the service environment.	Met / Not Met	NO	70-71
4-6	The program takes timely action to address individuals' dissatisfaction with living and/or service environment.	Met / Not Met	NO	76-77
<b>SECTION 5 : DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS</b>				
5-1	Staff can describe/know the Individuals' supervision needs.	Met / Not Met	NO	98-99
5-7	The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) Prompt contacting of other responsible personnel in emergencies.	Met / Not Met / NA	NO	112-113

**SECTION 6: RIGHTS PROTECTIONS**

6-2	The site is absent of generally applied rules, policies or procedures that limit people’s rights, independence, choice and autonomy.	Met / Not Met	NO	117-119
6-3	Individuals are permitted by the program to engage in any legal activities per their interests.	Met / Not Met	NO	120-121
6-4	Individuals have full access to the typical facilities in the site.	Met / Not Met	NO	122-124
6-5	Individuals’ health and other protected information is kept private/protected.	Met / Not Met	NO	125-126
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.	Met / Not Met / NA	NO	134-135
6-10	Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.	Met / Not Met / NA	NO	136-137
6-11	Immediate care and treatment identified was provided to the individual involved in the incident.	Met / Not Met / NA	NO	138-139
6-12	Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.	Met / Not Met / NA	NO	140-141
6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.	Met / Not Met / NA	NO	142-144
6-14	Measures identified to prevent future similar events were <u>planned and implemented.</u>	Met / Not Met / NA	NO	145-148
6-15	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.	Met / Not Met / NA	NO	149-152
6-16	Part 625 events and actions reported in IRMA regarding recommendations, were implemented as reported.	Met / Not Met / NA	NO	153-154

## SECTION 7: SITE & SAFETY

7-2	Surveillance cameras are not present in the site.	Met / Not Met	NO	157
7-4	The site's physical characteristics support the independence, comfort, preference and needs of the individuals.	Met / Not Met	NO	160-161
7-5	All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.	Met / Not Met	NO	162-163
7-6	There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.	Met / Not Met	NO	164-165
7-7	Bathrooms provide personal privacy.	Met / Not Met	NO	166
7-8	The site is clean.	Met / Not Met	NO	167-168
7-9	The site is well maintained for the safety and comfort of the individuals receiving services.	Met / Not Met	NO	169-171
7-10	The facility operates in accordance with OPWDD smoking requirements.	Met / Not Met	NO	172-174
7-11	The temperature of the hot water is appropriate to the abilities of people served at the site.	Met / Not Met	NO	175-176
7-12	Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.	Met / Not Met / NA	NO	177-179
7-13	The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools.	Met / Not Met / NA	NO	180-181
7-14	The facility has a land line (see section 635-99.1) telephone service which is in working order and functions during power outages.	Met / Not Met	NO	182

**SECTION 8: FIRE SAFETY REQUIRED (by OFPC or DQI )**

Qualifier Question	Are there any immediate Fire Safety issues that must be identified?	Y/N		186
8-1	The site has an acceptable fire evacuation plan.	Met / Not Met	NO	187-189
8-2	All fire and evacuation drills or events MUST be documented on the standardized drill report form developed by OPWDD.	Met / Not Met	NO	190
8-3	The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.	Met / Not Met	NO	191-192
8-4	Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.	Met / Not Met	NO	193-194
8-5	The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.	Met / Not Met	NO	195-196
8-6	Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).	Met / Not Met	NO	197-198
8-7	Facility staff can describe fire safety and emergency evacuation procedures.	Met / Not Met	NO	199-200
8-8	The certified site provides safe exiting to a public way.	Met / Not Met	NO	201-203
8-9	There is fire <b>alarm</b> and detection equipment in the facility as required by regulation and/or LSC.	Met / Not Met	NO	204-206
8-11	Fire alarm and notification systems are operational and effective.	Met / Not Met	NO	209-210
8-12	Other fire protection equipment is operational.	Met / Not Met / NA	NO	211-212
8-13	Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.	Met / Not Met	NO	213-214

8-14	Maintenance and inspection of Fire Alarm and Detection systems are performed by competent parties and according to OPWDD standards.	Met / Not Met	NO	215-216
8-15	Maintenance and inspection of Sprinkler Systems is performed by competent parties and according to OPWDD standards.	Met / Not Met / NA	NO	217-218
8-16	At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.	Met / Not Met	NO	219-220
8-19	The facility, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.	Met / Not Met	NO	225-226
<b>SECTION 9: SITE SPECIFIC REQUIREMENTS</b>				
9-1	The site/program has a written Quality Assurance Plan that has been implemented.	Met/Not Met	NO	227-229
9-2	Corrective actions identified per the QA Plan Activities are implemented.	Met / Not Met	NO	230

# DAY HABILITATION

QNO.	Program Class & Type STANDARD	Decision	Targeted Sample	Pg. No.
Standard #	STANDARD:	DECISION:	Verify for 1 individual min.	Site Guidance Page Number
<b>SECTION 1 - HEIGHTENED SCRUTINY TRIGGERS</b>				
Qualifier Question	Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?	Y/N	NO	9
1-1	The site is in a location <u>other than</u> on the grounds of a public institution.	Met / Not Met	NO	10
1-2	The site is in a building separate from a publically or privately operated facility that provides inpatient institutional treatment.	Met / Not Met	NO	11
1-3	The site is in a location <u>other than</u> immediately adjacent to a public institution.	Met / Not Met	NO	12
1-4	The home meets the following description:It did not convert from an ICF on or after March 17, 2014.	Met / Not Met	NO	13
1-5	The site is located apart from other certified facilities - <i>It is not part of co-located and/or clustered programs/site that are operationally related.</i>	Met / Not Met	NO	14-16
1-6	The site's design, appearance and location is not institutional and does not isolate people from the broader community.	Met / Not Met	NO	17-19
<b>SECTION 2: HEALTH SUPPORT &amp; MEDICATIONS</b>				

2-1	There is a written plan detailing how the facility will deal with life-threatening emergencies.	Met / Not Met	NO	20
2-2	Staff working know actions to take in the event of a medical emergency.	Met / Not Met	NO	21
Qualifier Question	The Day Service site provides nursing and/or delegated nursing services such as medication administration.	Y/N		22
2a-1	There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.	Met / Not Met	NO	23-24
2a-2	DSP staff know how to contact the RN using the site/agency mechanism.	Met / Not Met	NO	25-26
2a-3	Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA or MD administers medications and/or prescribed treatments to individuals.	Met / Not Met	NO	27-28
2a-4	Individual's medications and treatments have been correctly administered per physicians' orders and his/her needs.	Met / Not Met	YES if QQ is Yes	29-31
2a-5	Medication Administration Records (MARs) are legible, correctly identify the current physician's orders/prescriptions and required documentation of administration.	Met / Not Met	YES if QQ is Yes	32-33
2a-6	Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.	Met / Not Met	YES if QQ is Yes	34-36
2a-7	Medications and treatments are stored securely as required, including the security of keys or codes to access medications.	Met / Not Met	NO	37-39

2a-8	Medication that is discontinued or outdated is not retained at the site.	Met / Not Met	YES if QQ is Yes	40-41
2a-9	Used needles and syringes are disposed in puncture resistant containers.	Met / Not Met	NO	42
<b>SECTION 3: PERSONAL FUNDS</b>				
Qualifier Question	Is any portion of the individuals personal funds held or managed by the site?	Y/N		51
3a-2	Personal Allowance funds held by the site are secured and safeguarded, accessible only to authorized employees.	Met / Not Met	NO	54-55
3a-3	There are ledger cards for the accounting of individuals' personal allowance.	Met / Not Met	YES if QQ is Yes	56
3a-4	The ledger(s) clearly documents receipt of funds on site.	Met / Not Met	YES if QQ is Yes	57
3a-5	The ledger(s) clearly document disbursement of funds including their purpose for the individual .	Met / Not Met	YES if QQ is Yes	58-59
3a-6	The ledger(s) accurately reflect the individual's total fund amount available in the site.	Met / Not Met	YES if QQ is Yes	60-61
3a-7	Personal allowance funds are not used for items or expenses for which the agency is responsible.	Met / Not Met	YES if QQ is Yes	62-63
3a-8	Receipts required (by regulation) for items or services purchased, reconcile with ledger entries.	Met / Not Met	YES if QQ is Yes	64
3a-9	Individuals are reimbursed for any loss of money maintained at the site.	Met / Not Met	YES if applicable	65
<b>SECTION 4: GENERAL OPERATIONS FOR : INDIVIDUALIZE CHOICE, AUTONOMY &amp; SATISFACTION</b>				
4-1	Sufficient transportation is available and facilitated to support individualized choices of activities and schedules.	Met / Not Met	NO	66-67

4-2	The staff scheduling and general operations are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.	Met / Not Met	NO	68-69
4-3	The site has a mechanism to assess individuals' satisfaction with the service environment.	Met / Not Met	NO	70-71
4-6	The program takes timely action to address individuals' dissatisfaction with living and/or service environment.	Met / Not Met	NO	76-77
4-10	Individuals' schedules and routines are personally determined per their needs, interests and preferences (rather than per the staff or agency operations).	Met / Not Met	NO	84-86
4-11	Individuals <u>are observed</u> to engage in activities that are meaningful to them.	Met / Not Met	NO	87-88
4-13	Individuals are encouraged and supported to have full access to the broader community.	Met / Not Met	NO	90-92
4-14	Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by staff.	Met / Not Met	NO	93-95
4-15	Individuals are supported by staff to exercise control and choice in their own lives.	Met / Not Met	NO	96-97
<b>SECTION 5 : DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS</b>				
5-1	Staff can describe/know the Individuals' supervision needs.	Met / Not Met	NO	98-99
5-2	Individuals receive their meal/food in the form and consistency required by their plan, according to their needs and per OPWDD Choking Prevention Initiative (CPI) specifications.	Met / Not Met / NA	YES	100-102
5-3	Individuals receive support while eating in accordance with their assessed and observed needs.	Met / Not Met / NA	YES	103-104

5-4	Individuals receive support for mobility in accordance with observed needs.	Met / Not Met / NA	NO	105-106
5-5	Individuals receive appropriate support and supervision based on <u>other</u> observed needs.	Met / Not Met	NO	107-108
5-6	There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.	Met / Not Met / NA	NO	109-111
5-7	The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) Prompt contacting of other responsible personnel in emergencies.	Met / Not Met / NA	NO	112-113
<b>SECTION 6: RIGHTS PROTECTIONS</b>				
6-1	<u>Observed and reported</u> interactions and communications with individuals, both verbal and non-verbal, are respectful.	Met / Not Met	NO	114-116
6-2	The site is absent of generally applied rules, policies or procedures that limit people's rights, independence, choice and autonomy.	Met / Not Met	NO	117-119
6-3	Individuals are permitted by the program to engage in any legal activities per their interests.	Met / Not Met	NO	120-121
6-4	Individuals have full access to the typical facilities in the site.	Met / Not Met	NO	122-124
6-5	Individuals' health and other protected information is kept private/protected.	Met / Not Met	NO	125-126
6-7	People have access to food at any time	Met / Not Met	NO	130-131
6-8	People can choose to eat meals where/when desired.	Met / Not Met	NO	132-133
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.	Met / Not Met / NA	NO	134-135

6-10	Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.	Met / Not Met / NA	NO	136-137
6-11	Immediate care and treatment identified was provided to the individual involved in the incident.	Met / Not Met / NA	NO	138-139
6-12	Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.	Met / Not Met / NA	NO	140-141
6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.	Met / Not Met / NA	NO	142-144
6-14	Measures identified to prevent future similar events were <u>planned and implemented.</u>	Met / Not Met / NA	NO	145-148
6-15	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.	Met / Not Met / NA	NO	149-152
6-16		Part 625 events and actions reported in IRMA regarding recommendations, were implemented as reported.	Met / Not Met / NA	NO
<b>SECTION 7: SITE &amp; SAFETY</b>				
7-2	Surveillance cameras are not present in the site.	Met / Not Met	NO	157
7-4	The site's physical characteristics support the independence, comfort, preference and needs of the individuals.	Met / Not Met	NO	160-161
7-5	All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.	Met / Not Met	NO	162-163
7-6	There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.	Met / Not Met	NO	164-165
7-7	Bathrooms provide personal privacy.	Met / Not Met	NO	166
7-8	The site is clean.	Met / Not Met	NO	167-168
7-9	The site is well maintained for the safety and comfort of the individuals receiving services.	Met / Not Met	NO	169-171

7-10	The facility operates in accordance with OPWDD smoking requirements.	Met / Not Met	NO	172-174
7-11	The temperature of the hot water is appropriate to the abilities of people served at the site.	Met / Not Met	NO	175-176
7-12	Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.	Met / Not Met / NA	NO	177-179
7-13	The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools.	Met / Not Met / NA	NO	180-181
7-14	The facility has a land line (see section 635-99.1) telephone service which is in working order and functions during power outages.	Met / Not Met	NO	182
7-15	Time Out rooms constructed or significantly modified after April 1, 2013 meet the requirements identified in NYCRR Part 633.16(j).	Met / Not Met / NA	NO	183-185

**SECTION 8: FIRE SAFETY REQUIRED (by OFPC or DQI )**

Qualifier Question	Are there any immediate Fire Safety issues that must be identified?	Y/N		186
8-1	The site has an acceptable fire evacuation plan.	Met / Not Met	NO	187-189
8-2	All fire and evacuation drills or events MUST be documented on the standardized drill report form developed by OPWDD.	Met / Not Met	NO	190
8-3	The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.	Met / Not Met	NO	191-192
8-4	Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.	Met / Not Met	NO	193-194
8-5	The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.	Met / Not Met	NO	195-196

8-6	Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).	Met / Not Met	NO	197-198
8-7	Facility staff can describe fire safety and emergency evacuation procedures.	Met / Not Met	NO	199-200
8-8	The certified site provides safe exiting to a public way.	Met / Not Met	NO	201-203
8-9	There is fire <b>alarm</b> and detection equipment in the facility as required by regulation and/or LSC.	Met / Not Met	NO	204-206
8-11	Fire alarm and notification systems are operational and effective.	Met / Not Met	NO	209-210
8-12	Other fire protection equipment is operational.	Met / Not Met / NA	NO	211-212
8-13	Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.	Met / Not Met	NO	213-214
8-14	Maintenance and inspection of Fire Alarm and Detection systems are performed by competent parties and according to OPWDD standards.	Met / Not Met	NO	215-216
8-15	Maintenance and inspection of Sprinkler Systems is performed by competent parties and according to OPWDD standards.	Met / Not Met / NA	NO	217-218
8-16	At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.	Met / Not Met	NO	219-220
8-19	The facility, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.	Met / Not Met	NO	225-226

## SECTION 10: SPECIALIZED RISK FACTORS

### Section 10a: Risk Area: Skin Breakdown

Qualifier Question	Does anyone currently have skin breakdown or a history of skin breakdown?	Y/N		231
10a-1	There is a written plan to provide care for wounds and/or prevent worsening & further breakdown.	Met/ Not Met	YES if QQ is Yes	232-235
10a-2	Staff implement interventions related to care and monitoring of skin integrity and the prevention of skin breakdown, for which they are responsible.	Met/Not Met	YES if QQ is Yes	236-238
<b>Section 10e: Risk Area: Fluid Intake</b>				
Qualifier Question	Does any individual require a specific daily level of fluid intake?	Y/N		267
10e-1	The amount of fluid to be consumed by the person is clearly indicated in a written plan.	Met/Not Met	YES if QQ is Yes	267-269
10e-2	Clear written instruction is provided to further guide staff in how to implement the fluid intake requirements.	Met/Not Met	YES if QQ is Yes	270-272
10e-3	There is documentation/tracking of the person's fluid consumption.	Met/Not Met	YES if QQ is Yes	273-274
10e-4	The written plan for fluid consumption is implemented correctly.	Met/Not Met	YES if QQ is Yes	275-277
<b>Section 10f: Risk Area: Oxygen Use</b>				
Qualifier Question	Does any individual have an order for Oxygen use?	Y/N		278
10f-1	Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.	Met/Not Met	YES if QQ is Yes	279-280
10f-2	The written instruction includes how and what to document regarding oxygen administration and monitoring.	Met/Not Met	YES if QQ is Yes	281-282

10f-3	Necessary equipment is available per the medical order for oxygen.	Met/Not Met	YES if QQ is Yes	283
10f-4	There is documentation evidencing ordered administration of oxygen and monitoring of their condition.	Met/Not Met	YES if QQ is Yes	284-286
<b>Section 10g: Risk Area: Supervision</b>				
Qualifier Question	Enhanced supervision levels are required by one or more person supported by the sight.	Y/N		287
10g-1	There are sufficient staff on duty to maintain the supervision levels required by the Individuals.	Met/Not Met	YES if QQ is Yes	287-290
10g-2	Required enhanced supervision and staffing ratios are maintained per people's individualized plans.	Met/Not Met	YES if QQ is Yes	291-293
<b>Section 10h : Risk Area: All Rights Limitations/Restrictions</b>				
Qualifier Question	Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?	Y/N		293
10h-1	Limitation or restriction of rights <u>due to behaviors</u> occur only as part of a written behavior plan.	Met/Not Met	YES if QQ is Yes	293-294
10h-2	The Individuals Behavior Support Plan describes how the use of each restrictive intervention is to be documented.	Met/Not Met	YES if QQ is Yes	295-296
10h-3	Rights Limitations / restrictions occur only when written informed consent was obtained from an appropriate consent giver.	Met/Not Met	YES if QQ is Yes	297-298
10h-4	Rights Limitations / restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.	Met/Not Met	YES if QQ is Yes	299-300

10h-5	Rights limitations that are not part of a Behavior Support Plan comply with HCBS requirements for justification and documentation of rights limitations.	Met/Not Met	YES if QQ is Yes	301-304
10h-6	When environmental protections (that are in place due to an Individuals needs) restricts other Individuals in the facility, action is taken to ensure that they are not negatively affected.	Met/Not Met	YES if QQ is Yes	305-306
<b>Section 10i: Risk Area: Behavior Supports - General</b>				
Qualifier Question	Is a behavior support plan or medication monitoring plan required/in place for any Individual ?	Y/N		307
10i-1	Behavior Supports are provided per the written plan.	Met/Not Met	YES if QQ is Yes	307-309
10i-2	Behavior supports are reviewed for effectiveness by clinical staff responsible for the plan.	Met/Not Met	YES if QQ is Yes	210-311
10i-3	Behavior Supports are revised as needed.	Met/Not Met	YES if QQ is Yes	312-313
<b>Section 10j: Risk Area: Mechanical Restraints</b>				
Qualifier Question	Are there any limitation or restriction of rights, including use of approved physical interventions, evident and/or reported?	Y/N		314
10j-1	Criteria for the application, removal and duration of mechanical restraint device use is described in the written behavior support plan.	Met/Not Met	YES if QQ is Yes	314-317
10j-2	Restraints are applied only per the specific criteria described in the written plan.	Met/Not Met	YES if QQ is Yes	318-319

10j-3	Restraints are removed per the criteria and duration described in the written plan.	Met/Not Met	YES if QQ is Yes	320-321
10j-4	There is a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	YES if QQ is Yes	322-323
10j-5	There is documentation that is a "full record" of the use of the Mechanical Restraining device.	Met/Not Met	YES if QQ is Yes	324-325
<b>Section 10k: Risk Area: Time Out</b>				
Qualifier Question	Is 'Time-out' used for any Individuals?	Y/N		326
10k-1	Time-out is used only in accordance with the written Behavior Support Plan.	Met/Not Met	YES if QQ is Yes	326-327
10k-2	The use of a time out room is reported electronically to OPWDD.	Met/Not Met	YES if QQ is Yes	328-329
10k-3	Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.	Met/Not Met	YES if QQ is Yes	330-331
<b>Section 10l: Risk Area: Physical Interventions</b>				
Qualifier Question	Are physical Interventions used for any Individuals?	Y/N		332
10l-1	Physical interventions are used only in accordance with the written Behavior Support Plan.	Met/Not Met	YES if QQ is Yes	332-333
10l-2	The use of restrictive physical interventions is reported electronically to OPWDD.	Met/Not Met	YES if QQ is Yes	334.335

## DAY TRAININGS

QNO.	Program Class & Type STANDARD	Decision	33-31	33-33	34-34	Targeted Sample	Pg. No.
Standard #	STANDARD:	DECISION	Day Training	Day Training (Client Education)	Day Training (Work Act/Sheltered Work)	Verify for 1 individual min.	Site Guidance Page Number
<b>SECTION 1 - HEIGHTENED SCRUTINY TRIGGERS</b>							
Qualifier Question	Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?	Y/N	YES	YES	N/A		9
1-1	The site is in a location <u>other than</u> on the grounds of a public institution.	Met / Not Met	YES	YES	N/A	NO	10
1-2	The site is in a building separate from a publically or privately operated facility that provides inpatient institutional treatment.	Met / Not Met	YES	YES	N/A	NO	11
1-3	The site is in a location <u>other than</u> immediately adjacent to a public institution.	Met / Not Met	YES	YES	N/A	NO	12
1-4	The home meets the following description:It did not convert from an ICF on or after March 17, 2014.	Met / Not Met	YES	YES	N/A	NO	13
1-5	The site is located apart from other certified facilities - <i>It is not part of co-located and/or clustered programs/site that are operationally related.</i>	Met / Not Met	YES	YES	N/A	NO	14-16
1-6	The site's design, appearance and location is not institutional and does not isolate people from the broader community.	Met / Not Met	YES	YES	N/A	NO	17-19
<b>SECTION 2: HEALTH SUPPORT &amp; MEDICATIONS</b>							
2-1	There is a written plan detailing how the facility will deal with life-threatening emergencies.	Met / Not Met	YES	YES	YES	NO	20
2-2	Staff working know actions to take in the event of a medical emergency.	Met / Not Met	YES	YES	YES	NO	21
Qualifier Question	The Day Service site provides nursing and/or delegated nursing services such as medication administration.	Y/N	YES	YES	YES		22

2a-1	There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.	Met / Not Met	YES	YES	YES	NO	23-24
2a-2	DSP staff know how to contact the RN using the site/agency mechanism.	Met / Not Met	YES	YES	YES	NO	25-26
2a-3	Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA or MD administers medications and/or prescribed treatments to individuals.	Met / Not Met	YES	YES	YES	NO	27-28
2a-4	Individual's medications and treatments have been correctly administered per physicians' orders and his/her needs.	Met / Not Met	YES	YES	YES	YES if QQ is Yes	29-31
2a-5	Medication Administration Records (MARs) are legible, correctly identify the current physician's orders/prescriptions and required documentation of administration.	Met / Not Met	YES	YES	YES	YES if QQ is Yes	32-33
2a-6	Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.	Met / Not Met	YES	YES	YES	YES if QQ is Yes	34-36
2a-7	Medications and treatments are stored securely as required, including the security of keys or codes to access medications.	Met / Not Met	YES	YES	YES	NO	37-39
2a-8	Medication that is discontinued or outdated is not retained at the site.	Met / Not Met	YES	YES	YES	YES if QQ is Yes	40-41
2a-9	Used needles and syringes are disposed in puncture resistant containers.	Met / Not Met	YES	YES	YES	NO	42
<b>SECTION 3: PERSONAL FUNDS</b>							
Qualifier Question	Is any portion of the individuals personal funds held or managed by the site ?	Y/N	YES	YES	YES		51
3a-2	Personal Allowance funds held by the site are secured and safeguarded, accessible only to authorized employees.	Met / Not Met	YES	YES	YES	NO	54-55
3a-3	There are ledger cards for the accounting of individuals' personal allowance.	Met / Not Met	YES	YES	YES	YES if QQ is Yes	56
3a-4	The ledger(s) clearly documents receipt of funds on site.	Met / Not Met	YES	YES	YES	YES if QQ is Yes	57
3a-5	The ledger(s) clearly document disbursement of funds including their purpose for the individual.	Met / Not Met	YES	YES	YES	YES if QQ is Yes	58-59

3a-6	The ledger(s) accurately reflect the individual's total fund amount available in the site.	Met / Not Met	YES	YES	YES	YES if QQ is Yes	60-61
3a-7	Personal allowance funds are not used for items or expenses for which the agency is responsible.	Met / Not Met	YES	YES	YES	YES if QQ is Yes	62-63
3a-8	Receipts required (by regulation) for items or services purchased, reconcile with ledger entries.	Met / Not Met	YES	YES	YES	YES if QQ is Yes	64
3a-9	Individuals are reimbursed for any loss of money maintained at the site.	Met / Not Met	YES	YES	YES	Yes if applicable	65
<b>SECTION 4: GENERAL OPERATIONS FOR : INDIVIDUALIZE CHOICE, AUTONOMY &amp; SATISFACTION</b>							
4-1	Sufficient transportation is available and facilitated to support individualized choices of activities and schedules.	Met / Not Met	YES	YES	YES	NO	66-67
4-2	The staff scheduling and general operations are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.	Met / Not Met	YES	YES	YES	NO	68-69
4-3	The site has a mechanism to assess individuals' satisfaction with the service environment.	Met / Not Met	YES	YES	YES	NO	70-71
4-6	The program takes timely action to address individuals' dissatisfaction with living and/or service environment.	Met / Not Met	YES	YES	YES	NO	76-77
4-11	Individuals <u>are observed</u> to engage in activities that are meaningful to them.	Met / Not Met	YES	YES	YES	NO	87-88
4-14	Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by staff.	Met / Not Met	YES	YES	YES	NO	93-95
4-15	Individuals are supported by staff to exercise control and choice in their own lives.	Met / Not Met	YES	YES	YES	NO	96-97
<b>SECTION 5 : DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS</b>							
5-1	Staff can describe/know the Individuals' supervision needs.	Met / Not Met	YES	YES	YES	NO	98-99
5-2	Individuals receive their meal/food in the form and consistency required by their plan, according to their needs and per OPWDD Choking Prevention Initiative (CPI) specifications.	Met / Not Met / NA	YES	YES	YES	YES	100-102

5-3	Individuals receive support while eating in accordance with their assessed and observed needs.	Met / Not Met / NA	YES	YES	YES	YES	103-104
5-4	Individuals receive support for mobility in accordance with observed needs.	Met / Not Met / NA	YES	YES	YES	NO	105-106
5-5	Individuals receive appropriate support and supervision based on <u>other</u> observed needs.	Met / Not Met	YES	YES	YES	NO	107-108
5-6	There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.	Met / Not Met / NA	YES	YES	YES	NO	109-111
5-7	The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) Prompt contacting of other responsible personnel in emergencies.	Met / Not Met / NA	YES	YES	YES	NO	112-113
<b>SECTION 6: RIGHTS PROTECTIONS</b>							
6-1	<u>Observed and reported</u> interactions and communications with individuals, both verbal and non-verbal, are respectful.	Met / Not Met	YES	YES	YES	NO	114-116
6-2	The site is absent of generally applied rules, policies or procedures that limit people's rights, independence, choice and autonomy.	Met / Not Met	YES	YES	YES	NO	117-119
6-3	Individuals are permitted by the program to engage in any legal activities per their interests.	Met / Not Met	YES	YES	YES	NO	120-121
6-4	Individuals have full access to the typical facilities in the site.	Met / Not Met	YES	YES	YES	NO	122-124
6-5	Individuals' health and other protected information is kept private/protected.	Met / Not Met	YES	YES	YES	NO	125-126
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.	Met / Not Met / NA	YES	YES	YES	NO	134-135
6-10	Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.	Met / Not Met / NA	YES	YES	YES	NO	136-137
6-11	Immediate care and treatment identified was provided to the individual involved in the incident.	Met / Not Met / NA	YES	YES	YES	NO	138-139
6-12	Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.	Met / Not Met / NA	YES	YES	YES	NO	140-141

6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.	Met / Not Met / NA	YES	YES	YES	NO	142-144
6-14	Measures identified to prevent future similar events were <u>planned and implemented.</u>	Met / Not Met / NA	YES	YES	YES	NO	145-148
6-15	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.	Met / Not Met / NA	YES	YES	YES	NO	149-152
6-16	Part 625 events and actions reported in IRMA regarding recommendations, were implemented as reported.	Met / Not Met / NA	YES	YES	YES	NO	153-154
<b>SECTION 7: SITE &amp; SAFETY</b>							
7-2	Surveillance cameras are not present in the site.	Met / Not Met	YES	YES	YES	NO	157
7-4	The site's physical characteristics support the independence, comfort, preference and needs of the individuals.	Met / Not Met	YES	YES	YES	NO	160-161
7-5	All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.	Met / Not Met	YES	YES	YES	NO	162-163
7-6	There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.	Met / Not Met	YES	YES	YES	NO	164-165
7-7	Bathrooms provide personal privacy.	Met / Not Met	YES	YES	YES	NO	166
7-8	The site is clean.	Met / Not Met	YES	YES	YES	NO	167-168
7-9	The site is well maintained for the safety and comfort of the individuals receiving services.	Met / Not Met	YES	YES	YES	NO	169-171
7-10	The facility operates in accordance with OPWDD smoking requirements.	Met / Not Met	YES	YES	YES	NO	172-174
7-11	The temperature of the hot water is appropriate to the abilities of people served at the site.	Met / Not Met	YES	YES	YES	NO	175-176
7-12	Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.	Met / Not Met / NA	YES	YES	YES	NO	177-179
7-13	The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools	Met / Not Met / NA	YES	YES	YES	NO	180-181
7-14	The facility has a land line (see section 635-99.1) telephone service which is in working order and functions during power outages.	Met / Not Met	YES	YES	YES	NO	182

7-15	Time Out rooms constructed or significantly modified after April 1, 2013 meet the requirements identified in NYCRR Part 633.16(j).	Met / Not Met / NA	YES	YES	YES	NO	183-185
<b>SECTION 8: FIRE SAFETY REQUIRED (by OFPC or DQI )</b>							
Qualifier Question	Are there any immediate Fire Safety issues that must be identified?	Y/N	YES	YES	YES		186
8-1	The site has an acceptable fire evacuation plan.	Met / Not Met	YES	YES	YES	NO	187-189
8-2	All fire and evacuation drills or events MUST be documented on the standardized drill report form developed by OPWDD.	Met / Not Met	YES	YES	YES	NO	190
8-3	The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.	Met / Not Met	YES	YES	YES	NO	191-192
8-4	Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.	Met / Not Met	YES	YES	YES	NO	193-194
8-5	The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.	Met / Not Met	YES	YES	YES	NO	195-196
8-6	Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).	Met / Not Met	YES	YES	YES	NO	197-198
8-7	Facility staff can describe fire safety and emergency evacuation procedures.	Met / Not Met	YES	YES	YES	NO	199-200
8-8	The certified site provides safe exiting to a public way.	Met / Not Met	YES	YES	YES	NO	201-203
8-9	There is fire alarm and detection equipment in the facility as required by regulation and/or LSC.	Met / Not Met	YES	YES	YES	NO	204-206
8-11	Fire alarm and notification systems are operational and effective.	Met / Not Met	YES	YES	YES	NO	209-210
8-12	Other fire protection equipment is operational.	Met / Not Met / NA	YES	YES	YES	NO	211-212
8-13	Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.	Met / Not Met	YES	YES	YES	NO	213-214
8-14	Maintenance and inspection of Fire Alarm and Detection systems are performed by competent parties and according to OPWDD standards.	Met / Not Met	YES	YES	YES	NO	215-216
8-15	Maintenance and inspection of Sprinkler Systems is performed by competent parties and according to OPWDD standards.	Met / Not Met / NA	YES	YES	YES	NO	217-218

8-16	At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.	Met / Not Met	YES	YES	YES	NO	219-220
8-19	The facility, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.	Met / Not Met	YES	YES	YES	NO	225-226
<b>SECTION 10: SPECIALIZED RISK FACTORS</b>							
<b>Section 10a: Risk Area: Skin Breakdown</b>							
Qualifier Question	Does anyone currently have skin breakdown or a history of skin breakdown?	Y/N	YES	YES	YES		231
10a-1	There is a written plan to provide care for wounds and/or prevent worsening & further breakdown.	Met/ Not Met	YES	YES	YES	YES	232-235
10a-2	Staff implement interventions related to care and monitoring of skin integrity and the prevention of skin breakdown, for which they are responsible.	Met/Not Met	YES	YES	YES	YES	236-238
<b>Section 10e: Risk Area: Fluid Intake</b>							
Qualifier Question	Does any individual require a specific daily level of fluid intake?	Y/N	YES	YES	YES		267
10e-1	The amount of fluid to be consumed by the person is clearly indicated in a written plan.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	267-269
10e-2	Clear written instruction is provided to further guide staff in how to implement the fluid intake requirements.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	270-272
10e-3	There is documentation/tracking of the person's fluid consumption.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	273-274
10e-4	The written plan for fluid consumption is implemented correctly.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	275-277
<b>Section 10f: Risk Area: Oxygen Use</b>							
Qualifier Question	Does any individual have an order for Oxygen use?	Y/N	YES	YES	YES		278
10f-1	Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	278-280
10f-2	The written instruction includes how and what to document regarding oxygen administration and monitoring.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	281-282

10f-3	Necessary equipment is available per the medical order for oxygen.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	283
10f-4	There is documentation evidencing ordered administration of oxygen and monitoring of their condition.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	284-286
<b>Section 10g: Risk Area: Supervision</b>							
Qualifier Question	Enhanced supervision levels are required by one or more person supported by the sight.	Y/N	YES	YES	YES		287
10g-1	There are sufficient staff on duty to maintain the supervision levels required by the Individuals.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	287-290
10g-2	Required enhanced supervision and staffing ratios are maintained per people's individualized plans.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	291-293
<b>Section 10h : Risk Area: All Rights Limitations/Restrictions</b>							
Qualifier Question	Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?	Y/N	YES	YES	YES		293
10h-1	Limitation or restriction of rights <u>due to behaviors</u> occur only as part of a written behavior plan.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	293-294
10h-2	The Individuals Behavior Support Plan describes how the use of each restrictive intervention is to be documented.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	295-296
10h-3	Rights Limitations / restrictions occur only when written informed consent was obtained from an appropriate consent giver.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	297-298
10h-4	Rights Limitations / restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	299-300
10h-5	Rights limitations that are not part of a Behavior Support Plan comply with HCBS requirements for justification and documentation of rights limitations.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	301-304
10h-6	When environmental protections (that are in place due to an Individuals needs) restricts other Individuals in the facility, action is taken to ensure that they are not negatively affected.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	305-306
<b>Section 10i: Risk Area: Behavior Supports - General</b>							
Qualifier Question	Is a behavior support plan or medication monitoring plan required/in place for any Individual ?	Y/N	YES	YES	YES		307

10i-1	Behavior Supports are provided per the written plan	Met/Not Met	YES	YES	YES	YES if QQ is Yes	307-309
10i-2	Behavior supports are reviewed for effectiveness by clinical staff responsible for the plan.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	310-311
10i-3	Behavior Supports are revised as needed.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	312-313
<b>Section 10j: Risk Area: Mechanical Restraints</b>							
Qualifier Question	Are there any limitation or restriction of rights, including use of approved physical interventions, evident and/or reported?	Y/N	YES	YES	YES		314
10j-1	Criteria for the application, removal and duration of mechanical restraint device use is described in the written behavior support plan.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	314-317
10j-2	Restraints are applied only per the specific criteria described in the written plan.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	318-319
10j-3	Restraints are removed per the criteria and duration described in the written plan.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	320-321
10j-4	There is a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	322-323
10j-5	There is documentation that is a "full record" of the use of the Mechanical Restraining device.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	324-325
<b>Section 10k: Risk Area: Time Out</b>							
Qualifier Question	Is 'Time-out' used for any Individuals?	Y/N	YES	YES	YES		326
10k-1	Time-out is used only in accordance with the written Behavior Support Plan.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	326-327
10k-2	The use of a time out room is reported electronically to OPWDD.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	328-329
10k-3	Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.	Met/Not Met	YES	YES	YES	YES if QQ is Yes	330-331
<b>Section 10l: Risk Area: Physical Interventions</b>							
Qualifier Question	Are physical Interventions used for any Individuals?	Y/N	YES	YES	YES		332

10I-1	Physical interventions are used only in accordance with the written Behavior Support Plan.	Met/Not Met	<b>YES</b>	<b>YES</b>	<b>YES</b>	<b>YES if QQ is Yes</b>	332-333
10I-2	The use of restrictive physical interventions is reported electronically to OPWDD.	Met/Not Met	<b>YES</b>	<b>YES</b>	<b>YES</b>	<b>YES if QQ is Yes</b>	334-335

# DAY TREATMENT

QNO.	Program Class & Type STANDARD	Decision	Targeted Sample	Pg. No.
Standard #	STANDARD:	DECISION:	Verify for 1 individual min.	Site Guidance Page Number
<b>SECTION 2: HEALTH SUPPORT &amp; MEDICATIONS</b>				
2-1	There is a written plan detailing how the facility will deal with life-threatening emergencies.	Met / Not Met	NO	20
2-2	Staff working know actions to take in the event of a medical emergency.	Met / Not Met	NO	21
Qualifier Question	The Day Service site provides nursing and/or delegated nursing services such as medication administration.	Y/N		22
2a-1	There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.	Met / Not Met	NO	23-24
2a-2	DSP staff know how to contact the RN using the site/agency mechanism.	Met / Not Met	NO	25-26
2a-3	Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA or MD administers medications and/or prescribed treatments to individuals.	Met / Not Met	NO	27-28
2a-4	Individual's medications and treatments have been correctly administered per physicians' orders and his/her needs.	Met / Not Met	YES if QQ is Yes	29-31

2a-5	Medication Administration Records (MARs) are legible, correctly identify the current physician's orders/prescriptions and required documentation of administration.	Met / Not Met	YES if QQ is Yes	32-33
2a-6	Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.	Met / Not Met	YES if QQ is Yes	34-36
2a-7	Medications and treatments are stored securely as required, including the security of keys or codes to access medications.	Met / Not Met	NO	37-39
2a-8	Medication that is discontinued or outdated is not retained at the site.	Met / Not Met	YES if QQ is Yes	40-41
2a-9	Used needles and syringes are disposed in puncture resistant containers.	Met / Not Met	NO	42
<b>SECTION 3: PERSONAL FUNDS</b>				
Qualifier Question	Is any portion of the individuals personal funds held or managed by the site?	Y/N		51
3a-2	Personal Allowance funds held by the site are secured and safeguarded, accessible only to authorized employees.	Met / Not Met	NO	54-55
3a-3	There are ledger cards for the accounting of individuals' personal allowance.	Met / Not Met	YES if QQ is Yes	56
3a-4	The ledger(s) clearly documents receipt of funds on site.	Met / Not Met	YES if QQ is Yes	57
3a-5	The ledger(s) clearly document disbursement of funds including their purpose for the individual.	Met / Not Met	YES if QQ is Yes	58-59
3a-6	The ledger(s) accurately reflect the individual's total fund amount available in the site.	Met / Not Met	YES if QQ is Yes	60-61

3a-7	Personal allowance funds are not used for items or expenses for which the agency is responsible.	Met / Not Met	YES if QQ is Yes	62-63
3a-8	Receipts required (by regulation) for items or services purchased, reconcile with ledger entries.	Met / Not Met	YES if QQ is Yes	64
3a-9	Individuals are reimbursed for any loss of money maintained at the site.	Met / Not Met	YES if applicable	65
<b>SECTION 4: GENERAL OPERATIONS FOR : INDIVIDUALIZE CHOICE, AUTONOMY &amp; SATISFACTION</b>				
4-1	Sufficient transportation is available and facilitated to support individualized choices of activities and schedules.	Met / Not Met	NO	66-67
4-2	The staff scheduling and general operations are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.	Met / Not Met	NO	68-69
4-3	The site has a mechanism to assess individuals' satisfaction with the service environment.	Met / Not Met	NO	70-71
4-6	The program takes timely action to address individuals' dissatisfaction with living and/or service environment.	Met / Not Met	NO	76-77
4-11	Individuals <u>are observed</u> to engage in activities that are meaningful to them.	Met / Not Met	NO	87-88
4-13	Individuals are encouraged and supported to have full access to the broader community.	Met / Not Met	NO	90-92
4-14	Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by staff.	Met / Not Met	NO	93-95
4-15	Individuals are supported by staff to exercise control and choice in their own lives.	Met / Not Met	NO	96-97
<b>SECTION 5 : DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS</b>				
5-1	Staff can describe/know the Individuals' supervision needs.	Met / Not Met	YES	98-99

5-2	Individuals receive their meal/food in the form and consistency required by their plan, according to their needs and per OPWDD Choking Prevention Initiative (CPI) specifications.	Met / Not Met / NA	YES	100-102
5-3	Individuals receive support while eating in accordance with their assessed and observed needs.	Met / Not Met / NA	YES	103-104
5-4	Individuals receive support for mobility in accordance with observed needs.	Met / Not Met / NA	YES	105-106
5-5	Individuals receive appropriate support and supervision based on <u>other</u> observed needs.	Met / Not Met	YES	107-108
5-6	There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.	Met / Not Met / NA	YES	109-111
5-7	The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) Prompt contacting of other responsible personnel in emergencies.	Met / Not Met / NA	YES	112-113
<b>SECTION 6: RIGHTS PROTECTIONS</b>				
6-1	<u>Observed and reported</u> interactions and communications with individuals, both verbal and non-verbal, are respectful.	Met / Not Met	NO	114-116
6-2	The site is absent of generally applied rules, policies or procedures that limit people's rights, independence, choice and autonomy.	Met / Not Met	NO	117-119
6-3	Individuals are permitted by the program to engage in any legal activities per their interests.	Met / Not Met	NO	120-121
6-4	Individuals have full access to the typical facilities in the site.	Met / Not Met	NO	122-124

6-5	Individuals' health and other protected information is kept private/protected.	Met / Not Met	NO	125-126
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.	Met / Not Met / NA	NO	134-135
6-10	Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.	Met / Not Met / NA	NO	136-137
6-11	Immediate care and treatment identified was provided to the individual involved in the incident.	Met / Not Met / NA	NO	138-139
6-12	Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.	Met / Not Met / NA	NO	140-141
6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.	Met / Not Met / NA	NO	142-144
6-14	Measures identified to prevent future similar events were <u>planned and implemented.</u>	Met / Not Met / NA	NO	145-148
6-15	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.	Met / Not Met / NA	NO	149-152
6-16	Part 625 events and actions reported in IRMA regarding recommendations, were implemented as reported.	Met / Not Met / NA	NO	153-154
<b>SECTION 7: SITE &amp; SAFETY</b>				
7-2	Surveillance cameras are not present in the site.	Met / Not Met	NO	157
7-4	The site's physical characteristics support the independence, comfort, preference and needs of the individuals.	Met / Not Met	NO	160-161
7-5	All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.	Met / Not Met	NO	162-163
7-6	There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.	Met / Not Met	NO	164-165
7-7	Bathrooms provide personal privacy.	Met / Not Met	NO	166

7-8	The site is clean.	Met / Not Met	NO	167-168
7-9	The site is well maintained for the safety and comfort of the individuals receiving services.	Met / Not Met	NO	169-171
7-10	The facility operates in accordance with OPWDD smoking requirements.	Met / Not Met	NO	172-174
7-11	The temperature of the hot water is appropriate to the abilities of people served at the site.	Met / Not Met	NO	175-176
7-12	Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.	Met / Not Met / NA	NO	177-179
7-13	The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools.	Met / Not Met / NA	NO	180-181
7-14	The facility has a land line (see section 635-99.1) telephone service which is in working order and functions during power outages.	Met / Not Met	NO	182
7-15	Time Out rooms constructed or significantly modified after April 1, 2013 meet the requirements identified in NYCRR Part 633.16(j).	Met / Not Met / NA	NO	183-185
<b>SECTION 8: FIRE SAFETY REQUIRED (by OFPC or DQI )</b>				
Qualifier Question	Are there any immediate Fire Safety issues that must be identified?	Y/N		186
8-1	The site has an acceptable fire evacuation plan.	Met / Not Met	NO	187-189
8-2	All fire and evacuation drills or events MUST be documented on the standardized drill report form developed by OPWDD.	Met / Not Met	NO	190
8-3	The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.	Met / Not Met	NO	191-192

8-4	Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.	Met / Not Met	NO	193-194
8-5	The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.	Met / Not Met	NO	195-196
8-6	Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).	Met / Not Met	NO	197-198
8-7	Facility staff can describe fire safety and emergency evacuation procedures.	Met / Not Met	NO	199-200
8-8	The certified site provides safe exiting to a public way.	Met / Not Met	NO	201-203
8-9	There is fire alarm and detection equipment in the facility as required by regulation and/or LSC.	Met / Not Met	NO	204-206
8-11	Fire alarm and notification systems are operational and effective.	Met / Not Met	NO	209-210
8-12	Other fire protection equipment is operational.	Met / Not Met / NA	NO	211-212
8-13	Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.	Met / Not Met	NO	213-214
8-14	Maintenance and inspection of Fire Alarm and Detection systems are performed by competent parties and according to OPWDD standards.	Met / Not Met	NO	215-216
8-15	Maintenance and inspection of Sprinkler Systems is performed by competent parties and according to OPWDD standards.	Met / Not Met / NA	NO	217-218
8-16	At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.	Met / Not Met	NO	219-220
8-19	The facility, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.	Met / Not Met	NO	225-226

### SECTION 9: SITE SPECIFIC REQUIREMENTS

9-1	The site/program has a written Quality Assurance Plan that has been implemented.	Met/Not Met	NO	227-229
9-2	Corrective actions identified per the QA Plan Activities are implemented.	Met / Not Met	NO	230

### SECTION 10: SPECIALIZED RISK FACTORS

#### Section 10a: Risk Area: Skin Breakdown

Qualifier Question	Does anyone currently have skin breakdown or a history of skin breakdown?	Y/N		231
10a-1	There is a written plan to provide care for wounds and/or prevent worsening & further breakdown.	Met/ Not Met	YES if QQ is Yes	232-235
10a-2	Staff implement interventions related to care and monitoring of skin integrity and the prevention of skin breakdown, for which they are responsible.	Met/Not Met	YES if QQ is Yes	236-238

#### Section 10e: Risk Area: Fluid Intake

Qualifier Question	Does any individual require a specific daily level of fluid intake?	Y/N		267
10e-1	The amount of fluid to be consumed by the person is clearly indicated in a written plan.	Met/Not Met	YES if QQ is Yes	267-269
10e-2	Clear written instruction is provided to further guide staff in how to implement the fluid intake requirements.	Met/Not Met	YES if QQ is Yes	270-272
10e-3	There is documentation/tracking of the person's fluid consumption.	Met/Not Met	YES if QQ is Yes	273-274
10e-4	The written plan for fluid consumption is implemented correctly.	Met/Not Met	YES if QQ is Yes	275-277

#### Section 10f: Risk Area: Oxygen Use

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Qualifier Question	Does any individual have an order for Oxygen use?	Y/N		278
10f-1	Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.	Met/Not Met	YES if QQ is Yes	278-280
10f-2	The written instruction includes how and what to document regarding oxygen administration and monitoring.	Met/Not Met	YES if QQ is Yes	281-282
10f-3	Necessary equipment is available per the medical order for oxygen.	Met/Not Met	YES if QQ is Yes	283
10f-4	There is documentation evidencing ordered administration of oxygen and monitoring of their condition.	Met/Not Met	YES if QQ is Yes	284-286
<b>Section 10g: Risk Area: Supervision</b>				
Qualifier Question	Enhanced supervision levels are required by one or more person supported by the sight.	Y/N		287
10g-1	There are sufficient staff on duty to maintain the supervision levels required by the Individuals.	Met/Not Met	YES if QQ is Yes	287-290
10g-2	Required enhanced supervision and staffing ratios are maintained per people's individualized plans.	Met/Not Met	YES if QQ is Yes	291-293
<b>Section 10h : Risk Area: All Rights Limitations/Restrictions</b>				
Qualifier Question	Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?	Y/N		293
10h-1	Limitation or restriction of rights <u>due to behaviors</u> occur only as part of a written behavior plan.	Met/Not Met	YES if QQ is Yes	293-294
10h-2	The Individuals Behavior Support Plan describes how the use of each restrictive intervention is to be documented.	Met/Not Met	YES if QQ is Yes	295-296

10h-3	Rights Limitations / restrictions occur only when written informed consent was obtained from an appropriate consent giver.	Met/Not Met	YES if QQ is Yes	297-298
10h-4	Rights Limitations / restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.	Met/Not Met	YES if QQ is Yes	299-300
10h-5	Rights limitations that are not part of a Behavior Support Plan comply with HCBS requirements for justification and documentation of rights limitations.	Met/Not Met	YES if QQ is Yes	301-304
10h-6	When environmental protections (that are in place due to an Individuals needs) restricts other Individuals in the facility, action is taken to ensure that they are not negatively affected.	Met/Not Met	YES if QQ is Yes	305-306
<b>Section 10i: Risk Area: Behavior Supports - General</b>				
Qualifier Question	Is a behavior support plan or medication monitoring plan required/in place for any Individual?	Y/N		307
10i-1	Behavior Supports are provided per the written plan.	Met/Not Met	YES if QQ is Yes	307-309
10i-2	Behavior supports are reviewed for effectiveness by clinical staff responsible for the plan.	Met/Not Met	YES if QQ is Yes	310-311
10i-3	Behavior Supports are revised as needed.	Met/Not Met	YES if QQ is Yes	312-313
<b>Section 10j: Risk Area: Mechanical Restraints</b>				
Qualifier Question	Are there any limitation or restriction of rights, including use of approved physical interventions, evident and/or reported?	Y/N		314

10j-1	Criteria for the application, removal and duration of mechanical restraint device use is described in the written behavior support plan.	Met/Not Met	YES if QQ is Yes	314-317
10j-2	Restraints are applied only per the specific criteria described in the written plan.	Met/Not Met	YES if QQ is Yes	318-319
10j-3	Restraints are removed per the criteria and duration described in the written plan.	Met/Not Met	YES if QQ is Yes	320-321
10j-4	There is a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	YES if QQ is Yes	322-323
10j-5	There is documentation that is a "full record" of the use of the Mechanical Restraining device.	Met/Not Met	YES if QQ is Yes	324-325
<b>Section 10k: Risk Area: Time Out</b>				
Qualifier Question	Is 'Time-out' used for any Individuals?	Y/N		326
10k-1	Time-out is used only in accordance with the written Behavior Support Plan.	Met/Not Met	YES if QQ is Yes	326-327
10k-2	The use of a time out room is reported electronically to OPWDD.	Met/Not Met	YES if QQ is Yes	328-329
10k-3	Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.	Met/Not Met	YES if QQ is Yes	330-331
<b>Section 10l: Risk Area: Physical Interventions</b>				
Qualifier Question	Are physical Interventions used for any Individuals?	Y/N		332
10l-1	Physical interventions are used only in accordance with the written Behavior Support Plan.	Met/Not Met	YES if QQ is Yes	332-333
10l-2	The use of restrictive physical interventions is reported electronically to OPWDD.	Met/Not Met	YES if QQ is Yes	334-335

# FREE STANDING RESPITES

QNO.	Program Class & Type STANDARD	Decision	Targeted Sample	Pg. No.
<b>Standard #</b>	<b>STANDARD:</b>	<b>DECISION:</b>	Verify for 1 individual min.	Site Guidance Page Number
<b>SECTION 2: HEALTH SUPPORT &amp; MEDICATIONS</b>				
2-1	There is a written plan detailing how the facility will deal with life-threatening emergencies.	Met / Not Met	NO	20
2-2	Staff working know actions to take in the event of a medical emergency.	Met / Not Met	NO	21
Qualifier Question	The site provides nursing and/or delegated nursing services such as medication administration.	Y/N		22
2a-1	There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.	Met / Not Met	NO	23-24
2a-2	DSP staff know how to contact the RN using the site/agency mechanism.	Met / Not Met	NO	25-26
2a-3	Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA or MD administers medications and/or prescribed treatments to individuals.	Met / Not Met	NO	27-28
2a-4	Individual's medications and treatments have been correctly administered per physicians' orders and his/her needs.	Met / Not Met	YES if QQ is Yes	29-31

2a-5	Medication Administration Records (MARs) are legible, correctly identify the current physician's orders/prescriptions and required documentation of administration.	Met / Not Met	YES if QQ is Yes	32-33
2a-6	Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.	Met / Not Met	YES if QQ is Yes	34-36
2a-7	Medications and treatments are stored securely as required, including the security of keys or codes to access medications.	Met / Not Met	NO	37-39
2a-8	Medication that is discontinued or outdated is not retained at the site.	Met / Not Met	YES if QQ is Yes	40-41
2a-9	Used needles and syringes are disposed in puncture resistant containers.	Met / Not Met	NO	42
2a-11	The site ensures that in-home, routine support/care necessary for individuals' health needs is provided per their service plan.	Met / Not Met	YES	46-48
<b>SECTION 4: GENERAL OPERATIONS FOR : INDIVIDUALIZE CHOICE, AUTONOMY &amp; SATISFACTION</b>				
4-1	Sufficient transportation is available and facilitated to support individualized choices of activities and schedules.	Met / Not Met	NO	66-67
4-2	The staff scheduling and general operations are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.	Met / Not Met	NO	68-69
4-3	The site has a mechanism to assess individuals' satisfaction with the service environment.	Met / Not Met	NO	70-71

4-6	The program takes timely action to address individuals' dissatisfaction with living and/or service environment.	Met / Not Met	NO	76-77
4-11	Individuals <u>are observed</u> to engage in activities that are meaningful to them.	Met / Not Met	NO	87-88
4-14	Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by staff.	Met / Not Met	NO	93-95
4-15	Individuals are supported by staff to exercise control and choice in their own lives.	Met / Not Met	NO	96-97
<b>SECTION 5 : DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS</b>				
5-1	Staff can describe/know the Individuals' supervision needs.	Met / Not Met	NO	98-99
5-2	Individuals receive their meal/food in the form and consistency required by their plan, according to their needs and per OPWDD Choking Prevention Initiative (CPI) specifications.	Met / Not Met / NA	YES	100-102
5-3	Individuals receive support while eating in accordance with their assessed and observed needs.	Met / Not Met / NA	YES	103-104
5-4	Individuals receive support for mobility in accordance with observed needs.	Met / Not Met / NA	NO	105-106
5-5	Individuals receive appropriate support and supervision based on <u>other</u> observed needs.	Met / Not Met	NO	107-108
5-6	There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.	Met / Not Met / NA	NO	109-111

5-7	The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) Prompt contacting of other responsible personnel in emergencies.	Met / Not Met / NA	NO	112-113
<b>SECTION 6: RIGHTS PROTECTIONS</b>				
6-1	<u>Observed and reported</u> interactions and communications with individuals, both verbal and non-verbal, are respectful.	Met / Not Met	NO	114-116
6-2	The site is absent of generally applied rules, policies or procedures that limit people's rights, independence, choice and autonomy.	Met / Not Met	NO	117-119
6-3	Individuals are permitted by the program to engage in any legal activities per their interests.	Met / Not Met	NO	120-121
6-4	Individuals have full access to the typical facilities in the site.	Met / Not Met	NO	122-124
6-5	Individuals' health and other protected information is kept private/protected.	Met / Not Met	NO	125-126
6-6	People have privacy in their living quarters as appropriate to the situation.	Met / Not Met	NO	127-129
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.	Met / Not Met / NA	NO	134-135
6-10	Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.	Met / Not Met / NA	NO	136-137
6-11	Immediate care and treatment identified was provided to the individual involved in the incident.	Met / Not Met / NA	NO	138-139
6-12	Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.	Met / Not Met / NA	NO	140-141

6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.	Met / Not Met / NA	NO	142-144
6-14	Measures identified to prevent future similar events were <u>planned and implemented.</u>	Met / Not Met / NA	NO	145-148
6-15	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.	Met / Not Met / NA	NO	149-152
6-16	Part 625 events and actions reported in IRMA regarding recommendations, were implemented as reported.	Met / Not Met / NA	NO	153-154
<b>SECTION 7: SITE &amp; SAFETY</b>				
7-2	Surveillance cameras are not present in the site.	Met / Not Met	NO	157
7-4	The site's physical characteristics support the independence, comfort, preference and needs of the individuals.	Met / Not Met	NO	160-161
7-5	All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.	Met / Not Met	NO	162-163
7-6	There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.	Met / Not Met	NO	164-165
7-7	Bathrooms provide personal privacy.	Met / Not Met	NO	166
7-8	The site is clean.	Met / Not Met	NO	167-168
7-9	The site is well maintained for the safety and comfort of the individuals receiving services.	Met / Not Met	NO	169-171
7-10	The facility operates in accordance with OPWDD smoking requirements.	Met / Not Met	NO	172-174
7-11	The temperature of the hot water is appropriate to the abilities of people served at the site.	Met / Not Met	NO	175-176

7-12	Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.	Met / Not Met / NA	NO	177-179
7-13	The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools.	Met / Not Met / NA	NO	180-181
7-14	The facility has a land line (see section 635-99.1) telephone service which is in working order and functions during power outages.	Met / Not Met	NO	182
<b>SECTION 8: FIRE SAFETY REQUIRED (by OFPC or DQI )</b>				
Qualifier Question	Are there any immediate Fire Safety issues that must be identified?	Y/N		186
8-1	The site has an acceptable fire evacuation plan.	Met / Not Met	NO	187-189
8-2	All fire and evacuation drills or events MUST be documented on the standardized drill report form developed by OPWDD.	Met / Not Met	NO	190
8-3	The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.	Met / Not Met	NO	191-192
8-4	Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.	Met / Not Met	NO	193-194
8-5	The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.	Met / Not Met	NO	195-196
8-6	Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).	Met / Not Met	NO	197-198
8-7	Facility staff can describe fire safety and emergency evacuation procedures.	Met / Not Met	NO	199-200

8-8	The certified site provides safe exiting to a public way.	Met / Not Met	NO	201-203
8-9	There is fire <b>alarm</b> and detection equipment in the facility as required by regulation and/or LSC.	Met / Not Met	NO	204-206
8-11	Fire alarm and notification systems are operational and effective.	Met / Not Met	NO	209-210
8-12	Other fire protection equipment is operational.	Met / Not Met / NA	NO	211-212
8-13	Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.	Met / Not Met	NO	213-214
8-14	Maintenance and inspection of Fire Alarm and Detection systems are performed by competent parties and according to OPWDD standards.	Met / Not Met	NO	215-216
8-15	Maintenance and inspection of Sprinkler Systems is performed by competent parties and according to OPWDD standards.	Met / Not Met / NA	NO	217-218
8-16	At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.	Met / Not Met	NO	219-220
8-18	A carbon monoxide alarm is appropriately located in all new and existing residences on sleeping levels, per requirements.	Met/Not Met /NA	NO	223-224
8-19	The facility, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.	Met/Not Met	NO	225-226

**SECTION 10: SPECIALIZED RISK FACTORS**

**Section 10a: Risk Area: Skin Breakdown**

Qualifier Question	Does anyone currently have skin breakdown or a history of skin breakdown?	Y/N		231
10a-1	There is a written plan to provide care for wounds and/or prevent worsening & further breakdown.	Met/Not Met	YES if QQ is Yes	232-235
10a-2	Staff implement interventions related to care and monitoring of skin integrity and the prevention of skin breakdown, for which they are responsible.	Met/Not Met	YES if QQ is Yes	236-238
<b>Section 10e: Risk Area: Fluid Intake</b>				
Qualifier Question	Does any individual require a specific daily level of fluid intake?	Y/N		267
10e-1	The amount of fluid to be consumed by the person is clearly indicated in a written plan.	Met/Not Met	YES if QQ is Yes	267-269
10e-2	Clear written instruction is provided to further guide staff in how to implement the fluid intake requirements.	Met/Not Met	YES if QQ is Yes	270-272
10e-3	There is documentation/tracking of the person's fluid consumption.	Met/Not Met	YES if QQ is Yes	273-274
10e-4	The written plan for fluid consumption is implemented correctly.	Met/Not Met	YES if QQ is Yes	275-277
<b>Section 10f: Risk Area: Oxygen Use</b>				
Qualifier Question	Does any individual have an order for Oxygen use?	Y/N		278
10f-1	Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.	Met/Not Met	YES if QQ is Yes	279-280
10f-2	The written instruction includes how and what to document regarding oxygen administration and monitoring.	Met/Not Met	YES if QQ is Yes	281-282

10f-3	Necessary equipment is available per the medical order for oxygen.	Met/Not Met	YES if QQ is Yes	283
10f-4	There is documentation evidencing ordered administration of oxygen and monitoring of their condition.	Met/Not Met	YES if QQ is Yes	284-286
<b>Section 10g: Risk Area: Supervision</b>				
Qualifier Question	Enhanced supervision levels are required by one or more person supported by the sight.	Y/N		287
10g-1	There are sufficient staff on duty to maintain the supervision levels required by the Individuals.	Met/Not Met	YES if QQ is Yes	287-290
10g-2	Required enhanced supervision and staffing ratios are maintained per people's individualized plans.	Met/Not Met	YES if QQ is Yes	291-293

COMMON RESIDENTIAL TYPES :

**IRAs (Large & Small);**

**Community Residence/Group Homes/Apartments (supervised & supportive)**

QNO.	Program Class & Type STANDARD	Decision	Targeted Sample	Pg. No.
<b>Standard #</b>	<b>STANDARD:</b>	<b>DECISION:</b>	Verify for 1 individual min.	Site Guidance Page Number
<b>SECTION 1 - HEIGHTENED SCRUTINY TRIGGERS</b>				
Qualifier Question	Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?	Y/N	NO	9
1-1	The site is in a location <u>other than</u> on the grounds of a public institution.	Met / Not Met	NO	10
1-2	The site is in a building separate from a publically or privately operated facility that provides inpatient institutional treatment.	Met / Not Met	NO	11
1-3	The site is in a location <u>other than</u> immediately adjacent to a public institution.	Met / Not Met	NO	12
1-4	The home meets the following description:It did not convert from an ICF on or after March 17, 2014.	Met / Not Met	NO	13
1-5	The site is located apart from other certified facilities - <i>It is not part of co-located and/or clustered programs/site that are operationally related.</i>	Met / Not Met	NO	14-16
1-6	The site's design, appearance and location is not institutional and does not isolate people from the broader community.	Met / Not Met	NO	17-19
<b>SECTION 2: HEALTH SUPPORT &amp; MEDICATIONS</b>				

2-1	There is a written plan detailing how the facility will deal with life-threatening emergencies.	Met / Not Met	NO	20
2-2	Staff working know actions to take in the event of a medical emergency.	Met / Not Met	NO	21
2a-1	There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.	Met / Not Met	NO	23-24
2a-2	DSP staff know how to contact the RN using the site/agency mechanism.	Met / Not Met	NO	25-26
2a-3	Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA or MD administers medications and/or prescribed treatments to individuals.	Met / Not Met	NO	27-28
2a-4	Individual's medications and treatments have been correctly administered per physicians' orders and his/her needs.	Met / Not Met	YES	29-31
2a-5	Medication Administration Records (MARs) are legible, correctly identify the current physician's orders/prescriptions and required documentation of administration.	Met / Not Met	YES	32-33
2a-6	Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.	Met / Not Met	YES	34-36
2a-7	Medications and treatments are stored securely as required, including the security of keys or codes to access medications.	Met / Not Met	NO	37-39
2a-8	Medication that is discontinued or outdated is not retained at the site.	Met / Not Met	YES	40-41
2a-9	Used needles and syringes are disposed in puncture resistant containers.	Met / Not Met	NO	42

2a-10	The site ensures that individuals access professional health care services per their needs, physician recommendation and informed choice.	Met / Not Met	YES	43-45
2a-11	The site ensures that in-home, routine support/care necessary for individuals' health needs is provided per their service plan.	Met / Not Met	YES	46-48
<b>SECTION 3: PERSONAL FUNDS</b>				
3-1	Personal Allowance money is consistently available to individuals for routine expenditures and recreational activities.	Met / Not Met	YES	49-50
Qualifier Question	Is any portion of the individuals personal funds held or managed by the site ?	Y/N		51
3a-1	An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + \$20.	Met / Not Met	YES	52-53
3a-2	Personal Allowance funds held by the site are secured and safeguarded, accessible only to authorized employees.	Met / Not Met	YES	54-55
3a-3	There are ledger cards for the accounting of individuals' personal allowance.	Met / Not Met	YES	56
3a-4	The ledger(s) clearly documents receipt of funds on site.	Met / Not Met	YES	57
3a-5	The ledger(s) clearly document disbursement of funds including their purpose for the individual.	Met / Not Met	YES	58-59
3a-6	The ledger(s) accurately reflect the individual's total fund amount available in the site.	Met / Not Met	YES	60-61
3a-7	Personal allowance funds are not used for items or expenses for which the agency is responsible.	Met / Not Met	YES	62-63
3a-8	Receipts required (by regulation) for items or services purchased, reconcile with ledger entries.	Met / Not Met	YES	64
3a-9	Individuals are reimbursed for any loss of money maintained at the site.	Met / Not Met	YES, if applicable	65
<b>SECTION 4: GENERAL OPERATIONS FOR : INDIVIDUALIZE CHOICE, AUTONOMY &amp; SATISFACTION</b>				

4-1	Sufficient transportation is available and facilitated to support individualized choices of activities and schedules.	Met / Not Met	NO	66-67
4-2	The staff scheduling and general operations are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.	Met / Not Met	NO	68-69
4-3	The site has a mechanism to assess individuals' satisfaction with the service environment.	Met / Not Met	NO	70-71
4-4	The home has a mechanism to assess living arrangement choice.	Met / Not Met	NO	72-73
4-5	The home has a mechanism to assess roommate choice and satisfaction.	Met / Not Met	NO	74-75
4-6	The program takes timely action to address individuals' dissatisfaction with living and/or service environment.	Met / Not Met	NO	76-77
4-7	The home has a mechanism to offer individuals keys to enter their home (or other mechanism to enter their home independently).	Met / Not Met	NO	78-79
4-8	The home has a mechanism to offer individuals keys to their bedrooms (or other mechanism to secure and access their bedroom independently).	Met / Not Met	NO	80-81
4-9	The home takes timely action to provide requesting individuals with independent access to their home and/or bedroom.	Met / Not Met	NO	82-83
4-10	Individuals' schedules and routines are personally determined per their needs, interests and preferences (rather than per the staff or agency operations).	Met / Not Met	NO	84-86
4-11	Individuals <u>are observed</u> to engage in activities that are meaningful to them.	Met / Not Met	NO	87-88

4-12	Individuals are encouraged and invited to participate in the routine of their own home (e.g. cooking, menu planning, routine chores, etc.)	Met / Not Met	NO	89
4-13	Individuals are encouraged and supported to have full access to the broader community.	Met / Not Met	NO	90-92
4-14	Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by staff.	Met / Not Met	NO	93-95
4-15	Individuals are supported by staff to exercise control and choice in their own lives.	Met / Not Met	NO	96-97
<b>SECTION 5 : DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS</b>				
5-1	Staff can describe/know the Individuals' supervision needs.	Met / Not Met	NO	98-99
5-2	Individuals receive their meal/food in the form and consistency required by their plan, according to their needs and per OPWDD Choking Prevention Initiative (CPI) specifications.	Met / Not Met / NA	YES	100-102
5-3	Individuals receive support while eating in accordance with their assessed and observed needs.	Met / Not Met / NA	YES	103-104
5-4	Individuals receive support for mobility in accordance with observed needs.	Met / Not Met / NA	NO	105-106
5-5	Individuals receive appropriate support and supervision based on <u>other</u> observed needs	Met / Not Met	NO	107-108
5-6	There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.	Met / Not Met / NA	NO	109-111
5-7	The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) Prompt contacting of other responsible personnel in emergencies.	Met / Not Met / NA	NO	112-113
<b>SECTION 6: RIGHTS PROTECTIONS</b>				

6-1	<u>Observed and reported</u> interactions and communications with individuals, both verbal and non-verbal, are respectful.	Met / Not Met	NO	114-116
6-2	The site is absent of generally applied rules, policies or procedures that limit people's rights, independence, choice and autonomy.	Met / Not Met	NO	117-119
6-3	Individuals are permitted by the program to engage in any legal activities per their interests.	Met / Not Met	NO	120-121
6-4	Individuals have full access to the typical facilities in the site.	Met / Not Met	NO	122-124
6-5	Individuals' health and other protected information is kept private/protected.	Met / Not Met	NO	125-126
6-6	People have privacy in their living quarters as appropriate to the situation.	Met / Not Met	NO	127-129
6-7	People have access to food at any time.	Met / Not Met	NO	130-131
6-8	People can choose to eat meals where/when desired.	Met / Not Met	NO	132-133
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.	Met / Not Met / NA	NO	134-135
6-10	Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.	Met / Not Met / NA	NO	136-137
6-11	Immediate care and treatment identified was provided to the individual involved in the incident.	Met / Not Met / NA	NO	138-139
6-12	Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.	Met / Not Met / NA	NO	140-141
6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.	Met / Not Met / NA	NO	142-144
6-14	Measures identified to prevent future similar events were <u>planned and implemented.</u>	Met / Not Met / NA	NO	145-148
6-15	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.	Met / Not Met / NA	NO	149-152

6-16	Part 625 events and actions reported in IRMA regarding recommendations, were implemented as reported.	Met / Not Met / NA	NO	153-154
<b>SECTION 7: SITE &amp; SAFETY</b>				
7-1	The residence appears “home-like”, rather than Institutional.	Met / Not Met	NO	155-156
7-2	Surveillance cameras are not present in the site.	Met / Not Met	NO	157
7-3	There is evidence that residents are allowed to have visitors of their choosing at any time.	Met / Not Met	NO	158-159
7-4	The site’s physical characteristics support the independence, comfort, preference and needs of the individuals.	Met / Not Met	NO	160-161
7-5	All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.	Met / Not Met	NO	162-163
7-6	There are adequate supplies in the site to meet the needs of individuals per the service(s) provided	Met / Not Met	NO	164-165
7-7	Bathrooms provide personal privacy.	Met / Not Met	NO	166
7-8	The site is clean.	Met / Not Met	NO	167-168
7-9	The site is well maintained for the safety and comfort of the individuals receiving services.	Met / Not Met	NO	169-171
7-10	The facility operates in accordance with OPWDD smoking requirements.	Met / Not Met	NO	172-174
7-11	The temperature of the hot water is appropriate to the abilities of people served at the site.	Met / Not Met	NO	175-176
7-12	Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.	Met / Not Met / NA	NO	177-179
7-13	The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools.	Met / Not Met / NA	NO	180-181

7-14	The facility has a land line (see section 635-99.1) telephone service which is in working order and functions during power outages.	Met / Not Met	NO	182
7-15	Time Out rooms constructed or significantly modified after April 1, 2013 meet the requirements identified in NYCRR Part 633.16(j).	Met / Not Met / NA	NO	183-185
<b>SECTION 8: FIRE SAFETY REQUIRED (by OFPC or DQI )</b>				
Qualifier Question	Are there any immediate Fire Safety issues that must be identified?	Y/N	NO	186
8-1	The site has an acceptable fire evacuation plan.	Met / Not Met	NO	187-189
8-2	All fire and evacuation drills or events MUST be documented on the standardized drill report form developed by OPWDD.	Met / Not Met	NO	190
8-3	The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.	Met / Not Met	NO	191-192
8-4	Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.	Met / Not Met	NO	193-194
8-5	The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.	Met / Not Met	NO	195-196
8-6	Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).	Met / Not Met	NO	197-198
8-7	Facility staff can describe fire safety and emergency evacuation procedures.	Met / Not Met	NO	199-200
8-8	The certified site provides safe exiting to a public way.	Met / Not Met	NO	201-203
8-9	There is fire <b>alarm</b> and detection equipment in the facility as required by regulation and/or LSC.	Met / Not Met	NO	204-206
8-10	Heat detectors are present in the residence as required by OPWDD.	Met / Not Met	NO	207-208
8-11	Fire alarm and notification systems are operational and effective.	Met / Not Met	NO	209-210

8-12	Other fire protection equipment is operational.	Met / Not Met / NA	NO	211-212
8-13	Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.	Met / Not Met	NO	213-214
8-14	Maintenance and inspection of Fire Alarm and Detection systems are performed by competent parties and according to OPWDD standards.	Met / Not Met	NO	215-216
8-15	Maintenance and inspection of Sprinkler Systems is performed by competent parties and according to OPWDD standards.	Met / Not Met / NA	NO	217-218
8-16	At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.	Met / Not Met	NO	219-220
8-17	In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.	Met / Not Met / NA	NO	221-222
8-18	A carbon monoxide alarm is appropriately located in all new and existing residences on sleeping levels, per requirements.	Met / Not Met / NA	NO	223-224
8-19	The facility, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.	Met / Not Met	NO	225-226
<b>SECTION 10: SPECIALIZED RISK FACTORS</b>				
<b>Section 10a: Risk Area: Skin Breakdown</b>				
Qualifier Question	Does anyone currently have skin breakdown or a history of skin breakdown?	Y/N		231
10a-1	There is a written plan to provide care for wounds and/or prevent worsening & further breakdown.	Met/ Not Met	YES if QQ is Yes	232-235

10a-2	Staff implement interventions related to care and monitoring of skin integrity and the prevention of skin breakdown, for which they are responsible.	Met/Not Met	YES if QQ is Yes	236-238
<b>Section 10b: Risk Area: Discharge from Hospital</b>				
Qualifier Question	Has anyone been discharged from the hospital in the past 3 months?	Y/N		239
10b-1	Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring required by the person discharged.	Met/Not Met	YES if QQ is Yes	239-241
10b-2	The written instruction included how and what to document regarding required care and monitoring following hospital discharge.	Met/Not Met	YES if QQ is Yes	242
10b-3	There is evidence that the staff implement required care and monitoring following discharge.	Met/Not Met	YES if QQ is Yes	244-246
<b>Section 10c: Risk Area: Signs/Symptoms of Illness</b>				
Qualifier Question	Is any person in the site currently showing signs/symptoms of illness?	Y/N		247
10c-1	RN or other medical professional has been informed of the signs/symptoms.	Met/Not Met	YES if QQ is Yes	247-248
10c-2	Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition and notifications required.	Met/Not Met	YES if QQ is Yes	249-250
10c-3	The instruction included how and what to document regarding required care and monitoring for identified health concern.	Met/Not Met	YES if QQ is Yes	251-252
10c-4	There is evidence that the staff implement required care and monitoring.	Met/Not Met	YES if QQ is Yes	253-254
<b>Section 10d: Risk Area: Diabetes</b>				
Qualifier Question	Is any person diagnosed with diabetes?	Y/N		255

10d-1	Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required by the person.	Met/Not Met	YES if QQ is Yes	255-259
10d-2	The written instruction includes how and what to document regarding required care and monitoring for identified diabetic needs.	Met/Not Met	YES if QQ is Yes	260-262
10d-3	There is evidence that the staff implement required diabetic care and monitoring.	Met/Not Met	YES if QQ is Yes	263-266

**Section 10e: Risk Area: Fluid Intake**

Qualifier Question	Does any individual require a specific daily level of fluid intake?	Y/N		267
10e-1	The amount of fluid to be consumed by the person is clearly indicated in a written plan.	Met/Not Met	YES if QQ is Yes	267-269
10e-2	Clear written instruction is provided to further guide staff in how to implement the fluid intake requirements.	Met/Not Met	YES if QQ is Yes	270-272
10e-3	There is documentation/tracking of the person's fluid consumption.	Met/Not Met	YES if QQ is Yes	273-274
10e-4	The written plan for fluid consumption is implemented correctly.	Met/Not Met	YES if QQ is Yes	275-277

**Section 10f: Risk Area: Oxygen Use**

Qualifier Question	Does any individual have an order for Oxygen use?	Y/N		278
10f-1	Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.	Met/Not Met	YES if QQ is Yes	279-280
10f-2	The written instruction includes how and what to document regarding oxygen administration and monitoring.	Met/Not Met	YES if QQ is Yes	281-282
10f-3	Necessary equipment is available per the medical order for oxygen.	Met/Not Met	YES if QQ is Yes	283

10f-4	There is documentation evidencing ordered administration of oxygen and monitoring of their condition.	Met/Not Met	YES if QQ is Yes	284-286
<b>Section 10g: Risk Area: Supervision</b>				
Qualifier Question	Enhanced supervision levels are required by one or more person supported by the sight.	Y/N		287
10g-1	There are sufficient staff on duty to maintain the supervision levels required by the Individuals.	Met/Not Met	YES if QQ is Yes	287-290
10g-2	Required enhanced supervision and staffing ratios are maintained per people's individualized plans.	Met/Not Met	YES if QQ is Yes	291-293
<b>Section 10h : Risk Area: All Rights Limitations/Restrictions</b>				
Qualifier Question	Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?	Y/N		293
10h-1	Limitation or restriction of rights <u>due to behaviors</u> occur only as part of a written behavior plan.	Met/Not Met	YES if QQ is Yes	293-294
10h-2	The Individuals Behavior Support Plan describes how the use of each restrictive intervention is to be documented.	Met/Not Met	YES if QQ is Yes	295-296
10h-3	Rights Limitations / restrictions occur only when written informed consent was obtained from an appropriate consent giver.	Met/Not Met	YES if QQ is Yes	297-298
10h-4	Rights Limitations / restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.	Met/Not Met	YES if QQ is Yes	299-300
10h-5	Rights limitations that are not part of a Behavior Support Plan comply with HCBS requirements for justification and documentation of rights limitations.	Met/Not Met	YES if QQ is Yes	301-304
10h-6	When environmental protections (that are in place due to an Individuals needs) restricts other Individuals in the facility, action is taken to ensure that they are not negatively affected.	Met/Not Met	YES if QQ is Yes	305-306

**Section 10i: Risk Area: Behavior Supports - General**

Qualifier Question	Is a behavior support plan or medication monitoring plan required/in place for any Individual ?	Y/N		307
10i-1	Behavior Supports are provided per the written plan.	Met/Not Met	YES if QQ is Yes	307-309
10i-2	Behavior supports are reviewed for effectiveness by clinical staff responsible for the plan.	Met/Not Met	YES if QQ is Yes	210-311
10i-3	Behavior Supports are revised as needed.	Met/Not Met	YES if QQ is Yes	312-313

**Section 10j: Risk Area: Mechanical Restraints**

Qualifier Question	Are there any limitation or restriction of rights, including use of approved physical interventions, evident and/or reported?	Y/N		314
10j-1	Criteria for the application, removal and duration of mechanical restraint device use is described in the written behavior support plan.	Met/Not Met	YES if QQ is Yes	314-317
10j-2	Restraints are applied only per the specific criteria described in the written plan.	Met/Not Met	YES if QQ is Yes	318-319
10j-3	Restraints are removed per the criteria and duration described in the written plan.	Met/Not Met	YES if QQ is Yes	320-321
10j-4	There is a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	YES if QQ is Yes	322-323
10j-5	There is documentation that is a "full record" of the use of the Mechanical Restraining device.	Met/Not Met	YES if QQ is Yes	324-325

**Section 10k: Risk Area: Time Out**

Qualifier Question	Is 'Time-out' used for any Individuals?	Y/N		326
10k-1	Time-out is used only in accordance with the written Behavior Support Plan.	Met/Not Met	YES if QQ is Yes	326-327

10k-2	The use of a time out room is reported electronically to OPWDD.	Met/Not Met	YES if QQ is Yes	328-329
10k-3	Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.	Met/Not Met	YES if QQ is Yes	330-331
<b>Section 10l: Risk Area: Physical Interventions</b>				
Qualifier Question	Are physical Interventions used for any Individuals?	Y/N		332
10l-1	Physical interventions are used only in accordance with the written Behavior Support Plan.	Met/Not Met	YES if QQ is Yes	332-333
10l-2	The use of restrictive physical interventions is reported electronically to OPWDD.	Met/Not Met	YES if QQ is Yes	334.335

# CERTIFIED PREVOC SITE

QNO.	Program Class & Type STANDARD	Decision	Targeted Sample	Pg. No.
Standard #	STANDARD:	DECISION:	Verify for 1 individual min.	Site Guidance Page Number
<b>SECTION 1 - HEIGHTENED SCRUTINY TRIGGERS</b>				
Qualifier Question	Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?	Y/N	NO	9
1-1	The site is in a location <u>other than</u> on the grounds of a public institution.	Met / Not Met	NO	10
1-2	The site is in a building separate from a publically or privately operated facility that provides inpatient institutional treatment.	Met / Not Met	NO	11
1-3	The site is in a location <u>other than</u> immediately adjacent to a public institution.	Met / Not Met	NO	12
1-4	The home meets the following description:It did not convert from an ICF on or after March 17, 2014.	Met / Not Met	NO	13
1-5	The site is located apart from other certified facilities - <i>It is not part of co-located and/or clustered programs/site that are operationally related.</i>	Met / Not Met	NO	14-16
1-6	The site's design, appearance and location is not institutional and does not isolate people from the broader community.	Met / Not Met	NO	17-19
<b>SECTION 2: HEALTH SUPPORT &amp; MEDICATIONS</b>				

2-1	There is a written plan detailing how the facility will deal with life-threatening emergencies.	Met / Not Met	NO	20
2-2	Staff working know actions to take in the event of a medical emergency.	Met / Not Met	NO	21
Qualifier Question	The Day Service site provides nursing and/or delegated nursing services such as medication administration.	Y/N		22
2a-1	There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.	Met / Not Met	NO	23-24
2a-2	DSP staff know how to contact the RN using the site/agency mechanism.	Met / Not Met	NO	25-26
2a-3	Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA or MD administers medications and/or prescribed treatments to individuals.	Met / Not Met	NO	27-28
2a-4	Individual's medications and treatments have been correctly administered per physicians' orders and his/her needs.	Met / Not Met	YES if QQ is Yes	29-31
2a-5	Medication Administration Records (MARs) are legible, correctly identify the current physician's orders/prescriptions and required documentation of administration.	Met / Not Met	YES if QQ is Yes	32-33
2a-6	Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.	Met / Not Met	YES if QQ is Yes	34-36
2a-7	Medications and treatments are stored securely as required, including the security of keys or codes to access medications.	Met / Not Met	NO	37-39
2a-8	Medication that is discontinued or outdated is not retained at the site.	Met / Not Met	YES if QQ is Yes	40-41

2a-9	Used needles and syringes are disposed in puncture resistant containers.	Met / Not Met	NO	42
<b>SECTION 3: PERSONAL FUNDS</b>				
Qualifier Question	Is any portion of the individuals personal funds held or managed by the site ?	Y/N		51
3a-2	Personal Allowance funds held by the site are secured and safeguarded, accessible only to authorized employees.	Met / Not Met	NO	54-55
3a-3	There are ledger cards for the accounting of individuals' personal allowance.	Met / Not Met	YES if QQ is Yes	56
3a-4	The ledger(s) clearly documents receipt of funds on site.	Met / Not Met	YES if QQ is Yes	57
3a-5	The ledger(s) clearly document disbursement of funds including their purpose for the individual .	Met / Not Met	YES if QQ is Yes	58-59
3a-6	The ledger(s) accurately reflect the individual's total fund amount available in the site.	Met / Not Met	YES if QQ is Yes	60-61
3a-7	Personal allowance funds are not used for items or expenses for which the agency is responsible.	Met / Not Met	YES if QQ is Yes	62-63
3a-8	Receipts required (by regulation) for items or services purchased, reconcile with ledger entries .	Met / Not Met	YES if QQ is Yes	64
3a-9	Individuals are reimbursed for any loss of money maintained at the site.	Met / Not Met	YES if Applicable	65
<b>SECTION 4: GENERAL OPERATIONS FOR : INDIVIDUALIZE CHOICE, AUTONOMY &amp; SATISFACTION</b>				
4-1	Sufficient transportation is available and facilitated to support individualized choices of activities and schedules.	Met / Not Met	NO	66-67

4-2	The staff scheduling and general operations are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.	Met / Not Met	NO	68-69
4-3	The site has a mechanism to assess individuals' satisfaction with the service environment.	Met / Not Met	NO	70-71
4-6	The program takes timely action to address individuals' dissatisfaction with living and/or service environment.	Met / Not Met	NO	76-77
4-10	Individuals' schedules and routines are personally determined per their needs, interests and preferences (rather than per the staff or agency operations).	Met / Not Met	NO	84-86
4-11	Individuals <u>are observed</u> to engage in activities that are meaningful to them.	Met / Not Met	NO	87-88
4-13	Individuals are encouraged and supported to have full access to the broader community.	Met / Not Met	NO	90-92
4-14	Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by staff.	Met / Not Met	NO	93-95
4-15	Individuals are supported by staff to exercise control and choice in their own lives.	Met / Not Met	NO	96-97
<b>SECTION 5 : DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS</b>				
5-1	Staff can describe/know the Individuals' supervision needs.	Met / Not Met	NO	98-99
5-2	Individuals receive their meal/food in the form and consistency required by their plan, according to their needs and per OPWDD Choking Prevention Initiative (CPI) specifications.	Met / Not Met / NA	YES	100-102
5-3	Individuals receive support while eating in accordance with their assessed and observed needs.	Met / Not Met / NA	YES	103-104

5-4	Individuals receive support for mobility in accordance with observed needs.	Met / Not Met / NA	NO	105-106
5-5	Individuals receive appropriate support and supervision based on <u>other</u> observed needs.	Met / Not Met	NO	107-108
5-6	There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.	Met / Not Met / NA	NO	109-111
5-7	The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) Prompt contacting of other responsible personnel in emergencies.	Met / Not Met / NA	NO	112-113
<b>SECTION 6: RIGHTS PROTECTIONS</b>				
6-1	<u>Observed and reported</u> interactions and communications with individuals, both verbal and non-verbal, are respectful.	Met / Not Met	NO	114-116
6-2	The site is absent of generally applied rules, policies or procedures that limit people's rights, independence, choice and autonomy.	Met / Not Met	NO	117-119
6-3	Individuals are permitted by the program to engage in any legal activities per their interests.	Met / Not Met	NO	120-121
6-4	Individuals have full access to the typical facilities in the site.	Met / Not Met	NO	122-124
6-5	Individuals' health and other protected information is kept private/protected.	Met / Not Met	NO	125-126
6-6	People have privacy in their living quarters as appropriate to the situation.	Met / Not Met	NO	127-129
6-7	People have access to food at any time.	Met / Not Met	NO	130-131
6-8	People can choose to eat meals where/when desired.	Met / Not Met	NO	132-133
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.	Met / Not Met / NA	NO	134-135

6-10	Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.	Met / Not Met / NA	NO	136-137
6-11	Immediate care and treatment identified was provided to the individual involved in the incident.	Met / Not Met / NA	NO	138-139
6-12	Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.	Met / Not Met / NA	NO	140-141
6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.	Met / Not Met / NA	NO	142-144
6-14	Measures identified to prevent future similar events were planned and implemented.	Met / Not Met / NA	NO	145-148
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<b>SECTION 7: SITE &amp; SAFETY</b>				
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7-4	The site's physical characteristics support the independence, comfort, preference and needs of the individuals.	Met / Not Met	NO	160-161
7-5	All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.	Met / Not Met	NO	162-163
7-6	There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.	Met / Not Met	NO	164-165
7-7	Bathrooms provide personal privacy.	Met / Not Met	NO	166
7-8	The site is clean.	Met / Not Met	NO	167-168
7-9	The site is well maintained for the safety and comfort of the individuals receiving services.	Met / Not Met	NO	169-171

7-10	The facility operates in accordance with OPWDD smoking requirements.	Met / Not Met	NO	172-174
7-11	The temperature of the hot water is appropriate to the abilities of people served at the site.	Met / Not Met	NO	175-176
7-12	Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.	Met / Not Met / NA	NO	177-179
7-13	The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools.	Met / Not Met / NA	NO	180-181
7-14	The facility has a land line (see section 635-99.1) telephone service which is in working order and functions during power outages.	Met / Not Met	NO	182
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<b>SECTION 8: FIRE SAFETY REQUIRED (by OFPC or DQI )</b>				
Qualifier Question	Are there any immediate Fire Safety issues that must be identified?	Y/N	NO	186
8-1	The site has an acceptable fire evacuation plan.	Met / Not Met	NO	187-189
8-2	All fire and evacuation drills or events MUST be documented on the standardized drill report form developed by OPWDD.	Met / Not Met	NO	190
8-3	The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.	Met / Not Met	NO	191-192
8-4	Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.	Met / Not Met	NO	193-194
8-5	The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.	Met / Not Met	NO	195-196

8-6	Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).	Met / Not Met	NO	197-198
8-7	Facility staff can describe fire safety and emergency evacuation procedures.	Met / Not Met	NO	199-200
8-8	The certified site provides safe exiting to a public way.	Met / Not Met	NO	201-203
8-9	There is fire <b>alarm</b> and detection equipment in the facility as required by regulation and/or LSC.	Met / Not Met	NO	204-206
8-11	Fire alarm and notification systems are operational and effective.	Met / Not Met	NO	209-210
8-12	Other fire protection equipment is operational.	Met / Not Met / NA	NO	211-212
8-13	Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.	Met / Not Met	NO	213-214
8-14	Maintenance and inspection of Fire Alarm and Detection systems are performed by competent parties and according to OPWDD standards.	Met / Not Met	NO	215-216
8-15	Maintenance and inspection of Sprinkler Systems is performed by competent parties and according to OPWDD standards.	Met / Not Met / NA	NO	217-218
8-16	At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.	Met / Not Met	NO	219-220
8-19	The facility, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.	Met / Not Met	NO	225-226

**SECTION 10: SPECIALIZED RISK FACTORS**

**Section 10a: Risk Area: Skin Breakdown**

Qualifier Question	Does anyone currently have skin breakdown or a history of skin breakdown?	Y/N		231
10a-1	There is a written plan to provide care for wounds and/or prevent worsening & further breakdown.	Met/ Not Met	YES if QQ is Yes	232-235
10a-2	Staff implement interventions related to care and monitoring of skin integrity and the prevention of skin breakdown, for which they are responsible.	Met/Not Met	YES if QQ is Yes	236-238
<b>Section 10e: Risk Area: Fluid Intake</b>				
Qualifier Question	Does any individual require a specific daily level of fluid intake?	Y/N		267
10e-1	The amount of fluid to be consumed by the person is clearly indicated in a written plan.	Met/Not Met	YES if QQ is Yes	267-269
10e-2	Clear written instruction is provided to further guide staff in how to implement the fluid intake requirements.	Met/Not Met	YES if QQ is Yes	270-272
10e-3	There is documentation/tracking of the person's fluid consumption.	Met/Not Met	YES if QQ is Yes	273-274
10e-4	The written plan for fluid consumption is implemented correctly.	Met/Not Met	YES if QQ is Yes	275-277
<b>Section 10f: Risk Area: Oxygen Use</b>				
Qualifier Question	Does any individual have an order for Oxygen use?	Y/N		278
10f-1	Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.	Met/Not Met	YES if QQ is Yes	279-280
10f-2	The written instruction includes how and what to document regarding oxygen administration and monitoring.	Met/Not Met	YES if QQ is Yes	281-282

10f-3	Necessary equipment is available per the medical order for oxygen.	Met/Not Met	YES if QQ is Yes	283
10f-4	There is documentation evidencing ordered administration of oxygen and monitoring of their condition.	Met/Not Met	YES if QQ is Yes	284-286
<b>Section 10g: Risk Area: Supervision</b>				
Qualifier Question	Enhanced supervision levels are required by one or more person supported by the sight.	Y/N		287
10g-1	There are sufficient staff on duty to maintain the supervision levels required by the Individuals.	Met/Not Met	YES if QQ is Yes	287-290
10g-2	Required enhanced supervision and staffing ratios are maintained per people's individualized plans.	Met/Not Met	YES if QQ is Yes	291-293
<b>Section 10h : Risk Area: All Rights Limitations/Restrictions</b>				
Qualifier Question	Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?	Y/N		293
10h-1	Limitation or restriction of rights <u>due to behaviors</u> occur only as part of a written behavior plan.	Met/Not Met	YES if QQ is Yes	293-294
10h-2	The Individuals Behavior Support Plan describes how the use of each restrictive intervention is to be documented.	Met/Not Met	YES if QQ is Yes	295-296
10h-3	Rights Limitations / restrictions occur only when written informed consent was obtained from an appropriate consent giver.	Met/Not Met	YES if QQ is Yes	297-298
10h-4	Rights Limitations / restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.	Met/Not Met	YES if QQ is Yes	299-300

10h-5	Rights limitations that are not part of a Behavior Support Plan comply with HCBS requirements for justification and documentation of rights limitations.	Met/Not Met	YES if QQ is Yes	301-304
10h-6	When environmental protections (that are in place due to an Individual's needs) restricts other Individuals in the facility, action is taken to ensure that they are not negatively affected.	Met/Not Met	YES if QQ is Yes	305-306
<b>Section 10i: Risk Area: Behavior Supports - General</b>				
Qualifier Question	Is a behavior support plan or medication monitoring plan required/in place for any Individual?	Y/N		307
10i-1	Behavior Supports are provided per the written plan.	Met/Not Met	YES if QQ is Yes	307-309
10i-2	Behavior supports are reviewed for effectiveness by clinical staff responsible for the plan.	Met/Not Met	YES if QQ is Yes	210-311
10i-3	Behavior Supports are revised as needed.	Met/Not Met	YES if QQ is Yes	312-313
<b>Section 10j: Risk Area: Mechanical Restraints</b>				
Qualifier Question	Are there any limitation or restriction of rights, including use of approved physical interventions, evident and/or reported?	Y/N		314
10j-1	Criteria for the application, removal and duration of mechanical restraint device use is described in the written behavior support plan.	Met/Not Met	YES if QQ is Yes	314-317
10j-2	Restraints are applied only per the specific criteria described in the written plan.	Met/Not Met	YES if QQ is Yes	318-319
10j-3	Restraints are removed per the criteria and duration described in the written plan.	Met/Not Met	YES if QQ is Yes	320-321
10j-4	There is a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	YES if QQ is Yes	322-323

10j-5	There is documentation that is a “full record” of the use of the Mechanical Restraining device.	Met/Not Met	YES if QQ is Yes	324-325
<b>Section 10k: Risk Area: Time Out</b>				
Qualifier Question	Is ‘Time-out’ used for any Individuals?	Y/N		326
10k-1	Time-out is used only in accordance with the written Behavior Support Plan.	Met/Not Met	YES if QQ is Yes	326-327
10k-2	The use of a time out room is reported electronically to OPWDD.	Met/Not Met	YES if QQ is Yes	328-329
10k-3	Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.	Met/Not Met	YES if QQ is Yes	330-331
<b>Section 10l: Risk Area: Physical Interventions</b>				
Qualifier Question	Are physical Interventions used for any Individuals?	Y/N		332
10l-1	Physical interventions are used only in accordance with the written Behavior Support Plan.	Met/Not Met	YES if QQ is Yes	332-333
10l-2	The use of restrictive physical interventions is reported electronically to OPWDD.	Met/Not Met	YES if QQ is Yes	334.335

# **PRIVATE SCHOOL**

QNO.	Program Class & Type STANDARD	Targeted Sample	Pg. No.
Standard #	STANDARD:	Verify for 1 individual min.	Site Guidance Page Number
<b>SECTION 2: HEALTH SUPPORT &amp; MEDICATIONS</b>			
2-1	There is a written plan detailing how the facility will deal with life-threatening emergencies.	NO	20
2-2	Staff working know actions to take in the event of a medical emergency.	NO	21
2a-1	There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.	NO	23-24
2a-2	DSP staff know how to contact the RN using the site/agency mechanism.	NO	25-26
2a-3	Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA or MD administers medications and/or prescribed treatments to individuals.	NO	27-28

2a-4	Individual's medications and treatments have been correctly administered per physicians' orders and his/her needs.	YES	29-31
2a-5	Medication Administration Records (MARs) are legible, correctly identify the current physician's orders/prescriptions and required documentation of administration.	YES	32-33
2a-6	Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.	YES	34-36
2a-7	Medications and treatments are stored securely as required, including the security of keys or codes to access medications.	NO	37-39
2a-8	Medication that is discontinued or outdated is not retained at the site.	YES	40-41
2a-9	Used needles and syringes are disposed in puncture resistant containers.	NO	42
2a-10	The site ensures that individuals access professional health care services per their needs, physician recommendation and informed choice.	YES	43-45
2a-11	The site ensures that in-home, routine support/care necessary for individuals' health needs is provided per their service plan.	YES	46-48

### SECTION 3: PERSONAL FUNDS

3-1	Personal Allowance money is consistently available to individuals for routine expenditures and recreational activities.	YES	49-50
Qualifier Question	Is any portion of the individuals personal funds held or managed by the site ?		51
3a-1	An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + \$20.	YES	52-53
3a-2	Personal Allowance funds held by the site are secured and safeguarded, accessible only to authorized employees.	YES	54-55
3a-3	There are ledger cards for the accounting of individuals' personal allowance.	YES	56
3a-4	The ledger(s) clearly documents receipt of funds on site.	YES	57
3a-5	The ledger(s) clearly document disbursement of funds including their purpose for the individual .	YES	58-59
3a-6	The ledger(s) accurately reflect the individual's total fund amount available in the site.	YES	60-61
3a-7	Personal allowance funds are not used for items or expenses for which the agency is responsible.	YES	62-63
3a-8	Receipts required (by regulation) for items or services purchased, reconcile with ledger entries .	YES	64

3a-9	Individuals are reimbursed for any loss of money maintained at the site.	YES, if applicable	65
<b>SECTION 4: GENERAL OPERATIONS FOR : INDIVIDUALIZE CHOICE, AUTONOMY &amp; SATISFACTIO</b>			
4-1	Sufficient transportation is available and facilitated to support individualized choices of activities and schedules.	NO	66-67
4-2	The staff scheduling and general operations are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.	NO	68-69
4-3	The site has a mechanism to assess individuals' satisfaction with the service environment.	NO	70-71
4-4	The home has a mechanism to assess living arrangement choice.	NO	72-73
4-5	The home has a mechanism to assess roommate choice and satisfaction.	NO	74-75
4-6	The program takes timely action to address individuals' dissatisfaction with living and/or service environment.	NO	76-77
4-7	The home has a mechanism to offer individuals keys to enter their home (or other mechanism to enter their home independently).	NO	78-79
4-8	The home has a mechanism to offer individuals keys to their bedrooms (or other mechanism to secure and access their bedroom independently).	NO	80-81

4-9	The home takes timely action to provide requesting individuals with independent access to their home and/or bedroom.	NO	82-83
4-10	Individuals' schedules and routines are personally determined per their needs, interests and preferences (rather than per the staff or agency operations).	NO	84-86
4-11	Individuals <u>are observed</u> to engage in activities that are meaningful to them.	NO	87-88
4-12	Individuals are encouraged and invited to participate in the routine of their own home (e.g. cooking, menu planning, routine chores, etc.)	NO	89
4-13	Individuals are encouraged and supported to have full access to the broader community.	NO	90-92
4-14	Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by staff.	NO	93-95
4-15	Individuals are supported by staff to exercise control and choice in their own lives.	NO	96-97
<b>SECTION 5 : DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS</b>			
5-1	Staff can describe/know the Individuals' supervision needs.	NO	98-99

5-2	Individuals receive their meal/food in the form and consistency required by their plan, according to their needs and per OPWDD Choking Prevention Initiative (CPI) specifications.	YES	100-102
5-3	Individuals receive support while eating in accordance with their assessed and observed needs.	YES	103-104
5-4	Individuals receive support for mobility in accordance with observed needs.	NO	105-106
5-5	Individuals receive appropriate support and supervision based on <u>other</u> observed needs	NO	107-108
5-6	There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.	NO	109-111
5-7	The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) Prompt contacting of other responsible personnel in emergencies.	NO	112-113
<b>SECTION 6: RIGHTS PROTECTIONS</b>			
6-1	<u>Observed and reported</u> interactions and communications with individuals, both verbal and non-verbal, are respectful.	NO	114-116
6-2	The site is absent of generally applied rules, policies or procedures that limit people's rights, independence, choice and autonomy.	NO	117-119

6-3	Individuals are permitted by the program to engage in any legal activities per their interests.	NO	120-121
6-4	Individuals have full access to the typical facilities in the site.	NO	122-124
6-5	Individuals' health and other protected information is kept private/protected.	NO	125-126
6-6	People have privacy in their living quarters as appropriate to the situation.	NO	127-129
6-7	People have access to food at any time.	NO	130-131
6-8	People can choose to eat meals where/when desired.	NO	132-133
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.	NO	134-135
6-10	Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.	NO	136-137
6-11	Immediate care and treatment identified was provided to the individual involved in the incident.	NO	138-139
6-12	Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.	NO	140-141
6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.	NO	142-144
6-14	Measures identified to prevent future similar events were planned and implemented.	NO	145-148
6-15	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.	NO	149-152

6-16	Part 625 events and actions reported in IRMA regarding recommendations, were implemented as reported.	NO	153-154
<b>SECTION 7: SITE &amp; SAFETY</b>			
7-1	The residence appears “home-like”, rather than Institutional.	NO	155-156
7-2	Surveillance cameras are not present in the site.	NO	157
7-3	There is evidence that residents are allowed to have visitors of their choosing at any time.	NO	158-159
7-4	The site’s physical characteristics support the independence, comfort, preference and needs of the individuals.	NO	160-161
7-5	All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.	NO	162-163
7-6	There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.	NO	164-165
7-7	Bathrooms provide personal privacy.	NO	166
7-8	The site is clean.	NO	167-168
7-9	The site is well maintained for the safety and comfort of the individuals receiving services.	NO	169-171
7-10	The facility operates in accordance with OPWDD smoking requirements.	NO	172-174
7-11	The temperature of the hot water is appropriate to the abilities of people served at the site.	NO	175-176

7-12	Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.	NO	177-179
7-13	The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools.	NO	180-181
7-14	The facility has a land line (see section 635-99.1) telephone service which is in working order and functions during power outages.	NO	182
7-15	Time Out rooms constructed or significantly modified after April 1, 2013 meet the requirements identified in NYCRR Part 633.16(j).	NO	183-185
<b>SECTION 8: FIRE SAFETY REQUIRED (by OFPC or DQI )</b>			
Qualifier Question	Are there any immediate Fire Safety issues that must be identified?	NO	186
8-1	The site has an acceptable fire evacuation plan.	NO	187-189
8-2	All fire and evacuation drills or events MUST be documented on the standardized drill report form developed by OPWDD.	NO	190
8-3	The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.	NO	191-192

8-4	Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.	NO	193-194
8-5	The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.	NO	195-196
8-6	Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).	NO	197-198
8-7	Facility staff can describe fire safety and emergency evacuation procedures.	NO	199-200
8-8	The certified site provides safe exiting to a public way.	NO	201-203
8-9	There is fire <b>alarm</b> and detection equipment in the facility as required by regulation and/or LSC.	NO	204-206
8-10	Heat detectors are present in the residence as required by OPWDD.	NO	207-208
8-11	Fire alarm and notification systems are operational and effective.	NO	209-210
8-12	Other fire protection equipment is operational.	NO	211-212
8-13	Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.	NO	213-214
8-14	Maintenance and inspection of Fire Alarm and Detection systems are performed by competent parties and according to OPWDD standards.	NO	215-216

8-15	Maintenance and inspection of Sprinkler Systems is performed by competent parties and according to OPWDD standards.	NO	217-218
8-16	At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.	NO	219-220
8-17	In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.	NO	221-222
8-18	A carbon monoxide alarm is appropriately located in all new and existing residences on sleeping levels, per requirements.	NO	223-224
8-19	The facility, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.	NO	225-226

**SECTION 10: SPECIALIZED RISK FACTORS**

**Section 10a: Risk Area: Skin Breakdown**

Qualifier Question	Does anyone currently have skin breakdown or a history of skin breakdown?		231
10a-1	There is a written plan to provide care for wounds and/or prevent worsening & further breakdown.	YES if QQ is Yes	232-235

10a-2	Staff implement interventions related to care and monitoring of skin integrity and the prevention of skin breakdown, for which they are responsible.	YES if QQ is Yes	236-238
<b>Section 10b: Risk Area: Discharge from Hospital</b>			
Qualifier Question	Has anyone been discharged from the hospital in the past 3 months?		239
10b-1	Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring required by the person discharged.	YES if QQ is Yes	239-241
10b-2	The written instruction included how and what to document regarding required care and monitoring following hospital discharge.	YES if QQ is Yes	242
10b-3	There is evidence that the staff implement required care and monitoring following discharge.	YES if QQ is Yes	244-246
<b>Section 10c: Risk Area: Signs/Symptoms of Illness</b>			
Qualifier Question	Is any person in the site currently showing signs/symptoms of illness?		247
10c-1	RN or other medical professional has been informed of the signs/symptoms	YES if QQ is Yes	247-248
10c-2	Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition and notifications required.	YES if QQ is Yes	249-250

10c-3	The instruction included how and what to document regarding required care and monitoring for identified health concern.	YES if QQ is Yes	251-252
10c-4	There is evidence that the staff implement required care and monitoring.	YES if QQ is Yes	253-254
<b>Section 10d: Risk Area: Diabetes</b>			
Qualifier Question	Is any person diagnosed with diabetes?		255
10d-1	Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required by the person.	YES if QQ is Yes	255-259
10d-2	The written instruction includes how and what to document regarding required care and monitoring for identified diabetic needs.	YES if QQ is Yes	260-262
10d-3	There is evidence that the staff implement required diabetic care and monitoring.	YES if QQ is Yes	263-266
<b>Section 10e: Risk Area: Fluid Intake</b>			
Qualifier Question	Does any individual require a specific daily level of fluid intake?		267
10e-1	The amount of fluid to be consumed by the person is clearly indicated in a written plan.	YES if QQ is Yes	267-269
10e-2	Clear written instruction is provided to further guide staff in how to implement the fluid intake requirements.	YES if QQ is Yes	270-272

10e-3	There is documentation/tracking of the person's fluid consumption.	YES if QQ is Yes	273-274
10e-4	The written plan for fluid consumption is implemented correctly.	YES if QQ is Yes	275-277
<b>Section 10f: Risk Area: Oxygen Use</b>			
Qualifier Question	Does any individual have an order for Oxygen use?		278
10f-1	Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.	YES if QQ is Yes	279-280
10f-2	The written instruction includes how and what to document regarding oxygen administration and monitoring.	YES if QQ is Yes	281-282
10f-3	Necessary equipment is available per the medical order for oxygen.	YES if QQ is Yes	283
10f-4	There is documentation evidencing ordered administration of oxygen and monitoring of their condition.	YES if QQ is Yes	284-286
<b>Section 10g: Risk Area: Supervision</b>			
Qualifier Question	Enhanced supervision levels are required by one or more person supported by the sight.		287
10g-1	There are sufficient staff on duty to maintain the supervision levels required by the Individuals	YES if QQ is Yes	287-290

10g-2	Required enhanced supervision and staffing ratios are maintained per people's individualized plans.	YES if QQ is Yes	291-293
<b>Section 10h : Risk Area: All Rights Limitations/Restrictions</b>			
Qualifier Question	Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?		293
10h-1	Limitation or restriction of rights <u>due to behaviors</u> occur only as part of a written behavior plan.	YES if QQ is Yes	293-294
10h-2	The Individuals Behavior Support Plan describes how the use of each restrictive intervention is to be documented.	YES if QQ is Yes	295-296
10h-3	Rights Limitations / restrictions occur only when written informed consent was obtained from an appropriate consent giver.	YES if QQ is Yes	297-298
10h-4	Rights Limitations / restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.	YES if QQ is Yes	299-300
10h-5	Rights limitations that are not part of a Behavior Support Plan comply with HCBS requirements for justification and documentation of rights limitations.	YES if QQ is Yes	301-304
10h-6	When environmental protections (that are in place due to an Individuals needs) restricts other Individuals in the facility, action is taken to ensure that they are not negatively affected.	YES if QQ is Yes	305-306

**Section 10i: Risk Area: Behavior Supports - General**

Qualifier Question	Is a behavior support plan or medication monitoring plan required/in place for any Individual ?		307
10i-1	Behavior Supports are provided per the written plan	YES if QQ is Yes	307-309
10i-2	Behavior supports are reviewed for effectiveness by clinical staff responsible for the plan.	YES if QQ is Yes	210-311
10i-3	Behavior Supports are revised as needed	YES if QQ is Yes	312-313

**Section 10j: Risk Area: Mechanical Restraints**

Qualifier Question	Are there any limitation or restriction of rights, including use of approved physical interventions, evident and/or reported?		314
10j-1	Criteria for the application, removal and duration of mechanical restraint device use is described in the written behavior support plan.	YES if QQ is Yes	314-317
10j-2	Restraints are applied only per the specific criteria described in the written plan.	YES if QQ is Yes	318-319
10j-3	Restraints are removed per the criteria and duration described in the written plan.	YES if QQ is Yes	320-321
10j-4	There is a current physician's order for the use of the Mechanical Restraining device.	YES if QQ is Yes	322-323

10j-5	There is documentation that is a “full record” of the use of the Mechanical Restraining device.	YES if QQ is Yes	324-325
<b>Section 10k: Risk Area: Time Out</b>			
Qualifier Question	Is ‘Time-out’ used for any Individuals?		326
10k-1	Time-out is used only in accordance with the written Behavior Support Plan.	YES if QQ is Yes	326-327
10k-2	The use of a time out room is reported electronically to OPWDD	YES if QQ is Yes	328-329
10k-3	Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety	YES if QQ is Yes	330-331
<b>Section 10l: Risk Area: Physical Interventions</b>			
Qualifier Question	Are physical Interventions used for any Individuals?		332
10l-1	Physical interventions are used only in accordance with the written Behavior Support Plan.	YES if QQ is Yes	332-333
10l-2	The use of restrictive physical interventions is reported electronically to OPWDD.	YES if QQ is Yes	334.335

# **SPECIALTY HOSPITAL**

QNO.	Program Class & Type STANDARD	Targeted Sample	Pg. No.
Standard #	STANDARD:	Verify for 1 individual min.	Site Guidance Page Number
<b>SECTION 2: HEALTH SUPPORT &amp; MEDICATIONS</b>			
2-1	There is a written plan detailing how the facility will deal with life-threatening emergencies.	NO	20
2-2	Staff working know actions to take in the event of a medical emergency.	NO	21
2a-1	There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.	NO	23-24
2a-2	DSP staff know how to contact the RN using the site/agency mechanism.	NO	25-26
2a-3	Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA or MD administers medications and/or prescribed treatments to individuals.	NO	27-28

2a-4	Individual's medications and treatments have been correctly administered per physicians' orders and his/her needs.	YES	29-31
2a-5	Medication Administration Records (MARs) are legible, correctly identify the current physician's orders/prescriptions and required documentation of administration.	YES	32-33
2a-6	Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.	YES	34-36
2a-7	Medications and treatments are stored securely as required, including the security of keys or codes to access medications.	NO	37-39
2a-8	Medication that is discontinued or outdated is not retained at the site.	YES	40-41
2a-9	Used needles and syringes are disposed in puncture resistant containers.	NO	42
2a-10	The site ensures that individuals access professional health care services per their needs, physician recommendation and informed choice.	YES	43-45
2a-11	The site ensures that in-home, routine support/care necessary for individuals' health needs is provided per their service plan.	YES	46-48

### SECTION 3: PERSONAL FUNDS

3-1	Personal Allowance money is consistently available to individuals for routine expenditures and recreational activities.	<b>YES</b>	49-50
Qualifier Question	Is any portion of the individuals personal funds held or managed by the site ?		51
3a-1	An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + \$20.	<b>YES</b>	52-53
3a-2	Personal Allowance funds held by the site are secured and safeguarded, accessible only to authorized employees.	<b>YES</b>	54-55
3a-3	There are ledger cards for the accounting of individuals' personal allowance.	<b>YES</b>	56
3a-4	The ledger(s) clearly documents receipt of funds on site.	<b>YES</b>	57
3a-5	The ledger(s) clearly document disbursement of funds including their purpose for the individual .	<b>YES</b>	58-59
3a-6	The ledger(s) accurately reflect the individual's total fund amount available in the site.	<b>YES</b>	60-61
3a-7	Personal allowance funds are not used for items or expenses for which the agency is responsible.	<b>YES</b>	62-63
3a-8	Receipts required (by regulation) for items or services purchased, reconcile with ledger entries .	<b>YES</b>	64

3a-9	Individuals are reimbursed for any loss of money maintained at the site.	YES, if applicable	65
<b>SECTION 4: GENERAL OPERATIONS FOR : INDIVIDUALIZE CHOICE, AUTONOMY &amp; SATISFACTIO</b>			
4-3	The site has a mechanism to assess individuals' satisfaction with the service environment.	NO	70-71
4-4	The home has a mechanism to assess living arrangement choice.	NO	72-73
4-5	The home has a mechanism to assess roommate choice and satisfaction.	NO	74-75
4-6	The program takes timely action to address individuals' dissatisfaction with living and/or service environment.	NO	76-77
4-11	Individuals <u>are observed</u> to engage in activities that are meaningful to them.	NO	87-88
4-14	Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by staff.	NO	93-95
4-15	Individuals are supported by staff to exercise control and choice in their own lives.	NO	96-97
<b>SECTION 5 : DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS</b>			
5-1	Staff can describe/know the Individuals' supervision needs.	NO	98-99

5-2	Individuals receive their meal/food in the form and consistency required by their plan, according to their needs and per OPWDD Choking Prevention Initiative (CPI) specifications.	YES	100-102
5-3	Individuals receive support while eating in accordance with their assessed and observed needs.	YES	103-104
5-4	Individuals receive support for mobility in accordance with observed needs.	NO	105-106
5-5	Individuals receive appropriate support and supervision based on <u>other</u> observed needs.	NO	107-108
5-6	There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.	NO	109-111
5-7	The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) Prompt contacting of other responsible personnel in emergencies.	NO	112-113
<b>SECTION 6: RIGHTS PROTECTIONS</b>			
6-1	<u>Observed and reported</u> interactions and communications with individuals, both verbal and non-verbal, are respectful.	NO	114-116
6-2	The site is absent of generally applied rules, policies or procedures that limit people's rights, independence, choice and autonomy.	NO	117-119

6-3	Individuals are permitted by the program to engage in any legal activities per their interests.	NO	120-121
6-4	Individuals have full access to the typical facilities in the site.	NO	122-124
6-5	Individuals' health and other protected information is kept private/protected.	NO	125-126
6-6	People have privacy in their living quarters as appropriate to the situation.	NO	127-129
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.	NO	134-135
6-10	Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.	NO	136-137
6-11	Immediate care and treatment identified was provided to the individual involved in the incident.	NO	138-139
6-12	Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.	NO	140-141
6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.	NO	142-144
6-14	Measures identified to prevent future similar events were <u>planned and implemented.</u>	NO	145-148
6-15	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.	NO	149-152
6-16	Part 625 events and actions reported in IRMA regarding recommendations, were implemented as reported.	NO	153-154

**SECTION 7: SITE & SAFETY**

7-2	Surveillance cameras are not present in the site.	NO	157
7-4	The site's physical characteristics support the independence, comfort, preference and needs of the individuals.	NO	160-161
7-5	All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.	NO	162-163
7-6	There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.	NO	164-165
7-7	Bathrooms provide personal privacy.	NO	166
7-8	The site is clean.	NO	167-168
7-9	The site is well maintained for the safety and comfort of the individuals receiving services.	NO	169-171
7-10	The facility operates in accordance with OPWDD smoking requirements.	NO	172-174
7-11	The temperature of the hot water is appropriate to the abilities of people served at the site.	NO	175-176
7-12	Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.	NO	177-179
7-13	The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools	NO	180-181

7-14	The facility has a land line (see section 635-99.1) telephone service which is in working order and functions during power outages.	NO	182
7-15	Time Out rooms constructed or significantly modified after April 1, 2013 meet the requirements identified in NYCRR Part 633.16(j).	NO	183-185
<b>SECTION 8: FIRE SAFETY REQUIRED (by OFPC or DQI )</b>			
Qualifier Question	Are there any immediate Fire Safety issues that must be identified?	NO	186
8-1	The site has an acceptable fire evacuation plan	NO	187-189
8-2	All fire and evacuation drills or events MUST be documented on the standardized drill report form developed by OPWDD.	NO	190
8-3	The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.	NO	191-192
8-4	Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.	NO	193-194
8-5	The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.	NO	195-196
8-6	Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).	NO	197-198

8-7	Facility staff can describe fire safety and emergency evacuation procedures.	NO	199-200
8-8	The certified site provides safe exiting to a public way.	NO	201-203
8-9	There is fire <b>alarm</b> and detection equipment in the facility as required by regulation and/or LSC.	NO	204-206
8-10	Heat detectors are present in the residence as required by OPWDD.	NO	207-208
8-11	Fire alarm and notification systems are operational and effective.	NO	209-210
8-12	Other fire protection equipment is operational.	NO	211-212
8-13	Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.	NO	213-214
8-14	Maintenance and inspection of Fire Alarm and Detection systems are performed by competent parties and according to OPWDD standards.	NO	215-216
8-15	Maintenance and inspection of Sprinkler Systems is performed by competent parties and according to OPWDD standards.	NO	217-218
8-16	At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.	NO	219-220

8-18	A carbon monoxide alarm is appropriately located in all new and existing residences on sleeping levels, per requirements.	NO	223-224
8-19	The facility, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.	NO	225-226
<b>SECTION 10: SPECIALIZED RISK FACTORS</b>			
<b>Section 10a: Risk Area: Skin Breakdown</b>			
Qualifier Question	Does anyone currently have skin breakdown or a history of skin breakdown?		231
10a-1	There is a written plan to provide care for wounds and/or prevent worsening & further breakdown.	YES if QQ is Yes	232-235
10a-2	Staff implement interventions related to care and monitoring of skin integrity and the prevention of skin breakdown, for which they are responsible.	YES if QQ is Yes	236-238
<b>Section 10b: Risk Area: Discharge from Hospital</b>			
Qualifier Question	Has anyone been discharged from the hospital in the past 3 months?		239
10b-1	Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring required by the person discharged.	YES if QQ is Yes	239-241

10b-2	The written instruction included how and what to document regarding required care and monitoring following hospital discharge.	YES if QQ is Yes	242
10b-3	There is evidence that the staff implement required care and monitoring following discharge.	YES if QQ is Yes	244-246
<b>Section 10c: Risk Area: Signs/Symptoms of Illness</b>			
Qualifier Question	Is any person in the site currently showing signs/symptoms of illness?		247
10c-1	RN or other medical professional has been informed of the signs/symptoms.	YES if QQ is Yes	247-248
10c-2	Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition and notifications required.	YES if QQ is Yes	249-250
10c-3	The instruction included how and what to document regarding required care and monitoring for identified health concern.	YES if QQ is Yes	251-252
10c-4	There is evidence that the staff implement required care and monitoring.	YES if QQ is Yes	253-254
<b>Section 10d: Risk Area: Diabetes</b>			
Qualifier Question	Is any person diagnosed with diabetes?		255

10d-1	Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required by the person.	YES if QQ is Yes	255-259
10d-2	The written instruction includes how and what to document regarding required care and monitoring for identified diabetic needs.	YES if QQ is Yes	260-262
10d-3	There is evidence that the staff implement required diabetic care and monitoring.	YES if QQ is Yes	263-266
<b>Section 10e: Risk Area: Fluid Intake</b>			
Qualifier Question	Does any individual require a specific daily level of fluid intake?		267
10e-1	The amount of fluid to be consumed by the person is clearly indicated in a written plan.	YES if QQ is Yes	267-269
10e-2	Clear written instruction is provided to further guide staff in how to implement the fluid intake requirements.	YES if QQ is Yes	270-272
10e-3	There is documentation/tracking of the person's fluid consumption.	YES if QQ is Yes	273-274
10e-4	The written plan for fluid consumption is implemented correctly.	YES if QQ is Yes	275-277
<b>Section 10f: Risk Area: Oxygen Use</b>			
Qualifier Question	Does any individual have an order for Oxygen use?		278

10f-1	Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.	YES if QQ is Yes	279-280
10f-2	The written instruction includes how and what to document regarding oxygen administration and monitoring.	YES if QQ is Yes	281-282
10f-3	Necessary equipment is available per the medical order for oxygen.	YES if QQ is Yes	283
10f-4	There is documentation evidencing ordered administration of oxygen and monitoring of their condition.	YES if QQ is Yes	284-286

**Section 10g: Risk Area: Supervision**

Qualifier Question	Enhanced supervision levels are required by one or more person supported by the sight.		287
10g-1	There are sufficient staff on duty to maintain the supervision levels required by the Individuals.	YES if QQ is Yes	287-290
10g-2	Required enhanced supervision and staffing ratios are maintained per people's individualized plans.	YES if QQ is Yes	291-293

**Section 10h : Risk Area: All Rights Limitations/Restrictions**

Qualifier Question	Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?		293
10h-1	Limitation or restriction of rights <u>due to behaviors</u> occur only as part of a written behavior plan.	YES if QQ is Yes	293-294

10h-2	The Individuals Behavior Support Plan describes how the use of each restrictive intervention is to be documented.	YES if QQ is Yes	295-296
10h-3	Rights Limitations / restrictions occur only when written informed consent was obtained from an appropriate consent giver.	YES if QQ is Yes	297-298
10h-4	Rights Limitations / restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.	YES if QQ is Yes	299-300
10h-5	Rights limitations that are not part of a Behavior Support Plan comply with HCBS requirements for justification and documentation of rights limitations.	YES if QQ is Yes	301-304
10h-6	When environmental protections (that are in place due to an Individuals needs) restricts other Individuals in the facility, action is taken to ensure that they are not negatively affected.	YES if QQ is Yes	305-306

**Section 10i: Risk Area: Behavior Supports - General**

Qualifier Question	Is a behavior support plan or medication monitoring plan required/in place for any Individual ?		307
10i-1	Behavior Supports are provided per the written plan.	YES if QQ is Yes	307-309
10i-2	Behavior supports are reviewed for effectiveness by clinical staff responsible for the plan.	YES if QQ is Yes	210-311

10i-3	Behavior Supports are revised as needed.	YES if QQ is Yes	312-313
<b>Section 10j: Risk Area: Mechanical Restraints</b>			
Qualifier Question	Are there any limitation or restriction of rights, including use of approved physical interventions, evident and/or reported?		314
10j-1	Criteria for the application, removal and duration of mechanical restraint device use is described in the written behavior support plan.	YES if QQ is Yes	314-317
10j-2	Restraints are applied only per the specific criteria described in the written plan.	YES if QQ is Yes	318-319
10j-3	Restraints are removed per the criteria and duration described in the written plan.	YES if QQ is Yes	320-321
10j-4	There is a current physician's order for the use of the Mechanical Restraining device.	YES if QQ is Yes	322-323
10j-5	There is documentation that is a "full record" of the use of the Mechanical Restraining device.	YES if QQ is Yes	324-325
<b>Section 10k: Risk Area: Time Out</b>			
Qualifier Question	Is 'Time-out' used for any Individuals?		326
10k-1	Time-out is used only in accordance with the written Behavior Support Plan.	YES if QQ is Yes	326-327

10k-2	The use of a time out room is reported electronically to OPWDD	YES if QQ is Yes	328-329
10k-3	Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety	YES if QQ is Yes	330-331
<b>Section 10l: Risk Area: Physical Interventions</b>			
Qualifier Question	Are physical Interventions used for any Individuals?		332
10l-1	Physical interventions are used only in accordance with the written Behavior Support Plan.	YES if QQ is Yes	332-333
10l-2	The use of restrictive physical interventions is reported electronically to OPWDD.	YES if QQ is Yes	334.335



## Office for People With Developmental Disabilities

**ANDREW M. CUOMO**  
Governor

**KERRY A. DELANEY**  
Acting Commissioner

# **Section 2**

## **Fillable Protocol Form**

(Completion of each section is dependent upon the type of waiver service that is being reviewed. (Please refer to the charts in section 1 for further assistance).)

# *SITE Protocol*

***Agency Name:***

***Site Name:***

***Site Address:***

***Team #:***

***Observation Period:***

***Observation Type:***

General routines/activities/interactions

General routine – attentive to service/support implementation

Mealtime (at least 1 meal)

***Agency ID:***

***OC #:***

***Visit Date:***

***Surveyor:***

***Surveyor:***

***Surveyor:***

***Individual:***

***Individual:***

***Individual:***

***NO Individual***

## INFORMATION GATHERING ENTRANCE CONFERENCE

DISCUSSION TOPICS: The following topics were discussed in entrance and/or with site staff				
<i>SECTION</i>	Discussed	Not Discussed	COMMENT if 'Not'	Notes
FACILITY STAFF INFORMED OF PURPOSE OF VISIT				
<b><i>SITE DEMOGRAPHICS REVIEWED:</i></b>				
New admissions				
Individuals in respite on site				
Individuals visiting, not admitted				
Individuals absent during visit				
<b><i>STAFFING:</i></b>				
Staff on duty during visit: # and names				
Minimum staffing on each shift				

<b>SECTION</b>	<b>Discussed</b>	<b>Not Discussed</b>	<b>COMMENT if 'Not'</b>	<b>Notes</b>
Staff Vacancies				
New staff				
<b>TIME-OUT ROOMS</b>				
Time-Out room on site				
<b>OTHER SIGNIFICANT EVENTS</b>				
Theft of Individuals' money or property				
Fires on Site				
Individuals refusing evacuation drills				
Any fire safety equipment currently broken/inoperable				
Complaints received regarding the site/services				
Community Activities planned during visit				

SECTION	Discussed	Not Discussed	COMMENT if 'Not'	Notes
In-site activities planned during visit				
Jobs/Job Contracts individuals are working on				
<b>SPECIALIZED SUPPORT NEEDS</b>				
<b><i>SUPERVISION:</i></b>				
Individuals requiring 1:1 supervision level				
Individuals requiring line of sight supervision				
<b><i>BEHAVIOR SUPPORTS and general discussion of elements below:</i></b>				
Individuals with Behavior Support and/or Medication Monitoring Plans				
Individuals with rights limitations or restrictions in place				
Individuals with SCIP or Promote physical interventions in place and general description of use				
Individuals who use Time Out Room				

<b>SECTION</b>	<b>Discussed</b>	<b>Not Discussed</b>	<b>COMMENT if 'Not'</b>	<b>Notes</b>
Individuals using Mechanical Restraints for behavior and general description of use				
Individuals receiving Medication as a behavior support				
<b><i>HEALTH NEEDS and general overview of the issues discussed:</i></b>				
Individuals hospitalized in the past 3 months				
Oxygen used or administered on site and who				
Individuals have decubiti/breakdown now or in the past 12 months				
Individuals with diagnosis of diabetes				
Individuals requiring fluid tracking, a restriction in fluid intake or assurance of minimum intake				
Anyone currently showing sign/symptoms of illness				



<b>SECTION</b>	<b>Discussed</b>	<b>Not Discussed</b>	<b>COMMENT if 'Not'</b>	<b>Notes</b>
Any Individuals with: <ul style="list-style-type: none"> <li>• Constipation history</li> <li>• Bowel impaction history</li> <li>• Required bowel tracking</li> <li>• Bowel Management Plan</li> </ul>				
<b><i>DINING SUPPORTS and general overview of the issues discussed:</i></b>				
Altered consistency diets or dietary administration required by individuals (anything not “whole”, includes tube feeding)				
Specialized diets required by individuals (other than consistency needs)				
Supports and supervision required by individuals while eating				
Any choking episodes in the past year; and anyone with choking history.				



**Documents requested: The following documents MUST be requested as appropriate to the site/program type and conditions at the site**

	YES	NO	N/A	received within 4 hours	received after 4 hours	did not receive	Comment
Site Plan of Protection							
Staff Schedule							
Communication Log/Book/File							
<b>Documents related to Individuals Services and Supports:</b>							
Service Plan							
IPOP and/or other safeguard documentation							
Health Care Plans and Documents							
Behavior Support and Interventions							
Rights Restrictions & Required Documentation							
Treatment/Program/Goal/Habilitation Plans							
Evacuation Plan							
Evacuation Drills							
Fire Safety Equipment Maintenance Documents							
Fire Safety Staff Training Records							
Money/Personal Allowance Ledgers and Supporting Documentation							
Medication administration records							



**Remediation Verification:**

Validate that deficiencies cited at previous visit are corrected specifically and systemically

Previous Deficiencies	YES	NO	Comment
Yes - Deficiencies were reviewed for correction			
No - No unverified corrections			
No - No Deficiencies			
No - Did not review (requires comment)			



# SECTION 1

## HEIGHTENED SCRUTINY TRIGGERS

### *Characteristics Of Site*

<b>Qualifier Question:</b> Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?	<b>Yes</b>	<b>No</b>	
<b>If Yes – answer questions 1-6 If No – go to Section 2</b>			
1-1 The site is in a location <u>other than</u> on the grounds of a public institution.	Met	Not Met	
Notes:			
1-2 The site is in a building separate from a publically or privately operated facility that provides inpatient institutional treatment.	Met	Not Met	
Notes:			
1-3 The site is in a location other than immediately adjacent to a public institution.	Met	Not Met	
Notes:			



1-4 The home meets the following description: It did not convert from an ICF on or after March 17, 2014.	Met	Not Met	
Notes:			
1-5 The site is located apart from other certified facilities. <i>It is not part of co-located and/or clustered programs/sites that are operationally related resulting in the isolation from and/or inhibition of 1-5 interaction with the broader community.</i>	Met	Not Met	
Notes:			
1-6 The site's design, appearance and location is not institutional and does not isolate people from the broader community.	Met	Not Met	
Notes:			



## SECTION 2 HEALTH SUPPORT & MEDICATIONS

2-1 There is a written plan for how the facility will deal with life-threatening emergencies.	Met	Not Met	
Notes:			
2-2 Staff working know actions to take in the event of a medical emergency.	Met	Not Met	
Notes:			
<b>Qualifier Question:</b> The Day Service site provides nursing and/or delegated nursing services such as medication administration.  <b>If Yes, answer 2a-1 through 2a-11</b> <b>If No, go to Section 3</b>	YES	NO	
2a-1 There is Registered Nurse on site or immediately available to staff rendering professional nursing services.	Met	Not Met	
Notes:			



2a-2 DSP staff know how to contact the RN using the site/agency mechanism.	Met	Not Met	
Notes:			
2a-3 Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA or MD administers medications and/or prescribed treatments to individuals.	Met	Not Met	
Notes:			
2a-4 Individual's medications and treatments have been correctly administered per physicians' orders and his/her needs.	Met	Not Met	
Notes:			
2a-5 Medication Administration Records (MARs) are legible, <u>correctly identify</u> the current physician's orders/prescriptions and required documentation of administration.	Met	Not Met	
Notes:			
2a-6 Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.	Met	Not Met	
Notes:			



2a-7 Medications and treatments are stored securely as required, including the security of keys or codes to access medications.	Met	Not Met	
Notes:			
2a-8 Medication that is discontinued or outdated is not retained at the site.	Met	Not Met	
Notes:			
2a-9 Used needles and syringes are dispose in puncture resistant containers.	Met	Not Met	
Notes:			
2a-10 The site ensures that individuals access professional health care services per their needs, physician recommendation and informed choice.	Met	Not Met	
Notes:			
2a-11 The site ensures that in-home, routine support/care necessary for individuals' health needs is provided per their service plan.	Met	Not Met	
Notes:			



## SECTION 3 PERSONAL FUNDS

3-1 Personal Allowance money is consistently available to individuals for routine expenditures and recreational activities.	Met	Not Met	
Notes:			
<b>QUALIFIER QUESTION:</b> Is any portion of the individuals personal funds held or managed by the site? <ul style="list-style-type: none"> <li>• <b>If Yes, answer questions 3a-1 to 3a-9</b></li> <li>• <b>If No, go to Section 4</b></li> </ul>	Yes	No	
3a-1 An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + \$20.	Met	Not Met	
Notes:			
3a-2 Personal funds held by the site are secured and safeguarded, accessible only to authorized employees.	Met	Not Met	
Notes:			
3a-3 There are ledger cards for the accounting of individuals' personal allowance.	Met	Not Met	
Notes:			



3a-4 The ledger(s) clearly documents receipt of funds on site.	Met	Not Met	
Notes:			
3a-5 The ledger(s) clearly document disbursement of funds including their purpose for the individual.	Met	Not Met	
Notes:			
3a-6 The ledger(s) accurately reflect the individual's total fund amount available in the site.	Met	Not Met	
Notes:			
3a-7 Personal allowance funds are not used for items or expenses for which the agency is responsible.	Met	Not Met	
Notes:			
3a-8 Receipts required (by regulation) for items or services purchased, reconcile with ledger entries.	Met	Not Met	
Notes:			



3a-9 Individuals are reimbursed for any loss of money maintained at the site.	Met	Not Met	
Notes:			

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**SECTION 4**  
**General Operations for:**  
**Individualized Choice, Autonomy & Satisfaction**

4-1 Sufficient transportation is available and facilitated to support individualized choices of activities and schedules.	Met	Not Met	
Notes:			
4-2 The staff scheduling and general operations are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.	Met	Not Met	
Notes:			
4-3 The site has a mechanism to assess individuals' satisfaction with the service environment.	Met	Not Met	
Notes:			
4-4 The home has a mechanism to assess living arrangement choice.	Met	Not Met	
Notes:			



4-5 The home has mechanism to assess roommate choice and satisfaction.	Met	Not Met	
Notes:			
4-6 The program takes timely action to address individuals' dissatisfaction with living and/or service environment.	Met	Not Met	
Notes:			
4-7 The home has a mechanism to offer individuals keys to enter their home (or other mechanism to enter their home independently).	Met	Not Met	
Notes:			
4-8 The home has a mechanism to offer individuals keys to their bedrooms (or other mechanism to secure their bedroom independently).	Met	Not Met	
Notes:			
4-9 The home takes timely action to provide requesting Individuals with independent access to their home and/or bedroom.	Met	Not Met	
Notes:			



4-10 Individuals' schedules and routines are personally determined per their needs, interests and preferences (rather than per the staff or agency operations).	Met	Not Met	
Notes:			
4-11 Individuals <u>are observed</u> to engage in activities that are meaningful to them.	Met	Not Met	
Notes:			
4-12 Individuals are encouraged and invited to participate in the routine of their own home. (e.g. cooking, menu planning, routine chores, etc.)	Met	Not Met	
Notes:			
4-13 Individuals are encouraged and supported to have full access to the broader community.	Met	Not Met	
Notes:			
4-14 Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by staff.	Met	Not Met	
Notes:			



4-15 Individuals are supported by staff to exercise control and choice in their own lives.	Met	Not Met	
Notes:			



**SECTION 5  
DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS**

5-1 Staff can describe/know the Individuals' supervision needs.	Met	Not Met	
Notes:			
5-2 Individuals receive their meal/food in the form and consistency required by their plan, according to their needs and per OPWDD Choking Prevention Initiative (CPI) specifications.	Met	Not Met	N/A
Notes:			
5-3 Individuals receive support while eating in accordance with their <u>assessed and observed</u> needs.	Met	Not Met	
Notes:			
5-4 Individuals receive support for mobility in accordance with observed needs.	Met	Not Met	
Notes:			



5-5 Individuals receive appropriate support and supervision based on <u>other</u> observed needs for support.	Met	Not Met	
Notes:			
5-6 There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.	Met	Not Met	
Notes:			
5-7 The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) Prompt contacting of other responsible personnel in emergencies.	Met	Not Met	
Notes:			



**SECTION 6  
RIGHTS and PROTECTIONS**

6-1 Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.	Met	Not Met	
Notes:			
6-2 The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.	Met	Not Met	
Notes:			
6-3 Individuals are permitted by the program to engage in any legal activities per their interests.	Met	Not Met	
Notes:			
6-4 Individuals have full access to the typical facilities in the site.	Met	Not Met	
Notes:			



6-5 Individuals' health and other protected information is kept private/protected.	Met	Not Met	
Notes:			
6-6 People have privacy in their living quarters as appropriate to the situation.	Met	Not Met	
Notes:			
6-7 People have access to food at any time.	Met	Not Met	
Notes:			
6-8 People can choose to eat meals where/when desired.	Met	Not Met	
Notes:			



6-9 Events that meet the definition of reportable incident or notable occurrence have been reported.	Met	Not Met	N/A
Notes:			
6-10 Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.	Met	Not Met	N/A
Notes:			
6-11 Immediate care and treatment identified was provided to the individual involved in the incident.	Met	Not Met	N/A
Notes:			
6-12 Initial measures to <b>protect individuals</b> receiving services from harm and abuse, were implemented immediately.	Met	Not Met	N/A
Notes:			
6-13 Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.	Met	Not Met	N/A
Notes:			



6-14 Measures identified to <b>prevent future</b> similar events were <u>planned and implemented</u> .	Met	Not Met	N/A
Notes:			
6-15 Corrective Actions reported to OPWDD and the Justice Center in response to <b>Reportable Incidents of Abuse and/or Neglect</b> were implemented.	Met	Not Met	
Notes:			
6-16 Part 625 events and actions reported in IRMA regarding recommendations, were implemented as reported.	Met	Not Met	N/A
Notes:			



**SECTION 7  
SITE & SAFETY**

7-1 The residence appears “home-like”, rather than Institutional.	Met	Not Met	
Notes:			
7-2 Surveillance cameras are not present <u>in</u> the site.	Met	Not Met	
Notes:			
7-3 There is evidence that residents are allowed to have visitors of their choosing at <u>any</u> time.	Met	Not Met	
Notes:			
7-4 The site’s physical characteristics support the independence, comfort, preference and needs of the individuals.	Met	Not Met	
Notes:			
7-5 All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.	Met	Not Met	
Notes:			



7-6 There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.	Met	Not Met	
Notes:			
7-7 Bathrooms provide personal privacy.	Met	Not Met	
Notes:			
7-8 The site is clean.	Met	Not Met	
Notes:			
7-9 The site is well maintained for the safety and comfort of the individuals receiving services.	Met	Not Met	
Notes:			
7-10 The facility operates in accordance with OPWDD smoking protection requirements.	Met	Not Met	
Notes:			



7-11 The temperature of the hot water is appropriate to the abilities of people served at the site.	Met	Not Met	
Notes:			
7-12 Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.	Met	Not Met	
Notes:			
7-13 The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools.	Met	Not Met	
Notes:			
7-14 The facility has a land line (see section 635-99.1) telephone service which is in working order and functions during power outages.	Met	Not Met	
Notes:			
7-15 Time Out rooms constructed or significantly modified after April 1, 2013 meet the requirements identified in NYCRR Part 633.16(j).	Met	Not Met	
Notes:			



## SECTION 8 FIRE SAFETY

QUALIFIER QUESTION:	Yes	No	
<ul style="list-style-type: none"> <li>Are there any immediate Fire Safety issues that must be identified?</li> <li>If Yes, answer questions 8-1 to 8-19</li> <li>If No, go to Section 9</li> </ul>			
8-1 The site has an acceptable fire evacuation plan.	Met	Not Met	N/A
Notes:			
8-2 All fire and evacuation drills or events <b>MUST</b> be documented on the standardized drill report form developed by OPWDD.	Met	Not Met	N/A
Notes:			
8-3 The Evacuation Plan is practiced through drills with the <b>frequency</b> specified by OPWDD.	Met	Not Met	N/A
Notes:			
8-4 Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.	Met	Not Met	N/A
Notes:			



8-5 The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.	Met	Not Met	N/A
Notes:			
8-6 Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).	Met	Not Met	N/A
Notes:			
8-7 Facility staff can describe fire safety and emergency evacuation procedures.	Met	Not Met	N/A
Notes:			
8-8 The <u>certified site</u> provides safe exiting to a public way.	Met	Not Met	N/A
Notes:			
8-9 There is fire alarm and detection equipment in the facility as required by regulation and/or LSC.	Met	Not Met	N/A
Notes:			



8-10 Heat detectors are present in the residence as required by OPWDD.	Met	Not Met	N/A
Notes:			
8-11 Fire alarm and notification systems are operational and effective.	Met	Not Met	N/A
Notes:			
8-12 Other fire protection equipment is operational.	Met	Not Met	N/A
Notes:			
8-13 Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.	Met	Not Met	N/A
Notes:			
8-14 Maintenance and inspection of Fire Alarm and Detection systems are performed according to OPWDD standards.	Met	Not Met	N/A
Notes:			



8-15 Maintenance and inspection of Sprinkler Systems are performed according to OPWDD standards.	Met	Not Met	N/A
Notes:			
8-16 At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.	Met	Not Met	N/A
Notes:			
8-17 In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.	Met	Not Met	N/A
Notes:			
8-18 A carbon monoxide alarm is appropriately located in all new and existing residences on sleeping levels, per requirements.	Met	Not Met	N/A
Notes:			
8-19 The facility, at the time of the inspection, was free from other observed <u>fire safety</u> hazards not otherwise indicated in another standard.	Met	Not Met	N/A
Notes:			



**SECTION 9**  
**Site Specific Requirements**

9-1 The site/program has a written Quality Assurance Plan that has been implemented.	Met	Not Met	N/A
Notes:			
9-2 Corrective actions identified per the QA plan activities are implemented.	Met	Not Met	N/A
Notes:			



**SECTION 10**  
**Specialized Risk Factors**

**SECTION 10a: RISK FACTOR - SKIN BREAKDOWN**

**Does anyone currently have, or have a history of skin breakdown?**

If yes, the following standards open up for review:

If yes, ID Individual(s) Name:

	YES	NO	
10a-1 There is a <b>written plan</b> to provide care for wounds and/or prevent worsening & further breakdown.	Met	Not Met	N/A
Notes:			
10a-2 Staff implement interventions related to care and monitoring of skin integrity and the prevention of skin breakdown, for which they are responsible.	Met	Not Met	N/A
Notes:			



**SECTION 10b: RISK FACTOR - DISCHARGE FROM HOSPITAL**

**Has anyone been discharged from the hospital in the past 3 months?**

If yes, the following standards open up for review:

If yes, ID Individual(s) Name:

10b-1 Clear **written instruction** was provided to staff regarding the specific actions to take to provide care and monitoring required by the person discharged.

YES

NO

Met

Not Met

N/A

Notes:

10b-2 The written instruction included how and **what to document** regarding required care and monitoring following hospital discharge.

Met

Not Met

N/A

Notes:

10b-3 There is evidence that the staff **implement** required care and monitoring following discharge.

Met

Not Met

N/A

Notes:



**SECTION 10c: RISK FACTOR - CURRENT ILLNESS**

**Is any person in the home currently showing signs/symptoms of illness?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

YES	NO	
Met	Not Met	N/A
Met	Not Met	N/A
Met	Not Met	N/A
Met	Not Met	N/A

10c-1 RN or other medical professional **has been informed** of the signs/symptoms (s/s).

Notes:

10c-2 Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition and notifications required.

Notes:

10c-3 The instruction included how and **what to document** regarding required care and monitoring for identified health concern.

Notes:

10c-4 There is evidence that the staff **implement** required care and monitoring.

Notes:



**SECTION 10d: RISK FACTOR - DIABETES**

**Is any person diagnosed with Diabetes?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

10d-1 Clear **written instruction** is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required by the person.

YES

NO

N/A

Met

Not Met

Notes:

10d-2 The written instruction includes how and what to **document** regarding required care and monitoring for identified diabetic needs.

Met

Not Met

N/A

Notes:

10d-3 There is evidence that the staff **implement** required diabetic care and monitoring.

Met

Not Met

N/A

Notes:



**SECTION 10e: RISK FACTOR - FLUID INTAKE**

**Is any person prescribed a specific daily level of fluid intake?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

10e-1 The amount of fluid to be consumed by the person is **clearly** indicated in a **written plan**.

YES

NO

N/A

Met

Not Met

Notes:

10e-2 Clear written instruction is provided to further guide staff in how to **implement** the fluid intake requirements.

Met

Not Met

N/A

Notes:

10e-3 There is documentation/**tracking** of the person's fluid consumption.

Met

Not Met

N/A

Notes:

10e-4 The written plan for fluid consumption is **implemented** correctly.

Met

Not Met

N/A

Notes:



**SECTION 10f: RISK FACTOR - OXYGEN USE**

**Does any Individual have an order for Oxygen Use?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

10f-1 **Clear written instruction** is provided to guide staff in when and how to implement the order for oxygen.

YES

NO

N/A

Met

Not Met

Notes:

10f-2 The written instruction includes how and what to **document** regarding required oxygen administration and monitoring.

Met

Not Met

N/A

Notes:

10f-3 Necessary equipment is available per the medical order for oxygen.

Met

Not Met

N/A

Notes:

10f-4 There is documentation evidencing ordered administration of oxygen and monitoring of their condition.

Met

Not Met

N/A

Notes:



**SECTION 10g: RISK FACTOR - SUPERVISION**

**Enhanced supervision levels are required by one or more person supported by the site?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

10g-1 There are sufficient staff on duty to maintain the supervision levels required by the Individuals.

YES

NO

Met

Not Met

N/A

Notes:

10g-2 Required enhanced supervision and staffing ratios are maintained per people's individualized plans.

Met

Not Met

N/A

Notes:



**Section 10h: RISK FACTOR - ALL RIGHTS LIMITATIONS/RESTRICTIONS:**

**Are there any observed, reported, or documented limitations, restrictions or intrusions to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

	YES	NO	
10h-1 Limitation or restriction of rights <u>due to behaviors</u> occur only as part of a written behavior support plan.	Met	Not Met	N/A
Notes:			
10h-2 The Individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention or limitation is to be documented.	Met	Not Met	N/A
Notes:			
10h-3 Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.	Met	Not Met	N/A
Notes:			
10h-4 Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.	Met	Not Met	N/A
Notes:			



10h-5 Rights limitations that are not part of a Behavior Support Plan, comply with HCBS requirements for justification and documentation of rights limitation.	Met	Not Met	N/A
Notes:			
10h-6 When environmental protections (that are in place due to an individual's needs) restricts other individuals in the facility, action is taken to ensure that they are not negatively affected.	Met	Not Met	N/A
Notes:			



**SECTION 10i: RISK FACTOR - BEHAVIOR SUPPORTS – GENERAL**

Is a behavior support plan or medication monitoring plan required/in place for any Individual(s)?

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

YES

NO

10i-1 Behavior supports are provided per the written plan.

Met

Not Met

N/A

Notes:

10i-2 Behavior supports are **reviewed** for effectiveness by clinical staff responsible for the plan.

Met

Not Met

N/A

Notes:

10i-3 Behavior supports are **revised** as needed.

Met

Not Met

N/A

Notes:



**SECTION 10j: RISK FACTOR - MECHANICAL RESTRAINTS**

Are Mechanical Restraints used for at least one person at the Site?

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

	YES	NO	
10j-1 Criteria for the application, removal and duration of mechanical restraint device use is described <b>in the written</b> behavior support plan.	Met	Not Met	N/A
Notes:			
10j-2 Restraints are <b>applied only per the specific criteria</b> described in the written plan.	Met	Not Met	N/A
Notes:			
10j-3 Restraints are <b>removed per the criteria and duration</b> described in the written plan.	Met	Not Met	N/A
Notes:			
10j-4 There is a <b>current physician's order</b> for the use of the Mechanical Restraining device.	Met	Not Met	N/A
Notes:			



10j-5 There is <b>documentation</b> that is a “full record” of the use of the Mechanical Restraining device.	Met	Not Met	N/A
Notes:			



**SECTION 10k: RISK FACTOR - TIME OUT**

Is 'Time-out' used for any Individuals?

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

10k-1. Time-out is **used only in accordance with** the written Behavior Support Plan.

YES

NO

Met

Not Met

N/A

Notes:

10k-2 The use of a time out room is reported electronically to OPWDD.

Met

Not Met

N/A

Notes:

10k-3 **Constant auditory and visual contact** is maintained during time-outs to monitor the Individual's safety.

Met

Not Met

N/A

Notes:



**SECTION 10I: PHYSICAL INTERVENTIONS**

Are physical interventions used for any Individuals?

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

YES

NO

10I-1 Physical interventions are used only in accordance with the written Behavior Support Plan.

Met

Not Met

N/A

Notes:

10I-2 The use of restrictive physical interventions is reported electronically to OPWDD.

Met

Not Met

N/A

Notes:





## Office for People With Developmental Disabilities

**ANDREW M. CUOMO**  
Governor

**KERRY A. DELANEY**  
Acting Commissioner

# **Section 3**

## **Guidance Section**

(Identifies each section within the protocol, highlighting the type of waiver service to be reviewed, in accordance with NYS Regulation. Also providing a summary of when to identify whether the question is MET/NOT MET.)

# *SITE Protocol*

***Agency Name:***

***Site Name:***

***Site Address:***

***Team #:***

***Observation Period:***

***Observation Type:***

General routines/activities/interactions

General routine – attentive to service/support implementation

Mealtime (at least 1 meal)

***Agency ID:***

***OC #:***

***Visit Date:***

***Surveyor:***

***Surveyor:***

***Surveyor:***

***Individual:***

***Individual:***

***Individual:***

***NO Individual***

## INFORMATION GATHERING ENTRANCE CONFERENCE

DISCUSSION TOPICS: The following topics were discussed in entrance and/or with site staff				
<i>SECTION</i>	Discussed	Not Discussed	COMMENT if 'Not'	Notes
FACILITY STAFF INFORMED OF PURPOSE OF VISIT				
<b><i>SITE DEMOGRAPHICS REVIEWED:</i></b>				
New admissions				
Individuals in respite on site				
Individuals visiting, not admitted				
Individuals absent during visit				
<b><i>STAFFING:</i></b>				
Staff on duty during visit: # and names				
Minimum staffing on each shift				

Staff Vacancies				
<b>SECTION</b>	<b>Discussed</b>	<b>Not Discussed</b>	<b>COMMENT if 'Not'</b>	<b>Notes</b>
New staff				
<b>TIME-OUT ROOMS</b>				
Time-Out room on site				
<b>OTHER SIGNIFICANT EVENTS</b>				
Theft of Individuals' money or property				
Fires on Site				
Individuals refusing evacuation drills				
Any fire safety equipment currently broken/inoperable				
Complaints received regarding the site/services				

Community Activities planned during visit				
<b>SECTION</b>	<b>Discussed</b>	<b>Not Discussed</b>	<b>COMMENT if 'Not'</b>	<b>Notes</b>
In-site activities planned during visit				
Jobs/Job Contracts individuals are working on				
<b>SPECIALIZED SUPPORT NEEDS</b>				
<b><i>SUPERVISION:</i></b>				
Individuals requiring 1:1 supervision level				
Individuals requiring line of sight supervision				
<b><i>BEHAVIOR SUPPORTS and general discussion of elements below:</i></b>				
Individuals with Behavior Support and/or Medication Monitoring Plans				
Individuals with rights limitations or restrictions in place				

Individuals with SCIP or Promote physical interventions in place and general description of use				
Individuals who use Time Out Room				
<b>SECTION</b>	<b>Discussed</b>	<b>Not Discussed</b>	<b>COMMENT if 'Not'</b>	<b>Notes</b>
Individuals using Mechanical Restraints for behavior and general description of use				
Individuals receiving Medication as a behavior support				
<b>HEALTH NEEDS and general overview of the issues discussed:</b>				
Individuals hospitalized in the past 3 months				
Oxygen used or administered on site and who				
Individuals have decubiti/breakdown now or in the past 12 months				
Individuals with diagnosis of diabetes				

Individuals requiring fluid tracking, a restriction in fluid intake or assurance of minimum intake				
Anyone currently showing sign/symptoms of illness				
<b>SECTION</b>	<b>Discussed</b>	<b>Not Discussed</b>	<b>COMMENT if 'Not'</b>	<b>Notes</b>
Any Individuals with: <ul style="list-style-type: none"> <li>• Constipation history</li> <li>• Bowel impaction history</li> <li>• Required bowel tracking</li> <li>• Bowel Management Plan</li> </ul>				
<b><i>DINING SUPPORTS and general overview of the issues discussed:</i></b>				
Altered consistency diets or dietary administration required by individuals (anything not “whole”, includes tube feeding)				
Specialized diets required by individuals (other than consistency needs)				
Supports and supervision required by individuals while eating				
Any choking episodes in the past year; and anyone with choking history.				

**Documents requested: The following documents MUST be requested as appropriate to the site/program type and conditions at the site**

	YES	NO	N/A	received within 4 hours	received after 4 hours	did not receive	Comment
Site Plan of Protection							
Staff Schedule							
Communication Log/Book/File							
<b>Documents related to Individuals Services and Supports:</b>							
Service Plan							
IPOP and/or other safeguard documentation							
Health Care Plans and Documents							
Behavior Support and Interventions							
Rights Restrictions & Required Documentation							
Treatment/Program/Goal/Habilitation Plans							
Evacuation Plan							
Evacuation Drills							
Fire Safety Equipment Maintenance Documents							
Fire Safety Staff Training Records							
Money/Personal Allowance Ledgers and Supporting Documentation							
Medication administration records							

**Remediation Verification:**

Validate that deficiencies cited at previous visit are corrected specifically and systemically

Previous Deficiencies	YES	NO	Comment
Yes - Deficiencies were reviewed for correction			
No - No unverified corrections			
No - No Deficiencies			
No - Did not review (requires comment)			

# SECTION 1

## HEIGHTENED SCRUTINY TRIGGERS

### *Characteristics Of Site*

**Qualifier Question:** Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?

If Yes – answer questions 1-6 If No – go to Section 2

Guidance:

Applies only to the sites to which HCBS settings requirements apply.

Conditions involving the site may be altered since the last site review requiring a reassessment of heightened scrutiny (HS) triggers. This may mean a heightened scrutiny site may no longer require heightened scrutiny or a site not triggered may now trigger heightened scrutiny.

For example:

- A site has converted from an ICF to and IRA and has not yet been assessed against HS triggers.
- An IRA did not trigger heightened scrutiny (HS) in a previous review. Another IRA and a Day Habilitation program are built on adjacent property now requiring consideration of collocation/clustering.
- A site that did not trigger HS implements procedures that result in isolation of individuals from the greater community and institutional practices in the home.
- A site (with its operating certificate number) triggered heightened scrutiny due to where it is located (e.g. collocated, adjacent to public institution, etc.). The site is relocated to a new address. The site would be reassessed so that its heightened scrutiny can be correctly designated based on its new location.

Select **YES** if:

- There are changes in the location, environment, surroundings, circumstances or classification of the certified site that may result in changes in HS triggers or HS categorization.

## 1-1 The site is in a location other than on the grounds of a public institution.

Memo to Providers: October 13, 2015 Subject: Communication to Providers on the Home and Community Based Settings (HCBS) Heightened Scrutiny Process and Requirements for certified settings where waiver services are delivered

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
As needed	As needed	<u>Mandatory:</u> To confirm that the site is not in a location on the grounds of a public institution (as described below).

The site is **not** on the grounds of a public institution - A public institution means an institution that is the responsibility of a governmental entity over which a governmental entity exercises control.

OPWDD developmental centers and ICFs, OMH psychiatric centers, institutions for mental diseases, prisons, addiction centers, and state run nursing homes are considered public institutions. A former developmental center that has been closed is also considered a public institution.

A public institution **DOES NOT** include: medical institutions/hospitals, (including a VA hospital), child care institutions, publically operated non-ICFs community residences, universities, libraries, and public non-residential schools.

**If the site is on the grounds of a public institution as described above, the standard is *NOT MET*.**

1-2 The site is in a building separate from a publically or privately operated facility that provides inpatient institutional treatment.

Memo to Providers: October 13, 2015 Subject: Communication to Providers on the Home and Community Based Settings (HCBS) Heightened Scrutiny Process and Requirements for certified settings where waiver services are delivered

GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
As needed	As needed:	<u>Mandatory:</u> To confirm location in relation to a facility that provides inpatient institutional treatment (as described below).

The site is **not** on the grounds of a public institution in the same building a publically or privately operated facility that provides inpatient institutional treatment. This means it is not on the same property/property owned and operated by the inpatient institutional treatment facility. Inpatient institutional treatment includes all the settings listed above under definition of public institution as well as any private settings delivering inpatient institutional treatment such as a private mental health facility delivering inpatient care.

**If the site is in a building providing inpatient institutional treatment as described above, the standard is *NOT MET*.**

**1-3 The site is in a location other than immediately adjacent to a public institution.**

Memo to Providers: October 13, 2015 Subject: Communication to Providers on the Home and Community Based Settings (HCBS) Heightened Scrutiny Process and Requirements for certified settings where waiver services are delivered

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
As needed	As needed	<u>Mandatory:</u> To confirm that the site is in a location other than immediately adjacent to a public institution (as described below).

The site is **not** immediately adjacent to a public institution or former public institution.

Immediately adjacent means that the setting/site is next to and abuts, *but is not on the grounds of*, the public institution. See definition of public institution in number 1. "Abuts" means that the setting/site property is contiguous or touching the public institution's property with no intervening parcel of land between the two settings/sites.

If an IRA or Day Program site delivering HCBS Waiver services (e.g. Day Hab, Certified Prevoc) is adjacent to any of the following examples of Public Institutions this item would be "NOT MET" and trigger heightened scrutiny:

- State operated Developmental centers and former Developmental Centers
- State operated ICFs are also considered public institutions
- State run psychiatric centers
- State run addiction treatment centers
- Public nursing homes
- Prisons
- Private, in-patient mental health facilities

**If the site is immediately adjacent to a public institution as described above, the standard is *NOT MET*.**

1-4 The home meets the following description: It did not convert from an ICF on or after March 17, 2014.

Memo to Providers: October 13, 2015 Subject: Communication to Providers on the Home and Community Based Settings (HCBS) Heightened Scrutiny Process and Requirements for certified settings where waiver services are delivered

GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<u>As needed:</u> <ul style="list-style-type: none"><li>• Program and/or administrative staff with knowledge of site conversion</li></ul>	<u>As needed:</u> <ul style="list-style-type: none"><li>• QA System for history of program and conversion</li></ul>	<ul style="list-style-type: none"><li>• NA</li></ul>

The site is **not** a former ICF that converted to another program type **on or after March 17, 2014**.

Any setting/site that was formerly an ICF, on or after March 17, 2014, is subject to heightened scrutiny.

**If the site had been an ICF, but converted to a program providing HCBS Waiver services (e.g., IRA, Day Hab, Pre-Voc site) anytime between March 17, 2014 and the date of your visit, the standard is *NOT MET*.**

**1-5 The site is located apart from other certified facilities. *It is not part of co-located and/or clustered programs/sites that are operationally related resulting in the isolation from and/or inhibition of 1-5 interaction with the broader community.***

Memo to Providers: October 13, 2015 Subject: Communication to Providers on the Home and Community Based Settings (HCBS) Heightened Scrutiny Process and Requirements for certified settings where waiver services are delivered

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<ul style="list-style-type: none"> <li>• Site staff, individuals, family regarding:               <ul style="list-style-type: none"> <li>○ operations aligned with other sites</li> <li>○ services and activities of individuals</li> </ul> </li> </ul>	<p><u>As needed:</u> Agency Profile in QA database to identify proximity to other agency sites if not already known</p>	<p><u>Mandatory:</u> To confirm that the site is not isolated or likely to be stigmatized or by clustering or close proximity to other agency programs/sites and their operations (as described below).</p>

The site is **not** part of a group of multiple settings co-located and/or clustered and operationally related, that results in isolation or inhibiting community interaction.

A cluster is a grouping of two or more settings in the same vicinity/geographic location in which predominantly people with ID/DD and/or people receiving Medicaid HCBS are served. Co-located settings are those that are located on the same address/property, whether different floors or units within the same building or different buildings on the same property, where predominantly people with ID/DD and/or people receiving Medicaid HCBS are served. ***The key element of concern is whether these co-located or clustered sites have the effect of isolating/segregating people with disabilities or people receiving Medicaid HCBS from the broader community.***

**Classic examples of clustered and co-located sites:** The following are examples of settings/characteristics triggering heightened scrutiny where the standard would not be met.

- The setting is situated on a private campus where there are multiple group homes and/or facilities only for people who have disabilities and/or receive Medicaid HCBS **on the same provider's property** (e.g., a private community, campus, or village specifically for people with ID/DD and/or people who receive Medicaid HCBS).

- A “campus” does not necessarily need to be labeled as such by the agency, but may be any grouping of certified and non-certified residences and facilities purposed to provide services to the disabled, in a designated space, that may or may not include buildings associated with the administration of the agency/services.
- While not on the same tract of land, sites close by, such as across the street or a few doors down the street, and operated by the same agency, policies and administration should be considered clustered/co-located with the other sites.

The setting/site is collocated with other settings/sites/facilities for people with disabilities (e.g., group home located **on same property** as a day habilitation facility; group homes located **on same property** as administration building of the agency; group homes clustered/collocated congregating a large number of people with developmental disabilities; day settings co-located with other service types such that people who participate do not leave the site or participate in broader community) **to the extent that interaction with the broader community is inhibited and/or people are isolated from the broader community.**

- An apartment building/complex where **only** people with disabilities live
- A cul-de-sac with a cluster of only certified residences, set apart from a residential community
- A succession of IRAs on a street with no other residences nearby
- Sites that are co-located with administrative offices, day habilitation sites, article-16 clinics, workshops

The survey team would flag this standard as not met if the clusters of sites are separate and apart from other homes/businesses/organizations in the community, such that people with disabilities who live and/or engage in activities in and around these sites would be unlikely to run into/interact with anyone else in the vicinity other than people with disabilities or people receiving Medicaid HCBS.

For non-residential settings, heightened scrutiny would likely be triggered if service participants have limited or no access to the broader community or receive the majority of their non-residential supports in the same site/facility due to the collocation/clustering. For example, a Day Habilitation location collocated with an Article 16 Clinic and a Day Training/Prevocational setting where participants of the Day Habilitation setting do not go out in the community and spend their days either in Day Hab on site, in Prevoc on-site and/or attending Article 16 services (or some combination of these supports on any given day on site) would trigger heightened scrutiny. (Such settings would likely not meet HCBS settings standards.)

There may be communities where there are several sites for people with disabilities co-located or clustered in the same vicinity; however, if other homes, businesses, entertainment, places of worship or organizations that are not exclusive to people with disabilities are in close proximity and used by individuals it is not likely that these clustered/collocated sites would be subject to heightened scrutiny, because the vicinity of these settings is integrated, rather than isolating. Availability of sufficient transportation, public or private arrangements is also a consideration when determining whether sites are subject to heightened scrutiny.

A very rural setting may not provide the same access to community resources, compared with a more urban setting; however, that more limited access also affects people without disabilities who live and work in those settings. **The key to analysis used to determine the need for heightened scrutiny lies in the phrase, “to the same degree of access that non-disabled people have to their local community”.**

**Additional Considerations to determine collocations analyze the following factors in combination:**

- Consider Proximity:
  - Nearness of one certified site to another certified site
  - Shared property lines, shared driveways or parking
  - When you walk out the door of one house how close are the other certified sites or agency properties in your line of vision? Are they the only sites you see?
- Multiple certified sites under one roof: e.g. IRA and Day hab
- Consider the nature of the collocation/cluster:
  - Number of sites
  - Size and appearance of sites
  - Sites near each other & blending into a neighborhood/community vs. sites near each other & distinct and separate from community homes and services/businesses
- Consider how the broader community would perceive the group of sites
  - Does the nature of their collocation result in identification by the neighborhood or general public as “different” or do they blend into the rest of the neighborhood?
  - Do the clustered sites have an appearance that sets them apart unfavorably from typical residences or businesses in the area?
- Are the sites operationally-related, sharing staff, transportation, day program services, etc. which may result in the collocation also resulting in an isolating or institutional situation

**Sites that *should not* be identified as clustered or collocated *unless* isolation or institutional qualities are evident**

- Small apartments scattered throughout a building/complex that also has apartments of people without disabilities. The appearance and operations of the sites do not set them apart from other apartments in the building/complex.
- The people living in the apts./townhouses/small homes have some level of independence in and out of their home. People are accessing the community when they want.
- Staffing is intermittent. (Not meant to indicate that supervised must be deemed collocated.)
- Settings are intermingled in the neighborhood among other non-certified homes
- Other homes or businesses used by the general public and people not receiving waiver services are in close proximity

If the site is co-located or part of a cluster and this results in inhibiting interaction

1-6 The site's design, appearance and location is not institutional and does not isolate people from the broader community.

Memo to Providers: October 13, 2015 Subject: Communication to Providers on the Home and Community Based Settings (HCBS) Heightened Scrutiny Process and Requirements for certified settings where waiver services are delivered

GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
To explore possible operational factors that may or may not isolate. Interviewees include: <ul style="list-style-type: none"><li>• Program Staff</li><li>• Individuals receiving services</li><li>• Families &amp; advocates</li></ul>	As needed: <ul style="list-style-type: none"><li>• Community activity records</li><li>• Communication log</li><li>• Personal allowance records</li><li>• Site specific plan for protective oversight</li></ul>	<u>Mandatory:</u> To confirm that appearance, design, & location is not institutional and does not isolate (as described below).

If any of the following factors are present, the standard **would be NOT MET:**

- The setting/site is clustered (i.e., adjacent to, in close proximity to) other settings/sites for people with disabilities such that the cluster isolates people with disabilities and/or inhibits people from interacting with the broader community (see above guidance to number 5).
- The setting is designed to provide people with disabilities multiple types of services and activities on the same site (e.g., housing, day services, medical, behavioral, therapeutic, and/or social and recreational activities); (i.e. **people with disabilities have little to no interaction/experiences outside of the setting**); resulting in limited autonomy and/or regimented services.
- People in the setting have limited if any interaction with the broader community (i.e., the setting is set up and operated in such a way that people with disabilities have limited or no interaction/experiences outside the setting, regardless of the settings location).
- The setting/site appears to be more isolating than other settings in the same vicinity/neighborhood as the setting under review and/or CMS guidance has specifically mentioned the setting type as a setting presumed to isolate. For example:
  - setting is a gated community;
  - setting is a farmstead or disability specific farm community;

- setting is a residential school;
- setting has fencing, gates, or other structural items setting it apart from homes in the vicinity;
- setting is labeled by signage as a setting for people with disabilities, thus not blending with the broader neighborhood/community;
- setting is close to a potentially undesirable location (e.g., dump, factory, across the street from a prison or other institutional setting, etc.) that is isolating and/or inhibits people from interacting with the broader community;
- setting has video camera surveillance: This is a factor as it may indicate additional security measures different from those of typical residences in the community. This is different from security systems periodically or routinely used in residences/residential neighborhoods through local cable or digital security companies.

Weigh the day to day impact of the site's design, appearance and/or location on the individuals and the community response to the site, to determine if the site's design, appearance and/or location is institutional and isolating. Consider the following factors in that process:

Isolating Conditions, Institutional Practices:

- Not enough accessible transportation so that people are do not have community access.
- Individualized interests/activities are not supported. People are not able to choose their own activities and receive support to participate.
- People go out in large groups by design not by request.
- Activities are selected by staff or agency. For example, everyone is expected to attend the same day program, everyone goes out for coffee on Tuesday, etc.
- Transportation and staffing are shared among sites, resulting in limiting vs. expanding people's ability to make individual choices about activities/schedules.
- The agency/site has rules and restrictions about when and how often people can go out.
- Leisure activities and interactions involve only other people with disabilities and paid staff. For example, the agency offers on-site dances and other activities for only people with disabilities.

Institutional Appearance and Institutional Practices:

- The home looks and feels like an institution:
  - Rigid schedules, house rules
  - Access to areas denied, locked doors and cupboards (kitchen, linen and storage closets, exterior doors).
  - Individuals must ask staff for things rather than access themselves.
  - Staff space vs. home space

- Alarms, interior video surveillance, etc.
- Exterior signage identifying the home as other than a typical home
- Exterior appearance appears is that of a mini institutional facility. The site/home does not blend into the surrounding community/neighborhood.
- Institutional furniture and arrangement of home. “Day Room” vs. family room
- There is an array of services on site that lends to isolation and institutional effect
  - Examples:
    - Everyone receives on-site physician care rather than community medical services
    - Haircuts are given at the residence/day program
    - Religious services occur in the home rather than attending in the community
    - Clinical therapies are brought into the home consistently for everyone
    - Staff buy clothes for people rather than having them go out and pick for themselves or a “shopper service” delivers clothes to home
- Choice and Autonomy are limited:
  - Schedules in the house are not or varied with no variation or personal choice.
  - There are “house rules” and regimentation that impact the ability of people to choose what they want to do and when.

***When in doubt about the impact of collocation, isolation or institutional nature consider completing the rest of the protocol items related to HCBS setting requirements. By looking at more of the protocol, you will gather a fuller picture of whether or not the site is operating in a manner that is isolating and/or institutional.***

## SECTION 2

### HEALTH SUPPORT & MEDICATIONS

2-1 There is a written plan for how the facility will deal with life-threatening emergencies.

633.10(b)(2)(i-iii) There is a written plan specifying how the agency/facility will deal with life threatening emergencies. Such a plan shall address: (i) First aid; (ii) CPR; (iii) Access to emergency medical services.

GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
N/A	<u>Mandatory:</u> The actual written plan(s) describing how life-threatening emergencies are to be addressed	N/A

This standard assesses for a plan to address life threatening emergencies other than fire emergencies. Such emergencies may include medical emergencies, activation of CO detectors, and weather emergencies (e.g. tornado warning).

Review the facility's plan(s). Assess that it provides necessary information to include but not limited to:

- A communication system for the prompt contacting of emergency personnel in the event of the emergency
- A plan to evacuate the site, to include relocation if needed
- Plan to access emergency medical services
- Plan to address/provide CPR/First Aid as needed
- Prompt contacting of responsible agency personnel once the immediate needs of the individuals/site are addressed
- Assess whether the plan is likely to effectively handle the emergency.

**Select MET if:**        There is an acceptable plan.

**Select NOT MET if:**    There is NOT an acceptable plan.

## 2-2 Staff working know actions to take in the event of a medical emergency.

633.10(b)(3) OMRDD shall verify that staff have been made aware of their responsibilities in accordance with the agency/facility plan

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<u>Mandatory:</u> <ul style="list-style-type: none"> <li>DSP Staff re: understanding</li> <li>Management Staff prn regarding system to train staff in actions to take</li> </ul>	<u>As needed:</u> Staff training records specific to medical emergencies, if DISCUSSION raises concerns of staff understanding of actions to take.	Only if an event occurs during visit

Based on DISCUSSION of direct staff, verify that they are aware of the actions to take for life threatening emergencies per the written plan and the actions they describe are likely to be effective/are appropriate to the emergency. Ensure they understand their specific responsibilities including:

- The actions they are expected to take specific to the emergency: e.g. perform CPR (if trained), first aid and to access emergency medical services
- How to use the communication system for the prompt contacting of responsible agency personnel in the event of an emergency

If there are concerns regarding staff understanding, determine whether there is a system to train staff on the emergency plan(s) and if it was implemented.

#### Select **MET** If:

- Staff can effectively describe the actions to take in an emergency per the plan.
- If examples of emergencies were reviewed in routine survey activities and staff took appropriate actions in the emergency.

#### Select **NOT MET** if:

- Staff cannot effectively describe the actions to take in an emergency
- If examples of emergencies are were reviewed in routine survey activities and staff did NOT take appropriate actions.

**Qualifier Question:** The Day Service site provides nursing and/or delegated nursing services such as medication administration.

If Yes, answer 2a-1 through 2a-11

If No, go to Section 3

Guidance:

Protocol standards related to medication administration will apply to all residential facilities and will automatically be available for recording of findings.

This Qualifier Question allows you to identify non-residential programs where nursing/delegated nursing services are delivered. This includes day programs, Clinics, and IRA/FSRs.

**Select YES** if the day program, clinic or free standing respite staff:

- Administer medication and/or support individuals in medication administration
- Deliver supports to individuals related to their health diagnosis. Supports/services may be delivered by the registered nurse (RN) or delegated by and under the supervision of an RN

**Select NO** if staff or the day program, clinic or free standing respite site does not deliver nursing services/delegated nursing services such as medication administration or other health care procedures.

**2a-1 There is Registered Nurse on site or immediately available to staff rendering professional nursing services.**

633.17(a)(15)(i-ii); Any certified facility where delegated nursing services provided Supervision and monitoring of staff. (i) Medical or nursing supervision of those staff responsible for administering medication shall be provided. (ii) Supervision and monitoring shall be in accordance with agency/facility policies/procedures.

*FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

686.8(b)(1)(ii); (2); and (4); Certified Residences – 1 person capacity

*FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

ADM #2003-01 Certified Residences – 2 person or more **Professional Nursing Availability:** There shall be an RN available to unlicensed direct care staff 24 hours a day, 7 days a week. The RN must be either on site or immediately available by telephone. The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for an Individual and/or of changes in an Individual’s health status. *IRA, Apt, CR*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Ask DSPs providing nursing services whether an RN is available when needed, response time</li> <li>• RN re how this is ensured</li> <li>• What documentation is necessary</li> </ul>	<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Written plan for how to contact an RN when not on site.</li> <li>• Incident review may provide info on the implementation and effectiveness of agency mechanisms for 24/7 RN availability</li> <li>• Communication logs and prn note</li> </ul>	<p>Only if an applicable event occurs during visit</p>

The site/agency must have a mechanism to ensure an RN (or nurse practitioner- NP) is available to provide guidance to DSPs (including LPNs) with responsibility to deliver delegated nursing services. The mechanism must ensure response by a registered nurse within a reasonable time (30 minutes maximum). The mechanism should include expectations for documentation of the contact by both nursing and DSP staff.

Immediately availability may be through presence on site, telephone, or other verbal communication (e.g. skype, face time) at any time it may be necessary for staff to deliver delegated services. Services include but are not limited to medication administration, prescribed treatments, tube feeding, monitoring and care per Plans of Nursing Services (PONS); including notification requirements included in the person’s written plan. It

should be acknowledged that required medication, treatment, health care monitoring may be necessary at any time while the person is receiving services at the site/program. Therefore for residential program this will routinely require 24/7 coverage/availability. For other programs (e.g. day programs providing delegated nursing services, Free Standing Respite Sites) this would mean availability during hours of operation (days and time the site is delivering services). One reason for this is the ongoing responsibility of staff to monitor persons supported for both the expected effects of medications and treatments as well as adverse reactions.

Select **MET** if: DISCUSSION and documentation review indicate an effective mechanism to access an RN or NP at any time services are or are likely to be delivered.

Select **NOT MET** if: DISCUSSION and documentation review indicate that there is no mechanism or the mechanism is ineffective to guarantee RN/NP response to the requests for assistance/guidance.

**2a-2 DSP staff know how to contact the RN using the site/agency mechanism.**

633.8(b)(1)(viii); 633.8(b) Standards of certification. (1) OPWDD shall verify that employees, volunteers, and family care providers have received or will receive training within three months of initial employment, commencing volunteer activities, or initial certification as a family care provider. The training shall be on: viii) other appropriate topics relative to the safety and welfare as may have been specified by the agency. *FSR, IRA, Apt, CR, Day Training, Day treatment, Day Hab, Specialty Hospital, Private Schools, Certified Pre-Voc*

633.17(a)(15)(i-ii); 633.17 (a) (15) Supervision and monitoring of staff. (i) Medical or nursing supervision of those staff responsible for administering medication shall be provided. (ii) Supervision and monitoring shall be in accordance with agency/facility policies/procedures. *FSR, IRA, Apt, CR, Day Training, Day treatment, Day Hab, Specialty Hospital, Private Schools, Certified Pre-Voc*

633.4(a)(4)(x) No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion *FSR, IRA, Apt, CR, Day Training, Day treatment, Day Hab, Specialty Hospital, Private Schools, Certified Pre-Voc*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP staff re: how they contact the RN</li> <li>• DSP know what and where to document when RN is contacted</li> </ul> <p>As Needed:</p> <ul style="list-style-type: none"> <li>• RN to confirm or clarify information</li> </ul>	<p><u>As Needed</u></p> <ul style="list-style-type: none"> <li>• Agency required documentation when calling the RN</li> <li>• Incident review may provide info on staff knowledge of, use of and effectiveness of agency mechanisms for 24/7 RN availability</li> <li>• Communication logs and prn note</li> </ul>	<p>N/A</p>

Verify that site staff know how to contact the assigned RN or RN services to report health issues and/or request guidance on health care needs of persons supported. Their knowledge should include:

- How to seek RN services during routine agency business hours
- How to seek RN service “after-hours” per agency mechanism
- Agency required documentation by DSPs/site staff regarding contact with the RN

Select **MET** If: DISCUSSION (and documentation review if applicable) indicate staff understand how to contact RN/RN services at any time.

Select **NOT MET** if:

- DISCUSSION (and documentation review if applicable) indicate staff do not know how to contact the RN/RN service at any time.

Documentation reveals events which require RN notification, but it did not occur.

2a-3 Only a currently certified Direct Support Staff AMAP, LPN, RN, NP, PA or MD administers medications and/or prescribed treatments to individuals.

633.17(b)(5)(i-ii) All facilities where medications are administered.

*Clinic, FSR, IRA, Apt, CR, Day Training, Day treatment, Day Hab, Specialty Hospital, Private Schools, Certified Pre-Voc*

633.17 (b) (6) There is documentation that all medication being taken by a person residing in an OPWDD operated or certified facility or attending a nonresidential facility where medication is administered has been prescribed, ordered, or approved by a practitioner (except that in a supportive community residence, a family care home, or nonresidential facility, over-the-counter medication may be taken without a physician's prescription, order, or approval if the person taking the medications is capable of independent self-administration of medication).

*Clinic, FSR, IRA, Apt, CR, Day Training, Day treatment, Day Hab, Specialty Hospital, Private Schools, Certified Pre-Voc*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>PRN</u></p> <ul style="list-style-type: none"> <li>• RN and/or Site Supervisor:               <ul style="list-style-type: none"> <li>○ Determine staff titles passing medications (e.g. only DSP AMAPs or are LPNs or RNs/other qualified medical professionals administering or other me</li> <li>○ Regarding supervision and mechanisms to certify (especially if problems noted)</li> </ul> </li> <li>• Supervisors: regarding ensuring sufficient AMAP staff are scheduled/available</li> <li>• DSPs: if discovered to administer medications, do they understand AMAP requirements, knowledge of supervisor or RN of AMAP expiration, were they directed to pass meds despite knowledge of supervisor and/or RN</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• AMAP certification records</li> <li>• Medication Administration Records for past 6 months</li> <li>• Medication Errors for the past 6 months</li> </ul>	<p>NA</p>

**Review for at least one Person:**

- Review the documentation retained by the site/agency to evidence staff AMAP certification and certification for specialized care, and if applicable licenses of LPNs if also used by the site for medication administration.
- Review the six most recent medication administration records for at **least one individual** to verify that staff administering prescribed medications and treatments were/are qualified to do so, and it was appropriate to their job description. This can be done by verifying that only initials of qualified staff are evident.
- This may also include specialized certification for other prescribed care and treatments needed by individuals such as diabetic care/insulin administration, tube feeding, and catheter care. Additional specialized training/certification should be also be documented.
- Review Medication Error reports. Be alert to trends in staff member(s) making errors and if corrective action is taken to address staff performance.

Select **MET** If: Appropriately qualified staff and AMAPs with current certification are administering prescribed medications and treatments

Select **NOT MET if**: There is a pattern of administration of prescribed medications/treatments by unqualified staff. A pattern may be evidence of extended periods of time when staff administered with expired or no certification; or situations of multiple unqualified/uncertified staff administering medications and or treatments.

**2a-4 Individual's medications and treatments have been correctly administered per physicians' orders and his/her needs.**

633.17(b)(6); There is documentation that all medication being taken by a person residing in an OPWDD operated or certified facility or attending a nonresidential facility where medication is administered has been prescribed, ordered, or approved by a practitioner (except that in a supportive community residence, a family care home, or nonresidential facility, over-the-counter medication may be taken without a physician's prescription, order, or approval if the person taking the medications is capable of independent self-administration of medication).

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

633.17(a)(7) All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling.

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As Needed for Clarification</u></p> <ul style="list-style-type: none"> <li>• Site staff</li> <li>• RN</li> <li>• Individuals</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Medication Administration Records</li> <li>• Medication Prescriptions and/or Physician's orders</li> <li>• Bowel tracking records if applicable</li> <li>• Self Administration of Medication Assessment (SAM)</li> <li>• Medication Error reporting for past 6 months</li> </ul> <p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• Additional Health related documents such as PONS, physician consults, prn/health care notes</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Medication Packaging as compared to MAR and prescriptions/physician's orders.</li> <li>• Medication Cabinet.</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Observe a medication pass only if documentation review and DISCUSSION are insufficient to assess.</li> </ul>

**Review for at least one Person:**

**This standard is meant to assess that INDIVIDUALS RECEIVE MEDICATIONS/TREATMENTS AS ORDERED AND NEEDED.**

Determining whether people received the medications and treatments prescribed by the physician and needed by the person requires a review of documentation referred to above as well as comparison of the information among the various documents.

- Compare the current MAR with the physician's prescription/order. The MAR must accurately reflect the physician's order for the correctly identifying the correct medication, dosage, frequency, time/time of day if needed, administration method (e.g. p.o. (by mouth), topically, left eye, with 8 ounces of water, via nebulizer, etc.), and any other special instructions (e.g. 1/2 hour before meals, to crush, open capsule and add to food, vital signs or Blood Glucose Levels in certain range, etc.). If concerns, review/compare for previous months. This will also inform decision for the standard below.
- Review medications at the site in comparison to current physician's orders. Verify that all prescribed medication is available on-site in the correct dosage and form as prescribed and needed by the person. Medication should be in intact original medication packaging (e.g. bottle, blister pack) and correctly labeled per the order.
- Review MARs for the past 6 months.
  - Verify that medication had been administered and if not administered there is appropriate justification/explanation documented
    - Be alert to trends/frequency of irregularities in documentation such as blanks spaces where administration should be indicated.
    - Ensure that when not administered this is corrected and adequately indicated on the MAR. Most often this is indicated by a circle in the space where initials would indicate administration with explanatory note on the back of the MAR. There may be acceptable reasons for MARs to reflect non-administration such as the person visiting family, physician's instruction to hold a medication if vitals are not within certain parameters; or refusals by the person. (Note: persistent problems with administration should be reviewed and addressed.)
    - If medication/treatment orders require assessment, such as pulse or B/P or blood glucose level (BGL), prior to administration, verify that this has been completed and documented. Medication administration is incorrect if the assessment required prior to administration has not been completed.
    - When bowel medications are prescribed bowel tracking is required. See below. Reference to information such as bowel movement tracking, may be required to determine if and when medication administration is necessary.
  - PRNs: Medications ordered "as needed" based on whether certain symptoms or conditions are evident for the person require review for correct administration. It is necessary to verify that:
    - PRN Medications are provided when the need for which it is prescribed is present (e.g. bowel management medications)
    - PRN Medications are administered only when necessary based on the prn order; and
    - There is documentation supporting the need for administration of the prn medication.

- Bowel movement tracking is required for any person prescribed routine or PRN bowel management regularity medications. Bowel tracking is necessary to determine the effectiveness of bowel regimens that may, in addition to medication include dietary, fluid, and activity interventions. A PONs may be in place consolidating all interventions related to bowel management.
  - When **prn** bowel management medications are prescribed a review of the BM tracking record must be reviewed to verify that medications to be administered in the absence of BMs are administered when required (e.g. administer on 3<sup>rd</sup> day without BM).
  - BM tracking records should also be reviewed for bowel regularity and appropriate health care if issues are identified. This will be further addressed in a standard below. If these records are not kept and used to effectively manage a person with bowel irregularity, serious health consequences may occur, even death. Poorly controlled constipation can contribute to pain, anxiety, and poor appetite.
- Medications should not be pre-poured, meaning that they should only be prepared from packaging to format for administration, at the time of administration. If you observe small cups of poured medications in the med cabinet or med room, ask questions about the practice (why, how prevalent). Pre-pouring creates risk of wrong administration, especially to the wrong person.
- The site/agency must implement procedure to report and review medication errors when/if they occur.
- Review Medication Error reports. Be alert to trends in staff member(s) making errors and if corrective action is taken to address staff performance, Individual orders or particular medications that seem to result in errors, certain med pass times that have more errors. Determine whether site/RN is aware and corrective/preventive actions taken.
- It is not mandatory that you observe a medication pass but may choose to do so if you have concerns about proper administration that cannot be verified in other ways.

Select **MET** If:

- There is evidence of correct administration of routine and prn medications as prescribed and needed by individual(s); AND
- Medication errors are reported, documented and competently addressed

Select **NOT MET** if:

- There is evidence of patterns of incorrect medication administration to individual(s); OR
- Medications errors are not reported; OR
- Medication errors are not adequately remediated

2a-5 Medication Administration Records (MARs) are legible, correctly identify the current physician’s orders/prescriptions and required documentation of administration.

633.17 (b) (3)(i-iv)

Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains:

- (i) name of the person;
- (ii) name of medication, dosage, and route of administration;
- (iii) time and date of administration; and
- (iv) signature or initials of the party who supervised, assisted or administered the medication; or of the person who independently self-administered medication. If initials are used, there is a corresponding signature sheet.

*Clinic, FSR, IRA, Apt, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

633.17(b) (4)(i-ii)

(i) there is a record as specified in paragraph (3) of this subdivision; or (ii) for persons who are capable of independent self-administration, there is documentation of the supervision provided by the agency/facility to ensure that the person is taking medication as required.

CR

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<u>As Needed for Clarification</u> <ul style="list-style-type: none"> <li>• RN</li> </ul>	<u>Mandatory:</u> <ul style="list-style-type: none"> <li>• MAR(s)</li> <li>• Copy of doctor’s order ( may be handwritten or electronic)</li> </ul>	

**This standard is meant to assess that MARs contain accurate information about the order, and accurately and clearly document administration.**

**Review for at least one Person:**

- Compare the current MAR with the physician’s prescription/order. The MAR must accurately reflect the physician’s order for the correctly identifying the correct medication, dosage, frequency, administration method (e.g. p.o. – by mouth, topically, left eye, with 8 ounces of water,

via nebulizer, etc.), and any other special instructions (such as to crush, open capsule and add to food, etc.). If concerns, review/compare for previous months. This will also inform decision for the standard above.

- The MAR should include:
  - name of person receiving the medication;
  - name of medication, dosage, and route of administration;
  - time/time of day and date of administration; and
  - signature of the party who supervised, assisted or administered (or initials that correspond to those on a signature sheet)
- Review the MAR for accuracy, legibility and the absence of illegible cross-outs, erasures, or use of 'white-out'.
- There should be documentation of the effectiveness of a prn medication following its administration to the person

Select **MET** if ALL are evidenced:

- The physician's order is correctly transcribed to the MAR AND
- Documentation necessary to evidence administration is present & legible including pre-assessment (vital signs, O<sub>2</sub> levels, BGLs, etc.)
- Effectiveness of prn medications is documented

Select **NOT MET** if ANY of the following are present:

- The physician's order is incorrectly transcribed to the MAR AND/OR
- Documentation necessary to evidence administration is absent/incomplete/illegible
- Documentation of pre-assessment is not consistently present
- Effectiveness of prn medication is not documented following administration

**2a-6 Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.**

633.17(b)(9) For the safety of the people residing in or attending a facility and as a support to those staff who have medication administration related responsibilities, there shall be information specific to each person on all medications to be administered to that person while at or under the supervision of the facility and its staff. The sponsoring agency shall ensure maintenance of this information for people in family care homes and provide the information to the family care provider. For each medication a person is taking, this information shall include: (a) name of person taking the medication; (b) name of medication; (c) directions with regard to correct dose, form, method/route of administration, time of administration; (d) start and stop dates, if applicable; (e) expected therapeutic effects for the person taking the medication; (f) possible side effects to the person taking the medication; and (g) name of prescribing, ordering or approving practitioner

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633.17(a) (17) (iii) For the safety of the people residing in or attending a facility and as a support to those staff who have medication administration related responsibilities, there shall be information specific to each person on all medications to be administered to that person while at or under the supervision of the facility and its staff. The sponsoring agency shall ensure maintenance of this information for people in family care homes and provide the information to the family care provider. For each medication a person is taking, this information shall include:

- (a) name of person taking the medication;
- (b) name of medication;
- (c) directions with regard to correct dose, form, method/route of administration, time of administration;
- (d) start and stop dates, if applicable;
- (e) expected therapeutic effects for the person taking the medication;
- (f) possible side effects to the person taking the medication; and
- (g) name of prescribing, ordering or approving practitioner

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**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As Needed for Clarification</u></p> <ul style="list-style-type: none"> <li>• RN</li> <li>• Individuals receiving services that are self-medicating</li> </ul>	<p><u>Mandatory:</u> Review document(s) pertaining to each medication prescribed to each Individual receiving services This info may be provided differently per agency. Common methods are:</p>	

- |  |  |  |
|--|--|--|
|  | <ul style="list-style-type: none"> <li>○ use of Medication Information Forms</li> <li>○ inclusion on the MAR</li> <li>○ Pharmacy med information sheet may be used only if adapted and supplemented to provide only the information specific to the individual</li> <li>○ Referral to a Medication Formulary Book is not acceptable</li> </ul> |  |
|--|--|--|

**Review for at least one Person.**

Easily accessible, individual-specific, written information on intended effects and possible side effects for all prescribed medications, including OTC's must be available to staff. (E.g. if a medication is may or is known to cause noted drowsiness in a person supported, that should be noted here, for staff to respond accordingly.) This information must be available for all medications prescribed for the person, including prns and over the counter medications.

For each medication a person is taking, this information needs to include:

- name of person taking the medication;
- name of medication;
- directions with regard to correct dose, form, method/route of administration, time of administration;
- start and stop dates, if applicable;
- based on his/her individual health profile:
  - expected therapeutic effects for the person taking the medication,
  - possible side effects to the person taking the medication
- name of prescribing, ordering and/or approving practitioner

This info may be provided differently per agency. Common methods are:

- use of Medication Information Forms
- inclusion on the MAR
- Pharmacy med information sheet may be used only if adapted and supplemented to provide only the information specific to the individual
- Referral to a Medication Formulary Book is not acceptable

Select **MET** if:

- The physician's order is correctly transcribed to the MAR AND

- documentation necessary to evidence administration is present

Select **NOT MET** if:

- Physician's order is incorrectly transcribed to the MAR, OR
- Physician's order is missing from the MAR, OR
- There is a pattern of incorrect or inadequate documentation of medication administration

2a-7 Medications and treatments are stored securely as required, including the security of keys or codes to access medications.

633.17(b)(10) OPWDD shall verify that, except in a supportive community residence or a family care home, all medication is kept in a secure, locked storage area; and controlled substances and syringes and needles are kept in a double locked storage area (unless all persons residing at the facility are capable of independent self-administration of medication, in which case the controlled medication is kept in a locked area or container).

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633.17(a)(19)(ii) Safe, secure, appropriate, and adequate storage space shall be provided. (a) Other than in a supportive community residence or a family care home, medication shall be kept in a secure, locked storage area. (b) Persons who are capable of independent self-administration of medication may have their medication stored so as to be personally accessible to themselves and staff who are currently certified to administer medication, those who are health care professionals and family care providers, or their substitutes, if such a procedure does not expose other residents to harm. (c) Other than in a supportive community residence or a family care home, medication stored in a refrigerator containing food shall be placed in a separate locked container clearly marked to indicate that it contains medication. (d) Other than in a supportive community residence a family care home, or as specified in clause (e) of this subparagraph, all medication packaged and labeled by the issuing pharmacy as a "controlled substance," and syringes and needles, shall be kept in secure, double-locked storage unless all persons in the residence are capable of independent self-administration of medication, and such a procedure does not expose other residents to harm. In family care homes, controlled substances and syringes and needles shall be kept in locked storage. (e) In all facilities other than supportive community residences, when all persons in the residence are capable of independent self-administration of medication, a controlled substance, syringes, and needles shall be stored in a locked area or container so as to be accessible only to the person for whom it was prescribed, staff who are currently certified to administer medication or who are health care professionals, and family care providers or their substitutes.

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633.17(a)(7) All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling.

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GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
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<ul style="list-style-type: none"> <li>• AMAP(s)</li> </ul> <p><u>Optional:</u></p> <ul style="list-style-type: none"> <li>• Individuals who are self-medicating in group settings with non-self-medicating individuals</li> </ul>	<p>As Needed: The following may reveal practices evidencing inadequate medication security:</p> <ul style="list-style-type: none"> <li>• Review of medication error documentation</li> <li>• IRMA/Incident Reports</li> <li>• Communication Logs</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Observe medication storage area</li> <li>• Observe as opportunity presents, access to and security of medications</li> <li>• Observe as opportunity presents, staff handling of/access to key to medication storage when used</li> </ul>
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- Medications need to be stored as follows:
  - In the original, clearly labeled containers, in which they were received
  - In adequate, locked, safe and secure space
  - Medications requiring refrigeration need to be in either:
    - Locked refrigerator used for medications only
    - Or refrigerator is shared for other uses, in a storage device that is separately locked and labeled as containing medication
  - personally accessible space (which is inaccessible by peers) for persons who are capable of independent, self- med administration
  - Medication packaged and labeled by the issuing pharmacy as a “controlled substance,” and syringes and needles need to be stored in a secure, double-locked area unless all persons in the residence are capable of independent self-administration of medication and this procedure does not expose other residents to harm
- Keys to medication storage areas must only be available to staff who are authorized or certified to administer medications, including specific medical professionals and AMAP certified staff.
- When all persons in the residence are capable of independent self-administration of medication, a controlled substance, syringes, and needles must be stored in a locked area or container so as to be accessible only to the person for whom it was prescribed, staff who are currently certified to administer medication or who are health care professionals, and family care providers or their substitutes
- Medication removed from a storage area, it is never to be left unattended by the certified medication administration staff

Select **MET** if ALL of the following are present:

- Medications and Medication Storage areas are observed to be secured/locked/inaccessible to non-AMAP staff and individuals who are not self-medicating AND

- Security of the means of access to the medication storage area/cabinet is maintained. I.e. Keys are retained on AMAP's person or secured in an inaccessible space; combination locks to access med areas or med keys are known only to nurses and AMAP staff.

Select **NOT MET** if ANY of the following are present:

- Medication cabinets are open and unattended, unlocked, and/or accessible to individuals and non- med certified staff
- Pills, treatments or medication bottles are observed unattended by nurse or AMAP
- Non-AMAP staff are observed to access med storage rooms/cabinets
- Keys or combinations meant to secure medications are accessible to other than medical staff and AMAPs.

## 2a-8 Medication that is discontinued or outdated is not retained at the site.

633.17(b)(13) & (14): (13) OMRDD shall verify that there are no outdated medications in designated medication storage areas in the facility. (14) OMRDD shall verify that there are no discontinued medications in designated storage areas in the facility, unless a prescribing practitioner has specifically instructed that a medication be retained for possible future use; or the agency/facility, under the Department of Health dispensing license, is waiting for authorization from the Department of Health to destroy the medication.

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### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
As needed with RN and/or AMAPs re: handling of discontinued and outdated medications and treatments.	Mandatory: MAR, Medication orders; As Needed: Physician's consults	Review of medication storage area(s)

### **Review for at least one Person.**

- Outdated medication refers to medications and treatments that have an “expiration” date, use by date, and discard date. When reviewing medications for other purposes in the survey take note of such dates on medication bottles, tubes, boxes, etc.
- Discontinued medication/treatments refers to those that are no longer prescribed and/or the person is no longer taking. Current medication prescriptions/orders and accurate MAR are references to identify medications that are currently needed by the person. Medications not currently taken by the person may be retained if there are on hand, specific instructions from a prescribing practitioner to do so.
- If outdated or discontinued medications/treatments are discovered, DISCUSSION staff (AMAPs) and RN if needed to determine agency procedures of disposal and staff understanding of the procedure.

Select **MET if ANY** of the following are present:

- No outdated or discontinued medications/treatments are present

- If there is discontinued medication present it is an anomaly, there is no pattern of retention of discontinued medications, and any discontinued medication is separate from routinely administered current medications/treatments.
- If there is outdated medication present, it is not pervasive (there are only 1-2 examples) and/or the expiration date is within the past 2 months.
- Staff understand the procedures for removal of outdated/discontinued medications and any of the 3 conditions are above.

Select **NOT MET if ANY** of the following are present:

- There is a pattern of retention of discontinued/outdated medications/treatments as evidenced by discovery on site (pattern described as anything other than “anomalies” described above
- Facility staff do not know what to do with medications/treatments when they are discontinued/outdated.
- Agency processes do not address or do not adequately address removal of discontinued/outdated medications/treatments

## 2a-9 Used needles and syringes are disposed in puncture resistant containers.

633.17(a)(20)(iii) Needles and syringes. All needles and syringes are to be placed in puncture resistant containers immediately after use. When filled, the container should be taken or sent to an approved site for incineration. The disposal shall be documented.

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### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<ul style="list-style-type: none"> <li>• RN as needed</li> <li>• AMAPs</li> </ul>		If applicable (needles & syringes are on sight even infrequently for vaccines, bloodwork, etc.), observe disposal receptacle

All needles and syringes are to be placed in leak proof, puncture resistant containers immediately after use. The container should be designed to prevent easy removal of the items from the container.

When filled (approximately 2/3 full by accepted practice), the container should be taken or sent to an approved site for incineration. Staff DISCUSSION about this process and policy/procedure review should validate compliance.

Select **MET** if the following are present:

- There is an appropriate disposal container for needles/syringes
  - Full containers are not on site for extended time periods
  - Needles/syringes are disposed of properly using disposal container/There are no observed inappropriate disposal needles/syringes
- OR
- There is no need for disposal of needles/syringes on site

Select **NOT MET** if ANY of the following are present:

- Needles/syringes are not disposed of properly
  - Not in appropriate container
  - Full containers retained on site

**2a-10 The site ensures that individuals access professional health care services per their needs, physician recommendation and informed choice.**

633.4(a)(4)(x) No person shall be denied appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion

*IRA, CR, Apt, Specialty Hospital, Private School*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<ul style="list-style-type: none"> <li>• RN</li> <li>• Staff members</li> <li>• Individuals receiving services</li> </ul>	<ul style="list-style-type: none"> <li>• Request all records the facility uses to document evaluation planning, provision, and receipt of health care services. Agencies have different mechanisms. This may include physician consults, prn notes, nursing notes, Individual progress notes</li> <li>• Communication log</li> <li>• Prn notes as needed</li> <li>• IRMA/Incidents Reports</li> </ul>	

**Implement in RESIDENCES ONLY – This standard intends to verify that individuals see a doctor/practitioner/dentist/specialist when needed and recommended, and undergoes recommended testing, evaluation, blood work as needed.**

**Review for at least 1 person.**

- Through record review, DISCUSSION, and observation verify that the individuals is supported to access medical assessment and treatment for acute and emerging illness and symptoms.
- Through record review and DISCUSSION, ensure that the individual is attending all required and recommended appointments for routine care and monitoring and chronic conditions if any. This includes primary physician/nurse practitioner/physician’s assistant, specialists (as needed), dentist and clinicians (as needed).

- Verify that recommendations made by health care practitioners for appointments with specialists, lab work and diagnostic tests are completed and implemented.
- If an individual is not accessing the necessary health care services take action to determine contributing factors. E.g. facility tracking and monitoring of needed appointments, scheduling practices for needed appointments and assigned responsibility, RN oversight, etc.
- Cancelled appointments by practitioner, person, or facility are documented with reason and are rescheduled.
- Consider whether the person is documented, reported or observed to have a chronic condition that is not improving. Review whether advocacy for health care and further assessment is occurring.
- NOTE: individuals may make an informed choice to refuse an appointment, treatment, evaluation, medical test, etc. If the reason a person is not accessing needed profession medical services routinely is reported due to refusal:
  - speak to the person (and advocate as needed) to determine that this is an informed choice, that they have received clear information about their health issues and understandable information about the risks and benefits to recommended medical oversight and services.
    - Speak to facility RN or other health care professionals and review documentation regarding agency actions to review risks, discuss alternate solutions, and communicate clearly with the individual. This should include a review of the risk to the person presented by refusal; and efforts taken to educate the person regarding their health issues and need for services.

Select **MET** if two of the following are present:

- There is evidence that individuals are supported to access emergency departments and/or medical appointments for acute and emerging symptoms of illness or injury
- The person(s) is receiving professional medical care and assessment according to their needs, diagnosis and professional recommendations (medical appointments with physicians/practitioners, dentist, lab work & other testing as needed).
- The person is not participating in professional medical care and assessment appointment due to verified informed choice and agency regularly reviews options, information, risks and outcomes with the person.

**Note:**

- Use surveyor judgement regarding the impact a missed or delayed appointment may have on a person's health outcomes when determining MET or NOT MET. For example, if facility routinely ensures that professional health care is received appropriately by the individual sampled except for an unscheduled/delayed podiatry appointment, surveyor judgment may determine the standard is MET. However if the facility did not ensure that an individual received a necessary medical test, procedure, or appointment, that if missed increases the individual's risk of harm the standard may be NOT MET.

- An Individual's informed decision to not follow-through on recommended medical appointments or testing should be honored, so long as there is evidence of the person's informed decision making and due diligence in risk planning to support the person to the degree accepted by the individual.

Select **NOT MET** if:

- The person(s) is NOT receiving professional medical care and assessment according to their symptoms, needs, diagnosis and professional recommendations (medical appointments with physicians/practitioners, dentist, lab work & other testing as needed)
- The person's health is declining in health without explanation and/or without assessment by health care professional other than the RN. Individuals demonstrate chronic conditions without improvement
- Refusals to access medical care is not based on informed choice and conscientious discussion of risks and choice has not occurred.

2a-11 The site ensures that in-home, routine support/care necessary for individuals' health needs is provided per their service plan.

633.4(a)(4)(x) No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.

*IRA, CR, Apt, Specialty Hospital, Private School, Clinic*

633.10(a)(2)(iii) For the safety of the people residing in or attending a facility and as a support to those staff who have medication administration related responsibilities, there shall be information specific to each person on all medications to be administered to that person while at or under the supervision of the facility and its staff. The sponsoring agency shall ensure maintenance of this information for people in family care homes and provide the information to the family care provider. For each medication a person is taking, this information shall include: (a) name of person taking the medication; (b) name of medication; (c) directions with regard to correct dose, form, method/route of administration, time of administration; (d) start and stop dates, if applicable; (e) expected therapeutic effects for the person taking the medication; (f) possible side effects to the person taking the medication; and (g) name of prescribing, ordering or approving practitioner.

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<b>DISCUSSION:</b>	<b>DOCUMENTATION REVIEW:</b>	<b>OBSERVATION:</b>
<ul style="list-style-type: none"> <li>• RN</li> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul>	<ul style="list-style-type: none"> <li>• Individual health care records</li> <li>• Staff training records specific to Individuals' health care</li> <li>• ISP (all referenced health care documents)</li> <li>• IPOP</li> <li>• PONS</li> <li>• MARs</li> <li>• IMRA/Incident Reports</li> </ul>	<ul style="list-style-type: none"> <li>• As possible during observation, ascertain whether documented health care interventions to occur on site are provided.</li> </ul>

## Review for at least 1 person

**Implement in RESIDENCES ONLY** – This standard intends to verify that individuals are receive needed routine health care interventions and/or are supported to attend to their own routine care.

Through record review, DISCUSSION of staff and individual/advocate, and observation, validate that staff competently provide all needed and/or routine health care supports per plan and prescription. Review health care records to assure that:

Verify that the person's need for routine daily health care is documented and there is written instruction on how to support the individual. The person's service plan should include and document, the necessary and appropriate health related services and supports (paid and unpaid). The service plan includes associated plans (e.g. PONS, PT guidelines, and diet order). THE MAR may also include specific interventions, treatments, monitoring and care the person needs in their routine life to maintain or gain health.

Before the visit, review IRMA to ascertain if any unmet medical or health needs resulted in reportable or significant incidents at the site. Follow up on any corrections made to prevent future health problems

Through documentation review, DISCUSSION and observation determine if the person is maintaining or improving in health. If a person's health is declining, determine if interventions have been sought and received. Ensure there is demonstration for advocacy for assessment by the RN or other HC professional.

DISCUSSION direct support staff, nursing and management staff about their knowledge and provision of support of Individuals' health care needs. Ask the individual if they believe competent and desired health care supports are being provided to assist him/her to feel his/her best.

Provision of health related services must be documented. Review that the person receives ordered and/or needed interventions and support. Interventions may be the responsibility of a DSP or a nurse. Review for implementation of all needed care/support.

Examples include but are not limited to:

- RN is contacted/notified per service plan or PONs as warranted by the person's health, conditions, vital sign parameters
- Bowel management regimens are implemented correctly
- BM tracking records kept for people with history of constipation and/or on bowel mgmt. medication(s). Review of "regularity" per written plan/PONs and implementation of interventions when required. Poorly controlled constipation can contribute to pain, anxiety, poor appetite, and serious health concerns, even death.
- Administration of oxygen
- Blood pressure monitoring

- Assistance with needed equipment, braces, hearing aids, glasses, needed by the person
- Ensuring dietary requirements and interventions related to health are followed
- Diabetic care and monitoring is provided per PONs and medical orders
- Care and support required following injuries, surgery or hospitalization
- Instructions related maintenance of skin integrity such as routine positioning, bathroom support, and documentation of skin condition
- Colostomy care or catheterization

If omissions in care are noted, review staff training records to ensure that staff have been instructed to provide individualized health care supports (e.g., PONS trainings).

NOTE: Review of Health Care delivery identified in Section 10 may inform decisions in review of this standard.

**Select MET if:**

- Documentation, observation and DISCUSSION indicate Individuals receive necessary care and supports in their day to day life related to their health and health care needs

**Select NOT MET if:**

- Documentation, observation and/or DISCUSSION indicate Individuals DO NOT receive necessary care and supports in their day to day life related to their health and health care needs and plan

## SECTION 3 PERSONAL FUNDS

General Instruction: The Personal Funds standards determine whether: Individuals have access to and receive Personal Allowance (PA) monies; Individuals are supported to spend their money as they choose; PA funds are safeguarded and accounted for; and, expenditures made with PA funds are appropriate. A day programs/non-residential provider that accepts responsibility for handling personal allowance monies transferred to it by a residential facility for a person's use are also responsible for appropriate management, security and accounting for the funds.

**3-1 Personal Allowance money is consistently available to individuals for routine expenditures and recreational activities.**

633.15(k)(1) Present allowance funds shall be made readily accessible to the person.  
*IRA, CR, Specialty Hospitals, Private School*

**GUIDANCE:**

<b><u>DISCUSSION</u></b>	<b><u>DOCUMENTATION REVIEW</u></b>	<b><u>OBSERVATION</u></b>
<u>Mandatory:</u> <ul style="list-style-type: none"> <li>• Residential staff</li> <li>• Individuals</li> </ul>	<u>Mandatory:</u> <ul style="list-style-type: none"> <li>• Personal expenditure ledgers</li> </ul>	<u>Mandatory:</u> <p>Cash on hand at the home</p>

- Funds available should be in accordance with individual’s routine expenditure and/or the requests of the individuals or staff/family on their behalf.
- Review ledgers and cash on hand to assess that funds are kept at the residence in order to meet a person’s day-to-day and incidental needs and preferences.
- If agency policy is to keep minimal funds on-site, but it is compensated with procedures to access funds at ATM as part of the activity or make payment for activity or purchase using a debit card, this can also meet the intent if having personal allowance consistently available. In this case verify that the debit account is maintained with adequate funds.
- Through interview with staff and individuals verify that sufficient amount of money is available to them when they need and want it, and they are satisfied with the effectiveness of the home’s money disbursement system.

- It is not the expectation that funds be immediately at hand for major expenditures, but rather this addresses that there is enough personal allowance money to allow for impromptu recreational activities, dining out and shopping, etc.
- Reports of repeat occasions of limited or no funds on-site would require further inquiry into the agency practices for distribution of PA funds to individuals.

Select **MET** if :

- Ledger and money count appear to indicate adequate funds at the residence to allow for the routine purchases and activities by the person.
- If applicable per agency policy/practice, debit accounts maintain sufficient funds to allow for routine purchases and activities by the person.
- Individual(s) report that money is available to do what they want and buy what they want routinely and spontaneously, and can give examples if applicable.
- Staff report that there are adequate funds for individuals to for routine and spontaneous purchases and activities and can give examples.
- Funds are low but there is evidence that additional funds are requested and expected on site/available within 24 hours.

Select **NOT MET** if:

- Funds on site are low and do not appear adequate for the person's routine weekly purchases and spontaneous requests/purchases/activities
- If applicable per agency policy/practice, debit accounts have insufficient funds to allow for routine purchases and activities by the person.
- If there is sufficient money available at time of review, but there appears to be a pattern of not ensuring that sufficient funds are maintained at the residence:
  - Ledger review indicates a pattern time lags before personal funds are replenished
  - Individuals report examples of occasions when he/she could not participate in activity or make a small purchase because funds were not available
  - Staff reports examples of occasions when individual(s) could not participate in activity or make a small purchase because funds were not available

**QUALIFIER QUESTION:**

Is any portion of the individuals personal funds held or managed by the site?

- **If Yes, answer questions 3a-1 to 3a-9**
- **If No, go to Section 4**

Guidance:

**Select YES** if: The residence or day program and its staff holds, secures and implements accounting for any part of a person's personal allowance funds.

**Select NO** if: Individuals and/or their family hold, manage and account for the personal allowance funds. Agency staff have no role in management of any individual's personal funds.

**3a-1 An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + \$20.**

633.15(h)(4)(iii) The personal expenditure plan shall specify an upper limit on the amount of cash that shall routinely be maintained under the control of staff at the residence for each resident. The routine upper limit specified in the PEP and/or the cash actually maintained at the residence for any individual shall not exceed the monthly personal allowance amount established in section 131- o of the Social Services Law for individuals receiving enhanced residential care (Congregate Care Level III), plus \$20. However, this routine upper limit may be exceeded by any amount, so long as documentation of the specific amount, time and purpose for the excess amount is included in the cash account record. Cash in excess of the routine upper limit for each resident may only be held at the residence for a period not to go beyond 14 calendar days.

*IRA, Apt, Specialty Hospital, and Private School*

**GUIDANCE:**

<b><u>DISCUSSION</u></b>	<b><u>DOCUMENTATION REVIEW</u></b>	<b><u>OBSERVATION</u></b>
<p>As needed</p> <ul style="list-style-type: none"> <li>• Individuals, family, advocates</li> <li>• Direct support and program management staff</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Personal allowance expenditure ledgers</li> <li>• PEPs and related materials if maximum is exceeded.</li> </ul>	<p><u>Mandatory:</u></p> <p>Cash on hand at the home, gift card value</p>

Through ledger review and count of funds conducted by facility staff (described above), ensure the total amount does not exceed the person's current monthly PA payment plus \$20 (except with documentation of the purpose of the excess amount and timeframe for expenditure). Short term (maximum two weeks) overages may be acceptable for known upcoming expenditures. Ask facility staff to explain the reason for the overage and their agency's expectations for monitoring the amount on hand and the timely return of excess funds to their account should plans for the expenditure change.

If unsure of the current congregate level III level, the information is available on the OPWDD website. Click through the following: *Resources > Benefits Information > Social Security & Supplemental Security Income > SSI Benefits Level Chart* (select the current year).

Select **MET IF ALL** of the following are present:

- Funds on site are within the allowed maximum

- Funds on site exceed the allowed maximum but it is short term and justified based on the planned purchase or use of the excess funds by the person
- Ledgers demonstrate that total cash on hand remains within maximum routinely

Select **NOT MET if either** of the following are noted:

- Funds on site exceed the appropriate limit by more than a very small amount, and there is no short term plan for the excess money
- Ledgers demonstrate a pattern of cash on hand exceeding allowed maximum

**3a-2 Personal funds held by the site are secured and safeguarded, accessible only to authorized employees.**

633.15(d)(3) Policies and procedures shall address, at a minimum: security; accountability of staff, volunteers, and/or family care providers; recordkeeping both on paper and electronically; usage; and monitoring of all personal allowance monies and other income of residences received by the agency. Policies and procedures shall include specific measures that will be taken to safeguard cash, including location maintained and restrictions on access.

*IRA, Apt, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

Quality Indicator: Policies and procedures shall address, at a minimum: security; accountability of staff, volunteers, and/or family care providers; recordkeeping both on paper and electronically; usage; and monitoring of all personal allowance monies and other income of residences received by the agency. Policies and procedures shall include specific measures that will be taken to safeguard cash, including location maintained and restrictions on access.

FSR

**GUIDANCE:**

<b><u>DISCUSSION</u></b>	<b><u>DOCUMENTATION REVIEW</u></b>	<b><u>OBSERVATION</u></b>
<p><b><u>Mandatory:</u></b></p> <ul style="list-style-type: none"> <li>• Direct support and program management staff – for their knowledge and practice of financial safeguards</li> <li>• Individuals, family, advocates – for their satisfaction, concerns with financial safeguards</li> </ul>	<p><b><u>Mandatory:</u></b></p> <ul style="list-style-type: none"> <li>• IRMA- for any history of financial theft at setting</li> <li>• Personal expenditure ledgers</li> </ul> <p><b><u>If used by site:</u></b></p> <ul style="list-style-type: none"> <li>• Communication log</li> </ul>	<p><b><u>Mandatory:</u></b></p> <p>Observation of means of storage of and access to cash, debit cards, check books on hand.</p> <p><b><u>As needed:</u></b></p> <ul style="list-style-type: none"> <li>• Observe staff distributing PA funds</li> <li>• Corrective actions implemented as a result of any theft investigations are occurring</li> </ul>

- Interview staff and observe routine operations. Verify that access to money and/or debit cards is only accessible to authorized employees per agency procedures.
- Ensure that money/debit cards are securely located and that means of access (e.g. keys, lock combinations) are also secure.

- If debit cards are used, ensure that PIN codes are not accessible and secured separately from the cards.
- While there is no specific requirement for the number of people who have access funds, consider who has access to funds and if this has contributed to any poor accounting, mismanagement or theft.
- If any incidents of theft or fiscal mismanagement were noted in IRMA since last visit resulted in corrective actions related to security or access, verify their implementation. Reimbursement of funds will be verified and noted in 4-10
- Note: Funds include cash (currency, coins), or anything that can be easily converted into cash (e.g., checks, debit cards).

**Select MET if:**

- The facility has adequate mechanisms to maintain the security of funds and safeguard their access based on observation, interview and documentation review

**Select NOT MET if any** of the following are noted:

- Money, debit cards or other cash equivalents are observed to be unattended or unsecured
- Access to funds is available to unauthorized people such as to keys, combination codes, or PIN code to access funds or associated bank accounts
- Ledgers indicate a pattern of missing or unaccounted for money and the facility has not responded with corrective action to change procedures to provide security/ safeguarding and accounting for funds.

### 3a-3 There are ledger cards for the accounting of individuals' personal allowance.

633.15(h)(4)(i) There shall be an up-to-date person-specific cash account ledger card or equivalent maintained at the residential facility that documents the receipt, disbursement, and balance of all cash.

*IRA, Apt, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<u>DISCUSSION</u>	<u>DOCUMENTATION REVIEW</u>	<u>OBSERVATION</u>
N/A	<u>Mandatory:</u> Personal expenditure ledgers	N/A

This reviews that there is a ledger/means to ledger and ledgering is evident. This standard is not meant to comment on the accuracy or sufficiency of the ledgering/accounting for funds. That is reviewed elsewhere. Review on- site documentation for accounting of personal allowance. Verify that there is a means to ledger PA activity on separate ledger cards for each individual. Some agencies use electronic spreadsheets instead of paper ledgers. This is acceptable and simplifies accurate computations.

When Debit Cards are used, also ensure that the individual's name appears on the account attached to the debit card and the facility has a means to monitor funds available in the account. Account statements and other banking records should be reviewed to verify debit card transactions. The debit card ledger or equivalent should be checked against the bank records for accuracy.

Select **MET** if:

- Paper or electronic ledger are kept and maintained consistently
- If Debit cards are used, there is a means to record/monitor deposits and withdrawals consistently.

Select **NOT MET** if:

- Paper or electronic ledger are not kept, not available/missing, or there are gaps in maintenance of ledgers (e.g. missing for some months)
- If Debit cards are used, there is NOT a means to record/monitor deposits and withdrawals consistently

### 3a-4 The ledger(s) clearly documents receipt of funds on site.

633.15(h)(4)(i) There shall be an up-to-date person-specific cash account ledger card or equivalent maintained at the residential facility that documents the receipt, disbursement, and balance of all cash.

*IRA, Apt, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<u>DISCUSSION</u>	<u>DOCUMENTATION REVIEW</u>	<u>OBSERVATION</u>
N/A	<u>Mandatory:</u> <ul style="list-style-type: none"> <li>Personal expenditure ledgers</li> </ul>	N/A

This standard verifies accurate ledgering. Review on-site documentation.

- Verify that the each receipt of personal funds into the site is documented on each person's ledger card as a deposit. This may include PA funds from agency or bank account; change from money spent for recreation or personal purchases, monetary gifts, paychecks and other checks.
- Gift Cards and their values should also be documented on a ledger or accounted for in another manner. This documentation should occur at the time of receipt of money, and not delayed to a later time.
- Ledger entries must be clearly written and accurate as to amount and type of transaction.
- Ledger entries must be accurately dated, include a brief description of each transaction, and identify the exact amount of funds deposited and the staff person responsible for each transaction/ledger entry
- Banking records should be reviewed to verify that funds transferred from bank account to in-house funds are accurately accounted for. In – house ledgers (cash-on-hand or debit card) should be checked against the savings records for accuracy and to reconcile balance.
- Note: Funds include cash (currency, coins), or anything that can be easily converted into cash (e.g., checks, debit cards).

Select **MET** if:

- Clear and accurate documentation accounting for receipt of funds is present as described above (dated, described, correct amount and staff responsible). If there is an error or delay it is infrequent.

Select **NOT MET** if:

There is a pattern of incomplete, illegible, inaccurate, inconsistent, and/or untimely documentation accounting for receipt of personal funds.

3a-5 The ledger(s) clearly document disbursement of funds including their purpose for the individual.

633.15(h)(4)(i) There shall be an up-to-date person-specific cash account ledger card or equivalent maintained at the residential facility that documents the receipt, disbursement, and balance of all cash.

*IRA, Apt, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<u>DISCUSSION</u>	<u>DOCUMENTATION REVIEW</u>	<u>OBSERVATION</u>
	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Personal expenditure ledgers</li> <li>• Money management assessment (MMA)</li> <li>• PEP</li> </ul>	<p><u>As needed:</u></p> <p>Items listed as having been purchased by PA funds are available for the personal use of the Individual whose funds were used</p>

This standard verifies accurate ledgering.

Review on-site documentation. Verify that ledger card reflects:

- Each withdrawal of personal funds from the house account must be documented including the date of withdrawal must be documented. This documentation should occur at the time of disbursement of money.
  - For example if \$50 is given to an individual for shopping it should be noted rather than waiting for the return from the shopping trip to enter only the amount spent. \$50 should be entered as the withdrawal with description of purpose, and upon return, the change may be entered as a receipt of funds (see above).
- The purpose for the withdrawal (e.g. personal spending allowance, dinner out, craft supplies, cloths shopping, football game tickets, gift for grandma, day program spending) is documented on each person's ledger card as a withdrawal. PLEASE NOTE: The residential agency is also responsible to ensure that money disbursed to day program is specifically accounted for on a quarterly basis.
- Gift cards withdrawals and usage should also be tracked via a ledger or accounted for in another manner such as maintaining receipts of its use which includes use and expenditures and balance of card.

- Use of sub-ledgering is allowable. The system should clearly document the exchange of funds and the purpose. This is often used to ensure money is accessible to individuals at all times. For example: A person may have \$160 of PA funds in the safe. The Manager places \$50 in a Lock Box accessible to staff over the weekend. The Main Ledger shows \$50 withdraw to the Lock Box. The Lock Box sub-ledger shows a \$50 deposit. When any portion of the \$50 is accessed for recreation activities over the weekend, the amount and purpose is documented on the sub-ledger. Both ledgers become part of the documentation demonstrating the accounting for the funds.
- Ledger entries must be clearly written and accurate as to amount and type of transaction.
- Ledger entries must be accurately dated, include a brief description of each transaction, and identify the exact amount of funds withdrawn/dispensed and the staff person responsible for each transaction/ledger entry
- Banking records should be reviewed to verify that funds transferred from bank account to in-house funds (#4) or from in-house funds to bank account (#5) are accurately accounted for. In-house ledgers (cash-on-hand or debit card) should be checked against the savings records for accuracy and to reconcile balance.
- To verify a large purchase – such as a TV set or computer – observe for the item in the individual’s room and interview staff if its presence is not evident.

**Select MET if:**

- Clear and accurate documentation accounting for disbursement/withdrawal of funds is present as described above (dated, described, correct amount and staff responsible). If there is an error or delay it is infrequent.

**Select NOT MET if:**

- There is a pattern of incomplete, illegible, inaccurate, inconsistent, and/or untimely documentation accounting for disbursement/withdrawal of personal funds.

**3a-6 The ledger(s) accurately reflect the individual’s total fund amount available in the site.**

633.15(h)(4)(i) There shall be an up-to-date person-specific cash account ledger card or equivalent maintained at the residential facility that documents the receipt, disbursement, and balance of all cash.

*IRA, Apt, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b><u>DISCUSSION</u></b>	<b><u>DOCUMENTATION REVIEW</u></b>	<b><u>OBSERVATION</u></b>
N/A	<u>Mandatory:</u> <ul style="list-style-type: none"> <li>• Personal expenditure ledgers</li> </ul> <u>As needed:</u> <ul style="list-style-type: none"> <li>• Personal expenditure plan as needed</li> </ul>	Mandatory:  Money count by agency employee

- Request that responsible staff on-site count the personal allowance funds on-site in your presence. Verify that funds in residence match the amount indicated as total balance on the ledger.
- Sometimes there is more than one ledger for a person. The agency may keep one to record general transactions and the residence may keep another to record day-to-day activities with the cash on hand. Funds per both ledgers should be counted and reconciled with each ledger.
- Some agencies use electronic spreadsheets instead of paper ledgers. The spreadsheets are set-up to automatically calculate the personal allowance balance after each transaction. The balance is also carried over from month to month, which helps eliminate errors.
- The amount of cash that an Individual keeps on his own, consistent with his/her ability to do so, per the Money Management Assessment, is not included in this fund amount available.

Select **MET** if:

- Total money on site per count is same amount as total funds documented on ledger.
- Total money on site per count is not same amount as total funds documented on ledger; but after ledger reviewed for arithmetic errors the amount reconcile.

Select **NOT MET** if:

Total money on site per count is different from amount as total funds documented on ledger and the error is due to more than simple math error.

**3a-7 Personal allowance funds are not used for items or expenses for which the agency is responsible.**

633.15(p)(4) An agency or a sponsoring agency shall not: (4) demand, require, beneficially receive, or contract for all or any part of anyone's personal allowance to pay for expenses or supplies and services which the agency is mandated to provide in accordance with Subpart 635-9 of this Title.

*IRA, Apt, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<u>DISCUSSION</u>	<u>DOCUMENTATION REVIEW</u>	<u>OBSERVATION</u>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals – to verify funds spent only on preferred/chosen items and activities not the responsibility of the program</li> <li>• Facility staff – to verify their knowledge of allowed use of PA funds</li> </ul> <p><u>As Needed:</u> Program management staff – if any concerns arise regarding use of PA funds for general goods/services.</p>	<p><u>Mandatory:</u> Personal expenditure ledgers</p>	<p><u>As needed:</u> Verify items purchased by individual when needed to assess nature of item and whether use of an individual's personal allowance funds was appropriate.</p>

What people buy with their money should have **personal benefit**. It should be based on their choices, interests and preferences It should not be for the benefit of peers, provider agencies, or OPWDD. The items that people buy with their money are their property to do with as they see fit.

Per 14NYCRR Subpart 635-9 Personal Allowance Funds should not be used to for the following purposes:

- Purchase any item or service that must be provided or paid for by the service provider or the government
- Expenses that the residential or day provider must pay in accordance with Subpart 635-9
  - Routine Household items and supplies
  - Any activity that is part of the person's service plan for which the provider agency will be reimbursed. That is, PA monies cannot be used for expenses that are part of the provision of paid services or treatment that are part of a person's written plan (habilitation plan, treatment plan, behavior support plan, health care plan, etc.. In such instances, the cost for the item or activity should be coming from the reimbursement the agency receives.
  - Transportation to or from required services
- To compensate agency staff for services rendered at any time
- To pay for any necessary medical/dental/clinical supplies and services not paid by Medicaid/Medicare/private insurance. [See 633.15(b)(33) for exception if excess resources.]
- Make restitution for damages caused by the individuals unless documented in the person's plan of services per 633.15(p)(4)(v)(a-d)
- To pay any expenses of agency staff for activities or transportation related to the individual's plan of service or the facility's recreation program

**Note:** Use of PA for voluntary provider agency staff expenses to assist individuals on chosen vacations and recreational experiences is allowable when certain conditions are met. See the PA Manual for more information on allowable staff expenses. There is also an Agency Review question regarding the Agency's Procedures in this area.

- **Any** expenses for **New York State employees**. For state employees, **no** expenses can be paid from personal allowance monies.

Select **MET** if:

- Purchases made using personal allowance funds are per a person's interests, choices, and/or benefit the person and are allowable
- There is no evidence that a person has paid for items that are the responsibility of the provider agency or their insurance (e.g. Medicaid, Medicare, private insurance)

Select **NOT MET** if:

- Personal allowance funds were used for items or services that are the responsibility of the service party or other support such as insurance. Examples include but are not limited to:
  - Personal allowance funds are used to pay for items that are clinically necessary or required by the person's service plan; e.g. adaptive equipment, reinforcement items part of a Behavior support plan, work supplies
  - Personal allowance fund are used to pay for medically necessary health care services or supplies
  - Personal allowance funds are used to pay for routine hygiene items such as adult incontinence pads, hand soap, toothpaste, etc.
  - Personal allowance funds are used to pay for home maintenance or cleaning items
  - Personal allowance funds are used to pay for staff expenses except when allowable per regulation

### 3a-8 Receipts required (by regulation) for items or services purchased, reconcile with ledger entries.

633.15(l) Documentation with receipt is required if personal allowance monies are used to purchase any items or services by agency/facility or sponsoring agency staff or family care providers acting upon their own discretion. However, receipts are not required for expenditures under \$15 per person for, and related to, routine recreational activities. In such cases, the expenditures shall be noted in the ledger or other record.

*IRA, Apt, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<u>DISCUSSION</u>	<u>DOCUMENTATION REVIEW</u>	<u>OBSERVATION</u>
N/A	<u>Mandatory:</u> <ul style="list-style-type: none"> <li>• Personal expenditure ledgers</li> <li>• Receipts for purchase of goods and services, described below</li> </ul>	N/A

Verify through review of ledgers and associated receipts that receipts required are present. Receipts should be present in the following situations:

- For items or services purchased by agency staff acting upon their own discretion. (Note: Receipts are not required for expenditures under \$15 per person related to routine recreational activities. In such cases, the expenditures, amount and purpose, shall be noted in the ledger or other record.)
- Purchases made by the individual in excess of their assessed money handling ability
- Receipts for purchases/expenditures should identify:
  - the item(s) purchased/expenditure(s)
  - the cost of each item
  - the vendor
  - the date of purchase
- Receipts are required for all group purchases. The receipt should include the information required for any receipt (above) **and** list the people in the group. The receipt should show that the amount each person spent relative to his or her use of the purchase. For example, if three individuals had dinner at a restaurant and ordered different foods at different costs, each person would pay only the amount of his or her order, and a commensurate amount of the tax and tip.)
- NOTE: It is not necessary to verify receipts for each and every ledgered expenditure. Select a sampling of purchases from each monthly ledger for the sample accounts. This sampling should always include expenditures of significant amounts/value. If the sampled expenditures have been documented and receipted appropriately, there would be no need to continue.  
However if problems are noted, it may be necessary to expand the receipt sampling for the individual(s) already being reviewed and/or add additional individuals to determine the extent of the issue.

Select **MET** if:

- The receipts required for purchases as described above are available and correspond to entries made in the person’s ledger.

Select **NOT MET** if:

- There is a pattern of required receipts lacking for purchases as described

- Receipts are not available for large disbursements of funds and/or large purchases.

### 3a-9 Individuals are reimbursed for any loss of money maintained at the site.

633.15(h)(4)(iv) The agency/sponsoring agency is responsible in all instances for any loss of cash maintained at the residence or at the non-residential program until the cash is properly disbursed to the person.

*IRA, Apt, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

#### **GUIDANCE:**

<b><u>DISCUSSION</u></b>	<b><u>DOCUMENTATION REVIEW</u></b>	<b><u>OBSERVATION</u></b>
<p><b><u>As needed:</u></b> If a loss occurred -</p> <ul style="list-style-type: none"> <li>• Individual receiving services</li> <li>• Family and/or advocates</li> </ul>	<p><b><u>Mandatory:</u></b></p> <ul style="list-style-type: none"> <li>• IRMA review for theft or any finance-associated incidents since prior visit</li> <li>• Personal expenditure ledgers</li> </ul> <p><b><u>As needed:</u></b> Bank/account statements if reimbursement occurred at agency level to person's account rather than residence</p>	N/A

- IRMA review will assist you to identify any reported misuse of funds requiring reimbursement.
- Review required for Standards 4-3 to 4-9 may also identify occasions of misuse, mismanagement, inaccurate accounting and/or inappropriate purchases that may have required the individual to be reimbursed.
- When performing the review of ledgers, ensure restitution occurred. Verify, via both interview and documentation review, that any losses to Individuals were reimbursed fully and timely.
  - Missing, stolen or wrongfully withheld funds must be returned to the individual's personal allowance account at the earliest possible date. This is as soon as the amount is known. The agency or sponsoring agency cannot hold off the repayment of the individual until the investigation has been completed or restitution is made.

Select **MET** if:

- Individuals are reimbursed when necessary in a timely manner following discovery of misuse of or missing funds

Select **NOT MET if ANY** of the following are present:

- Individuals are not reimbursed when necessary
- Individuals are not reimbursed in a timely upon discovery of misuse of or missing funds.

**SECTION 4**  
**General Operations for:**  
**Individualized Choice, Autonomy & Satisfaction**

4-1 Sufficient transportation is available and facilitated to support individualized choices of activities and schedules.

Memo to Providers: October 13, 2015 pg. 5-6 and 441.301(c)(4)(vi)(C) – Sufficient transportation must be available and facilitated to support individualized choices of activities and schedules.

*IRAs, CRs, Apts, Day Habs, Certified Pre-Voc*

Quality Indicator – ADM 2014-04 Sufficient transportation must be available and facilitated to support individualized choices of activities and schedules

*FSR, Day Training, Day Treatment*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• program staff</li> </ul> <p><u>As needed</u></p> <ul style="list-style-type: none"> <li>• family/advocates if needed to support input from individual</li> </ul>	<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Facility documentation that provided information regarding community activities. This may vary based on agency mechanism. May include community log, activity logs and calendars, individual service notes, etc.</li> </ul>	

This standard reviews the availability of transportation and the possible barriers to community access due to transportation issues. Determine whether sufficient transportation is provided, facilitated, and/or arranged so that people have opportunities to access to their local community /neighborhood in accordance with their unique and individualized priorities for meaningful community inclusion per their plan. This includes the ability to accommodate more than one person's choices. Lack of transportation to activities contributes to a residence having isolating qualities. The obligation of the provider may vary to a certain extent with the setting's location and the practical availability of public transportation. For example, if public transportation is not readily available and accessible, the provider has an obligation to help people make arrangements for transportation to community activities.

- Interview people, advocates and staff at the residence regarding desired activities occurring outside the home and how sufficient transportation is arranged to ensure that people are able to participate in their community and social activities, especially when several choices are requested during the same or overlapping time periods.
- Transportation may be include use of vehicles available to the site, public transportation, or transportation arranged with volunteers and natural supports
- Consider availability of accessible transportation sources if needed by individuals
- Review documentation such as activity logs, daily notes, and transportation logs
- Note whether this corresponds to the information you have gathered in Question 2-1 regarding full access to the broader community
- Consider whether insufficient transportation results in predominantly large group activities and/or an inability to accommodate unscheduled/spontaneous community activities.

**Select 'MET' if:**

- Individuals' priorities for meaningful community activities based on their interests and need for supports are accommodated and do not appear to be hampered by lack of transportation based on discussion and documentation review. **And**
- Access to transportation is facilitated by residential staff, whether provided directly or through assistance in accessing public transportation or other arranged transportation methods to support individuals' priorities for meaningful community inclusion.
- Transportation arrangement is sufficient to allow for planned and unplanned activities

**Select 'NOT MET' if any of the following are evident:**

- Individuals' priorities for meaningful community inclusion activities are hampered by lack of transportation based on discussion and documentation review.

- Transportation is not provided by the residence nor do people receive support to access other transportation sources to accomplish their community inclusion priorities
- The only time transportation is facilitated is in group trips of four or more people and not based on individuals' priorities for community inclusion activities
- Impromptu activities cannot occur due to transportation issues

4-2 The staff scheduling and general operations are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.

*Memo to Providers: October 13, 2015 & 441.301(C)(4)(i)* The staff scheduling and general operations must be sufficient and responsive to support individualized and personally meaningful community activities.  
*IRAs, CRs, Apts, Day Habs, Certified Pre-Voc*

Quality Indicator – The staff scheduling and general operations must be sufficient and responsive to support individualized and personally meaningful community activities.  
*FSR, Day Training, Day Treatment*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<u>Mandatory:</u> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• program staff</li> </ul> <u>As needed</u> <ul style="list-style-type: none"> <li>• family/advocates if needed to support input from individual</li> </ul>	<u>Mandatory:</u> <ul style="list-style-type: none"> <li>• Site staffing schedule</li> <li>• Staff assignments</li> </ul> <u>As Needed:</u> <ul style="list-style-type: none"> <li>• Documentation evidencing Community activities</li> </ul>	<u>As needed</u>

This standard reviews whether **staff resources, schedules and site operations to arrange supports for activities** allow the provision of meaningful community activities for people. Determine whether community activities are limited for people due to staffing issues or due to failure of the site and/or staff to support the person to resolve other barriers to their participation. This can include efforts to arrange for use of natural

supports and other creative resources to ensure that an individual's priority activities are met, activities are individualized, and activities do not routinely need to occur in groups.

**Select 'MET' if:**

**Both of the following are evident:**

- Staffing resources and other arranged supports are sufficient to support the individuals in their priority/chosen community activities (use evidence from 2-1 to inform this determination); AND
- Survey activities verify that the home's management is responsive to facilitate staffing changes, scheduling adjustments and other accommodations so that priorities for meaningful community activity in accordance with their plans may occur.

***And***

***Any of the following are evident***

- Staff **work together** on an ongoing and routine basis to ensure that priorities for meaningful activities are met.
- Staff demonstrate an **overall willingness, flexibility, and good attitude** about supporting people in the community
- Staff, upon interview, demonstrate **understanding and thoughtfulness** regarding the priorities identified for people in their **person-centered plans**.
- Staff can cite examples of when opportunities for **individualized** activities have been facilitated
- There is concerted effort to collaborate with **natural supports and community resources**.
- Staffing schedules appear sufficient and allow for individualized activities on a consistent basis
- There are active endeavors to overcome staff related **barriers** to community activities.

**Select 'NOT MET' if any of the following:**

- There is a lack of evidence that staff members are aware of the priorities identified in individuals' person-centered plans.
- Activities are reported to only occur in groups because of staffing issues rather than the interests of people.
- Based on interview, observation, and documentation, **staffing appears to be insufficient** to support individualized and personally meaningful community activities, and there are recent examples that support this finding

**4-3 The site has a mechanism to assess individuals' satisfaction with the service environment.**

*Memo to Providers: October 13, 2015 & 441.301(C)(1)(vii)* The site must have a mechanism to assess individuals' satisfaction with the service environment.

*Clinic, IRAs, CRs, Apts, Day Habs, Certified Pre-Voc*

QI – The site must have a mechanism to assess individuals' satisfaction with the service environment.

*Clinic, FSR, Day Training, Day Treatment, Specialty Hospital, Private School*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> </ul>	<p><u>Mandatory:</u></p> <p>documents evidencing satisfaction mechanism</p>	

This standard examines where the service site/setting has a systemic and clear process in place to ensure that people are satisfied with their current living arrangement.

- Assess whether the site has **mechanisms** to obtain input from individuals to determine whether people are happy with their current service environments and related services.
- The mechanisms do not have to fit a particular template. It can be a formal agency assessment focused on satisfaction with the particular services/service environment, it could be a component of routinely scheduled service planning activities, or it could be another mechanism.
- It is communicated to the person supported in language and style that he/she relates to best.
- There **must** be evidence that this topic of satisfaction is specifically and thoroughly assessed and addressed. It asks for specific, practical examples of persons' experience with supports and services (e.g. asks specifically about the actual services the person receives). It should not be a simple question asking "Do you like living here? Or "Do you like your day program?"

- It is proactive in the way it draws out feedback from the person; uses open-ended questions which result in more than 'yes' or 'no' responses. (E.g. How do staff in day hab help you to work on your goal of getting a new job? Is the help they give you all you need or what else would you like them to do to help you this way?)
- This mechanism should include **documentation** of the individual's response.
- Assessing satisfaction includes providing the person with information on other living arrangements options and/or service environments. This means other options whether or not they are currently available or need to be developed and arranged.

**Select MET if both are evidenced:**

- The residential agency and/or residence have mechanisms in place to assess satisfaction with living situation and there is documentation to evidence this AND
- The process includes discussion with the person that they have a choice of living arrangement and options that are possible, including a non-disability specific setting

**Select NOT MET if any of the following are noted:**

- Satisfaction/choice of living arrangements is not at least annually evaluated by the residence/residential agency,
- There is no documentation available to evidence that a mechanism that assesses satisfaction with living arrangement is implemented
- If an agency only has a means to react to voiced dissatisfaction but does not solicit input on satisfaction

#### 4-4 The home has a mechanism to assess living arrangement choice.

*Memo to Providers: October 13, 2015 & 441.301(C)(4)(ii) The home must have a mechanism to assess living arrangement choice.  
IRAs, CRs, Apts*

Quality Indicator – The home must have a mechanism to assess living arrangement choice.  
*Private Schools, Specialty Hospital*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> </ul>	<p><u>Mandatory:</u></p> <p>Review documentation per agency practice specific to discussion of living arrangement options and decisions/choice of living arrangement</p>	

This standard examines that the residence has a clear process in place to ensure that people are satisfied with their current living arrangement.

- Assess whether the residence has **mechanisms** to obtain input from individuals to determine whether people are happy with their current living situation.
- The mechanisms do not have to fit a particular template. It can be a formal agency assessment focused on satisfaction with living arrangements, it could be a component of routinely scheduled service planning activities, or it could be another mechanism.
- There **must** be evidence that this topic of satisfaction is specifically and thoroughly assessed and addressed. It should not be a simple question asking “Do you like living here? Or “Do you like your home?”
- This mechanism should include **documentation** of the individual’s response.
- Assessing satisfaction includes providing the person with information on other living arrangements options. This means other options whether or not they are currently available or need to be developed and arranged.

**Select ‘MET’ if both are evidenced:**

- The residential agency and/or residence have mechanisms in place to assess satisfaction with living situation and there is documentation to evidence this AND
- The process includes discussion with the person that they have a choice of living arrangement and options that are possible, including a non-disability specific setting

**Select 'NOT MET' if any of the following are noted:**

- Satisfaction/choice of living arrangements is not at least annually evaluated by the residence/residential agency,
- There is no documentation available to evidence that a mechanism that assesses satisfaction with living arrangement is implemented

## 4-5 The home has mechanism to assess roommate choice and satisfaction.

*Memo to Providers: October 13, 2015 & 441.430 (c)(4) (vi) (B) (2) The home must have a mechanism to assess roommate choice and satisfaction. IRAs, CRs, Apts*

Quality Indicator – The home must have a mechanism to assess roommate choice and satisfaction.  
*Private Schools, Specialty Hospital*

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<u>Mandatory:</u> <ul style="list-style-type: none"> <li>Individuals receiving services</li> <li>Program staff</li> </ul> <u>As needed:</u> <ul style="list-style-type: none"> <li>Families &amp; advocates</li> </ul>	<u>Mandatory:</u> Review documentation per agency practice re: choosing roommate (if appropriate) & satisfaction with arrangement.	<u>As needed:</u> Observe Individuals within living environment.

This standard examines whether the residence has a clear process in place to ensure that people are satisfied with their current roommate situation. This can include assessing whether they:

- are satisfied having a roommate
- are satisfied their current roommate, and/or
- whether they have no roommate but would prefer to have one

Conduct review activities to identify:

- Whether the residence has **mechanisms** to obtain input from individuals to determine whether people are happy with their current roommate situation.
- The mechanisms do not have to fit a particular template. It can be a formal agency assessment focused on satisfaction with living arrangements, it could be a component of routinely scheduled service planning activities, or it could be another mechanism.

- There **must** be evidence that this topic is specifically and thoroughly assessed and addressed. It should not be a simple question asking *“Do you like you roommate?”*
- This mechanism should include **documentation** of the individual’s response.
- Assessing satisfaction includes providing the person with information on other living arrangements options. This means other options whether or not they are currently available or need to be developed and arranged.

**Select MET if:**

- The residential agency and/or residence have mechanisms in place to assess satisfaction with roommates and there is documentation supporting this **AND:**
- During the process there is discussion with the person that they have a choice of living arrangement and options that are possible arrangement including a non-disability specific setting

**Select NOT MET if any of the following is evident:**

- Satisfaction with roommates is not at least annually evaluated by the residence/residential agency;
- There is no documentation available to evidence that a mechanism that assesses satisfaction with roommate living arrangement is implemented

4-6 The program takes timely action to address individuals' dissatisfaction with living and/or service environment.

*Memo to Provider: October 13, 2015 & 441.301(C)(4)(v)* The program takes timely action to address individuals' dissatisfaction with living and/or service environment.

*IRAs, CRs, Apts,*

Quality Indicator – The program takes timely action to address individuals' dissatisfaction with living and/or service environment.

*Clinic, FSR, Day Training, Day Treatment, Specialty Hospital, Private School, Cert Pre-Voc*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<u>Mandatory:</u> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <u>As needed:</u> Families & advocates	<u>As needed:</u> Review documents specific to agency's response to Individuals' dissatisfaction with living arrangement and/or service environment, noting the timeframe for the agency to respond.	N/A

If in the course of determining if the individuals are living and/or receiving services where and how they want to, dissatisfaction is expressed, the agency needs to take action possible to address.

The residence and agency should have mechanisms to address identified **dissatisfaction** with living arrangements in a timely manner. This may be addressing factors in the current home (e.g. conflict resolution for roommate problems) or if necessary, supporting people to pursue alternative living arrangements. If dissatisfaction has been reported, verify that the agency has taken steps to evaluate the reasons for the person's dissatisfaction, address any issues identified, and propose possible solutions.

- If a person is unhappy with his/her current living arrangement, there should be documentation that the agency is assisting the individual in looking for/arranging an alternative setting or option that better meets the person's needs/preferences.
- The residential facility does not need to act alone. Communication of the issues with the person's MSC, family members and others who may play an active role in assisting the person and facilitating the solution.
- The residential agency should **implement and monitor** actions take to address dissatisfaction, to ensure the actions are taken and effective.

- Sometimes options are limited, but the agency should be making a **concerted effort** to find creative solutions to honor individual preferences.

***Select MET if:***

- There is no evidence of dissatisfaction with the living and/or service environment.
- Dissatisfaction had been expressed or documented, but at the time of the visit it has been resolved to the person's satisfaction.
- Dissatisfaction has been expressed or documented and there are active and consistent actions to bring to resolution, whether is an in house resolution or obtaining a new living situation or if the service environment has been made satisfactory.
- If the first discovery of dissatisfaction is during your visit; and the agency has implemented a mechanism to assess satisfaction at least annually, select MET if you assess there were no other indicators that would have evidenced to facility staff that the person was not happy.

***Select NOT MET if any of the following are evident:***

- While action is initially taken to address dissatisfaction, there is not monitoring of progress and actions taken until longer term resolutions can be provided. **OR:**
- Interviews reveal that one or more residents are unsatisfied with their current living arrangement or services and the concern has gone unaddressed, with no documentation or explanation why.
- If the first discovery of dissatisfaction is during your visit and there was no mechanism to assess satisfaction
- If the first discovery of dissatisfaction is during your visit; and the agency has implemented a mechanism to assess satisfaction at least annually, select NOT MET if you assess there were other clear indicators that evidenced that the person was not happy, but not recognized and addressed by the agency.

4-7 The home has a mechanism to offer individuals keys to enter their home (or other mechanism to enter their home independently).

*Memo to Provider: October 13, 2015 & 441.301(c)(4)(vi)(B)(1)* The home must have a mechanism to offer individuals keys to enter their home (or other mechanism to enter their home independently).

*IRAs, CRs, Apts,*

Quality Indicator – The home must have a mechanism to offer individuals keys to enter their home (or other mechanism to enter their home independently).

*Private Schools*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>Individuals receiving services</li> <li>Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>Families &amp; advocates</li> </ul>	<p><u>Mandatory:</u></p> <p>Review documents specific to offering keys, or other mechanism(s), to all Individuals so they may enter their home independently.</p>	<p><u>Mandatory:</u></p> <p>Observe how Individuals access and enter their home.</p>

People should have a means to control their access to their home similar to all people who have a place of residence. This reduces reliance on others and encourages independence and enhances personal autonomy regarding entrance, security and use of their home. Accordingly, the residence/residential agency should have **mechanisms** that **inform** residents that they may have a key (access) to their home and verify whether they would like this. The most frequently is addressed by offering individuals a key to their home. The challenge to both providers and reviewers is to ensure that judgments of cognitive and/or physical abilities and resultant ability to use/benefit do not result in decisions to not make the offer. “Key” is the most common form of access and most understandable, however “key” should be recognized to equate with more independent access. So the mechanism should allow for offers beyond a “key” if another means should be considered and is more functional for the individual based on their unique circumstances. Access is dependent both on house design and needs of the individuals. While it may be providing keys to door locks, other options include but are not limited to lock codes, card swipes, automatic sensors, etc. *If people express interest in the offer of more autonomy in access to their home, the facility should work with the individual and/or their supports to a meaningful solution, even if the person will likely never independently use the key.*

Verify that the residence implements procedures to offer individuals a key/or other autonomy-oriented access to their residence. **It is simply not enough for the residence to provide keys/access to people only “upon request”.** The option to have a key/more independent access must be explicitly offered to **each** person living in the residence.

The standard approach of the residence should be that **all** people are informed and offered the above without residential staff making an assumption for the person. Some people may require support and guidance in making the decision whether or not they would like more autonomy to enter their home.

**Select ‘MET’ if:**

- There is evidence that the residential agency has systems (mechanisms) in place to offer all residents the opportunity to have more independent access (e.g. a key) to their residence on a routine and ongoing basis: AND
- There is evidence that the mechanism is implemented

**Select ‘NOT MET’ if any of the following is evident:**

- The residential agency lacks any verifiable mechanism or system to offer people the option of having a key/means of access to their residence
- There is evidence that the residence only provides keys/access “upon request” of the person
- Based on interviews, there are indications that the residence is dismissive of people’s capabilities to use keys or have more independent access, and restrict the implementation of the mechanism to offer to a select few accordingly.
- It is evident people are not offered the opportunity to possess keys/have more independent access to their home, and/or are not provided keys to their home even when requested.
- People are denied keys without justification for the rights limitation.

4-8 The home has a mechanism to offer individuals keys to their bedrooms (or other mechanism to secure their bedroom independently).

*Memo to Provider: October 13, 2015 & 441.301 (c)(4)(vi)(B)* The home must have a mechanism to offer individuals keys to their bedrooms (or other mechanism to secure their bedroom independently).

*IRAs, CRs, Apts*

Quality Indicator – The home must have a mechanism to offer individuals keys to their bedrooms (or other mechanism to secure their bedroom independently).

*Private Schools*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> </ul>	<p><u>As Needed:</u></p> <p>Review documents specific to offering keys, or other mechanism(s), to all Individuals so they may secure access to their bedroom independently.</p>	<p><u>Mandatory:</u></p> <p>Observe how Individuals access and assure privacy in their bedrooms.</p>

The residence should have **mechanism(s) to inform** residents that they may have a key/a means to secure access to their bedroom. This means that the residence has procedures, and an overall system in place that offer and support the provision of bedroom keys to residents. **It is simply not enough for the residence to provide keys/means of security and access to people only “upon request”.** The option must be explicitly **offered to each** person living in the residence.

As this requirement is intended to provide individuals the privacy, security and independence we have in our own homes and bedrooms, it is incumbent upon the agency as part of its procedures to ensure that only appropriate staff have access to the person’s bedroom. Staff that do have access should have a justifiable and reasonable need to have access to the person’s room.

The standard approach of the residence should be that **all** people are informed and offered the means to control access to their bedroom. Some people may require support and guidance in making the decision whether or not they would like the use of a key to enter their home.

If people are not permitted to have a key to their bedroom, it must only be due to clearly evaluated, justifiable, and documented reasons. **Prohibiting or preventing someone from the use of a key is a modification to the person’s rights**, and informed consent must be present and

must be based upon a specific and individualized assessed need. Positive supports and interventions must be tried first, before any restrictive measures. This restriction must also be reviewed periodically in order to determine whether it is still necessary.

**Select 'MET' if all of the following are met:**

- There is evidence that the residential agency has systems (mechanisms) in place to ensure that all residents have been offered the opportunity to have a key/means to secure their bedroom; AND
- There is evidence that the mechanism is implemented.

**Select 'NOT MET' if any of the following are evident:**

- The residential agency lacks any mechanism or system to offer people the option of having a key/or other means to control access to their bedroom
- There is evidence that the residence only provides keys/means to control access "upon request" of the person
- There are indications that the residence is quickly dismissive of people's capabilities to use keys and therefore do not offer
- It is evident people are not offered the opportunity to possess keys to their home, and/or are not provided keys to their home even when requested.

**4-9 The home takes timely action to provide requesting Individuals with independent access to their home and/or bedroom.**

Memo to Provider: October 13, 2015 & 441.301 (c)(4)(vi)(B) and 441.301(c)(4) (vi)(B)(1) The home must take timely action to provide requesting Individuals with independent access to their home and/or bedroom.

*IRAs, CRs, Apts,*

Quality Indicator – The home must take timely action to provide requesting Individuals with independent access to their home and/or bedroom.

*Private Schools*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>Individuals receiving services</li> <li>Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>Families &amp; advocates</li> </ul>	<p><u>As needed:</u></p> <p>Review documents specific to agency’s response to Individuals requesting independent access to their home and/or bedroom, noting the timeframe for the agency to respond.</p>	N/A

Verify that the residence has taken action to accommodate people identified to want more autonomy regarding residence and bedroom access, whether identified through the agency’s mechanism to inform and offer or through self-initiation.

This standard should be answered through interviews and documentation review with people identified in the sample.

- When an individual has expressed more independent access, determine that the residence has taken timely action to respond to the request.
- “Timely action” means that the residence acts upon a person’s wishes without unnecessary delays or generalized excuses.
- If you discover requests are unresolved determine whether consistent and appropriate actions are being taken to address the request.
- It is inappropriate for a residence to immediately dismiss the option of someone having a key/independent access because the facility considers them to be “not capable”. If a person has difficulties with using a key, they might benefit from training and may need additional environmental or staff supports to access their home and/or bedroom in a more independent manner. For example, an environmental

modification might be able to be made to the door, or a key pad may be possible alternatives to the use of a key. A consideration of “degree” of autonomy should be considered. For example: an individual may always need staff support or supervision for entry and exit, but the person’s autonomy may be bolstered if they keep their own key in their purse, and its use is their means to enter the house. The residence should thoughtfully investigate possible alternatives.

- If individuals are not permitted to have a key/means of access to their home and/or room it must only be due to clearly evaluated, justifiable, and documented reasons.
- **Prohibiting or preventing someone from the use of a key is a modification to the person’s rights**, and informed consent must be present and must be based upon a specific and individualized assessed need. Positive supports and interventions must be tried first, before any restrictive measures. This restriction must also be reviewed periodically in order to determine whether it is still necessary.

**Select MET if all applicable bullets below are met:**

- There is evidence that people have received the key and/or more independent access as requested. **AND:**
- People are supported to use and learn these features when necessary, to increase their autonomy.
- If people are not provided key/independent access, it is only because they have either made the decision that they are not interested or there is clear justification, documentation, and informed consent for the rights restriction.

**Select NOT MET if:**

- People are not provided keys/independent access to their home when requested (allowing for time to arrange)
- People are denied keys without justification for the rights limitation
- There are indications that the residence is dismissive of people’s capabilities to benefit from use of keys or other modalities therefore do not provide
- The residence dismisses independent access without due diligence (such as training, additional supports, environmental modifications)

**4-10 Individuals' schedules and routines are personally determined per their needs, interests and preferences (rather than per the staff or agency operations).**

Memo to Provider: October 13, 2015 & 441.430 (c)(4)(vi)(C) Individuals' schedules and routines are personally determined per their needs, interests and preferences (rather than per the staff or agency operations).

*IRAs, CRs, Apts, Day Habs, Specialty Hospitals, Private Schools, Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> </ul>	<p><u>As needed:</u></p> <p>Documentation related to individual's daily lives e.g.</p> <ul style="list-style-type: none"> <li>• Individual progress notes</li> <li>• Individual's daily schedules</li> </ul>	<p><u>Mandatory:</u></p> <p>Observe site routine to assess if routine is based on Individual's needs, interests, &amp; preferences, or staff/agency operations.</p>

This standard considers whether the program *operationally supports* individualized schedules and routines. This includes activities of daily living as well as recreational and leisure activities. Determine how people are accommodated to live their life and complete activities at times and in a manner that is meaningful and preferred. Gauge whether there are opportunities for residents to make choices about their day-to-day schedules, in the same way that people who do not receive HCBS can do.

Consider whether the site promotes and enables people to follow an individualized daily routine without having to adhere to general rules and schedules. A "house schedule" may be written, or it may only be evident through observation of the operations and flow of activities in the program. Evaluate whether the program uses a set routine that is strictly followed. It is natural in most households as well as certified residences to have some general routines, such as offering routine meals within a certain time frame, but the residence should also demonstrate accommodations in those routines when people either verbally or behaviorally demonstrate that they would prefer not to engage in them at a set time.

**Things to consider:**

- Schedules individualized, rather than everyone following the same schedule inside the residence, and when accessing community activities and events.
- Staff demonstrate willingness to offer choice and accommodate individualized preferences or requests regarding daily activities

- Staffing is sufficient and flexible to accommodate, optimize, and support individual choice
- The facility is operated optimizing the choice, autonomy, and satisfaction of residents rather than for the convenience and efficiency of staff.
- When a person is not feeling well, he/she can choose to stay home from work or day program on that day
- Everyone does not and/or is not expected to participate in the same regimented meal times, activities, bed times, waking times, leisure activities, television time, etc.
- Residents know they have a choice or they have been given a choice regarding how to schedule their activities
- There should not be one posted schedule that everyone is expected to follow: e.g. group outing at 4pm, dinner at 5, showers at 6, meds at 7, without any indication of choice or the right of the person to refuse?
- People and/or staff report following the same schedule all the time
- There should not be a house curfew or scheduled time that people have to return to the residence
- Any schedule of activities posted/available makes clear that people have a choice to participate. Such schedules should offer multiple options based on the interests and preferences of the residents.

**Select 'MET' if 4 or more of the following are evidenced:**

- The person reports that he/she has informed choice regarding his/her schedule and priorities for activities are supported
- There is evidence that schedules for activities are individualized, person-centered, and adapted when necessary
- Interview with people and staff indicate that people are supported/encouraged to communicate with staff regarding preferences for their daily schedule and are not prevented from doing so.
- There is evidence based upon your observation and interviews that there is variation in daily schedules and in routines
- The residence overall is making a concerted effort to honor individualized schedules that best meet peoples' needs/requests.
- Schedules of routines and other activities are created based on peoples' priorities, preferences and needs of the people who reside there.
- Staff and/or people report a wide variety of activities that vary from person to person.
- People are aware of and can exercise their right to refuse to participate in an activity if they so choose.

**Select 'NOT MET' if (any of the following are present) :**

- Activity schedules are regimented with little individualized choice or decision-making evident
- The person is coerced to engage in certain activities when they choose not to, explicitly/verbally or through other cues.

- There are blanket house rules about watching TV, curfews, playing music, phone calls and using computers, etc.
- The person expresses dissatisfaction with the opportunity to control his/her own schedule and make choices about activities
- There is no evidence available to verify that the person's known preferences are being respected and acted upon.
- There are schedules posted that everyone is required to follow on a daily basis with no individualization.
- Most activities occur in groups and are based on convenience rather than request.
- People report/display dissatisfaction with the schedule that they follow and this has been unaddressed by the residential staff.
- Schedules of people appear identical or very similar to one another.
- Staff or people report that the entire house follows the same routine daily, with little variance of day-to-day activities and
- People are not offered opportunities to make informed choices regarding free time, meal time, etc.
- Staffing schedules are rigid, so that supports are not provided so that people can engage in routines and leisure activities at a time and manner that benefits them. For example, staffing does not allow people to make different choices of what they would like to do for leisure activities or when people are not able to make a choice to stay home from their day program or other scheduled activity if they do not feel well, or for reasons that you and I can decide to stay home on a given day (e.g., vacation day, mental health day).

**4-11 Individuals are observed to engage in activities that are meaningful to them.**

633.4(a)(4) (viii)(c) No person shall be denied: the provision for meaningful and productive activities within the person's capacity although some risk may be involved, and which take into account his or her interests

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> </ul>	<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Habilitation plans</li> <li>• ISP</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Observe if Individuals are engaging in activities that are meaningful to them, per demonstrated interest and interview</li> <li>• Confirm these activities are normally occurring, not an anomaly of the visit</li> </ul>

Validation of this standard also requires that the surveyor:

- ***Interviews with people in the sample and observation are critical for determining whether or not their habilitation plans reflect what is meaningful and important to them and if staff is providing the individualized supports necessary for persons to do those activities.***
- review the activity and service delivery documentation as needed to ensure that the activities it contains are meaningful to the person;
- verify that supports necessary are available to engage in preferred activities on site and during service delivery;
- Observe and verify that these activities are what person wants. Interview should confirm that the observation during the survey visit is what is usually occurring, and not an anomaly of the visit.

**Considerations:**

- Based on information available on personal interests and priorities do people, verify that people report that they, have the support needed to pursue their interests and priorities.

**Select 'MET' if** the observations and interview verify that activities are chosen and of interest to the individuals.

**Select 'NOT MET' if** most of the following are verified:

- The activities are determined by staff without input from individuals
- Individuals express or demonstrate disinterest or dislike in activities offered and/or occurring
- Individuals are observed or reported to not be supported to engage in activities on site that they prefer per their service plan.

4-12 Individuals are encouraged and invited to participate in the routine of their own home. (e.g. cooking, menu planning, routine chores, etc.)

633.4(a)(4)(viii)(c) No person shall be denied: the provision for meaningful and productive activities within the person's capacity although some risk may be involved, and which take into account his or her interests

*IRAs, CR, Apts, Private Schools*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> </ul>		<p><u>Mandatory:</u></p> <p>Observe site routine, noting Individual participation in activities as desired.</p>

Through observation validate that:

- Individuals recognize and/or are supported to recognize that this is their home and that they have an active role in its routines
- Even if a person will probably not achieve total independence at a certain activity, they are encouraged and supported to be as independent as possible by participating in routine activities in the home;
- Individuals are practicing skills
- Individuals participate, to the extent they are able, in the routine tasks of the household as opposed to things being done for them (e.g., breakfast prepared and served by staff when Individuals have the ability to participate);
- Individuals receive support when appropriate, in 'teachable moments'

**Select 'MET' if** the observations verify that individuals are supported to actively participate in routines of the home including but not limited meal planning, preparation and serving, routine chores, gardening and organization, planning for events/holidays/special occasions, etc.

**Select 'NOT MET' if** staff are observed to "do" for the individuals and fail to encourage the participation of individuals in the home's routines

4-13 Individuals are encouraged and supported to have full access to the broader community.

Memo to Providers: October 13, 2015 & 441.301(C)(4)(i) Individuals are encouraged and supported to have full access to the broader community.  
*IRAs, CRs, Apts, Day Habs, Certified Pre-Voc*

Quality Indicator - Individuals are encouraged and supported to have full access to the broader community.  
*Private schools*

GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> </ul>	<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• ISP</li> <li>• Service plans and notes</li> <li>• Community activities records</li> <li>• Personal funds records</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Observe if Individuals are being encouraged &amp; supported to have full access to the broader community (as described below).</li> <li>• Confirm documentation &amp; interview</li> </ul>

Having “**FULL ACCESS**” to the community means:

- Supports and services do not segregate or isolate people from their own neighborhoods.
- The expectations for people with disabilities should be the same as any other people living in their community.
- People are **encouraged and supported to interact with others who do not have disabilities.**
- Community activities do not require individuals to stay as an entire group of others with disabilities that are insulated/isolated from the public at large.
- Group community activities were chosen individually by the person among options and the group trip is not the only activity that the person ever engages in to access the broader community.
- Individuals are provided options for community activities other than group activities.
- **Please note:** People may not be able to frequent their local community as often as they like in very rural settings, but this may also true for the public at large in that rural area.

### **Survey Activities and Considerations:**

- The **service plan** must identify the person's choices for meaningful community inclusion activities and the desired frequency/duration of these activities. The service plan includes the Habilitation Plan or other applicable attachments.
- Verify that the person's priorities and preferences and desired frequency for community activities are being supported by the residence. Verify that the community activities **identified in the plan** are provided **as described**.
- There should also be evidence that people have opportunities to participate in unscheduled community activities as well
- Indications of community involvement may identified via **personal allowance** records and through **community logs/activity logs** or **daily notes** kept by the residence
- Interview the person and other parties who can provide accurate information regarding the person's interest in community and integrated activities and their participation.
- Verify that the person has community experiences other than through group "outings" or through their day program. If the activity was with others consider whether this was because the person wanted to be with/chose to be with the others.
- **People are "supported"**: People who have less experience with community life may need more supports and exposure to new opportunities. Staff or other arranged supports should encourage people to take part in the community in a way that is experiential or meaningful to each individual person. When uncovering personal interests and preferences, staff should also be attentive to non-verbal cues, especially for those who are unable to communicate verbally. Supports could also include providing assistance and training in identifying activity options, identifying what is occurring in their community, navigating public transportation and arranging **access** to get to these activities. Where public transportation is unavailable (e.g., bus, subway, cab), the person should be supported by utilizing other resources to access the broader community, such as finding volunteers and natural supports.

### **Select 'MET' if all the following are evident :**

- The person's priorities and preferences for community engagement identified in their written plan are provided as described;
- The person experiences both planned/scheduled and spontaneous community activities
- The person receives needed assistance and supports to **engage** in community activities and perform social roles that are of interest. This can include but is not limited to: volunteer, choir member, neighbor, sibling, serving on a committee, being in a club, church member, etc.
- Staff support the person to discover and participate in new experiences and activities, and facilitate **access to information** (flyers, newspapers, internet, and/or word of mouth) to learn of activities occurring outside of the setting. **AND:**

- There are specific and **recent examples** of when the person was encouraged and supported to have full access to the community and/or supported through a discovery process in the community (within the past 2-3 weeks)

**Select 'NOT MET' if any of the following are present:**

- The person is not supported to participate in community and social activities identified in their written plans
- The person is not supported to participate in preferred, chosen, requested community or social activities
- There are obstructions that serve to **isolate** the person from full access to the community, and there has been no effort to address these barriers/obstacles in a timely manner for the person.
- Nothing is done to help the person access the broader community/discover the broader community
- The person appears isolated from full access to the broader community, e.g., the person reports that the only community activities that he/she engages in were group activities involving only other residents of the house and paid staff.
- If all people including the sample attend the same types of activities with little choice of options or evidence of individualized interests.
- Documentation and interviews suggest that people **only** frequent the community through the same limited set of activities, with little variance or options being offered and usually in larger groups (4 or more).
- People are not able to participate in activities alone (with supports as needed)
- People are not able to participate in activities with only those people/friends/peers chosen by them (because staffing requires certain groups or group sizes)

4-14 Individuals’ cultural, religious, and lifestyle backgrounds and choices are supported by staff.

Memo to Providers: October 13, 2015 & 441.301(C)(1)(iv) Individuals’ cultural, religious, and lifestyle backgrounds and choices are supported by staff.

*FSR , IRAs, CRs, Apts, Day Habs, Certified Pre-Voc, Clinic*

Quality Indicator: Individuals’ cultural, religious, and lifestyle backgrounds and choices are supported by staff.

*Private schools, Specialty hospital and Day treatments*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> </ul>	<p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• ISP</li> <li>• Service plans</li> <li>• Individual service documentation</li> <li>• Community activities records</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Observe staff demonstrating support &amp; respect towards Individuals</li> <li>• Bedroom and site is appointed as appropriate per the cultural, spiritual and life style preferences</li> <li>• Observe Individuals wearing the clothes, hair, makeup, etc. as they choose.</li> </ul>

There should be evidence that staff make efforts to respect and offer opportunities for people to understand their ethnic and cultural backgrounds and offer various cultural, religious, or ethnic experiences. Natural supports for people may also have family traditions and favorite food dishes, etc. that the site should be aware of. People should have opportunities to participate in the traditions and activities with their peers that are of interest to them and to share personal values and beliefs. If people have not previously made decisions related to learning about or expression of cultural backgrounds, there should have be an introduction of the topic to the individual/family, and efforts to assist the person to explore in order to determine interest and whether further future engagement should occur.

**Please also note:** There may also be instances where the *values and beliefs of family members* of a person may *conflict with the person’s own beliefs*. It is important that the program and staff ultimately respect the wishes of the person, *and the wishes of the person should be their primary concern*.

**Select ‘MET’ if most of the following are either met, or there are no apparent barriers to the following:**

- People have choice and personal expression in their room decorations related lifestyle, spiritual and cultural choices
- There is evidence that people attend religious activities of their choice that are important to them.
- People are able to visit ethnic shops, attend ethnic festivals, and follow international sports
- Menus reflect ethnic diversity reflective of the people living in the residence.
- Staff offer opportunities for unique experiences based on the cultural, religious, and ethnic backgrounds of people. This includes supporting exploration of options if interest is expressed by the person.
- Clothing and grooming is appropriate to religious or cultural choices of the individual.
- The sexual preferences and gender identities of people are respected
- There is evidence that staff communicates with natural supports and are sensitive to fostering family traditions and values.

**Select 'NOT MET' if any of the following is evident:**

- Actions are not taken to discover and explore the backgrounds of people and support people in this discovery if interested.
- Interviews with staff and/or people reveal that there are missed opportunities for participation in religious, cultural or ethnic events that are individualized due to facility inattentiveness to requests or opportunities
- Observation and interview reveals that individual preferences for ethnic foods is ignored or denied by staff
- Holiday decorations are not reflective of all the cultures of residents.
- There is evidence that the values, beliefs, and traditions shared by staff or the agency directly conflict with those of the person, and have resulted in the person being unable to participate in activities important to them or express themselves the way that they choose
- Individuals who are interested to do so are denied participation in celebrations of other cultures or religions, because it is not associated with their ethnic or spiritual origin and therefore considered inappropriate.

***Examples of circumstances resulting in a "NOT MET" answer:***

- Carlos is originally from the Philippines. He visits his family in NYC on a routine basis. His family sends him back to his residence with his favorite foods which include exotic dishes such as fish eyes. Staff routinely disposes of the food upon receipt, finding the food to be disgusting, and provide him with excuses like the food was not chilled enough on the trip (spoiled) or contains too much sodium for his diet. Carlos complains to staff on a routine basis that he is unable to eat the food that he wants to because "staff won't let him".
- An Orthodox Jewish resident is unable to have separate dishes and refrigerator for kosher foods because no one else in the house follows those religious observances.

- Residents routinely attend the church that staff or the majority of their housemates attend rather than supporting people to attend churches based on their own religious preferences.
- A Muslim resident is not allowed the opportunity to participate in the house celebration for Christmas and feels left out of group festivities. Staff does not offer the opportunity and choice to participate.

4-15 Individuals are supported by staff to exercise control and choice in their own lives.

*Memo to Provider: October 13, 2015 & 441.301 (C)(4)(iv) Individuals are supported by staff to exercise control and choice in their own lives  
Clinic, IRAs, CRs, Apts, Day Habs, Certified Pre-Voc,*

Quality Indicator - Individuals are supported by staff to exercise control and choice in their own lives  
*Private schools, Specialty hospital and Day treatments*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> </ul>	<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• ISP</li> <li>• Service plans</li> <li>• Individual’s notes</li> <li>• Community activities records</li> <li>• Individual’s daily schedules</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Observe if Individuals are being supported to exercise control and choice (as described below).</li> <li>• Confirm interview as needed</li> </ul>

This standard is a global one, and should be based on your overall findings from section 3 standards. It looks at whether the person is empowered to exercise choice and control over their own lives. There should be evidence and observation should support whether the program actively promotes individual **choice, autonomy, and decision-making**. This includes having choices of activities for **meaningful** community inclusion and having the ability to form and maintain relationships with people of their choosing. This also means that their religious and spiritual preferences are respected. The program should not be quick to make decisions for people without engaging them and ensuring that they have an active role in making their own choices to the highest degree possible.

**Select ‘MET’ if:**

- There is documentation of membership in community groups and organizations
- Community activities that the person participates in are meaningful to the person
- Sexual preferences and gender identities are respected

- People have their own calendars with interests and personal plans (whether or not they make and schedule their own plans independently)
- There are mechanisms in place to ensure that people provide input and choice into the activities that they would like to participate in.
- Personal decisions related to relationships are respected
- Religious/spiritual preferences are honored
- There are examples of people demonstrating choice and control and interviews with people support this

**Select 'NOT MET' if:**

- People are denied the ability to participate in community LGBT activities and events that they would like to attend.
- People have few opportunities for input into choices of activities or interests
- Community activities are not personalized or meaningful for people. (Does everyone go to just a few, local places like the dollar store with little evidence of having input into individualized outings?)
- There are examples of people not being allowed to maintain personal relationships with people who are important to them. (Are people supported, for example, to have a romantic relationship or does the site limit or prohibit the ability of people to associate with people of their choosing?)
- There is little evidence of community memberships or participation in any meaningful or individualized way.
- The staff plan out community activities without involving people and people lack opportunities for decision-making related to those activities.
- Evidence and observation reveal that staff make choices for people in many facets of their lives rather than engaging them in a person-centered way

## SECTION 5 DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS

### 5-1 Staff can describe/know the Individuals' supervision needs.

686.16(b)(4)(i)-(ii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following:(i) any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid; (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight

*IRAs including FSRs*

633.4(a)(4)(ix) No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity

*Clinic, Day training, Day Treatment, Day Hab, Specialty Hospitals, Private Schools, Certified Pre-Voc*

#### GUIDANCE:

<u>DISCUSSION</u>	<u>DOCUMENTATION REVIEW</u>	<u>OBSERVATION</u>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Direct support staff – to discuss individuals and their supervision needs. The intent is not necessarily to quiz staff on each and every individual, but rather to get a sense that they are competent to provide the routine supervision people need.</li> <li>• Individual: to discuss when staff need to be with them and when they can be independent</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Family and/or advocate</li> <li>• Program management staff</li> </ul>	<p><u>As Needed:</u></p> <p><b>Assessment of this standard relies on your assessment of what staff explain to you in conjunction with what you observe.</b> If you observe something that raises concerns and/or contradicts what staff report, you may check to see what their plan states they should be getting. Review of documentation is only necessary in that scenario.</p> <ul style="list-style-type: none"> <li>• ISP, IPOP or other plans that may answer concerns regarding supervision needs</li> </ul>	<p><u>Mandatory:</u></p> <p><b>Assessment of this standard is expected to be based on your observation paired with interview.</b> Observe individuals in the setting and during activities occurring, functioning in their environment and interactions with staff. <b>Make an assessment based on the observed needs and abilities of the individuals whether staff know the supervision/support to provide to individuals to maintain their well-being and needs.</b></p>

Staff supervision are those actions provided by the provider staff when the person is not expected to independently perform an activity without supervision that is essential to preserve the person's health or welfare and/or meet a presented need.

**Staff should be able to describe and give examples of the supervision and supports they provide to individuals.** Facility staff need to know, what safeguarding and supervision they are expected to provide to individuals, especially those for whom they are assigned responsibility during your visit.

Some examples of **supervision and supports** they may describe include the following situations:

- During general activities in the home and leisure time
- During personal hygiene activities and ensuring appropriate dress
- Assistance with communication, effective coping skills, supporting positive behaviors, etc.
- Activities of daily living such as dining, ambulation, leisure activities, etc.
- Activities to support community based activities
- Health care and medication supports

Select **MET if ALL** of the following are present:

- Staff are knowledgeable regarding the supervision they need to provide to individuals to meet their needs for supervision and support in routine activities
- Observations reveal that staff deliver the supervision needed by the individuals during observed activities
- Observations reveal that Individuals' well-being is supported

Select **NOT MET** if ANY of the following are present:

- Staff interviewed do not know/cannot explain the supervision needed/required by the individuals of individuals' needs for supervision
- Observations reveal that staff are not competent to provide the supervision/support required based on events/activities observed

5-2 Individuals receive their meal/food in the form and consistency required by their plan, according to their needs and per OPWDD Choking Prevention Initiative (CPI) specifications.

633.4(a)(4)(ix) No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity

*FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

686.16(b)(4)(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.

*IRAs including FSR*

**GUIDANCE:**

<b>DISCUSSION</b>	<b><u>DOCUMENTATION REVIEW</u></b>	<b><u>OBSERVATION</u></b>
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Direct support staff – to assess or clarify their knowledge of the food and beverage consistency they need to provide to individual(s)</li> <li>• Individual re: consistency needs and whether they receive help they need from staff</li> <li>• Program management or clinical staff as needed re: oversight if serious concerns noted</li> </ul>	<p><u>Mandatory:</u>  <b>For at least one (1) individual</b> review service plan documentation that describes the services and supports the person needs while eating and drinking (e.g. IPOP, ISP, dining plan)</p> <p><u>As Needed:</u>            If observations eating result in concerns for any person’s well-being while eating/drinking</p>	<p><u>Mandatory:</u>  <b>Observe any mealtime</b> to verify:</p> <ul style="list-style-type: none"> <li>• For the <u>one person’s</u> for whom you reviewed dining needs documentation:               <ul style="list-style-type: none"> <li>○ food and beverage is provided in the consistency/form described in the plan</li> <li>○ consistencies appear to be appropriate based on observed dining behavior and needs</li> </ul> </li> <li>• Individuals appear to be receive their meal/food in a form and consistency that they can manage and is appropriate to their well-being, based on your observational assessment of:               <ul style="list-style-type: none"> <li>○ dining behaviors and skills</li> <li>○ physical needs</li> </ul> </li> </ul>

**SAMPLE:** If meals/snacks are provided at the certified site:, **for at least one person present at the site conduct a verification of consistency of the food and beverage they eat and or are provided with the person’s written plan/diet order.** That means review documentation regarding at least one person’s consistency needs and verify through observation that they receive nutrition in that manner.

- Review the person’s plan (e.g. ISP, service plan and/or an associated dining plan. It should identify the food/drink form and consistency the individual requires/is to receive. The type of food form and/or consistency should be stated in the service plan per terminology approved in the OPWDD Choking Prevention Initiative (CPI). See [Choking Prevention Training Resources | OPWDD](#)
  - Food: whole, 1” pieces cut to size, ½” pieces cut to size, ¼ “ pieces cut to size, ground or puree
  - Liquids: Thin, Thickened with designation of Nectar Thick, Honey Thick, and Pudding Thick
  - Other terminology for the consistencies and piece sizes should not be used. Clarification descriptors may be added if it lends to better understanding but not substituted.
  - If non-OPWDD clinicians are involved in recommending/determining the consistency for the individual, the facility should ensure that recommendations result in terminology consistent with CPI requirements.
  
- Observe and verify:
  - For Sample person:
    - That the appearance of the food and beverage provided/available for the sampled person is consistent with their written plan and CPI description of food/beverage consistencies.
    - The food/beverage appear to be appropriate/managed safely by the person based on dining behavior and ability to eat and drink.
  - For others participating in the meal:
    - Individuals are safely managing to eat and swallow the food and beverages in their provided consistency. For example, people are not coughing frequently while eating/drinking, people are taking bites of food presented whole and chewing adequately; food is not falling or fluid is not drooling out of a person's mouth. If you have concerns, review the written plan to determine what the person should be receiving and/or whether appropriate planning is occurring.
  - If surveyor observations reveal an unmet dining need (e.g. a person is eating food rapidly and coughing but there is no written direction and/or staff is not doing anything to intervene to lessen the risk of choking or aspiration) take action to address by calmly bringing to the attention of the staff.

Select **MET if all** of the following are present:

- The person sampled for this standard receives their food/beverage in the consistency described in their written plan and based on observation it appear appropriate to meet their needs.
- The written description of the sampled person's food/beverage consistency is consistent with CPI terminology.
- Other individuals present for the meal appear to receive food and beverage in consistencies appropriate to their observed needs and eating habit.

Select **NOT MET** if any of the following are present:

- The person sampled for this standard does not receive their food/beverage in the consistency described in their written plan.
- The person sampled for this standard cannot manage the consistency of food/beverage provided based on observation.
- Any person present for the meal is observed to be unable to manage the consistency of food/beverage provided based on observation.

**Select N/A ONLY if:** Individuals do not eat or have meals at the facility during hours of service delivery.

**5-3 Individuals receive support while eating in accordance with their assessed and observed needs.**

633.4(a)(4)(ix); (x) & (xvii) No person shall be denied: (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; (xvii) a balanced and nutritious diet.

*Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

686.16(b)(4)(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.

*FSR, IRAs*

**GUIDANCE:**

<b><u>DISCUSSION</u></b>	<b><u>DOCUMENTATION REVIEW</u></b>	<b><u>OBSERVATION</u></b>
<p><b><u>As Needed:</u></b></p> <ul style="list-style-type: none"> <li>• Direct support staff – to assess or clarify their knowledge of supports and supervision while eating</li> <li>• Individual – to clarify the supports they receive and need while dining</li> <li>• Family and/or advocate</li> <li>• Program management or clinical staff</li> </ul>	<p><b><u>Mandatory:</u></b></p> <ul style="list-style-type: none"> <li>• ISP and any associated dining related service plan</li> <li>• Individualized Plan of Protective Oversight (IPOP) and associated dining or eating service plans</li> <li>• Prescribed Diet Order</li> <li>• Nutritional Assessment</li> </ul> <p><b><u>As needed:</u></b> Agency policy and procedure on nutritional assessment services</p>	<p><b><u>Mandatory:</u></b></p> <ul style="list-style-type: none"> <li>• <i><u>While Individuals are eating in the setting</u></i>, observe to verify that dining supervision, supports and monitoring are occurring effectively and respectfully</li> </ul>

**SAMPLE:** If meals/snacks are provided at the certified site, **for at least one person present at the site conduct a verification that they receive the following in accordance with their written plan** (e.g. IPOP, ISP, written dining plan, care plan, habilitation plan):

- supervision, support and assistance from staff
- any special or adaptive equipment for eating, drinking, or positioning

That means review documentation regarding at least one person's supervision, support and equipment needs and verify through observation that they receive what they need and as described in the plan.

- Observe and verify:
  - SAMPLE: Based what is observed also assess whether the provided support and equipment is applicable are effective and appropriate for the individual. Do the supports result in their eating and drinking in a manner that is safe (e.g. appropriate pace, size of fork/spoonful); ensures appropriate food and portions sizes; allows personal dignity and encourages good social skills; provides supports to prevent food taking if applicable, etc.
  - For others participating in the meal:
    - Ensure individuals have the supports they need to eat safely, at an appropriate pace, with appropriate mouthfuls, and appropriate portions sizes. Determine whether they are provided supports they need to eat as independently and appropriate as possible.
- The IPOP, dining, plan, or other section of the service plan should identify what the Individual requires in the way of staff support, and the level and type of assistance needed (e.g. pacing needs, staff within arm's length during dining, adaptive flatware or plate) while eating. Provider agency staff need to know and provide the services/supports described in the plan.

Select **MET if all** of the following are present:

- Staff provide the person sampled for this standard, the support described in their plan and it is appropriate based on observed needs and effectiveness;
- The written description of needed supports for the sampled person is observed to be appropriate;
- Other individuals present for the meal appear to receive support and supervision during mealtime sufficient to meet their observed needs while dining.

Select **NOT MET** if any of the following are present:

- Staff do not provide the person sampled for this standard, the supports described in their written plan
- Although staff provide the person sampled for this standard the supports described in the written plan, they are ineffective or inadequate to meet their needs
- Any person present for the meal is observed to be in need of supports, supervision or assistant equipment, but support is not provided or is inadequate

**Select N/A ONLY if:** Individuals do not eat or have meals at the facility during hours of service delivery.

## 5-4 Individuals receive support for mobility in accordance with observed needs.

633.4(a)(4)(ix)& (x) No person shall be denied: (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; (xvii) a balanced and nutritious diet.

*Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc, Clinic*

686.16(b)(4)(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.

*FSRs, IRAs*

### GUIDANCE:

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• Direct support staff – to assess or clarify their knowledge of supports and supervision while ambulating</li> <li>• Individual – to verify that they are receiving the supervision and supports they need and provided respectfully</li> <li>• Family and/or advocate</li> <li>• Program management or clinical staff</li> </ul>	<p><u>As Needed if concerns or questions are raised during observation:</u></p> <ul style="list-style-type: none"> <li>• ISP and any associated related service plan</li> <li>• Individualized Plan of Protective Oversight (IPOP) and associated ambulation or mobility plans</li> <li>• Orders for supports or equipment for mobility</li> <li>• Assessment by Physical Therapist if applicable</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• <i>While Individuals are moving about the setting</i>, observe to verify that mobility supervision, supports and monitoring are occurring effectively and respectfully</li> </ul>

**Assess this standard based on your observations of routine activities and individuals moving around the service environment and/or to and from transportation sources, etc.**

While observing be attentive to the mobility skills of individuals and if applicable, equipment used, such as wheelchairs, rollators, walkers, canes, etc. Ensure that individuals appear to be safe during their ambulation, movement and transfers. E.g.

- Individuals who are ambulatory with or without assistive equipment: Watch for steadiness, pace, appropriate use of equipment, actions that indicated desire for support such as leaning against the wall, using furniture as support to get from one place to another.

- Individuals using wheelchairs independently: verify that they are able to move about their environment as needed and do so in a manner that is attentive to others in their path of travel.
- If individuals are observed to have needs for staff support for mobility, verify that staff are available, nearby and attentive to provide the level of assistance that appears appropriate to maintain the person's well-being. Observe that staff are attentive to individuals' needs for supervision, contact guard and other assistance to navigate their environment.
- ONLY IF individuals are observed to have mobility needs but do not appear to have the equipment or staff assistance/supervision/support they need, talk to staff about their mobility supports and review their written plan for any written strategy to mobility support. If you assess that individuals are at risk for injury bring your concern calmly to the attention of staff.

**Select MET if:**

- Individuals move safely and independently in their service environment to meet their needs; and/or.
- Staff provide Individuals adequate support and/or they have adaptive equipment to move safely in their service environment.

**Select NOT MET if:**

- You observe individuals to be at risk for falls or injury but not receive support/assistance from staff appropriate to their observed needs
- Concerns for a person's safe navigation in their environment led you to review a person's service plan and it is determined that he/she did not receive the supports/supervision they need.

5-5 Individuals receive appropriate support and supervision based on other observed needs for support.

633.4(a)(4)(ix)& (x) No person shall be denied: (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; (xvii) a balanced and nutritious diet.

*FSRs, IRAs, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

686.16(b)(4)(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.

*FSRs, IRAs*

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p>As needed:</p> <ul style="list-style-type: none"> <li>• Direct support staff – to assess knowledge of needed supports of Individuals and how they see themselves meeting these</li> <li>• Individual – to verify that all of their support needs are being met</li> <li>• Family and/or advocate</li> <li>• management or clinical staff as needed</li> </ul>	<p><b>Only As needed:</b></p> <ul style="list-style-type: none"> <li>• ISP and any associated service plan e.g. Behavior Support Plan</li> <li>• Individualized Plan of Protective Oversight (IPOP) and associated plans</li> <li>• Other clinical assessments which may have identified support needs</li> </ul>	<p><u>Mandatory:</u>  <b><i>While Individuals are in the setting</i></b>, observe to assess that they are receiving supports and supervision according to their demonstrated needs</p>

**Assess this standard based on your observations during routine activities in the service setting. While standards above and below focus on specific activities and needs, this standard requires you to use you observations and experience to make a judgment if needs for supports are being met.** It requires you to use your observations and make a determination whether individuals for the most part are adequately supervised and supported by staff during the activity observed to maintain safety and well-being. Consider whether staff monitor the Individuals for changing needs for support. When individuals need assistance in accessing the bathroom, getting materials needed for an activity or maintain modest and appropriate behavior consider whether staff are attentive and responsive. Consider whether supports are provided to ensure individuals engage with each other appropriately, do not enter others rooms without permission, and do not put themselves or others at risk. Observe if staff are effectively responding to a person whose behavior may be atypical by monitoring and using their training and knowledge of the person to meet the unmet need being expressed.

**Select MET if any of the following applicable findings are present:**

- Staff provide routine supervision and supports as needs related to safety and well-being arise. Individuals were observed to have their needs met.
- During observations, individuals do not exhibit needs for support regarding health and safety
- If concerns/questions regarding unmet needs for support arise during observation, interview and documentation review result in conclusion that appropriate supports were provided.

**Select NOT MET if any of the following are present:**

- You observe individuals displaying sustained unmet needs in the course of the observation
- Individuals are observed to be at risk for harm due to lack of supervision and/or supports from staff

**5-6 There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.**

633.4(a)(4)(ix) No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity

*FSRs, IRAs, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc, Clinic*

**GUIDANCE:**

<b><u>DISCUSSION</u></b>	<b><u>DOCUMENTATION REVIEW</u></b>	<b><u>OBSERVATION</u></b>
<p><b><u>Mandatory:</u></b></p> <ul style="list-style-type: none"> <li>• Direct support to discuss the needs of individuals and their perception of the adequacy of staffing</li> <li>• Individual – to discuss their perception of staffing adequacy to meet their needs</li> </ul> <p><b><u>As needed:</u></b></p> <ul style="list-style-type: none"> <li>• Family and/or advocate</li> </ul>	<p><b><u>Mandatory:</u></b></p> <ul style="list-style-type: none"> <li>• Information in IRMA</li> <li>• Communication Log</li> <li>• Staff schedule</li> </ul> <p><b><u>Only As Needed, unless necessary for other standards in the protocol (e.g. dining needs, mobility, special risk areas)</u></b></p> <ul style="list-style-type: none"> <li>• ISP and any associated related service plan</li> <li>• Individualized Plan of Protective Oversight (IPOP) containing required levels of supervision (LOS)</li> <li>• Prescribed orders</li> <li>• Clinical assessments</li> <li>• Behavior Support Plans</li> <li>• Staff Schedules, current and historical</li> </ul>	<p><b><u>Mandatory:</u></b></p> <p><b><u>While Individuals are in and about the setting,</u></b> observe to verify that supervision, supports and monitoring are occurring effectively, respectfully</p>

**Assess this standard based on your observations during routine activities in the service setting. Standards above and below focus on the staff provision of services for specific concerns and individual needs. This standard requires you to use you observations and experience to determine whether there are sufficient staff on duty to address individuals observed and stated needs for support during routine and activities associated with the certified setting.**

Review incidents in IRMA before the visit to see if any incidents have occurred in which insufficient staff is, or could have been, identified as a factor. Review the site communication log or similar mechanism if one exists which might provide clues regarding staffing issues, successful staffing and concerns of inadequate staffing. Surveyor should observe activities at the site. Review the staffing plan for the facility, including the number of staff on duty. Consider:

- If there are sufficient staff to meet the individualized service needs of the individuals and to provide adequate supervision.
- Verify that the numbers of staff present and on-duty correspond to the numbers scheduled.
- Ascertain if the number is sufficient to supervise Individuals and carry out the activities and sufficient to attend to people's support needs.
- Ask about the system for replacing staff that may be ill, on vacation or otherwise absent.
- Ask staff and Individuals if they believe that there are sufficient staff to provide support and supervision for people both in the facility and during community activities.
- Identify if people have to wait for long periods of time to receive attention from staff.
- Determine if meal times are well organized and sufficient staff are available to meet the needs of all individuals during dining
- Determine if recreational activities and/or medical appointments canceled because of insufficient staffing.
- See if an IRMA review of incidents show a high number of elopements, accidents or injuries of unknown origin, which may indicate that staffing is inadequate to protect people.
- Based on identified (or not yet identified) needs for staff intervention for behavioral and health care issues, determine if adequately trained staff perform these supports.
- Attend to the appearance and hygiene of Individuals for adequate seasonally appropriate clothing, personal preference of clothing and cleanliness.

A negative answer to any of these questions may be an indication that staffing is insufficient to meet people's needs for basic care, protection, and habilitation and goal attainment, making this standard 'not met'.

Mealtimes, late afternoon and the early morning routine are good times in a residence to observe and assess whether or not staffing is adequate to take care of people's health and safety since these are times when individuals frequently need assistance with ADL activities, medications, meals and leisure/rec/social activities etc.

Select **MET** if both of the following are present:

- Based on observations and limited documentation review as described above, staffing levels during the visit appear adequate to provide needed supervision and supports, and are typical with the site's usual staffing
- Staff levels allow for effective responsiveness to individuals needs and routines.

Select **NOT MET** if any:

- Based on observations and limited documentation review as described above, staffing levels during the visit appear inadequate to meet individuals' needs for support and supervision
- Staff levels do not allow for effective responsiveness to individuals' needs for supports and routines.

5-7 The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) Prompt contacting of other responsible personnel in emergencies.

635-7.3(h)(11)(i-ii) There is a communication system which ensures the following: (i) the prompt contacting of on-duty personnel; and (ii) the prompt notification of responsible personnel in the event of an emergency.

*Clinic, Large FSRs and IRAs, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

635-7.4(b)(3)(iii) The home shall have land line (see section 635-99.1 of this Part) telephone service which is in working order and functions during power outages.

*Small IRAs and FSRs*

**GUIDANCE:**

<b><u>DISCUSSION</u></b>	<b><u>DOCUMENTATION REVIEW</u></b>	<b><u>OBSERVATION</u></b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Direct support and Program management staff – to assess their knowledge of their communication responsibilities and the established communication system’s effectiveness</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Family and/or advocate</li> <li>• Individuals</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• IRMA review before visit</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Agency policy and procedure on communication system as above</li> </ul>	<p><u>As needed:</u> or if opportunity arises, the use of the communication system by staff regarding an urgent need</p>

Discuss with site staff the procedures they would follow to contact agency staff and management, especially in an emergency. Review the site specific emergency plan. Consider the following:

- Ask staff to share what they know about what is in the communication plan and where to access it on site
- Verify that the plan includes a communication system for the prompt contacting of responsible personnel in the event of an emergency.

- Based on document review, interview of Individuals and staff, determine if the plan is effective to prevent negative outcomes. By review of incidents in IRMA before the visit, ascertain if any weakness in the communication system contributed to the occurrence of the incident.
- Ascertain that the plan addresses CPR, first aid and access to emergency medical services.
- Analyze if the mechanisms of the communication system in place, if implemented correctly, has the potential to effectively handle, or prevent, an emergency situation.

**Select MET if both of the following are present:**

- An adequate and effective communication plan is in place
- Staff know the communication plan

**Select NOT MET if any of the following are present:**

- The sites does not have a communication plan
- The staff do not know the plan for communication in an emergency
- There is evidence that the communication plan is ineffective

## SECTION 6 RIGHTS and PROTECTIONS

6-1 Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.

633.4(a)(4)(ix) No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity

*Clinic, FSRs, IRAs, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u> Individuals receiving services</p> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> <li>• Program staff</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Review of incidents in IRMA. Ensure there is no pattern of disrespectful interactions and/or verbal abuse from staff (whether one employee or multiple) toward any individual (one or multiple). If problems are noted, verify that contributing factors have been satisfactorily addressed.</li> <li>• Communication log if present</li> </ul> <p><u>As needed</u></p> <ul style="list-style-type: none"> <li>• If concerns, sample of daily notes used to record day to day activities, status of individuals, and/or service delivery</li> </ul>	<p><u>Mandatory:</u> Observe interactions/communications between staff &amp; Individuals</p>

Verify that staff interact with individuals humanely and with full respect for the individual's dignity and personal integrity through observing interactions and activities among staff and individuals. While not inclusive of all considerations, assessment of this standard should include but not be limited to the following:

- Consider whether staff use a tone of voice or displays affect towards individuals appropriate to the situation and current activity.
- Individuals should be addressed using their preferred name in a respectful and age appropriate manner.
- Interactions should be collegial and not set a tone of hierarchy or power of staff over individuals. Respect includes acknowledging that each individual is the author of his/her day when provided with experiences and choices and staff's role is to provide the support they need to make decisions and engage in their choices.
- Consider whether staff communicates and engages "*with*" individuals regardless of their communication abilities in a way that acknowledges that they are the principals in the activity and service environment vs. the object of an activity or service. When staff are supporting the individual(s), they should be engaging with them rather than talking *about* them to others and/or engaging in unrelated conversations with others to the exclusion of the individual(s). While there are occasions when information needs to be relayed among staff members regarding the site's business or individual(s)' needs, status, activities, as much as possible the individual(s) should be part of the conversation and information provided from the perspective of the individual.
- Consider the appropriateness and intensity of physical supports. Individuals should be guided and physically assisted supportively as needed and appropriate to the situation vs. grabbed, pulled, jerked and pushed.
- Staff take the time to engage and interact with individuals
- If your observations or results of interview raise your concern regarding interactions, conversation content, tone of voice or specific styles of engagement ask about the person's service plan and review the applicable plan to see if it provides any perspective or explanation from a clinical perspective and are appropriate.

**Select MET** if the following are observed:

- Staff interact in a supportive matter with verbal and gestural communication as described above
- Interactions are supportive and responsive to individuals observed or expressed preferences
- Individuals and their interests and needs are the primary focus vs. the interests of staff members

**Select NOT MET** if any of the following are observed or identified through interview and/or documentation review:

- The interactions and communication are not age appropriate, e.g. adults are interacted with as if they are children interactions
- Interactions and/or communications are staff focused versus individual focused. Staff do not engage individuals while working with them. Staff talk among themselves rather than engaging individuals in the conversations.
- Staff are rude, unkind, harsh and/or intimidating toward individual(s)

Note that if staff behavior rises to the level of abuse, neglect or intimidation, the surveyor should intervene appropriately, and notify facility management.

6-2 The site is absent of generally applied rules, policies, or procedures that limit people’s rights, independence, choice and autonomy.

Memo to Providers: October 13, 2015 The site must be absent of generally applied rules, policies, or procedures that limit people’s rights, independence, choice and autonomy.

*IRAs, CRs, Apts, Day Hab,, Certified Prevoc*

Quality Indicator: The site must be absent of generally applied rules, policies, or procedures that limit people’s rights, independence, choice and autonomy.

*Clinic, IRAs, Day Training, Day Treatment, Specialty Hospitals, Private Schools*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <p>Families &amp; advocates</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Communication Log</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Posted information about home operations/rules</li> <li>• Site policy/procedures or rules if applicable</li> </ul>	<p><u>Mandatory:</u></p> <p>Observe site routine to assess if any site rules are communicated and/or encouraged that individuals are expected to follow which limit independent activities and choices</p>

**This is a systemic review of the facility/house rules/as well as agency/facility policies and procedures.** This review is different than a review of the *person's experience*.

Ask staff and people if there are any general rules. Look for any blanket restrictions on any of the HCBS Settings rights or other individual rights (including Part 633.4). In some cases, the agency may have general and systemic policies & procedures for house/program rules and resident responsibilities that will need to be reviewed. Be aware the blanket house rules are sometimes unwritten but are still routinely applied. Observation and interview may evidence if this is the case. If blanket rules are identified, determine if this is a systemic agency-wide rule or specific to the program being surveyed.

**In addition to the rights under Part 633.4, HCBS Settings Rights also include the following:**

- Written lease agreement that includes due process and protections from eviction
- Privacy in bedrooms and bathrooms
- The ability to lock bedroom doors with only appropriate staff having keys
- Having a key/access to the front door
- Being informed of living environment options and choices including living alone or with roommates I choose/prefer
- Freedom to furnish and decorate their bedroom the way that they choose (but within the agreed upon specifications in the written lease agreement)
- Freedom and support to control their own schedules and activities
- Freedom to come and go from the site at any time
- Access to food at any time
- The ability to receive visitors of their choosing at any time
- A setting that is physically accessible to the person

***Examples of "rules" or limiting policies:***

- Set times for bathroom use
- Set times when the kitchen or laundry can be accessed.
- Phone use times
- Bed times/Lights out times
- Rules regarding when and how people may leave the site that are not clinically or programmatically relevant
- Rules about when and how people can access their home or program (for example, residents are not allowed keys, cannot come home unless staff is home, or cannot access food outside of designated mealtimes, individuals cannot request to attend program for only a partial day.)
- Visitation rules and restrictions
- Restrictions to possessions, clothing, or appearance unrelated to serious safety concerns
- Restricting people from decorating their bedrooms the way that they choose
- House curfews or scheduled times that people have to return to the residence
- Strict, inflexible mealtimes.

Generalized program rules can result in unnecessary or inappropriate restrictions on choice, independence, rights and personal autonomy for people. Blanket policies and procedures and/or house rules should not unnecessarily restrict the ability of people to make choices. People should also be able to complete routine activities in a manner at the times they prefer. For example, there should not be a curfew or other requirement for a scheduled return to the setting that is applied to all residents of the setting regardless of the capabilities of the residents. There should not be blanket expectations put upon people without appropriate justification and documentation.

**Select MET if both of the following are met:**

- There are no **blanket** rules, policies/procedures, or expectations that restrict the ability of people to determine their own "schedule" for activities in and out of the program; **AND:**
- Observations and documentation review demonstrate and people/staff report that people are free to determine their activities and activity times (This means that they provide no information that there may be unwritten blanket rules restricting people).

**Select NOT MET if either of these is evident:**

- There are house or site rules/ policies/procedures or expectations that restrict people. (This does not include rules that are expectations of mutual respect and polite behavior among housemates.)

While not written explicitly, there is evidence through observation or interview that there are general understandings of blanket rules that result in restricting people without justification.

**6-3 Individuals are permitted by the program to engage in any legal activities per their interests.**

Memo to Providers: October 13, 2015 Individuals must be permitted by the program to engage in any legal activities per their interests.  
*IRAs, CRs, Apts, Day Hab, Certified Prevoc*

Quality Indicator: Best Practice: Individuals must be permitted by the program to engage in any legal activities per their interests.  
*Clinic, IRAs, Day Training, Day Treatment, Specialty Hospitals, Private Schools*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> <li>• Executive staff</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Communication Log</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Posted information about home operations/rules</li> <li>• Site policy/procedures or rules if applicable</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Observe site routine to assess if the site follows generally applied rules</li> <li>• Observe if “house” or “site” or “program” rules are posted</li> </ul>

This verifies that practices, policies and procedures in place at the setting do not prohibit the rights of people to participate in activities of their choosing (as long as the activity is legal). The residence and staff do not necessarily have to agree or believe in the choice of the individual, but it is important that the choice is still honored.

Support for activities of choice requires that meaningful discussions on risks and safeguards occur, and that people are making informed choices.

**Considerations:**

- Are the rights of people to make choices regarding their activities and associations honored?

- Are choices arbitrarily restricted or limited because of value judgments or beliefs of staff?
- Did you observe instances in which the choices of people were not honored?
- Policies and procedures or rules do not bar people's engagement in legal activities.
- Examples of legal activities include but are not limited to: Legal venues for gambling, alcohol use, sexual activity, pornography, attendance at movies with "R" ratings; etc.

**Select MET if:**

- There is evidence that people are engaging in legal activities of their choosing, and are not arbitrarily prohibited from participation in those activities.
- If people engage in legal activities that present a risk to their well-being, **it is based on informed decision-making** that includes discussion of risks, safeguards and alternatives.
- If restrictions to engage in legal activities are enforced, it is only with **specific** justification and documentation, as per CMS requirements.

**Select NOT MET if:**

- There are indications that people are denied the opportunity to engage in legal activities without justification and required documentation. **OR:**
- The facility or agency has policies and procedures or rules that prohibit legal activities.

## 6-4 Individuals have full access to the typical facilities in the site.

Memo to Providers: October 13, 2015 Individuals must have full access to the typical facilities in the site.  
*IRAs, CRs, Apts, Day Hab, Certified Prevoc*

Quality Indicator: Best Practice: Individuals must have full access to the typical facilities in the site.  
*Clinic, FSRs,, Day Training, Day Treatment, Specialty Hospitals, Private Schools*

### GUIDANCE:

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<u>As Needed for clarification:</u> <ul style="list-style-type: none"> <li>Individuals receiving services</li> <li>Program staff</li> </ul>	<u>As needed:</u> Service Plans addressing specific restrictions	<u>Mandatory:</u> Observe for environmental factors that enhance independence or impose limitations and/or dependencies as described below

Individuals should have full and independent access to all areas and routine living spaces of the residence without restrictions\* or barriers. (\*If restrictions are modified for clinical need, modifications meet the 8 requirements for such modification). The person should have access to their home and service sites and to all typical spaces in the home, with as much independence as possible as determined by the person, their skills, and individualized needs for environmental, adaptive, and human supports. Environmental modifications, the use of technology, and personal assistance from staff are all ways that a person can have greater control over and more independent access of their environment. Some people may need specialized training and encouragement to feel comfortable fully accessing and utilizing their home and its features. However, a residence may also have unnecessary “locked areas, and other practices that prevent a person’s increased access to his/her own environment.”<sup>29</sup> These questions determine if the person is being supported to increase his/her independence to move about his/her home and community.

- People should have full and independent access to all areas and routine living spaces of the residence/site without restrictions or barriers (e.g. locks, gates, requiring permission, etc.)

- People have access to and are supported to access the bathroom, kitchen, laundry, access to cupboards/closets for supplies and activity materials, areas where their excess personal possessions are stored (e.g. off-season clothing, seasonal room decorations, etc.) and use of the appliances and facilities in the home.
- The site and its facilities should be physically accessible according to the needs of the residents.
- If needed, the home or site provides environmental supports and adaptations to assist people to use and access their home environment. Adaptations may include: Grab bars, wheel chair accessibility, ramps, modified equipment, and features that support people's use of their home. For example, if a person uses a wheelchair, consider whether their closet is arranged so that their belongings are reachable by them, a counter top in the kitchen modified to support their interests in preparing meals and accessing the food and utensils
- In a residence, if the laundry, supplies and or storage are on another floor, e.g. basement or attic, or 2<sup>nd</sup> floor that is non-accessible, consider whether the residence takes action to facilitate access in a manner that does not limit autonomy or creates a staff dependent situation.
- Assess whether house/site rules and practices limit or interfere with access by the residents.
- In addition to physical access do individuals receive education and support to use equipment such as stoves, microwaves, and washer/dryer?
- Equipment is adapted, if needed, due to people' physical characteristics.
- The setting should supports ways to enhance the independence of people according to their needs and abilities? (Home modifications, use of technology, and other innovative ways that the site is able to enhance the ability of residents to have more independence).
- Ask people and staff if any modifications to the residence are needed, or have been made to increase the ability of people to access their environment.

Please Note: This applies if it is the site's **features or operations** that lead to dependence. It does not apply if people require staff assistance due to **clinical needs** that must be addressed with inclusion of access limitations, either temporarily or permanent.

**Select MET if:**

- People have full access to and use of the site and its features and appliances.
- The site is arranged and designed to facilitate independence.
- People are observed to and supported to function as independently as possible within the environment and/or supported toward independence and/or as needed.
- If barriers are in place due the needs of one or a few, the residents who can have free access are accommodated in effective ways (e.g. provided a key, physical barrier is specific only to the person clinically restricted, etc.)

- Barriers and limited access occurs only with clear clinical justification after deliberation and alternative methodologies were ineffective, and there is required supporting documentation.

**Select NOT MET if:**

- Areas of the home or site are "off limits" to people living there either by physical barriers or rules, policies, and procedures without justification and related rights limitations evidence and documentation
- Areas of the home or site are accessible only for limited time periods without justification and related rights limitation evidence and documentation.
- People are not encouraged or supported to function independently in the site or home.

The site is not conducive to ensuring independence, resulting in dependence on staff.

**6-5 Individuals' health and other protected information is kept private/protected.**

Memo to Providers: October 13, 2015 Individuals' health and other protected information must kept private/protected.  
*IRAs, CRs, Apts, Day Habs, Certified Prevoc*

633.4(a)(4)(vii) No person shall be denied: confidentiality with regard to all information contained in the person's record, and access to such information, subject to the provisions of article 33 of the Mental Hygiene Law and the commissioner's regulations. In addition, confidentiality with regard to HIV-related information shall be maintained in accordance with article 27-F of the Public Health Law, 10 NYCRR Part 63 and the provisions of section 633.19 of this Part  
*Clinic, FSRs, IRAs, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> <li>• Clinical staff</li> <li>• Families &amp; advocates</li> </ul>	<p>Documents posted and in plain view</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Observe where Individual health information &amp; protected information is stored</li> <li>• Observe for any Individual health or private information being posted at site (as described below).</li> </ul>

***Assess this standard through observation of the program***

The standard addresses both protection of an individual's personal information as well as whether the facility is creating a homelike environment (residences) or a community friendly environment (day settings). Having protected health information and other personal information publicly posted is a violation of the person's right to privacy. Besides violating the person's right to privacy, it also contributes towards creating a more clinical

and institutional atmosphere more like that of a hospital/clinic than that of someone's home or integrated service environment. This type of personal information should be discreetly available only to relevant staff that need access to the information.

- **Things to consider:** Are diagnosis, health care regimens, or other personal information related to the person's ID/DD services in view of others?
- Are person-specific diet orders and food consistency requirements posted visibly for anyone to see?
- Are bowel management regimens posted publicly in the program?
- Are medical appointment notices, changes in medications, and other private and personal health care information posted publicly and visibly?

**Select MET if:**

- There is no evidence of private information being accessible to other residents, visitors, etc., in the site based on observation and walk through.

**Select NOT MET if any of the following are evidenced:**

- Schedules for people's private medical appointments and medical information are posted in the site visible to anyone.
- People's dietary restrictions/modifications are posted and visible to anyone.
- Other information considered private is not secured but posted, visible, and/or available to others to view.

## 6-6 People have privacy in their living quarters as appropriate to the situation.

Memo to Providers: October 13, 2015 People have privacy in their living quarters as appropriate to the situation.  
*IRAs, CRs, Apts.*

633.4(a)(4)(xx) No person shall be denied: a reasonable degree of privacy in sleeping, bathing and toileting areas  
*FSRs, IRAs, CRs, Apts, Private schools, Specialty hospitals, and Pre-Voc.*

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Families &amp; advocates</li> <li>• Clinical staff</li> </ul>	<p><u>As needed:</u></p> <p>Service Plans addressing specifics of a person not having privacy in their living quarters</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Observe for any breaches in privacy (as described below)</li> </ul>

The privacy of a person supported should be respected in all aspects of life. Preservation of the person's right to privacy is a basic human dignity. The residence and staff must ensure that the person's need for privacy is respected and protected. This includes being able to have private conversations, having a say in who has access to their personal possessions and living space, as well as having privacy in bathing, grooming, and dressing. This question must be answered through observation of the residence and interview with the person.

Via **observation**, verify the following:

- Staff do not talk with the person about private issues in front of others
- Staff do not communicate among themselves about any individual in front of others

- Staff respect the person's privacy by asking the person's permission (e.g. knocking and making request), waiting for a response, before entering his/her bedroom or living space.
- People can find space to have hold private conversations with others present or communication mechanisms.
- Bedroom doors close and latch. Persons who wish to, can lock their bedroom door and have a key (or modified secure entry method) to his/her bedroom with only appropriate staff also having access to a 'key'.
- The bathroom provides privacy for the person. The door be closed and locked.
- The individual is afforded privacy in the bathroom and bedroom, which is only breached based on identified clinical needs for assistance and supervision related to their safety.
- In shared bedrooms, does persons have the degree of privacy desired and possible.
- Persons have the opportunity to be by him/herself throughout the day or evening.
- Individuals provide consent regarding who has access to personal information about them.
- If applicable, the person given the opportunity to take their medications and receive treatments privately.
- Persons are supported, assisted, and reminded to facilitate their own privacy.
- Individuals, their peers and housemates are supported, reminded, and assisted to respect each other's privacy.
- There are no other observed potential barriers to the person's privacy.

**Via Interviews** with Persons supported, verify the following:

- They have enough privacy when dressing, using the bathroom, or bathing.
- They can decide who can enter their bedroom.
- They have their own key (or other modified secure access) to their bedroom. They know which staff also has a key.
- He/she can be by him/herself when they want to be.
- He/she believes that staff respects their privacy.

**Select MET if all the following are present:**

- Observations evidence that privacy of individuals is respected as described above
- Individuals as capable, report that their privacy is assured according to their needs

- Staff take action to maintain the privacy of individuals in their daily activities and social interactions (phone use, social media and computer use, conversations) as needed

Select **NOT MET** if any of the following are evident:

- The privacy of individuals (as described above) is not considered/respected as observed in the actions of staff and operations of the home
- Documentation or interview reveals a pattern of disregard or lack of support for peoples' privacy in their own space, in their conversations and social interactions, and/or in the assistance provided for personal care.

## 6-7 People have access to food at any time.

Memo to Providers: October 13, 2015 People must have access to food at any time  
*IRAs, CRs, Day –Hab, Certified Prevoc,*

Quality Indicator: Best Practice: People must have access to food at any time  
*Private Schools*

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program/Agency/Clinical staff</li> </ul>	<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• If limitations or unable to assess through interview and observation review service plans or plan components addressing specifics of behavioral and/or dietary needs for support and guidelines (including consistencies)               <ul style="list-style-type: none"> <li>○ E.g. IPOP, behavior support plan, dietary support plan, NCP</li> </ul> </li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Observe for any limitations on Individual(s) having access to foods, to include choices with meals (as described below)</li> </ul>

This requirement means that people should have opportunities to choose the foods they want to eat, have the ability to store food in their room if they choose, eat in their room, and decide when to eat. Presenting a person with narrow food choice options, without their input, does NOT satisfy this requirement. Having access to food at any time does NOT mean that FULL dining services or meals should be available 24 hours a day, but rather applies to having **ACCESS** to food at any time.

**Rights Modification:** Through your interview and review of the person’s record, determine if there have been any restrictions placed on the person’s access to food. Any modification or restriction to a person’s food choices or choice of mealtimes is considered a restriction of the person’s rights. If

there is an appropriate rights modification documented that restricts the right of the person to have access to food at any time, the rights modification must have been discussed and reviewed as part of the person-centered planning process and must be supported by a specific assessed need. ***If related to an assessed behavioral need, it must be documented in a Behavior Support Plan in accordance with all of the requirements of 633.16 (assess separately as needed).***

**Please Note:** If other people are impacted by a restriction that is necessary for a specific person, the expectation is that reasonable approaches are taken to support the people who are impacted by the restriction and arrangements should be made so that other individuals have the right to access food at any time. This might mean having a means to request and gain access to food when they want, having a secure and locked pantry in their own room, or having a key to access the locked kitchen or pantry. For those affected by a rights restriction for someone else, **documentation** of the following is required in their person-centered service plan (or attachments):

1. The **impact** that the rights modification has on the person
2. The **efforts taken to lessen the impact** on the person, **and**:
3. The written **informed consent** of the person

**Select MET if:**

- In residences, people have access to food 24-7, either through storing the food in their room and/or getting food from the refrigerator, pantry, and/or being supported, as needed to obtain food at any time, as appropriate to their individualized need. In day settings, people may have a meal/snack at a time and place of their choosing consistent with people in similar settings not receiving waiver services
- If a person does not have free access to food, there is an appropriate rights modification in place through the person-centered planning process that includes all the required elements.
- The residence/staff makes clear that access to food is the person's right unless there is an appropriate rights modification.
- The staff/service setting provided support to individuals to budget, purchase, and store food that they choose so that it is available to the person at any time, consistent with and appropriate to people in a similar setting, similar unless there is an appropriate rights modification in place.
- **Note:** if the rights modification includes all of the required elements and has been appropriately considered through the PCP process, the answer can be MET.

**Select NOT MET if:**

- The person does not have access to food at any time
- The person is not supported to purchase/store food per their interest (residential and if applicable for day setting).

- There are blanket rules/policies or operational practices in place that are obstacles/barriers to this right.

If the person has a rights modification, or is affected by someone else’s rights restriction, but it does **not** contain the required elements.

## 6-8 People can choose to eat meals where/when desired.

Memo to Providers: October 13, 2015 People must be allowed to choose to eat meals where/when desired  
*IRAs, CRs, Day –Hab, Certified Prevoc,*

Quality Indicator: Best Practice: People must be allowed to choose to eat meals where/when desired  
*Private Schools*

### GUIDANCE:

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<u>Mandatory:</u> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program/Agency/Clinical staff</li> </ul>	<u>As needed:</u> <ul style="list-style-type: none"> <li>• If limitations or unable to assess through interview and observation review applicable service plans or plan components addressing specifics of behavioral and/or dietary needs for support and guidelines (including consistencies)               <ul style="list-style-type: none"> <li>○ E.g. IPOP, behavior support plan, dietary support plan, NCP</li> </ul> </li> </ul>	<u>Mandatory:</u> <ul style="list-style-type: none"> <li>• Observe for any limitations on Individual(s) having access to foods, to include choices in mealtimes (as described below)</li> </ul>

Also refer to guidance in 6-7 regarding access to food at any time. The right to access food at any time also means that people can not only choose what food that they want, they also have the right to decide where and when they eat.

It is recognized that homes and day service settings may have some routines in place regarding mealtimes, break times, snack times. These routines should be related to the schedules, interests and requests of the individuals, rather than staff preference, staff schedules or facility organizational

practices. Even with a daily or weekly routine, individuals should have the ability to eat their meals at other times chosen by them and may choose where to eat.

While more difficult in some day settings, individuals should be allowed to have a meal/snack at the time and place of their choosing consistent with day and work settings of people not receiving waiver services. The setting should provide access to an area for breaks and meals that is conducive to eating/drinking. Individuals should be afforded an alternative location for meals if requested.

**Please Note:** Any change to a person's right to eat where and when desired is considered a rights restriction and must be supported by a specific assessed need and justified in the person-centered plan or behavior support plan., See guidance on standard 4.6 for further specific rights modification documentation requirements.

**Select MET if:**

- Individuals report being able to eat their meals when they choose, if they do not wish to have their meal at the scheduled time.
- During observation of meal times, people are not coerced to come to the table and eat at a 'designated' time.
- During interviews with staff and others and/or documentation review, it is evident that there is flexibility provided for meals to accommodate individual schedules and preferences.

**Select NOT MET if:**

- During observation, people appear to be coerced to eat during the routine mealtime.
- A person requests to have their meal in their room or at another time and staff does not honor the request.
- There is documentation/written evidence that indicates there is no choice/flexibility to alter one's mealtime schedule.

**6-9 Events that meet the definition of reportable incident or notable occurrence have been reported.**

624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part. Custodians of programs and facilities certified or operated by OPWDD are mandated reporters and are also required to report reportable incidents pursuant to section 491 of the Social Services Law. Reports shall be made in accordance with agency policies/procedures.

Clinic, FSRs, IRAs, Apts, CRs, Day Training, Day treatment, Day Hab, Private Schools, Specialty Hospitals, Certified Pre-Voc

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Staff</li> <li>• Families &amp; advocates</li> </ul> <p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• Management and/or Clinical staff</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• IRMA</li> <li>• Review site documents/records for the previous three (3) months such as daily logs, house logs, communication logs, accident reports, etc., in order to verify that all events that should have been reported as incidents or notable occurrences have been so reported.</li> <li>• If Minor notable occurrence is discovered, request verification of form OPWDD 147 and notification to Executive Director</li> </ul> <p><u>As Needed to clarify information:</u></p> <ul style="list-style-type: none"> <li>• Accident/Injury reports</li> <li>• Service notes</li> <li>• Health care documentation</li> </ul>	<p>If an incident is observed during visit, verify that the event was reported per requirements once the individual(s) needs for protections and care are addressed.</p>

Verify that agency employees, interns, volunteers, consultants, contractors, and family care providers who are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence, have done so.

Speak with staff, individuals receiving services, family members regarding significant events involving individuals. Ask staff persons if there have been any recent significant events, injuries, ER visits, etc. Follow up on any information provided by staff to assess whether it should have been reported as an incident or notable occurrence and whether it was or was not.

**Select MET if:**

- Known incidents or occurrences requiring reporting are confirmed to have been reported.

**Select NOT MET if :**

- Events meeting the definition of an incident or occurrence requiring to be reported to OPWDD, the Justice Center, and/or Agency Executive management are noted, discussed or discovered during site review but were not reported in IRMA (Significant incident and Serious Notable Occurrence) or via 147 in the case of a Minor notable occurrence (state operated report MNOs in IRMA, voluntary agencies may but are not required).

**Select N/A if:**

- No incidents or occurrences requiring reporting occurred based on review findings.

**6-10 Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.**

625.4(a) Reporting to OPWDD. The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (a)(1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA).(a) (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. (a) (3) The agency must report updates on the event or situation in IRMA on a monthly basis or more frequently upon the request of OPWDD until the event or situation is resolved. Such updates must include information about subsequent interventions (see section 625.3[b] of this Part) and must include information about the resolution of the event or situation. (a) (4) Requirements concerning OPWDD involvement in deaths that are not under the auspices of an agency are in section 625.5 of this Part.

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625.5(c)(2): The agency must submit an initial report about the death in IRMA within 24 hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD

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**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Staff</li> <li>• Families &amp; advocates</li> </ul> <p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• Management and/or Clinical staff</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• IRMA</li> <li>• Review site documents/records for the previous three (3) months such as daily logs, house logs, communication logs, accident reports, etc., in order to verify that all events that should have been reported as incidents or notable occurrences have been so reported.</li> <li>• If event/situation is discovered, request verification of form OPWDD 150 and/or recheck IRMA if applicable to the type of event.</li> </ul> <p><u>As Needed to clarify information:</u></p>	<p>N/A</p>

- |  |   |  |
|--|---|--|
|  | <ul style="list-style-type: none"> <li>• Accident/Injury reports</li> <li>• Service notes</li> <li>• Health care documentation</li> </ul> |  |
|--|---|--|

~This applies to events occurring **not under the auspices** of the agency~

Events and situations to be reported include those that meet the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation.625.4(a); Deaths 625.5(c)(2)

Speak with staff, individuals receiving services, family members regarding significant events involving individuals. Ask staff persons if there have been any recent significant events. Follow up on any information provided by staff to assess whether it should have been reported and whether it was or was not. Per 625.4(a) (1) applicable events should be entered into IRMA.

**Select MET if:**

- Known events/situations requiring reporting are confirmed to have been reported.
- No events/situations requiring reporting occurred based on review findings.

**Select NOT MET if :**

- Events/situations meeting the definition of an situation requiring to be reported to OPWDD and/or Agency Executive management are noted, discussed or discovered during site review but were not reported in IRMA (Significant incident and Serious Notable Occurrence) or via form OPWDD 150.

**Select N/A if:**

No events or situations requiring reporting occurred based on review findings.

**6-11 Immediate care and treatment identified was provided to the individual involved in the incident.**

Pre 01/01/16: 624.5(f)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she shall take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse.

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Post 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse.

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Post 01/01/16 624.5(g)(4) If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained.

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**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Staff</li> <li>• Families &amp; advocates</li> <li>• Management and/or Clinical staff</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• IRMA</li> <li>• As needed incident documentation not required to be entered into IRMA due to classification of event</li> </ul> <p><u>As Needed to clarify information:</u></p> <ul style="list-style-type: none"> <li>• Service notes</li> <li>• Health care, clinical documentation</li> </ul>	<p>N/A</p>

**SAMPLING FOR All IRAs/CRs and FSRs and Day Programs <20 capacity**

- review this standard for the 5 most recent RIs and 3 most recent Notable Occurrences reported for the site

**SAMPLING FOR DAY PROGRAMS >20**

- Review this standard for 10% sample of RIs maximum 10
- Review this standard for the five most recent Notable Occurrences

A person's safety must always be the primary concern of the chief executive officer (or designee). The agency must take the necessary and reasonable steps to ensure that a person receiving services who has been affected by the event receives any necessary treatment or care whether medical, clinical or supportive.

In addition, If a person is physically injured, an appropriate medical examination of the individual must be obtained. The name of the examiner must also be recorded and his or her written findings must be maintained. (624.5(g)(4))

The IRMA reporting of the event should document initial treatment and care provided to the person. Verify that this was implemented through documentation review and interview. Ensure that this care appears to be adequate.

**Select MET if:**

- There is evidence verifying that the care and treatment documented as provided to the individual was indeed provided.

**Select NOT MET if:**

- You are unable to verify that the care and treatment documented as provided to the individual was indeed provided.

**Select N/A if:**

There were no incidents or occurrences.

**6-12 Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.**

**Pre 01/01/16:** 624.5(f)(2-3) (f) (2) When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person shall be removed from direct contact with, or responsibility for, all persons receiving services from the agency.

(f) (3) When appropriate, an individual receiving services shall be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility.

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**Post 01/01/16:** 624.5(g)(1-3); (1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse.

(2) When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency.

(3) When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. ALL

*Clinic, FSRs, IRAs, Apts, CRs, Day Training, Day treatment, Day Hab, Private Schools, Specialty Hospitals, Certified Pre-Voc*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Staff</li> <li>• Families &amp; advocates</li> <li>• Management and/or Clinical staff</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• IRMA</li> <li>• As needed incident documentation not required to be entered into IRMA due to classification of event</li> </ul> <p><u>As Needed to clarify information:</u></p> <ul style="list-style-type: none"> <li>• Documentation of initial training, staff enhancement, or other initial protective actions as relevant if not already noted and validated in IRMA</li> </ul>	<p>N/A</p>

**SAMPLING FOR All IRAs/CRs and FSRs and Day Programs <20 capacity**

- review this standard for the 5 most recent RIs and 3 most recent Notable Occurrences reported for the site

**SAMPLING FOR DAY PROGRAMS >20**

- Review this standard for 10% sample of RIs maximum 10
- Review this standard for the five most recent Notable Occurrences

The IRMA reporting of the event should document initial actions taken to protect the individual(s). Verify that this was implemented through documentation review and interview. Ensure that the actions appear to be adequate.

- An employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency.
- An individual receiving services shall be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility.
- Immediate protection may also include provision of increased staff support and/or supervision, specialized equipment, immediate changes in interventions, etc.

**Select MET if:**

- There is evidence verifying that initial protective measures that were documented as part of the reporting and investigation were implemented.

**Select NOT MET if:**

- You are unable to verify that the initial protective measures were provided.

**Select N/A if:**

- There were no incidents or occurrences.

## 6-13 Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.

**Pre 01/01/16:** 624.5(g)(1); 624.5(g)(3); 624.5(g)(5)

(g) (1) Any report of a reportable incident or notable occurrence (both serious and minor) shall be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision (h) of this section).

(3) Investigations conducted by agencies or the Central Office of OPWDD shall incorporate the following:

(i) If a person is physically injured, an appropriate medical examination of the injured person shall be obtained. The name of the examiner shall be recorded and his or her written findings shall be retained.

(ii) Witnesses to the incident or occurrence shall be identified and shall be interviewed in as private an environment as possible.

(iii) Interviews should be conducted separately by qualified, objective parties. Interviews of individuals receiving services should be conducted by parties with an understanding of the persons' unique needs and/or capabilities.

(iv) Pertinent information shall be reviewed (e.g., records, photos, observations of incident scene, expert assessments).

(v) Physical evidence, if any, shall be identified and appropriate steps shall be taken to safeguard and preserve physical evidence.

(5) When an agency is responsible for the investigation, the investigation shall be documented. Such documentation shall include an investigative report.

(5) (i) For all reportable incidents and notable occurrences, investigative reports shall be in the form and format specified by OPWDD or in a similar format approved by the Central Office of OPWDD. At a minimum, the report shall contain the following information:

(i) (a) identifying data, such as the name(s) of person(s) receiving services involved in the incident or occurrence; the date the incident/occurrence was reported and/or discovered; the classification of the incident; and the incident/occurrence number. For incidents/occurrences entered into IRMA, this includes the master incident number assigned by IRMA;

(i) (b) a description of the incident or notable occurrence;

(i) (c) immediate protections provided to person(s) receiving services;

(i) (d) investigatory question(s);

(i) (e) a description of the investigative process and specific evidence obtained;

(i) (f) a summary of the evidence obtained in the investigation;

(i) (g) conclusions, including the findings (see subdivision (i) of this section) in the case of a report of abuse or neglect; and

(i) (h) recommendations, including recommendations for remedial actions.

(5) (ii) For reportable incidents and serious notable occurrences, the full text of the investigative report shall be entered into IRMA pursuant to subparagraph 624.5(e)(1)(iii). (Note: In the event that the Central Office of OPWDD conducts an investigation of an incident or notable occurrence, the Central Office of OPWDD will enter the investigative report into IRMA.)

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**Post 01/01/16:** 624.5(h)(1); 624.5(h)(3); 624.5(h)(5)

*General investigation requirements.*

(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section).

(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.

(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete.

*Clinic, FSRs, IRAs, Apts, CRs, Day Training, Day treatment, Day Hab, Private Schools, Specialty Hospitals, Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• Agency investigator</li> <li>• Individuals receiving services</li> <li>• Staff</li> <li>• Families &amp; advocates</li> <li>• Management and/or Clinical staff</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• IRMA</li> <li>• As needed incident documentation not required to be entered into IRMA due to classification of event</li> </ul> <p><u>As Needed to clarify information:</u></p> <ul style="list-style-type: none"> <li>• Documentation of initial training, staff enhancement, or other initial protective actions as relevant if not already noted and validated in IRMA</li> </ul>	<p><u>As Needed:</u> only necessary if information in the investigation report seems incongruent to the setting.</p>

**SAMPLING FOR All IRAs/CRs and FSRs and Day Programs <20 capacity**

- review this standard for the 5 most recent RIs **that are NOT allegations of physical or sexual abuse, or deaths** and 3 most recent Notable Occurrences reported for the site

**SAMPLING FOR DAY PROGRAMS >20**

- Review this standard for 10% sample of RIs maximum 10 **that are NOT allegations of physical or sexual abuse, or deaths**
- Review this standard for the five most recent Notable Occurrences

**Note:** IMU staff review investigations for the excluded reportable incident classifications.

Review investigation reports and investigative record when available as entered into IRMA. Request and review additional documentation from the provider agency for events that do not require record upload and/or entry into IRMA (e.g. MNOs).

Investigations may vary in their scope and intensity depending on the event, location and circumstances. In all cases, investigation reports/records should demonstrate every effort to determine what happened. In some cases, the investigation may need to determine whether the event actually occurred. Investigative reports should include specifics such as what happened, when it happened, who was involved; who was present, where the situation occurred, and whether the event is indicative of abuse, neglect or mistreatment. Staffing levels, environmental factors, immediate response/protective actions and/or care provided, and relevant information from the individual's program plan and/or health care plan should also be considered. Based on analysis of that information the investigation report should provide an explanation of why the event happened by identifying contributing factors and probable causes. Based on the identified causes and contributing factors appropriate recommendations should be made to address the event and to prevent similar events from occurring in the future.

Review of the investigation should consider the following:

- Were the circumstances of the event (e.g. timeframe, place, people present, activity, etc.) established?
- Did the investigation include a review of immediate care provided to individuals?
- Was information gathered (e.g., statements and/or interviews) from witnesses and all other relevant parties? (These parties may include, but are not limited to, clinical service providers who can provide relevant information, but who did not witness the incident.)
- Were relevant medical and clinical assessments conducted prior or subsequent to the incident and was relevant documentation reviewed?
- Was other documentation reviewed based on the nature of the event? (These records may include staff communication logs, staff schedules, service plans, IPOP, BSPs and behavior documentation, prn notes, medication records, training records, etc.)
- Were conclusions made based on the findings
- Were recommendations made to address causes of the incident and prevention of similar incident?

Paragraph 624.5(h)(4)(i) requires that the investigative report must be in the form and format specified by OPWDD. The “Form OPWDD 149” is the required form and format specified by OPWDD. The form must be completed for all investigations that a provider agency is required to complete, including reportable incidents and all notable occurrences.

The form is designed to document a detailed record of an investigation, including specific information about information collected and interviews conducted during the investigation. All fields of the report must be completed as applicable to each investigation

**Select MET if both of the following are evident:**

- The investigation on the whole addresses the key factors and questions applicable to the reported event as described above, leading to reasoned conclusions and recommendations.
- The OPWDD form was used to document the investigative report.

**Select NOT MET if either of the following are evident:**

- The investigation fails to address key aspects applicable to the reported event as described above
- The OPWDD form was not used to document the investigative report.

**Select N/A if:**

- There were no incidents or occurrences.

## 6-14 Measures identified to **prevent future** similar events were planned and implemented.

### Pre 01/01/16

624.5(g)(1);(3);(5) (g) (1) Any report of a reportable incident or notable occurrence (both serious and minor) shall be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision (h) of this section).

(3) Investigations conducted by agencies or the Central Office of OPWDD shall incorporate the following:

(i) If a person is physically injured, an appropriate medical examination of the injured person shall be obtained. The name of the examiner shall be recorded and his or her written findings shall be retained.

(ii) Witnesses to the incident or occurrence shall be identified and shall be interviewed in as private an environment as possible.

(iii) Interviews should be conducted separately by qualified, objective parties. Interviews of individuals receiving services should be conducted by parties with an understanding of the persons' unique needs and/or capabilities.

(iv) Pertinent information shall be reviewed (e.g., records, photos, observations of incident scene, expert assessments).

(v) Physical evidence, if any, shall be identified and appropriate steps shall be taken to safeguard and preserve physical evidence.

(5) When an agency is responsible for the investigation, the investigation shall be documented. Such documentation shall include an investigative report.

(5) (i) For all reportable incidents and notable occurrences, investigative reports shall be in the form and format specified by OPWDD or in a similar format approved by the Central Office of OPWDD. At a minimum, the report shall contain the following information:

(i) (a) identifying data, such as the name(s) of person(s) receiving services involved in the incident or occurrence; the date the incident/occurrence was reported and/or discovered; the classification of the incident; and the incident/occurrence number. For incidents/occurrences entered into IRMA, this includes the master incident number assigned by IRMA;

(i) (b) a description of the incident or notable occurrence;

(i) (c) immediate protections provided to person(s) receiving services;

(i) (d) investigatory question(s);

(i) (e) a description of the investigative process and specific evidence obtained;

(i) (f) a summary of the evidence obtained in the investigation;

(i) (g) conclusions, including the findings (see subdivision (i) of this section) in the case of a report of abuse or neglect; and

(i) (h) recommendations, including recommendations for remedial actions.

(5) (ii) For reportable incidents and serious notable occurrences, the full text of the investigative report shall be entered into IRMA pursuant to subparagraph 624.5(e)(1)(iii). (Note: In the event that the Central Office of OPWDD conducts an investigation of an incident or notable occurrence, the Central Office of OPWDD will enter the investigative report into IRMA.)

*Clinic, FSRs, IRAs, Apts, CRs, Day Training, Day treatment, Day Hab, Private Schools, Specialty Hospitals, Certified Pre-Voc*

**Post 01/01/16:** 624.5(h)(1); (3); (5) *General investigation requirements.*

(1) *Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section).*

(3) *When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.*

(5) *The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete.*

*Clinic, FSRs, IRAs, Apts, CRs, Day Training, Day treatment, Day Hab, Private Schools, Specialty Hospitals, Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Program staff</li> <li>• Individuals receiving services</li> <li>• Families &amp; advocates</li> <li>• Management and Clinical staff</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• IRMA</li> </ul> <p><u>As Needed Depending on the Recommendations related to the Incident or Occurrence:</u></p> <ul style="list-style-type: none"> <li>• Communication logs</li> <li>• Service documentation</li> <li>• Health Care Documentation</li> <li>• Clinical Assessments</li> <li>• Service plans, IPOP, ISP</li> <li>• Staff training documentation</li> <li>• Revised written policy/procedure</li> </ul>	<p><u>Mandatory</u> if visual verification of corrective and/or preventative action is necessary; e.g. installation of grab bars, physical plant renovations.</p>

This requirement is about verifying that recommendations to prevent similar situations from occurring again, are implemented.

**SAMPLING FOR ALL IRAs/CRs and FSRs and Day Programs <20 capacity**

- review this standard for the 5 most recent RIs and 3 most recent Notable Occurrences reported for the site

**SAMPLING FOR DAY PROGRAMS >20**

- Review this standard for 10% sample of RIs maximum 10
- Review this standard for the five most recent Notable Occurrences

This requirement is meant to address verification of the implementation of actions that are recommended by non-Justice Center sources: i.e. the agency investigator; OPWDD Office of Investigations and Internal Affairs (OIIA); and/or Agency Incident Review Committee. Implementation of Justice Center recommendations are reviewed in #7-16 below.

Review documentation and verify that the actions related to the person, the site, and or the service were implemented. The corrective actions may be identified by: the agency investigator; OPWDD Office of Investigations and Internal Affairs (OIIA); Agency Incident Review Committee or the Justice Center investigation or letter of determination (if JC is the source, review under #7-16 below). These corrective and/or preventive recommendations and or actions will be documented in the investigative report, IRC minutes or may be identified as a separate plan for prevention/correction/remediation. The actions may include site and support staff training, staffing issues, supervision and oversight, service plan clarifications, revision of the ISP/program plan related to changes in the services, supports or care; etc.

On Site Verification:

While documentation of actions taken will be available in IRMA, DQI surveyors may need to complete additional activities on survey to verify that actions required were implemented and effective, (e.g. verify that staff understand their responsibilities related to training, new procedures, new service plan result in improved supervision or better strategies to address behaviors; verify that equipment has been provided and helpful, verify that medical interventions are provided, etc.) Take action to verify those actions related to the person, the site and or the service. This should be verifiable through observation, interview and additional (if necessary) documentation review.

Some systemic agency corrective actions that would not be verifiable in the site or service level operations will be reviewed during a separate process during agency reviews.

The regulatory references below indicate the requirements of the agency to take action to implement actions and recommendations to prevent further incidence of similar events.

- Paragraph 624.7(b)(2) applies to all incidents and occurrences. As the incident review committee must “ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences...”,
- Paragraphs 624.5(k)(1)-(3) apply to plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (The plans must be developed within 10 days of IRC review.)
- Paragraph 624.5(i)(2) applies to incidents or occurrences that are investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities). (Recommendation must be implemented or justification for not implementing recommendation and alternative plan must be submitted to OPWDD within a month after the recommendation is made.)

**Select MET if:**

- There is evidence verifying that preventive/corrective actions were implemented.

**Select NOT MET if:**

- You are unable to verify that the preventive/corrective actions were implemented.

**Select N/A if:** There were no incidents or occurrences.

**6-15 Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.**

**Pre 01/01/16**

624.5(h)(3) When the Justice Center makes findings concerning matters referred to its attention and the Justice Center issues a report and recommendations to the agency regarding such matters, the agency shall make a written response, within ninety days of receipt of such report, of action taken regarding each of the recommendations in the report. Effective June 30, 2013, when the agency is responsible for the investigation of an incident or notable occurrence, such investigation shall be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation shall be considered complete upon completion of the investigative report.

624.5 (l) (1) Investigations that were initiated for incidents that occurred before June 30, 2013 shall be completed no later than July 29, 2013.

However, this does not apply to incidents that occurred before June 30, 2013 but were not discovered until on or after June 30, 2013.

624.5 (l) (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency shall document its justification for the extension. Circumstances that may justify an extension include (but are not limited to):

624.5 (l) (2) (i) whether a related investigation is being conducted by an outside entity (e.g. law enforcement) that has requested that the agency delay necessary investigatory actions; and

624.5 (l) (2) (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g. an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).

624.5(l)(1)-(2) Effective June 30, 2013, when the agency is responsible for the investigation of an incident or notable occurrence, such investigation shall be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation shall be considered complete upon completion of the investigative report. (1) Investigations that were initiated for incidents that occurred before June 30, 2013 shall be completed no later than July 29, 2013. However, this does not apply to incidents that occurred before June 30, 2013 but were not discovered until on or after June 30, 2013.

(2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency shall document its justification for the extension.

*Clinic, FSRs, IRAs, Apts, CRs, Day Training, Day treatment, Day Hab, Private Schools, Specialty Hospitals, Certified Pre-Voc*

**Post 01/01/16**

624.5(l) *Corrections in response to findings and recommendations made by the Justice Center.*

*When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must:*

*(1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and*

*(2) submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. Clinic, FSRs, IRAs, Apts, CRs, Day Training, Day treatment, Day Hab, Private Schools, Specialty Hospitals, Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Program staff</li> <li>• Individuals receiving services</li> <li>• Families &amp; advocates</li> <li>• Management and Clinical staff</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• IRMA</li> </ul> <p><u>As Needed Depending on the Recommendations related to the Incident or Occurrence:</u></p> <ul style="list-style-type: none"> <li>• Communication logs</li> <li>• Service documentation</li> <li>• Health Care Documentation</li> <li>• Clinical Assessments</li> <li>• Service plans, IPOP, ISP</li> <li>• Staff training documentation</li> </ul> <p>Revised written policy/procedure</p>	<p><u>Mandatory</u> if visual verification of corrective and/or preventative action is necessary; e.g. installation of grab bars, physical plant renovations.</p>

**REVIEW OF JUSTICE CENTER CAPs**

- Identify **ALL** Reportable Incidents of Abuse and Neglect that were required to report a Corrective Active Plan (CAP) to the Justice Center. CAPs required for Reportable Incidents of Abuse and Neglect will be identified and available through IRMA, inclusive of the plan and documentation related to implementation. Verify that the CAP was implemented effectively. **Only the cap plan in IRMA can be considered.**

*This requirement is different from #8 above as it **applies only to Corrective Action Plans (CAPs) developed in response to recommendations directed by the Justice Center.** So while recommendations for actions to address, prevent, and correction can come from multiple sources as noted in #8*

above, this review is specifically for the actions taken on recommendations resulting from the Justice Center investigation or letter of determination. For **reports of abuse/neglect** a plan for prevention/remediation must be developed within 60 days of the date of the Letter of Determination from the Justice Center. The plan must include projected dates of implementation and the agency staff responsible to monitor the implementation and efficacy of the actions. As of 01/01/15 this plan is referred to as the Corrective Action Plan (CAP).

Agencies are required to upload/enter CAP information for reportable incidents of abuse/neglect occurring after January 1, 2015. IRMA will enable this upload effective January 15, 2015.

In IRMA you will be able to review:

- The completed OPWDD 161-Corrective Action Plan Submission Form. The OPWDD 161 will indicate all corrective actions recommended and the agency response/actions to be taken in response to each recommendation
- Documentation evidencing of the implementation of each recommendation (e.g. staff training sign-in sheet, revised service plan, communication memo, revised policy and procedure, equipment purchase, etc. Corrective actions may also be identified in the Justice Center investigation or Letter of Determination)

Agencies are required to upload/enter CAP information for reportable incidents of abuse/neglect occurring after January 1, 2015, so information will be available for your review through IRMA effective January 15, 2015.

In IRMA you will be able to review:

- The completed OPWDD 161-Corrective Action Plan Submission Form. The OPWDD 161 will indicate all corrective actions recommended and the agency response/actions to be taken in response to each recommendation
- Documentation evidencing of the implementation of each recommendation (e.g. staff training sign-in sheet, revised service plan, communication memo, revised policy and procedure, equipment purchase, etc.,

On Site Verification:

While documentation of actions taken will be available in IRMA, DQI surveyors may need to complete additional activities on survey to verify that actions required were implemented and effective, (e.g. verify that staff understand their responsibilities related to training, new procedures, new service plan result in improved supervision or better strategies to address behaviors; verify that equipment has been provided and helpful, verify that medical interventions are provided, etc.) Take action to verify those actions related to the person, the site and or the service. This should be verifiable through observation, interview and additional (if necessary) documentation review.

Some systemic agency corrective actions, that would not be verifiable in the site or service level operations, will be reviewed during a separate process during agency reviews.

**Select MET if:**

- There is evidence verifying that corrective actions reported in CAP were implemented.

**Select NOT MET if:**

- You are unable to verify that the corrective actions in CAP were implemented.

**Select N/A if:**

There were no incidents or occurrences.

**6-16 Part 625 events and actions reported in IRMA regarding recommendations, were implemented as reported.**

625.3(b)(1-6) The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following: (1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties;(3) interviewing the involved individual and/or witnesses;(4) assessing and monitoring the individual;(5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.

*Clinic, FSRs, IRAs, Apts, CRs, Day Training, Day treatment, Day Hab, Private Schools, Specialty Hospitals, Certified Pre-Voc*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Program staff</li> <li>• Individuals receiving services</li> <li>• Families &amp; advocates</li> <li>• Management and Clinical staff</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• IRMA</li> </ul> <p><u>As Needed Depending on the Recommendations related to the event or Occurrence:</u></p> <ul style="list-style-type: none"> <li>• Communication logs</li> <li>• Service documentation</li> <li>• Health Care Documentation</li> <li>• Clinical Assessments</li> <li>• Service plans, IPOP, ISP</li> <li>• Staff training documentation</li> <li>• Revised written policy/procedure</li> </ul>	<p><u>Mandatory</u> if visual verification of corrective and/or preventative action is necessary; e.g. installation of grab bars, physical plant renovations.</p>

**Sample: Review at least the 5 most recent reported Part 625 events/occurrence.**

IRMA information will include OPWDD recommendations for and event. See BPC Preparation Instructions in general guidance.

Review the information and take action to verify those actions related to the person, the site and or the service. These may include site and support staff training, staffing issues, supervision and oversight, service plan clarifications, etc. This should be verifiable through documentation review, observation and interview dependent on the actions needed.

Systemic agency corrections will be reviewed during a separate process.

625.4 (b)(2) When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency shall either:

- (i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or
- (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

**Select MET if:**

- There is evidence verifying that recommendations were implemented.

**Select NOT MET if:**

- You are unable to verify that the recommendations were implemented.

**Select N/A if:**

There were no incidents or occurrences.

## SECTION 7 SITE & SAFETY

7-1 The residence appears “home-like”, rather than Institutional.

Memo to Providers: October 13, 2015 (441.301(c)(5)) The residence must appear “home-like”, rather than Institutional.  
*IRAS, CRs, Apts.*

Quality Indicator Best Practice: The residence must appear “home-like”, rather than Institutional.  
*Private Schools*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
To determine Individuals’ opinion of home appearance, decorations, furniture, comfort and/or amenities to be ‘home-like’ to them	<u>As needed:</u>	<u>Mandatory:</u> To discern the impact of the residential appearance.

**Review for the following:**

- The site reflects the interests and needs of the people living there:
  - Communal living spaces, such as living rooms, are comfortably furnished and decorated per the interests and needs of the residents;
  - Personal living spaces such as bedrooms are individualized to the person’s tastes and preferences
- The home is decorated and furnished in a comfortable, pleasant manner as opposed to an institutional manner (e.g. furniture is closer to what a family would choose for pleasure, as opposed to what a clinical setting would choose for ease of sanitizing it.)
- There are sufficient accommodations and seating for leisure, dining, and other routine activities when people are home;
- Therapeutic equipment required by people in the home, it is evident that efforts are made to place/store/arrange it in a manner that minimizes impact on home-like appearance as well as possible. (E.g. if there is adaptive equipment, lifts, shower chairs, etc. unnecessarily in hallways and living rooms, this may not be met.)
- Location and display of equipment and documentation related to operations of the home (staff desktop computers, file cabinets, binders, medication storage) should not result in an institutional or non-homelike appearance

- Clinically justified door alarms or annunciators that sound every time that they are opened are not overly loud, imposing and distracting to the people living there.
- Efforts are made to maintain the exterior and outside of the residence to blend in with the rest of the neighborhood, to the extent possible. (For example, if garbage dumpsters out front in plain sight, cigarette butt dispensers conspicuously in front yard, and/or there are other features lend to an institutional appearance, it may be that sufficient effort to minimize an institutional appearance has not been made.)

**Select 'MET' if:**

- The setting is "home-like" in appearance and features.
- The home is not institutional in appearance and features.
- People appear comfortable in their home.

**Select 'NOT MET' if:**

- The home is institutional or office-like in appearance inside and/or outside.
- The home is not personalized in accordance with the people living there.
- The home/physical environment does not meet the needs of the people living there.

## 7-2 Surveillance cameras are not present in the site.

Memo to Providers: October 13, 2015 (441.301(c)(5)) The use of video cameras inside of a residence is considered to be institutional and/or isolating.

*IRAS, CRs, Apts.*

Quality Indicator Best practice: The use of video cameras inside of a residence is considered to be institutional by CMS.. *FSRs, Day Hab,-Private School and Certified Pre-Voc*

### GUIDANCE:

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<u>As needed:</u> <ul style="list-style-type: none"><li>Staff at setting, to confirm if cameras are, or aren't present, based on observation.</li></ul>	<ul style="list-style-type: none"><li>N/A</li></ul>	<u>Mandatory:</u> To discern if cameras are present in the setting.

Through observation and interview, determine whether one or more surveillance cameras are used inside the residence. Video cameras are should not be placed inside HCBS residences, as per CMS. This includes in bedrooms, bathrooms, kitchens, and other common living areas of the residence. The use of video cameras inside of a residence is considered to be institutional.

OPWDD is in process of examining video camera use and policy development.

**Note:** This does not apply to some security cameras used *outside* of the residence, such as an apartment building owned by a landlord who uses surveillance cameras at entryways and public hallways. This also does not apply to security systems like ADT that utilize surveillance cameras for security purposes which monitor *outside* of the residence and are typical in residential communities.

### Select 'MET' if:

- NO** surveillance cameras are in use inside of the residence.

### Select 'NOT MET' if:

- Surveillance cameras **are** present inside the residence, for any reason

If cameras are used inside a residence, collect information regarding the purpose, the reason(s) for placement, alternate strategies attempted prior to camera use, notifications and permissions, etc. Discuss with your Area Director.

**7-3 There is evidence that residents are allowed to have visitors of their choosing at any time.**

Memo to Providers: October 13, 2015 There is evidence that residents are allowed to have visitors of their choosing at any time.  
*IRAS, CRs, Apts.*

Quality Indicator There is evidence that residents are allowed to have visitors of their choosing at any time.  
*Private Schools*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program/agency staff</li> <li>• Families &amp; advocates</li> </ul>	<p><u>As applicable:</u></p> <ul style="list-style-type: none"> <li>• Visitors logs</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Service or activity notes</li> <li>• Service Plans addressing specifics of limitations on Individual(s) having visitors</li> </ul>	<p><u>Mandatory:</u></p> <p>Observe for any limitations on Individual(s) having visitors (as described below)</p> <p><u>As needed:</u></p> <p>Verify Service Plan limiting visitors</p>

***Assess through interview with the person and staff as well as review of documentation***

People have the right to have visitors at any time under HCBS settings. The staff should be supportive and should encourage people to maintain relationships that are important to them, to the extent desired by the person. To answer this standard, determine through interview if the person is satisfied with their ability to foster their personal relationships by having friends and family visit them in their home. Determine if they feel supported by staff in maintaining them. They should be able to visit with others to the degree and frequency desired. You may also want to interview staff to determine how they support and encourage residents to invite friends/family to their home as any person does with people important to them.

**Rights Modification:** Through your review of the person's record, determine if there have been any restrictions placed on their ability to receive visitors. If there is an appropriate rights modification documented that restricts the right of the person to have a certain visitor or visitors in general, the rights modification must have been discussed and reviewed as part of the person-centered planning process. **If related to an assessed behavioral need, it must be documented in a Behavior Support Plan in accordance with all of the requirements of 633.16.** See Standard 4.6 for further specific rights modification documentation requirements.

**Select MET if the following are met:**

- There is evidence that people visit the person in his/her home.
- The person reports that he/she can have visitors whenever he/she chooses.
- The person receives encouragement and support from residential staff to have visitors (such as assistance in scheduling visits)
- The person reports satisfaction with their ability to receive visitors at any time
- OR, there is good evidence that the person has made the decision and is not interested in people visiting at this time, but understands they could if they wanted to.

**Select NOT MET if any of the following are evident:**

- There are blanket rules/visiting hours restricting the person from having visitors of their choosing at any time.
- The person does not receive any support or assistance to have visitors.
- The person is dissatisfied, and reports wanting people to visit and has been denied the opportunity and/or assistance not provided. They want to have visitors but are not facilitated to invite and receive visitors.
- There are rights restrictions in place regarding the person and visitors that do not include the required elements as specified in 633.16

**7-4 The site’s physical characteristics support the independence, comfort, preference and needs of the individuals.**

686.3(a)(1) A community residence shall provide an environment that ensures client (see glossary, section 686.99 of this Part) rights, promotes freedom of client movement, and increases opportunities for clients to make decisions and to participate in regular community activities consistent with their needs and capability. A community residence shall allow for the maximum level of independence consistent with a client's disability and functional level.

*IRAs, CRs, Apts.*

633.4(a)(4)(i) *No person shall be denied: (i) a safe and sanitary environment*

*Clinic, FSRs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<ul style="list-style-type: none"> <li>• Individuals (and/or family/advocates): to know what they think about the comfort and accessibility of the setting</li> </ul> <p>As needed:</p> <ul style="list-style-type: none"> <li>• Agency staff: re their opinion about these characteristics; determine if they are consistent with those of the Individuals; efforts taken to make the environment comfortable and appropriate to people’s needs/wants</li> </ul>	<p><u>As Needed:</u></p> <p>If observations result in concerns/questions that physical environment may NOT be appropriate for people living there</p>	<p><u>Mandatory:</u></p> <p>To discern if the setting is set up to maximize the comfort, independence, and well-being of the Individuals who reside in it</p>

Consider and verify the following:

- Verify that the site’s ambient temperature, noise level and lighting is comfortable and adequate for persons supported;
- The environment allows people to be as independent as possible. For example: the floors are kept impediment free for individuals who clinically are appropriate to scoot, crawl on the floor for mobility, there are smooth transitions between rooms for people who use walkers and wheelchairs;

- The physical plant is appropriate or appropriately adapted to meet the needs of Individuals with physical disabilities (ramps, hand rails, sufficient room to maneuver wheelchairs, adaptive appliances and strobes, bed shakers, turnaround space in toilets, key pads, etc.)
- Determine if there is adequate amount of space for planned activities, private phone calls, spending time with visitors and comfort for persons supported;
- The physical plant is easily navigated by Individuals who do, and those who do not, use adaptive equipment;
- Appliances are easily accessible as needed for participating individuals;
- Supplies such as toilet paper, soap and towels for drying are available in bathrooms;
- Furniture accommodates the needs of individuals, e.g. tables with appropriate height for wheelchairs are available if individuals must remain in their chairs for clinical reasons;

Select MET if the site is for the most part appropriately comfortable, configured and equipped to meet the needs of the individuals.

Select NOT MET if: NOTE: this is not an assessment of maintenance, which is addressed separately.

- There is any one significant aspect of the site's characteristics that negatively impacts individuals' comfort, use, and navigation of the site routinely
- There are multiple characteristics of the site that negatively impact individuals' comfort, use, and navigation of the site routinely

If you have serious concerns about size of rooms or use of space, consider the following: Based on observation, use your best judgment to determine whether the bedroom size and arrangement appears to be sufficient for the number of individuals using the room. Situations which may require particular attention are bedrooms which have been converted from other uses (e.g. offices, storage). Assess that they provide appropriate bedroom space with natural lighting, adequate ventilation and egress without impediment. NOTE: There is not an expectation that reviewers routinely measure bedroom size during site visit. This should be an observational assessment. Measure only if room size appears significantly small, strangely configured, or non-homelike and has a negative impact on the individual(s). The exception would be pre-openings. Effective as of 8/1/07, regulation requires that bedrooms in Large IRAs and Supervised CRs provide, exclusive of closets, at least 70 sq. ft. per person in multiple sleeping rooms, and at least 80 sq. ft. in single bedrooms. This is a best practice for Small IRAs.

**7-5 All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.**

635.7.4(b)(3)(xiv) All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.

*Small IRAs only*

635-7.3(h)(3) All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.

*Clinic, FSRs, Large IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u> Individuals (and/or family/advocates) and/or staff, if a history of inoperable adaptations is suspected.</p>	<p><u>Mandatory:</u> ISP to know what the adaptive device needs of the persons who receive services there are.</p>	<p><u>Mandatory:</u> To discern if there are any inoperable adaptive devices.</p>

- Adaptive equipment is available if needed, correctly installed and in good working order to maximize individuals' independence in and around their home
- Based on observation and interview, verify the condition of special devices and adaptive equipment in place. Examples include but are not limited to:
  - Adaptive lifts
  - Handrails are secured
  - Ramps are in good condition
  - Door opening devices are working
  - Elevators work
  - Phones and associated equipment for people with hearing impairments are operable
  - Special adaptive shower, and tubs and their lifts operate properly, and grab bars and shower chairs are secure and safe;
  - Adaptive and therapeutic tubs, showers, sink are operable and in good repair

- Ask staff and Individuals if the needed and preferred adaptations are meeting the needs of the Individual.

**Select MET if:**

- Special adaptations to the site needed by the individuals are present and operational.
- No special adaptations are needed

**Select NOT MET if:** Special adaptations to the site needed by the individuals are not operational or absent due to failure to replace/repair.

**7-6 There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.**

635-9.1(a)(1) Intermediate care facilities for persons with developmental disabilities (ICF/DDs), community residences including Individualized Residential Alternatives (IRAs), private schools, and specialty hospitals shall assume the cost of:(i) Any item or service for which local, State, or Federal funds are provided; or for which reimbursement is made through a rate, fee, or grant-in-aid.

*IRAs, CRs, Apts, private schools, and specialty hospitals*

635-9.2 (a)(1) Nonresidential facilities shall assume the cost of: (i) Any item or service for which local, State, or Federal funds are provided; or for which reimbursement is made through a rate, fee, or grant-in-aid.

*Clinic, FSRs, Day Treatment, Day Training, Day Hab,, Certified Pre-Voc*

633.4(a)(4)(xx) Applies all but secondary reference

*Clinic, FSRs, IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u> Individuals and/or staff based on observation and/or site history. If supplies seem limited ask about next planned shopping trip or delivery of supplies and whether the response seems reasonable.</p>	<p>Mandatory: Communication log if used</p>	<p><u>Mandatory:</u> To verify adequate supplies.</p>

Individuals supported must be provided adequate routine supplies for their life necessities and available in the home. These supplies must be available for Individuals to use at their discretion with any needed supports (and not locked away without evidence of due process rights restrictions.) **Consider the adequacy and availability of the following based on the program type you are reviewing, services offered by the program type, and needs of the people living in or receiving services from the facility:**

Residential may include but is not limited to:

- Adequate amount of nutritious food, including any for prescribed diet orders;
- Potable water;

- personal hygiene supplies;
- needed health care supplies;
- linens for bed and bath;
- useful clean furniture for the home
- storage space for belongings;
- appliances for kitchen and cleaning
- clothing for all seasons;
- If you are reviewing a residence and find a pattern of supplies and resources not being provided, you must also make a judgment as to whether or not protective oversight is being provided
- Inadequate food and water supply should be immediately reported to the Area Director when determined to be problematic

Day Services, Clinics, Educational Environments:

- nutritious food, including any for prescribed diet orders if providing meals or snacks is the responsibility of the site;
- potable water;
- personal hygiene supplies (running water, soap, paper products for hygiene, etc.)
- needed health care supplies if the responsibility of the site;
- useful clean furniture appropriate to activities
- If you are reviewing a residence and find a pattern of these rightful supplies and resources not being provided, you must also make a judgment as to whether or not protective oversight is being provided.

**Select MET if:** There are adequate supplies and materials to meet the daily/routine need of the individuals for a couple of days

**Select NOT MET if:** There are NOT adequate supplies and materials to meet the daily/routine need of the individuals

NOTE: If there are serious concerns regarding adequacy of food, potable water, and any other item determined to be an immediate necessity, contact your Area Director.

## 7-7 Bathrooms provide personal privacy.

635-7.4(b)(3)(xii) Toilet rooms and bathrooms shall provide personal privacy.

*Small IRAs*

635-7.3(h)(1) Toilet rooms and bathrooms shall provide personal privacy.

*Clinic, FSRs, Large IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

633.4(a)(4)(xx) Applies all but secondary reference

*Clinic, FSRs, IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u> Individuals: regarding their comfort and satisfaction with level of privacy provided for bathrooms</p>		<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Verify that bathrooms are designed to provide privacy including lockable door</li> <li>• Verify that privacy is provided</li> </ul>

Through observation, verify that bathrooms are equipped with doors that close fully and are lockable or other means to provide adequate privacy, and window coverings that ensure privacy.

**Select MET if:** The bathrooms present no immediate concerns with ability to provide privacy.

Note: If there is an observed issue with privacy that is NOT due to the physical characteristics of the bathroom it should will be addressed as a different issue (staff training, rights). This is about the bathroom from a physical plant perspective.

**Select NOT MET if:** Bathrooms by their design, features or missing features or ill repair cannot provide privacy.

## 7-8 The site is clean.

635-7.3(h)(6) Cleaning and maintenance of the physical plant shall be performed on a regular basis.

*Clinic, FSRs, Large IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

635-7.4(b)(3)(xix) *The home or IRA shall be clean and well maintained.*

*Small IRAs*

### GUIDANCE:

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<u>As needed:</u> Individuals: If concerns regarding cleanliness Staff: If concerns about cleanliness, to verify that staff know and implement, cleaning procedures in the site.	As needed.	<u>Mandatory:</u> To verify cleanliness of the site.

During routine observations at the facility and during the formal physical plant "walk through" make note of the condition and cleanliness of the environment.

A clean environment should include but is not limited to the following:

- Walls, doors, door knobs are not stained and are free of food or other residues
- Floors surfaces and rugs are clean and free of large or excessive stains.
- Furniture is clean, unstained and free of residue
- Bedrooms, allowing for some personal variances are relatively clean, organized, and free of clutter which can impede safe exiting.
- Bathrooms and bathroom fixtures are clean and sanitary, including adaptive equipment needed for hygiene activities.
- Bathrooms are clean and free of visible mold and mildew on walls, ceiling, showers and tubs, shower curtains, toilets, adaptive equipment and non-slip bath mats.
- Kitchen surfaces are clean (include counters, cabinets, pantries, shelving, cupboards, appliances, etc.)
- Appliances (include: microwave, refrigerator, freezer, dishwasher etc.) are clean and free of food spillage. Stove or range burners and reflector pans are clean.

- The oven interiors are clean and free from spill-over and burnt on food
- Exhaust fans and/or filters above the stove are clean.
- Facility grounds are free of litter. Trash is disposed of properly and not littered on the grounds posing a risk for persons with PICA or attracting vermin.
- All areas of the facility are free of unpleasant odors. During visit to the facility take note of whether any of the following are present:
  - Urine odors in bathrooms
  - Urine odors in bedrooms (May be a result of incontinence and/or inappropriate urination. Take follow-up action to determine whether the issue has been identified and whether it is being addressed from a service planning and provision perspective.)
  - Odors emanating from furniture or mattresses
  - Odors from uncovered garbage receptacles
  - Musty smells associated with mold and mildew; this may be indicative of water leaks or seepage
- Extensive lint accumulation on the lint filter in the dryer and/or at the terminus of the dryer vent arrangement (indicative of infrequent cleaning)

NOTE: Surveyors are to use their best judgment when assessing for compliance with this requirement. Take into account the environment as a whole and the number and degree of cleaning issues noted. For bedrooms of individuals who make decisions on how to “maintain” their space, there may be a range of “cleanliness”. Consider whether the space represents neglect by the residential staff or personal choice of a “tolerable” level of dust and debris. However, if any issue raises to unhygienic (dirty dishes, half eaten food, sugary drink bottles/can, urine) “personal choice” must be addressed.

**Select MET if:** The site is generally clean and hygienic. A few minor non-impactful cleanliness issues need not result in deficiency.

**Select NOT MET if:**

- There are multiple negative findings/unclean areas
- Findings indicate a pattern of inattention to cleanliness as a whole or a particular area of the site, including inattention to a person’s bedroom
- Unhygienic conditions exist

**7-9 The site is well maintained for the safety and comfort of the individuals receiving services.**

635-7.3(h)(6) Cleaning and maintenance of the physical plant shall be performed on a regular basis.

*Clinic, FSRs, Large IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

635-7.4(b)(3)(xix) *The home or IRA shall be clean and well maintained.*

*Small IRA*

633.4(a)(4)(i) *All*

*Clinic, FSRs, IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u>                      Individuals: If everything they use in the home is working maintenance                      Staff: If everything they need and use in the home is in good condition and usable.</p>	<p>As needed.</p>	<p><u>Mandatory:</u>                      To verify adequate maintenance of the site.</p>

During routine observations at the facility and during the formal physical plant ‘walk through’ make note of the condition of the environment. Ask persons supported and staff about the condition of the site, whether everything (e.g. appliances, plumbing, and lighting) is working properly and whether anything is broken or has a history of being chronically broken.

An adequately maintained environment should include but is not limited to the following:

All facilities:

- Walls and doors are free from damage and holes;
- Doors fit properly in casing and close and open freely. Door knobs are firmly installed and work easily;
- Floors surfaces are in good repair without uneven surfaces, chips, loose tiles, bare spots, loose tiles, curled seaming, etc.
- Carpets and area rugs are without bare spots, and lie flat without lumps, bumps, fraying or poor seaming that create trip hazards;
- If throw rugs are used, they should lay on the floor smoothly, without curling or bunching. They should be arranged so that they stay in place and do not easily slide;

- The facility is free of rodent or insect infestation, and the facility has addressed potential entry access points for such vermin;
- Furniture is in good condition. Wooden furniture and chairs are not broken. Upholstery is not ripped. Seat cushions and mattresses are not sagging;
- Light fixtures and lamps are working and bulbs are not missing or burnt out;
- Lighting is sufficient for the space and activities;
- Bathroom fixtures work properly. Sinks, tubs and showers drain adequately. Toilets flush properly. There is no evidence of leaks.
- Ground fault interrupters (GFI) in bathrooms, kitchens and laundry rooms are operable. GFIs should be installed within 6 feet of sinks, tubs etc. including laundry sinks;
- Appliances are in good working order and can be used by the facility;
- The stove/range burners and oven are in good working order;
- The over door should close fully and seal;
- Exhaust fans are working;
- If the facility stove(s) has an ANSUL or residential fire suppression system, there is evidence that it is inspected and serviced as needed;
- Without evidence to the contrary, refrigerators and freezers are maintained to ensure that food is stored at appropriate temperatures for safe storage. During routine observation for adequate food supply, verify that the refrigerators appear to be in working appropriately. Evidence to the contrary may include a loose seal when opening, the interior feels warmer than normal, there is water pooling, there are unpleasant odors. Only if such examples or others indicate that there may be a problem, use a thermometer to verify that refrigerators are maintained between 32 – 40 degrees Fahrenheit, and freezers are maintained at 0 degree F or less. It is ideal that refrigerators and freezers should be equipped with thermometers.
- There is no evidence of roof leaks, broken windows;
- Exterior of the facility appears in good repair. Exterior surfaces are appropriately maintained, painted, cleaned and illuminated. Gutters are not sagging and are free from excessive debris. Walkways/driveways are free of large cracks and height changes that may pose trip hazards. Outdoor furniture and picnic tables are in good repair;
- House numbers are clearly visible from the street. This maintenance issue is important for timely 911 responses by emergency services such as ambulance or fire department. Upon arrival to the site, you should be able to identify the address of the site from the road while in your vehicle. Avoid use of numbers similarly colored to the background.

Work Facility (e.g. Day Training; Certified Pre-Voc) Considerations:

- Machines such as packaging and sealing equipment are in good working order

- There are staff on duty who have expertise in the equipment use
- The facility adequately vented; there are no odors such as chemical smells
- The lighting appears sufficient
- The facility is maintaining minimum paths of travel on the work floor. Pallets do not obstruct paths of travel
- There are no trip hazards due to wires or other obstructions
- Means of egress are maintained at all times

**NOTE:**

The facility is required to ensure that fire protection equipment is in good working order. However problems with the equipment should be cited elsewhere in this document.

**Select MET if:** The site is generally well maintained. A few minor non-impactful maintenance issues need not result in deficiency.

**Select NOT MET if:**

- There are multiple negative finding regarding upkeep and maintenance
- Findings indicate a pattern of inattention to maintenance of the site as a whole or a particular area of the site
- An item is in ill-repair, not working properly or inoperable so that it negatively impacts individuals' independent use their environment or requires them to have staff assistance which would not be necessary if item/issue was maintained.
- Poor maintenance creates a potential of injury but would not be considered "hazardous".

**NOTE:** At times, poor maintenance may cause hazardous conditions. Such findings should be cited elsewhere in this document.

**7-10 The facility operates in accordance with OPWDD smoking protection requirements.**

633.23(d)(1-2) An agency may prohibit smoking on the grounds of any or all of its certified facilities, including supportive IRAs and supportive CRs. If an agency permits smoking on the grounds of its facilities, the agency must restrict smoking on grounds that the agency is authorized to control, as follows: (1) Location of designated smoking areas: (i) designated outdoor smoking areas must be at least 30 feet from the building which houses a facility that is operated or certified by OPWDD; or (ii) if there is no available space for a designated smoking area at least 30 feet from the building, the designated area must be as far from the building as is practical without infringing on neighboring properties and without putting individuals, or others, in an unsafe location (e.g., in the street). (2) Any designated outdoor smoking area must be equipped with an appropriate and properly maintained non-combustible disposal receptacle in accordance with section 635-7.3(c)(8) or 635-7.4(b)(4) of this Title.

*Clinic, FSRs, IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u> Staff and possibly Individuals about their understanding of the smoking requirements.</p>	<ul style="list-style-type: none"> <li>• Communication log if used</li> <li>• In supportive residences: The site specific appraisal/decision is documented in the IRA site specific plan for protective oversight (in IRAs) or CR Policy &amp; Procedure Manual (CRs)</li> </ul>	<p><u>Mandatory:</u> General home and exterior environment</p> <ul style="list-style-type: none"> <li>• Location of smoking area</li> <li>• Presence and maintenance of appropriate receptacles (availability and emptied when full)</li> <li>• Correct disposal of smoking waste (use of receptacle as evidenced by LACK of butts, on ground, in landscaping, on sidewalk, around entryways, etc.</li> <li>• Evidence of smoking in building</li> </ul>

Smoking Regulations apply to all **facilities operated or certified by OPWDD**, except Family Care Homes.

**At 24 Hour supervised residences, day programs, and clinic treatment facilities, and diagnostic and research clinics, where agencies permit smoking, verify the following through observation and interview:**

- Smoking is NOT permitted inside the certified site buildings, including offices:
- There is a designated smoking area outdoors *and it is the only location on premises* used for smoking
- The designated smoking area is at least 30 feet from the facility building; or if space at least 30 feet from the building is not available, the designated smoking area is as far from the building as practical, without putting people in an unsafe location, or infringing on neighboring properties. Placement may also be per recommendation of the local fire authority.
- The designated smoking area is equipped with an appropriate non-combustible receptacle **which is used** for the disposal of ashes, tobacco, and other smoking remnants. [See also 635-7.3(c)(8) and 635-7.4(b)(4)]. Smoking remnants should not be observed on the walkway, driveway, porch, deck, yard or landscaping.
- The non-combustible receptacle is properly maintained with routine emptying and removal of potential fire hazards, e.g. paper products, cigarette butts. [See also 635-7.3(c)(8) and 635-7.4(b)(4)].

In supportive s IRAs and supportive CRs, smoking is allowed at/in the site only in circumstances where all of the following conditions are met:

- A site specific decision has been made based on an appraisal of the circumstances presented at the particular site
- The site specific appraisal/decision is documented in the IRA site specific plan for protective oversight (in IRAs) or CR Policy & Procedure Manual (CRs)
- The site specific appraisal includes minimally, a review of:
  - Local laws
  - Building policies and lease agreements
  - Smoking practices of the individual(s) living in the residence (e.g. The individuals smoking behavior/habits, use of appropriate receptacles, disposal practices, etc.).
  - Description of each resident's interest in or objection to smoking at the site

NOTE: An agency may choose to have a policy prohibiting smoking on facility grounds including supportive residences.

**Select MET if:** Requirements described above appear to be followed as there is no evidence to the contrary as described below in not met.

**Select NOT MET:** If evidence of smoking in violation of OPWDD's smoking regulations is found, surveyors will identify deficiencies accordingly. For situations that present an immediate risk to the safety of any individual, contact your regional director & require immediate correction.

There is evidence of non-compliance with smoking regulations by the facility/facility staff, as evidenced by but not limited ANY of the following:

- Disallowed smoking is occurring in buildings as evidenced by ashtray, butts, or other tobacco waste smoking in buildings
- Individuals and/or staff are observed or report that smoking occurs in the building (and this is not a supportive residence with documented appraisal decision to approve)
- Accumulation of cigarette butts are observed to be improperly disposed
- Receptacles are not appropriate non-combustible types

There is evidence of fire damage to the site interior/exterior related to smoking that has not been identified and addressed by the facility

**7-11 The temperature of the hot water is appropriate to the abilities of people served at the site.**

635-7.4(b)(3)(xv) Any hazardous conditions that present a threat to an individual's safety or welfare are repaired in a timely manner.

*Small IRAs*

635-7.3(i)(2) *The temperature of the hot water at all faucets accessible to persons residing in the facility does not exceed 110 degrees Fahrenheit except in areas utilized to train individuals in the use and control of hot water.*

*Clinic, FSRs, Large IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u> Staff and possibly Individuals about whether water temp too hot/cold/just right</p>	<p>As needed.</p> <ul style="list-style-type: none"> <li>• Documentation of water temperature check monitoring.</li> <li>• Agency policy and procedure on water temperature check monitoring as per below.</li> </ul>	<p><u>Mandatory:</u> To verify compliance with water temperature requirements as described below.</p>

The surveyor should measure the temperature of hot water in a bath or shower or bathroom sink at every site visit. If more than one hot water source is used for sinks, baths, and showers test water temperature coming from each of the hot water heaters.

Verify that the temperature of the hot water is no greater than 110° F where people have not been or are not being trained to use and control water temperature.

Water temperature may ONLY exceed 110 degrees Fahrenheit in areas utilized to train individuals in the use and control of hot water and/or in areas where individual are able to control/adjust water temperature.

***Temperatures in excess of 140 degrees F, or more, are considered to be imminent danger whether or not persons served have been or are being trained and regardless of program type.***

Also verify:

- The facility has a thermometer to check water temperature
- There is facility procedure for regular testing of hot water temperature

- There are mechanism to control access to hot water heating equipment and prevent tampering

Note: Some Day Program facilities may have bathing facilities as well.

**Select MET if:** Water is measured at appropriate temperature as described above. AND There is no evidence that the facility is having difficulty maintaining the appropriate temperature.

**Select NOT MET if:** Water is measured at temperature exceeding maximum for the environment (as described above). OR There is evidence that the facility is having difficulty maintaining the appropriate temperature.

7-12 Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.

635-7.3(c)(4) Water shall conform to the chemical and bacteriological quality standards for potable water established by the health authority having jurisdiction. For facilities having a private water source for drinking or cooking purposes, the facility shall test the private water source on at least an annual basis to ensure that the water conforms to such established standards.

*Clinic, FSRs, Large IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

635-7.4(b)(3)(xx) In homes or IRAs with private water sources for drinking or cooking purposes, the facility shall test the private water source on at least an annual basis to ensure that the water conforms to the chemical and bacteriological quality standards for potable water established by the health authority having jurisdiction.

*Small IRAs*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u> Management Staff about their understanding of the process to comply with private water source monitoring requirements.</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Documents evidencing private water source testing as required and needed</li> <li>• Agency policy and procedure on private water source monitoring as per below.</li> </ul>	<p>N/A</p>

Obtain and review a copy of the facility's well water test reports.

**Annual testing is minimally required for the following four (4) parameters.** Testing parameters exceeding the maximum contaminant level for that substance in drinking water will require corrective action. This typically is noted on the test report.

- **Coliform;**
- **Standard plate count;**
- **Chlorides; and**
- **Nitrates**

**Additional testing may be required** if the well is located near potential sources of contamination. If you know or suspect that any of the conditions for additional testing exist determine whether it has been completed. If testing did not occur, seek clarification from the provider agency regarding why it has not. If the risk is indeed known, and the reason is that it was determined unnecessary, require documentation that is based on sound professional recommendation. Potential additional testing includes:

**Lead:** Facilities built prior to 1980 (and not updated) will have a lead test done to determine if there is any lead migrating from lead piping or solder into the water supply. If there is a positive test, a retest should be done six months after corrective action has been taken and annually thereafter. If the lead source is removed and the facility has a subsequent negative test, or if there is no lead noted on the initial test, no further testing would be required.

**Unspecified organic contaminants:** This test must be done for wells which are located near farms, old underground gasoline tanks and landfills where there is a high probability of contamination from pesticide spraying or infiltration of the well from contaminants in a landfill. If there is a positive test, corrective actions must have been taken until a negative result is obtained. Thereafter the facility must test for this on an annual basis.

**Heavy Metals:** These metals will be tested when the facility is located near a landfill. Minimal testing should include mercury, lead, arsenic and any others recommended by the local county health department. Once corrective measures are taken if needed, the facility must retest on a biannual basis.

**Sodium:** This should be tested if the facility has any individual who are on sodium free or sodium restricted diets. If the test is positive, corrective measures should be taken to ensure the sodium level falls within the acceptable limits for the restriction. Retests must be done on a biannual basis thereafter.

Refer to ADM 96-02 "Revised Testing Standards for Private Wells" dated April 8, 1996. The memo is applicable to all OPWDD-certified facilities that have wells as their source of potable water.

**Select MET if:**

- There is documentation that to evidence **ALL** of the following:
  - Required testing has occurred

- Testing occurs with appropriate frequency
- Unacceptable Levels or positives have been corrected/are being corrected

OR

- The standard is N/A as the site has a public water source.

**Select NOT MET if: ANY of the following are determined:**

- Required testing has NOT occurred (there has been no testing or some but not all required tests were done)
- Testing does not occur with frequency required
- Unacceptable Levels or positives have not been corrected/are not being addressed

7-13 The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools.

635-7.3(h)(7) Any hazardous conditions that present a threat to an individual's safety or welfare shall be repaired in a timely fashion.  
*Clinic, FSRs, Large IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

633.4(a)(4)(i) No person shall be denied: a safe and sanitary environment  
*Small IRAs*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u>                      Staff about their understanding of policy and procedures for safeguarding Individuals while using pool</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Documentation of staff training on the pool safety : general and person specific</li> <li>• Agency policy and procedure on pool safeguards to prevent drowning.</li> <li>• Incidents involving pool use</li> </ul>	<p><u>Mandatory:</u>                      As able, to observe the pool itself and any adaptive and safety equipment associated with it. Pools include swimming pools, wading pools, therapeutic pools and hot tubs.  <u>As needed:</u> use of pool if happens to be occurring while on site</p>

Verify the following. For purposes of this review, pools include swimming pools, wading pools, therapeutic pools and hot tubs.

**Security:** Access to the pool must be adequately protected.

- This is dependent on the type of pool (in-ground or above-ground) or local laws. Generally, in-ground pools require a four (4) foot high enclosure, with self-closing locked gate. For above-ground pools the barrier can be around the pool or mounted on top of the pool structure. For both types of pools, the barriers must be sturdy. Removable ladders should not be draped across a barrier (which defeats the purpose of the barrier).
- Pools constructed or substantially modified after 12/14/06 must be equipped with an approved pool alarm
- Safety devices must be working properly (pool alarms, door alarms, etc.)
- Access to filled hot tubs are secured through locking covers or in secured room/area

**Policy/Procedure and Training:**

- The program/agency have policies and procedures in place to ensure the safety of individuals using the pool. It should address ( but not limited) the following: Access/security,
- Staff and program participants are trained in pool safety precautions developed by the agency
- Individuals are assessed regarding their swimming capabilities/needs
- Staff are aware of each individual’s needs regarding pool safety, such as limitations, need for supervision, adaptive devices, etc.; and provide same (if use of pool in progress)
- Program participants are supported to understand pool safety, to the best of their ability

*The Safeguarding Alert from OPWDD 00-01-Drowning Alert has helpful information. <http://www.opwdd.ny.gov/node/892>*

**Select MET if:**

- All of the following are evidenced:
  - The pool or hot tub is adequately secure/protected for unauthorized and unsupervised access
  - Adequate policy and procedure for use of water source and supervision/safeguards
  - Staff are trained and understand their responsibility per the policy and procedure
  - If in use, safe practices are observed

OR

- The site does not have pool or has rendered it unusable and inaccessible

**Select NOT MET if** a pool is onsite and accessible, regardless of level of use and:

- Access to the pool or hot tub is not secure
- The facility lacks adequate policy and procedure for safeguarding and/or use
- Staff cannot explain of required safeguards related to the pool, regardless if training records are evident
- If in use, unsafe practices are observed during pool use
- Unsafe practices identified as part of an incident investigation and have not been addressed/corrected

7-14 The facility has a land line (see section 635-99.1) telephone service which is in working order and functions during power outages.

635-7.4(b)(3)(iii) All family care homes and IRAs for eight or fewer persons shall comply with the following general safety and welfare requirements: (iii) The home shall have land line (see section 635-99.1 of this Part) telephone service which is in working order and functions during power outages.

*Small IRAs*

635-7.3(c)(6) The facility shall have land line (see section 635-99.1 of this Part) telephone service which is in working order and functions during power outages.

*Clinic, FSRs, Large IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u> Site staff about existence of reliable land line.</p>		<p><u>Mandatory:</u> To verify the presence of a functioning land line, as described below.</p>

There must be at least one 'land Line' phone on premises.

- Cordless phones with a base unit that requires electricity are not acceptable as the only phone available.
- Phone service through a Cable TV provider is not acceptable as the sole source of phone service.
- If the facility uses digital phones as the main source of communication, there should be a fully charged cell phone accessible at the site as an emergency back-up.  
(see section 635-99.1)

**Select MET** if there is a landline phone on premises.

**Select NOT MET** if there is not a landline phone on premises.

If it is evident that only digital and cellular service are available in the community of the facility, contact your Area Director.

**7-15 Time Out rooms constructed or significantly modified after April 1, 2013 meet the requirements identified in NYCRR Part 633.16(j).**

633.16(j)(3)(iv)(e)(3) Environmental requirements are set forth as follows. Except as provided in sub clause (4) of this clause, the room shall conform to the following requirements: (i) Size: The minimum measurements of the room shall be 6' length x 8' wide x 8' height. (ii) Decoration: Colors are selected to create a calm, relaxed atmosphere. (iii) Electrical: (A) There shall be no electrical fixtures, outlets, switches, or wiring which may cause harm or injury to a person. (B) There shall be no protruding light fixtures on any ceiling lower than 10' in height. (C) There shall be no protruding light fixtures on any wall. (D) Recessed light fixtures shall be designed to withstand tampering or destruction by the person in the room. (E) Sprinkler heads, if provided, shall be the concealed type.

*IRAs, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u> Site staff about the historical functioning of the Time Out room</p>	<p><u>As needed:</u> Agency policy and procedure on Time Out room</p>	<p><u>Mandatory:</u> To verify the presence of a Time Out room which exists within regulatory requirements, as described below</p>

Time out room structural requirements are:

- Size: measure at least 6' length x 8' wide x 8' height.
- Decoration: Colors are selected to create a calm, relaxed atmosphere.
- Recessed light fixtures must withstand tampering or destruction by the person in the room.
- Minimal and unbreakable glass or mirrors should be used whenever possible. Coverings for glass that is breakable are to be designed in such a way as to prevent being grasped by the occupant.
- Padding or resilient wall covering must be affixed to walls and the floor in such a fashion that it cannot be easily removed by the occupant. Provisions must be made for the removal of the padding or wall covering for cleaning, repairing or altering of any such material (*e.g.*, padding fastened securely to plywood panels which are then screwed to the walls), unless the wall surface cover is such that it can be cleaned, maintained, and repaired in place. In facilities where the interior finish rating is required (*i.e.*, Life Safety Code compliant facilities) the finish rating of the wall or floor surfaces must be equal to or greater than that required by the Life Safety Code.

- To ensure occupant comfort, there needs to be adequate measurement equipment to ensure control of temperature, humidity and circulation of air within the room.
- The floor surface covering needs to be consistent with the needs of the person using the room.
- If soundproofing of the time-out room is necessary for the comfort of other people receiving services, it must be determined if there will be sufficient transmittal of sound (adequate to hear words spoken by the person within the room) through the observation window or whether other means of maintaining auditory contact are necessary.
- The viewing area must be sufficiently large to maximize visual observation. The person must be in at least partial view at all times (*i.e.*, there must be no blind areas large enough for the person to be completely out of sight). (This does not mean that the design of the room must provide for the capability of observing every action, facial expression, etc., should the person be standing/sitting in such a position or location that limits the view.)
- There should be no:
  - electrical fixtures, outlets, switches, or wiring which may cause harm or injury to a person;
  - protruding: light fixtures on any ceiling lower than 10' in height; protruding light fixtures on any wall; protruding door thresholds (flush or ramped only.)
  - exposed holes, sprinkler heads or pipes;
  - protrusions on which a person might be injured, such as a doorknob in the room. If the door is sufficiently padded to recess the knob, but still cause it to be accessible, this is permissible;
  - furniture or other objects in the room;
  - Observation windows made of, or covered by, mesh, bars, or wire material.
- The viewing area must be designed to be functional, taking into account the comfort and suitability for use by staff.
- Windows (other than observation windows) must be completely covered with a false wall to ensure the person's safety and to eliminate distraction and/or visual stimulation in what is intended to be a non-stimulating environment.
- Doors need to swing outward from the inside. Doors may be locked only by the continuous physical action of staff. The door release mechanism must be designed in such a way that if staff are not applying pressure, or physically holding the release mechanism, the door lock automatically releases.
- A clock needs to be visible to staff to monitor the duration of the time-out.
- The room must be cleaned and disinfected regularly and after each use.
- If a time-out room must be secured when not in use, the mechanism used for this purpose must be such that the door can be opened, at will, from the inside.

Exceptions to specific physical plant requirements for Time-out rooms are:

- OPWDD may waive specific physical plant requirements upon the application of an agency.
- Time-out rooms which were in existence on April 1, 2013 are not required to comply with the specific physical plant requirements if the time-out room was approved by OPWDD prior to April 1, 2013. A new OPWDD waiver is not required in this situation. However, OPWDD approval is required for any significant modification of such time-out room which occurs on or after April 1, 2013.

**Select MET if ANY** of the following are evident:

- There is not a time out room on site
- The time out room predates the 633.16 applicability
- The applicable time out room meets required standards
- The applicable time out room does not meet all standards, but there is documented approved from OPWDD waiver of the requirements not met

**Select NOT MET if ANY** of the following are evident:

- Time out room(s) do not meet required specifications and there is not documentation of OPWDD approved waiver of requirement

## SECTION 8 FIRE SAFETY

### QUALIFIER QUESTION:

Are there any immediate Fire Safety issues that must be identified?

This means: Do fire safety requirements need to be reviewed at this time?

- If Yes, answer questions 8-1 to 8-19
- If No, go to Section 9

### Guidance:

Section 8 will be implemented as follows:

- OFPC will implement routinely in all state and voluntary operated Life Safety Code residences
- DQI will implement routinely in all non-LSC sites and all day programs.
- DQI will implement as needed in any site (even those that OFPC reviews) when fire safety issues are noted and need to be addressed and recorded at the time of the DQI visit.

## 8-1 The site has an acceptable fire evacuation plan.

686.16(b)(1)

*IRAs only includes FSR*

635-7.5(e) An evacuation and safety plan specific to the certified premises shall be developed and implemented that is designed with consideration of the capabilities of the persons receiving services, the staffing of the premises, and the physical plant configuration. A description of the evacuation and safety training for individual participants and staff shall be included in the plan.

*certified Day Hab sites (current); Site Based Pre-Voc Sites (eff. 09/01/16)*

ADM 2012-02 There is a written plan specifying how the agency/facility will deal with life threatening emergencies.

*Clinic, IRAs, FSR, Superv Apt, CRs, Group Home Day Hab, Day Treatment, Specialty Hospital, Private School*

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><b>As needed:</b></p> <ul style="list-style-type: none"> <li>• If questions regarding the plan and/or how it is implemented</li> <li>• If general observation of site and/or individuals raises questions regarding the plan.</li> </ul>	<p><b><u>Mandatory:</u></b></p> <ul style="list-style-type: none"> <li>• The written evacuation plan</li> <li>• Supporting documentation such as diagrams or assessments if referenced/considered part of the plan</li> </ul>	N/A

An evacuation plan specifies emergency procedures that staff are to implement in the event of an emergency, e.g. fire. A floor plan should be included in the evacuation plan. In the case of IRAs, the site-specific protective oversight plan should include evacuation procedures or reference the evacuation plan, which is usually a separate document.

The plan should follow generally accepted safety principles.

The site's evacuation plan should describe actions to be taken upon discovery of an emergency. Review the site's evacuation plan. It should:

- Be clearly written and understandable
- Be site-specific
- Describe actions to be taken upon:
  - actual discovery of the fire

- smelling smoke
- hearing the alarm
- Describe how to notify site occupants of the need to evacuate e.g. pull alarm.
- Identify evacuation routes and exit doors
- Describe how to safely check and enter rooms during the evacuation process
- Describe any priorities with regard to the evacuation of specific individuals
- Describe any priorities with regard to the use of exits
- Clearly assign and describe individual staff responsibilities for protection, rescue, and evacuation, designated by staff role on the shift, not by name or title of staff
- Instruct staff to call 911/Fire Department
- Identify by name, the meeting place for head count
- Be updated and revised and reviewed by all staff when revisions required based on individuals at the site:
  - When individuals' abilities and needs for support change
  - When individuals are new to the site (e.g. respite or new admissions), needs for support are identified and including in evacuation planning:
    - Persons newly admitted
    - Persons at the site for a temporary period
- The plan should take into account the individuals' significant fire safety needs as discussed in interview and indicated in assessments such as the ISP and individual protective oversight plans. This should include the level and type of supervision and assistance needed.
- Note that defend-in-place strategies may be applicable, depending on the type of building. The plan should identify defend-in-place use and areas of refuge.
  - For structures where the strategy used, the plan should include what should be done in the event that conditions become untenable in the building.
  - If defend-in-place strategies are used, the physical plant safety enhancements which allow for its use must be identified by the facility and their functionality verified by a *LSC surveyor*.

**For Apartments:** Additional Considerations for inclusion in evacuation plans for sites in apartment buildings. It is critical to include a distinction between apartment building fires that originate in the certified apartment unit and those that originate elsewhere in the building.

- When the **fire is in** the apartment unit, the appropriate plan is to get everyone in the apartment unit out of the building.

- If **fire is not in** the specific apartment reviewed, the following actions are appropriate practice in all apartments regardless of location:
  - If there is a fire in a *non-fireproof* building it is usually safer to leave the building immediately.
  - If there is a fire in a *fireproof* building but not in your dwelling unit, it is usually safer to stay inside the apartment rather than entering smoke filled hallways, especially if the fire is above your apartment.
- Additional information on evacuation planning and preparedness in apartment settings is available on the New York City Fire Dept. Website at [www.nyc.gov/fdny](http://www.nyc.gov/fdny) and [nyc residential apartment fire safety.pdf](#)

**8-2 All fire and evacuation drills or events MUST be documented on the standardized drill report form developed by OPWDD.**

ADM # 2012-02 Pg. 1 Bullet 1 Standardized fire drill forms are to be used by July 1, 2012.

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<b>As needed:</b> Regarding form use	<b>Mandatory:</b> Completed evacuation report forms	N/A

The use of OPWDD standardized evacuation report forms is required to be used in all certified programs. The facility should document evacuation drills on the standardized form\* appropriate to the program type.

- Verify that the appropriate OPWDD forms are used to document evacuations/drills
- Verify that required information is documented on the form correctly

\*There are 5 different forms that encompass the multiple types of occupancy found throughout OPWDD programs: LSC Board and Care Impractical, LSC Board and Care Prompt or Slow, LSC Health Care, Residence/IRA with 3 minute Strategy (non-LSC), and Day Habilitation (expected to include certified Prevocational sites). [ADM #2012-02 Fire Safety Attachments](#)

**Select MET if:** The correct OPWDD Evacuation Report Forms for the site/LSC status are used and completed correctly.

**Select NOT MET if either of the following are present:**

- The correct OPWDD Evacuation Report Forms for the site/LSC status are not used consistently

There is a pattern of incomplete documentation of drill information onto the forms

**8-3 The Evacuation Plan is practiced through drills with the **frequency** specified by OPWDD.**

ADM # 2012-02 All In order to provide specific direction to the field and to provide consistency, OPWDD has standardized the minimum frequencies of required evacuation and fire drills in both homes and day settings.

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

686.16(b)(1) OPWDD shall verify that each individualized residential alternative has implemented a facility evacuation plan. OPWDD shall verify that staff and persons residing in the facility are trained and evaluated regarding their performance of said plan.

*IRAs*

*635-7.5(e) An evacuation and safety plan specific to the certified premises shall be developed and implemented that is designed with consideration of the capabilities of the persons receiving services, the staffing of the premises, and the physical plant configuration. A description of the evacuation and safety training for individual participants and staff shall be included in the plan.*

*Day Habs and Pre-voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u> Program site staff: If fire drill report documentation fails to verify compliance with frequency required by the program setting</p>	<p><u>Mandatory:</u> Completed evacuation report forms</p>	<p>As Needed: If drills lacking and cannot verify that individuals will be safe in fire emergency</p>

OPWDD has standardized the minimum frequency of evacuation - fire drills in both residential and day program settings per **ADM #2012-02 (ADM #2012-02 Fire Safety Attachments )**

Through review of drill documentation/evacuation report forms, assess that evacuation/fire drills are minimally implemented as follows:

**24 Hour Staffed Residential Settings:**

- Non-LSC: One (1) full evacuation drill per shift per quarter
- LSC Board & Care Prompt or Slow: One (1) full evacuation drill per shift per quarter
- LSC Board & Care Impractical: One (1) full evacuation drill per shift per quarter
- LSC Board & Care Impractical, with individuals unable to participate: One (1) drill per shift per quarter with One (1) drill per shift per year being full evacuation drills *if the site is designed to defend in place*
- LSC Health Care Occupancy: One (1) drill per shift per quarter with One (1) drill per shift per year being full evacuation drills.

**Non-24 Hour Staffed Residential Settings (supportive IRAs and supportive CRs) :**

- Four (4) full evacuation drills per year
- For fire resistive apartment buildings with at least one hour enclosed interior stairs, two (2) of the four (4) evacuation drills could be limited to the stair well landing.
- In situations where there is only one exit and the alternate means is a window or a porch not leading directly to grade level, four full evacuations and an additional two drills which practice use of the alternate means

**Day Programs and Article 16 Clinics:** One (1) full evacuation drill per quarter.

- Day programs which are designed to defend in place: four drills per year/two of which include two full evacuations per year.

**Select MET if:** There is documentation evidencing evacuations drills are practiced with the required frequency **and** type of practice activities required for the setting

**Select NOT MET if either of the following are present:**

- Evacuation drills are not practiced with the required frequency required for the setting
- Evacuation drills do not include the required practice activities with the frequency specified (e.g. Health Care or Board and Care using defend in place hold the correct number of drills but do not practice one full evacuation)

8-4 Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.

686.16(b)(1) and (2) All IRAs For individualized residential alternatives of eight or fewer beds, OPWDD shall verify that each person's individualized services plan (see glossary) contains a current evaluation of the fire evacuation capacity of the person based on actual performance. OPWDD shall verify the accuracy of the information in each person's individualized services plan relative to fire evacuation performance. OPWDD shall verify that each person has a plan for protective oversight, based on an analysis of the person's need for same, and that such need has periodically, but at least annually, been reviewed, revised as appropriate, and integrated, as appropriate, with other services received.

*All IRAs of eight or fewer beds,*

633.4(a)(4)(i) No person shall be denied: (i) a safe and sanitary environment *Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

ADM # 2012-02 Supportive Administrative Memo

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Program site staff: If fire drill report raises questions or fails to verify that drills are conducted appropriately as described below</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• The written evacuation plan</li> <li>• Completed evacuation report forms to verify that the actions taken during a drill meet the requirements described below</li> </ul>	<p>As Needed: If drills lacking and cannot verify that individuals will be safe in fire emergency</p>

Review drill documentation. Drills should be conducted as follows:

- Drills should normally mirror the elements of a real fire emergency. Drills should be held at unexpected times and under varying times and conditions.
- Drills should be held with normal staffing levels; not with extra staff working.
- Individuals and staff practice what they are actually going to be expected to do in the event of a fire emergency, as designated in their evacuation plan.
- In **LSC homes**, the night shift drill should occur after the 1st hour of sleep and before the 3rd hour of sleep.

- Evacuation drills should be occurring as quickly and safely as possible. Evacuation times for the facility should be appropriate to the site and time frames established for it, if applicable.
  - For **Small IRAs** (unless meeting LSC), the time frame should be three minutes or less
  - For **Apartment Buildings**, evacuation needs to occur to the exterior at ground level within the three minutes to meet the three minute all out requirement, unless the apartment building is a fire resistive building with an enclosed interior stairwell. In the case of an enclosed interior stairwell, the three minute maximum would apply to time the time it took to get to that stairwell.
  - For **LSC Board and Care IRAs** evacuation should occur swiftly, but not to exceed the following **maximums** for the LSC designation for their site: Prompt – 3 minutes, Fast/Slow-8 minutes, Slow/Slow-13 minutes.
- For all sites, drill times should be reviewed and any problems or concerns identified.

See also [ADM #2012-02 Fire Safety Attachments](#) **FIRE DRILL REQUIREMENTS**

**Select MET if:** There is documentation evidencing evacuations drills are practiced in accordance with appropriate expectations: varied time/conditions, normal staffing levels, per the evacuation plan strategies and per the individuals' needs and with attention to safety and timeliness.

**Select NOT MET if a pattern of any of the following is evidenced:**

- Evacuation drills are not practiced with normal staffing, but run with increased staffing (e.g. full staff day or shift change) or participation parties that would not routinely be present (e.g. clinical or management staff)
- Evacuation drill documentation or discussion evidence that practice does not include the strategies identified in an acceptable evacuation plan.
- Documented staff evacuation activities increase potential for harm to the themselves or the individuals
- Required assistance and supervision is not provided to the individuals per their needs
- Defend in place strategies are implemented in environments where it is not an acceptable practice.

Any practice identified that has an effect of providing a false assessment of effectiveness of the drill or dangerous practice that has the potential for harm to individuals

8-5 The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.

ADM # 2012-02 In addition to the review of fire drill reports by administrative staff, OPWDD implemented a policy in the state operated homes that requires administrative staff above the house manager level to be present on an unannounced basis to observe fire and evacuation drills. OPWDD is requiring that this activity be conducted at each supervised home, a minimum of once per year on the overnight shift, and once per year on a shift chosen by the agency. If problems are found during these drills, the agency may need to do additional unannounced observations in order to ensure resolution of problems raised. The purpose of this activity is to confirm that the operational minimum staffing pattern for a given home and shift is sufficient to successfully implement the fire evacuation plan in the timeframes relevant to that home. This activity also serves as a way to verify that the information contained on fire drill reports is consistent with the staff and individual's observed performance.

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As Needed:</u> Management and Program site staff: If evacuation report forms do not indicate administrative monitoring</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Evacuation report forms to verify that fire drills are monitored per the criteria staffing and actions described below</li> </ul>	<p>N/A</p>

Assess how management staff supervise that drills are conducted properly. There should be evidence of on-going review of the fire evacuation plan for effectiveness, correct implementation and for need for revisions. Review includes review of evacuation report forms as well as the required unannounced observation of drills.

Talk to staff, supervisors and administrators. Ask how they monitor that the evacuation plan is appropriate and how often they do so. Review for the following monitoring actions:

- Verify that for **supervised** residences, that **unannounced, management observed** drills have been conducted (i.e. by an administrative staff member above the level of a house manager).
  - These unannounced observations must be done minimally:
    - Once per year on the overnight shift, and

- Once per year on a shift chosen by the agency
- Verify that the observation results and any corrective actions are documented.

• Reports of fire drills conducted by staff outside normal business hours (i.e. night shift) should be reviewed and verified by agency administrative staff (above the level of a house manager) within 24 hours (or next business day) to ensure that the report filed by staff is an accurate reflection of what actually occurred.

NOTE: Unannounced observed drills are required as administrative oversight of fire drills in supervised settings. In **supportive settings** it is the responsibility of the agency to periodically assess individuals' continued independence in evacuation, particularly in situations in which that independence is in doubt. The agency may apply whatever oversight methods are needed to provide reasonable assurances of this in the non-24 hour supervised setting.

**Select MET if Both of the following are verified:**

The Evacuation Report Forms provide for documentation of these activities on the form. The site may also use supplemental documentation:

- There is documentation of the review for adequacy and effectiveness of the drill by management and/or administrators through review of evacuation report forms
- There is documentation of the management/administrative completion of required unannounced observations of actual drills

**Select NOT MET if any of the following are verified:**

- Required unannounced observation of drills are not occurring
- There is pattern of failure to review the adequacy and effectiveness of the drills by management and/or administrators through review of evacuation report forms

## 8-6 Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).

ADM # 2012-02 In addition to the review of fire drill reports by administrative staff, OPWDD implemented a policy in the state operated homes that requires administrative staff above the house manager level to be present on an unannounced basis to observe fire and evacuation drills. OPWDD is requiring that this activity be conducted at each supervised home, a minimum of once per year on the overnight shift, and once per year on a shift chosen by the agency. If problems are found during these drills, the agency may need to do additional unannounced observations in order to ensure resolution of problems raised. The purpose of this activity is to confirm that the operational minimum staffing pattern for a given home and shift is sufficient to successfully implement the fire evacuation plan in the timeframes relevant to that home. This activity also serves as a way to verify that the information contained on fire drill reports is consistent with the staff and individual's observed performance.

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<u>Mandatory:</u> <ul style="list-style-type: none"> <li>Management and site staff regarding drills, any problems, and actions taken to identify and address concerns</li> </ul>	<u>Mandatory:</u> <ul style="list-style-type: none"> <li>Written evacuation plan</li> <li>Evacuation report form</li> </ul>	N/A

Verify that the facility management effectively monitors evacuation drills, staff actions, and the effectiveness of the evacuation plan, through inclusion of the criteria below:

- The evacuation was completed within time/duration requirements
- The evacuation procedures are effectively and safely implemented reviewed for safety, and provision of appropriate assistance and supervision to individuals requiring it.
- Staff actions and the need for staff training are identified and provided as needed.
- Each staff member participates in **at least** one drill per year.
- Staffing levels are effectively reviewed to ensure there is sufficient, capable staff on all shifts to ensure individuals with physical limitations, behavior issues, or other concerns can be evacuated safely.

- Administrative review includes review of implementation of protect-in-place strategies for appropriateness given the drill scenario
- Plans are modified based on drill performance concerns and staff recommendations.

For **UNSUCCESSFUL DRILLS**: Verify that the facility/agency identifies and takes action for unsuccessful drills; i.e. those in which all program participants were not evacuated in the expected time frame and/or unsuccessful implementation of the fire plan, as per criteria above: unsuccessful drills, that identification and correction of root cause result in successful follow up drills, as described below.

- Agency administrative staff are contacted immediately, regardless of shift, if a drill was unsuccessful.
- The contacted administrative staff has decided if the situation requires immediate remediation response to preserve individuals' health and safety.
- This decision is documented on the fire drill reporting form.
- If an immediate response is not required, then action to correct occurs within 24 hours of the unsuccessful drill.
- Action is taken to identify root cause of unsuccessful drills.
- There is evidence that identified problems have been addressed
- If a pattern of unsuccessful drills is present, the agency takes timely and systemic action to ensure safety of the individuals served.
- If such a pattern emerges, the agency must report it to the local DDSO and DQI-BPC for monitoring.

**Select MET if ANY of the following are evidenced:**

- There is documentation evidencing that problems with the implementation, effectiveness, or appropriateness of the evacuation drill have been identified, documented and appropriate corrective actions taken;
- OR
- 9-5 is MET in that monitoring activities are occurring appropriately, there are no concerns identified regarding the evacuation drills and this appears to be an appropriate assessment

**Select NOT MET if any of the following are identified:**

- Documentation of evacuation drills indication concerns, problems, ineffectiveness but these were not identified by the program and program administrative review
-

## 8-7 Facility staff can describe fire safety and emergency evacuation procedures.

633.4(a)(4)(i) All No person shall be denied: (i) a safe and sanitary environment

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

633.8(b)(1)(vii) All OPWDD shall verify that employees (other than exempted administrators), volunteers or family care providers have received or will receive training within three months of initial employment on... appropriate topics relative to the safety and welfare as may have been specified by the facility.

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

633.8(b)(2)(v) All Employees, volunteers and family care providers shall receive training in the following areas on at least an annual basis: (v) the agency's safety and security procedures (including fire safety).

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u> Facility staff regarding:</p> <ul style="list-style-type: none"> <li>• Training received</li> <li>• Their responsibilities in emergency evacuations and the individualized needs of the individuals</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Written evacuation plans of the site</li> <li>• Evacuation report forms</li> </ul> <p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• Supporting documentation, e.g. IPOP, ISP, other documentation of safeguards</li> </ul>	N/A

### **Through interview with staff, assess that:**

- All Staff (supervisory and direct care) have been trained on and know about individuals' fire safety needs, including level of physical assistance needed
- Staff have received training on the implementation of the evacuation plan
- Staff can describe the procedure in full, including use of: all fire protection equipment to include use of alarm activation devices and central station, notification of staff and occupants, and 911.

- Staff can describe use of primary and alternate exits.

**Select MET if:** staff on duty can adequately explain to you actions they are required to take in the event of a fire emergency per the evacuation plan, the individuals' needs and safe practices.

**Select NOT MET if:** staff on duty cannot adequately explain to you actions they are required to take in the event of a fire emergency per the evacuation plan, the individuals' needs and safe practices.

## 8-8 The certified site provides safe exiting to a public way.

635-7.4 (b)(3)(xiii) Safe, continuous and unobstructed exits shall be maintained from the interior of the home or IRA to the exterior at a street or to a yard, courtyard or passageway leading to an open public area. A landlocked courtyard must have unrestricted access to a location which is at least 30 feet away from the building.

*Small IRAs including FSR*

635-7.3(h)(2) Safe, continuous and unobstructed exits are maintained from the interior of a facility to the exterior at a street or to a yard, courtyard or passageway leading to an open public area. A landlocked courtyard must have unrestricted access to a location which is at least 30 feet away from the building.

*Clinic, Large FSR, Large IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Management staff</li> <li>• Program site staff</li> </ul> <p>Regarding any questions, concerns, findings if observations point to any situations which fail to assure safe exiting to a public way.</p>		<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• During physical plant tour to assure compliance, as described below.</li> <li>• If special locking mechanisms are disengaged by alarm system, assessment must include request for activation of the system by facility staff. In addition emergency bypass of locking mechanism must be tested</li> </ul>

Through observation and physical plant walk through, verify the following:

- Doors (except in Supportive CRs, Self-Preserving CRs and small IRAs) should be provided with single-function locks. Occupants must be able to use a dual-function locking arrangement if one exists at small IRAs or Supportive and Self-Preserving CRs. If any individual is unable to use a dual function lock in these settings, a single function locking mechanism must be used.
- Special locking mechanisms on doors function properly, disengaging for emergencies as required when the alarm system is activated
- Aisles/corridors are unobstructed.

- There is adequate lighting of exit ways
  - EXTERIOR: This is applicable to facilities that serve individuals during hours of darkness/nighttime. During Physical Plant "walk through" assess whether exterior lights work. Evaluate their locations to see if they are sufficient to guide individuals from the facility to the meeting place. If possible (early mornings and evenings, winter late afternoons) note during times of darkness whether illumination is sufficient to allow safe travel to meeting areas. Also when possible, test that lights that are activated by darkness or motion do so.
- There is a clear path to a public way in good condition. It is not required that these surfaces are paved.
- The facility has a reliable system for the removal of snow and ice from exterior exit ways including exterior stairs and walkways in a timely manner.
- Gates along the exit way and the street, can be opened easily
- Safe exiting includes the exterior of the building (to the street and/or – in New York City – a courtyard, which shall be a minimum of 30 feet unless there is an unlocked gate with access to adjacent yard or open public space).
- Apartment windows provided with gates, are of the Fire Dept. approved variety only and can be opened from the inside without a key.

**For Apartment Buildings**

- The exit routes from the apartment unit to the public way must be properly lit and unobstructed. In cases where the apartment building has enclosed interior stairs, surveyors should check the common corridor at the certified apartment unit level and at the level of exit discharge as well as the integrity of stair doors at all intervening levels. In open stairwell construction, surveyors would need to assess all levels. In particular, check the following:
  - The door to the certified site apartment unit should self-close and latch.
  - Stairwell doors (if provided) should self-close and latch.
  - Trash compactor chutes or doors to trash compactor rooms should self-close and latch.
  - Emergency lighting units should be operational.
  - If egress routes pass boiler, laundry, storage, trash compactor or other utility rooms, the hardware provided on those rooms (self-closers and latches) must be operational.
  - Doors noted above should not be propped open.
- Note that while the agency may have no jurisdiction over the building, it is the agency's responsibility to ensure safe and unobstructed exit routes for the home. This would involve identifying problems, bringing them to building management, and monitoring for resolution.

**Select MET if:** Safe and barrier free exiting is verified based on your observation, testing and the guidance for this standard.

**Select NOT MET if:** There are observed impediments to safe and barrier free exiting as described in guidance such as: items blocking hallways, inappropriate and/or inoperable locking/unlocking mechanisms, snow/ice covered walkways, etc.

**8-9 There is fire alarm and detection equipment in the facility as required by regulation and/or LSC.**

635-7.3(e)(1) (i)-(vii) (i) All required heat and smoke-detecting services shall be interconnected as necessary to ensure that activation of anyone device will sound an alarm that is audible throughout the facility. Heat-detecting devices shall be either the rate-of-rise or fixed self-restorative type. (ii) A smoke detector shall be installed in each bedroom. (iii) A smoke detector shall be installed in each corridor adjacent to sleeping rooms. In corridors or adjacent open areas such as living rooms, dining rooms or recreation rooms, smoke detectors shall be installed at a maximum of 30 feet on center and no more than 15 feet from a wall. (iv) A smoke detector shall be installed at the head of each open stairway located within the facility; or a smoke detector shall be installed within six feet of the bottom opening of a stairway that is enclosed at the top. (v) At least one smoke detector shall be installed in basements (see section 635-99.1 of this Part) and at least one heat detector installed in accessible and usable attics at a ratio of one detector for each 1,000 square feet of floor space. Additional detectors may be required for those basements and attics subdivided by partitions. (vi) A heat detector shall be installed in kitchens. (vii) A heat detector shall be installed in storage rooms and near a furnace, boiler or any heat producing equipment located within the facility.

*supervised CRs and Large IRAs including FSR*

635-7.4(b)(3)(v)(a)-(c) Safe, continuous and unobstructed exits shall be maintained from the interior of the home or IRA to the exterior at a street or to a yard, courtyard or passageway leading to an open public area. A landlocked courtyard must have unrestricted access to a location which is at least 30 feet away from the building.

*Small IRA including FSR*

635-7.5(f) – Unless the building is fully sprinklered, each certified site shall be equipped with interconnected, hardwired smoke detection and alarm devices to assure early notification of the certified site. At a minimum, the devices shall be installed in required exit ways from the certified space.

*Day Habilitation and Prevocational sites*

Clarifying requirements: ADM # 97-01; ADM # 99-01

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Vo*

**GUIDANCE:**

**DISCUSSION**

**DOCUMENTATION REVIEW**

**OBSERVATION**

As needed	<u>Mandatory:</u> Alarm and Detection equipment/system check/test documentation which will indicate presence/absence of needed equipment and whether operable or defective	<u>Mandatory:</u> During physical plant tour review for installation of required devices
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Verify during the physical plant walkthrough that smoke detectors and heat detectors are present in accordance with regulatory requirements. There is a separate standard that addressed heat detectors required per ADM #2012-12.

**NOTE: For situations that present an immediate risk to the safety of an individual, contact your area director & require immediate correction.**

**SMOKE & HEAT DETECTION & ALARM:**

- Surveyors should familiarize themselves with the different types of smoke and heat detectors (or combo smoke/heat detectors).
- During a physical plant walk-through, surveyors should ensure that the facility is meeting the requirements for smoke and heat detection identified.
- Some detectors can be physically tested for interconnectivity.
- Ensure that smoke detectors are installed greater than three (3) feet or less of operable ceiling fans. Smoke detectors in a room with a ceiling fan must be photoelectric vs. ionization type unless specifically listed for conditions of rapid air movement. **(ADM # 99-01).**

***RESIDENTIAL SITES:***

**General Smoke detection Requirements:** Systems are required to be:

- hard wired
- powered by house electrical service
- must sound an alarm that is audible in all parts of the facility
- The battery operated smoke detector exception should be applied in VERY RARE instances. Battery-operated smoke detectors are allowed by exception only, and if used must be a combination photoelectric/ionization type. For guidelines for exceptions to battery-operated smoke detectors ban, see referenced memorandum. (ADM #97-01)

***Applies to Small IRA's (8 beds or less):***

- A smoke detector is installed in each corridor adjacent to sleeping rooms.

- Smoke detectors are installed in corridors or adjacent open areas such as living rooms, dining rooms or recreation rooms at a maximum of 30 feet on center and no more than 15 feet from a wall.
- A smoke detector is installed at the head of each open stairway located within the home or IRA or a smoke detector is installed within six feet of the bottom opening of a stairway that is enclosed at the top.
- At least one smoke detector is installed in basements (see section 635-99.1). If a basement alarm is placed six feet from the bottom of the staircase, it counts as coverage for the basement (a detector at the top of the staircase does not).
- Additional detectors may be required for those basements and attics subdivided by partitions

***DAY HABILITATION SITES ONLY:***

- Unless the building is fully sprinklered, each certified site shall be equipped with interconnected, hardwired smoke detection and alarm devices to assure early notification of the certified site. At a minimum, the devices shall be installed in required exit ways from the certified space.
- Smoke detectors in hallways should be spaced every 30 feet. This is under normal conditions where the hallways are of average width, height and slope.

*Also refer to the grid entitled: **REQUIRED FIRE PROTECTION EQUIPMENT BY FACILITY TYPE** in the fire safety protocol.*

**Select MET if ALL of the following are verified:**

REGULATION REQUIRED Smoke detector, heat detection and alarm devices are installed and operable per the facility type.

**Select NOT MET if ANY of the following are missing or inoperable:**

- Smoke detectors as required by regulation per facility type
- Heat detectors as required by regulation per facility type
- Alarms devices as required by regulation per facility type

**8-10 Heat detectors are present in the residence as required by OPWDD.**

ADM 2012-02 ...OPWDD is requiring that all attics, crawl spaces and roofed porches within residential sites be eventually equipped with fixed self-restorative heat detectors that are hard wired, powered by the building electrical service and are interconnected to the building's fire alarm and smoke detection system. Surveyors will routinely identify sites which lack heat detectors in attics, crawl spaces and roofed porches during site visits.

*IRAs, CRs, Private Schools, Apts, specialty hospitals*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
As needed	<u>Mandatory:</u> Alarm and Detection equipment/system check/test documentation which will indicate presence/absence of needed equipment and whether operable or defective	<u>Mandatory:</u> During physical plant tour observe for installation of required heat detectors

**See ADM 2012-02** In an effort to increase the level of detection and resultant safety in residential sites, OPWDD requires that specified areas of the residences be equipped with heat detectors as indicated below.

**The installation of heat detection per these requirements is effective 05/01/2012 in the following circumstances:**

- All new residential development projects where construction begins after 5/01/2012
- All significant physical plant upgrades or **replacement of existing fire alarm/smoke detection systems.**

**The heat detection requirements are:**

All attics, crawl spaces and roofed porches within residential sites will be equipped with rate-of-rise or fixed self-restorative heat detectors that are hard wired, powered by the building electrical service and are interconnected to the building's fire alarm and smoke detection system. ADM #2012-02.

• Attics:

- All attics need heat detectors and must be accessible for inspection. If inaccessible, attics must be made accessible and heat detectors installed.

• Crawl Spaces:

- Accessible crawl spaces need heat detectors
- Previously inaccessible crawl spaces need not be make accessible.
- Crawl spaces that are not accessible to routine staff, have only restricted access for inspection purposes, and with no equipment installed, do not require heat detectors. (Restricted access: e.g. locked gate or access panel for which access is limited to maintenance staff or a contractor.)
- **Overhangs:**
  - Heat detectors are required for overhangs that extend out from the building four (4) feet or more when the overhang is at least four (4) feet wide.
  - In specific locations exposed to weather, heat detectors rated for outdoor use should be used
  - Heat detector coverage must not exceed 1000 sq. ft. of coverage per detector
  - Heat detectors must provide lateral coverage of thirty (30) feet on center.
  - Exception: Heat detector are not required for buildings with overhangs having solid surfaces (non- perforated/non-ventilated), non-combustible soffits and fascias, and non-combustible exterior walls or siding.

For specific sites to which the requirements do not apply, in which the lack of heat detectors in proposed locations appears to present a particular vulnerability, based on the population served or other factors, surveyors will strongly recommend that the provider agency promptly explore the feasibility of installing heat detectors at the site.

**Select MET if ANY of the following are verified:**

- The requirement does not apply as the residence was constructed prior to 05/01/2012 and has not implemented any physical plant upgrades or **replacement of existing fire alarm/smoke detection systems since 05/01/2012**; OR
- Required heat detectors in attics, crawl spaces and overhangs, as described in guidance (per ADM #2012-02) are installed and operable.

**Select NOT MET if ANY of the following are evidenced:**

- Construction of the residence began at or after 05/01/2012 and required heat detectors in attics, crawl spaces and overhangs as described in guidance (per ADM #2012-02) are NOT installed and/or NOT operable.
- The residence has implemented **physical plant upgrades** and/or **replacement of existing fire alarm/smoke detection systems** since 05/01/2012 and required heat detectors in attics, crawl spaces and overhangs as described in guidance (per ADM #2012-02) are NOT installed and/or NOT operable.

**8-11 Fire alarm and notification systems are operational and effective.**

633.4(a)(4)(i) Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.  
*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

635-7.3(h)(7) Any hazardous conditions that present a threat to an individual's safety or welfare shall be repaired in a timely fashion.  
*Clinic, Large FSR, Large IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

635-7.4(b)(3)(xviii) Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.  
*Small IRA and small FSR*

686.16(b)(5) OPWDD shall verify, in facilities of eight beds or less that the alarms of fire detectors installed pursuant to section 635-7.4(b)(3)(v) of this Title are clearly audible in sleeping areas with intervening doors closed.  
*Small IRA and small FSR*

635-7.5(f) Unless the building is fully sprinklered, each certified site shall be equipped with interconnected, hardwired smoke detection and alarm devices to assure early notification of the certified site. At a minimum, the devices shall be installed in required exit ways from the certified space.  
*Day Habilitation and Prevocational sites*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
Site and/or agency staff as needed for clarification	<u>Mandatory:</u> <ul style="list-style-type: none"> <li>• documentation of the testing, inspection, and maintenance of the fire alarm/notification equipment</li> <li>• proof of repair and/or replacement of any faulty equipment</li> </ul>	<u>Mandatory:</u> <p>During physical plant tour request activation of alarms to assess operation and that they are audible as required.</p>

All fire alarm systems must be maintained in continuously operable condition at all times. Fire alarm and notification systems may include but are not limited to: Alarms, strobes, bed and pillow shakers, and any other mechanisms installed to support notification. No one may interfere with

the operation of the equipment by practices such as silencing fire alarm systems. In some sites a formal system may not be in place, however the interconnected hard wired smoke alarms must be tested and operable also.

Review the documentation of the testing, inspection, and maintenance of the fire alarm/notification equipment. The documented reports should indicate that the equipment is operational and that any problems identified have been addressed/corrected. Testing documentation must adhere to NFPA 72 requirements. **See ADM 2012-02 for guidance ([ADM #2012-02 Fire Safety Attachments](#)).**

During the walk-through, review the following:

- In all sites except apartment buildings, request facility staff to activate the alarm system in the most naturally occurring way possible: e.g. test/activate smoke detection, activate the pull station, etc. If the facility is connected to the fire department or a central monitoring station, it may be helpful to remind staff to notify the parties that a test will be occurring. Verify the following:
- The alarms activate
- Alarms are clearly audible in sleeping areas with intervening doors closed, and typical ambient room noise such as air conditioners or televisions running. The sound should be likely to wake the occupants.
- Strobes flash
- Bed shakers activate, properly placed and are protected from tampering
- The alarm relays to the monitoring station or fire department, if applicable
- For sites that are divided into apartments, the alarm, when sounded in one apartment, must be audible in all apartments.

**Select MET if ALL of the following are verified:**

- Based on activation the alarm/notification system, the system and all required components are working and effective to alert according to the needs of the individuals
- Documentation of alarm system and component testing indicates the system has been maintained as operable and any needed repairs/replacements occur timely.

**Select NOT MET if ANY of the following are evidenced:**

- Based on activation the alarm/notification system, the system and/or any required component is NOT working and/or not effective to alert according to the needs of the individuals

Documentation of alarm system and component testing indicates identified needed repair and/or replacement of any portion of the system has not occurred or has not occurred timely

## 8-12 Other fire protection equipment is operational.

635-7.3(h)(9) Door stops, wedges or other non-automatic releasing hold-open devices are not used on openings in fire walls, fire separations and smoke barriers.

*Clinic, Large FSR, Large IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

635-7.4(b)(3)(xviii) Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.  
Small IRAs and small FSR

633.4(a)(4)(i) No person shall be denied: (i) a safe and sanitary environment.

*Clinic, FSR, Day Training, Day Treatment, Day Hab, Spec Hospital, Private School, cert Prevoc*

### GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As Needed:</u> Site and/or agency staff as needed for clarification</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• documentation of testing, monitoring of other fire protection equipment</li> <li>• proof of repair and/or replacement of any faulty equipment</li> </ul>	<p><u>Mandatory:</u> During physical plant tour to assure working and effective fire protection equipment, other than that specified in other standards in this protocol</p>

All fire safety equipment must be maintained in continuously operable condition at all times. Other fire protection equipment may include: Self Closing and Auto-Closing doors\*, special locking devices; emergency lighting units; smoke dampers, auto-disengagement of locked exit doors, and any other mechanisms installed to support fire and smoke protection and evacuation.

Interview knowledgeable management staff, conduct a walk through and review maintenance documentation to determine whether the site has any additional fire safety equipment. Some of the items may not be specifically addressed in fire alarm system or sprinkler system testing and maintenance reports.

Through review of maintenance reports and during the walk-through verify that the equipment works as intended. Some items are best verified at the time of alarm activation. Review may include but is not limited to the following:

- Locked exit doors automatically disengage

- Auto-closing doors close and latch. There should be nothing that interferes with the action of doors that are required to be equipped with self-closing devices. These doors are so equipped to provide fire and smoke partitions; separation of potentially hazardous areas, separation of stories and separation of egress routes from common living areas. Using tie backs, door stops etc. defeats the function of the self-closing device.
- Emergency lighting illuminates when tested

**Select MET if ALL of the following are verified:**

- Based on activation of other fire protection equipment it is working properly (if activation applicable).
- Observable equipment is in working order without damage.
- There is no documentation to indicate that the equipment has not been maintained.
- The site does not have, nor is required to have “other” fire protection equipment.

**Select NOT MET if ANY of the following are evidenced:**

- Based on activation of other fire protection equipment it is NOT working properly (if activation is applicable).
- Observable equipment is damaged
- There is documentation to indicate that the equipment has not been maintained, repaired, replaced as needed and in a timely manner.

8-13 Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.

635-7.3(i)(1) There is documentation that all heat and smoke-detecting alarm devices have been tested quarterly.

*Clinic, Large FSR, Large IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc 10-10, 19-27, 20-15, 20-17, 20-19, 20-20, 20-21, 31-30, 33-31, 33-33, 34-34, 32-35, 44-44, 50-50, 70-70, 99-99*

635-7.4(b)(3)(xviii) Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.

*Small IRAs and FSRs 19-84, 20-14, 20-16*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u> Site and/or agency staff as needed for clarification manufacturer's recommendations.</p>	<p><u>Mandatory:</u> Records which document fire alarm, smoke detection and sprinkler system inspections</p>	<p>N/A</p>

Through documentation review and interview, verify that this equipment was tested, inspected and maintained in accordance with the manufacturer's recommendations.

**Quarterly** inspection is required unless documentation is provided by the agency evidencing contrary inspection instruction by the manufacturer, or alternate instruction is on the Maintenance Inspection Schedule.

Documentation of inspection/testing maintenance is dependent on the equipment and the party responsible for the task. For example sites with hard wired smoke detectors that may be tested by agency staff will likely be documented on an agency form for that purpose, while inspection of complex alarm and detection systems by contracted professional will be indicated on documents meeting NFPA standards. Some testing may be indicated right on the device, such as tags on Fire extinguishers where notations of required inspections may be noted.

Refer to MAINTENANCE INSPECTION SCHEDULE for specific requirements for maintenance frequency per equipment/system type.

**Select MET** if the facility has documentation that verifies testing/inspection at required frequencies.

**Select NOT MET If ANY** of the following are evidenced:

- There is no documentation of inspection
- Documented inspection indicates a pattern of missed testing and inspections/inspections do not occur with required frequency

**8-14 Maintenance and inspection of Fire Alarm and Detection systems are performed according to OPWDD standards.**

ADM # 2012-02 To ensure consistency and code compliance across the state, contract templates for sprinkler system testing and maintenance and fire alarm and smoke detection system testing and maintenance, that include information related to fire alarm system central station monitoring requirements, are available. Agencies that are negotiating or renewing contracts for these services must utilize these templates to ensure that contracts are sufficiently clear and comprehensive with regard to the responsibilities of the vendor. 10-10, 19-27, 19-84, 20-14, 20-15, 20-16, 20-17, 20-19, 20-20, 20-21, 31-30, 33-31, 33-33, 34-34, 32-35, 44-44, 50-50, 70-70, 99-99

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u> Site and/or agency staff as needed for clarification</p>	<p><u>Mandatory:</u> Records which document fire alarm and smoke detection inspections</p>	<p>N/A</p>

**While completing the site reviews, verify that there are testing and maintenance reports for Alarm and Detection Systems that provide a full record of all testing (including results) and maintenance actions taken in regards to the equipment and/or system. The inspections/testing should be documented on National Fire Protection Association forms “Inspection and Testing Form”, as appropriate for the inspection and testing work being performed. A similar maintenance, inspection and testing form may be substituted and must include at a minimum all of the information required by NFPA 72.**

***It is acceptable for hard-wired line voltage interconnected smoke detectors without a panel system to be inspected by non-certified agency personnel, including, but not limited to maintenance personnel.***

Per ADM #2012-02 the following is Inspection and Testing expected for Fire Alarm Systems. This list does not apply to the systems described immediately above:

**FIRE ALARM SYSTEM INSPECTION and TESTING GENERAL REQUIREMENTS:**

The contractor or in some situations an agency's own appropriately trained staff must complete testing and maintenance for system components as applicable.

- **Initial Visual Examinations** of fire alarm system components for proper operation, position and condition as appropriate.
- Fire Alarm System Testing General Requirements

*QUARTERLY (four times per year):* Initiating Devices; Central Station operation; Emergency Voice/Alarm Communications Equipment

*SEMI ANNUAL (Two times per year):* Batteries; Sprinkler Alarming Devices

*ANNUAL (Once per year):* Control Equipment Building Systems – Functions, fuses, interfaced equipment, lamps and LED's, primary power supply, transponders; Batteries (other); Fiber Optic Wiring; Control Unit trouble signals; Heating, Ventilating, and Air Conditioning (HVAC) System; Remote annunciators; Main Panel; Supervising Station Equipment Receivers (Central Station)

*EVERY TWO YEARS:* Sensitivity testing on initiating devices and in accordance with NFPA 72

*NOTE: Assurance that the contracts for inspection and testing include detail of all required activities and by competent parties will be reviewed during the Agency review.*

**Select MET if** the facility has documentation that verifies that required maintenance, testing and inspection of the smoke alarms (where applicable) or alarm and detection system (where applicable) is occurring with appropriate components included.

**Select NOT MET if ANY** of the following are evidenced:

- There is no documentation of required maintenance, inspection and testing of the smoke alarms (where applicable) or the alarm and detection system (where applicable)
- Documented maintenance/inspection/testing of the alarm and detection system indicates a pattern of incompleteness of the expected activities per timelines.

**8-15 Maintenance and inspection of Sprinkler Systems are performed according to OPWDD standards.**

ADM # 2012-02 To ensure consistency and code compliance across the state, contract templates for sprinkler system testing and maintenance and fire alarm and smoke detection system testing and maintenance, that include information related to fire alarm system central station monitoring requirements, are available. Agencies that are negotiating or renewing contracts for these services must utilize these templates to ensure that contracts are sufficiently clear and comprehensive with regard to the responsibilities of the vendor. 10-10, 19-27, 19-84, 20-14, 20-15, 20-16, 20-17, 20-19, 20-20, 20-21, 31-30, 33-31, 33-33, 34-34, 32-35, 44-44, 50-50, 70-70, 99-99

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u> Site and/or agency staff as needed for clarification</p>	<p><u>Mandatory:</u> Records which document fire alarm and smoke detection inspections</p>	<p>N/A</p>

**While completing the site reviews, verify that there are testing and maintenance reports for Sprinkler Systems that provide a full record of all testing (including results) and maintenance actions taken in regards to the sprinkler system. The inspections/testing should be documented on National Fire Sprinkler Association (NFPA) forms “Inspection, Testing and Maintenance of Fire Sprinkler Systems” or equivalent as deemed acceptable by OWPDD as appropriate for the inspection and testing work being performed.**

The contractor or in some situations an agency’s own appropriately trained staff must complete testing and maintenance. The facility /agency should have documentation noting the sprinkler system type and that evidences the water supply is sufficient. The requirements for specific inspection and testing of sprinkler systems per ADM #2012-02 are as follows (see ADM for more details as needed).

- QUARTERLY (four times per year) Visual Examinations of all sprinkler system components for proper operation, position and condition as appropriate, and sprinkler system inspection and testing
- ANNUAL sprinkler system inspection and testing:
  1. Wet Pipe Sprinkler System: Test the freezing point of anti-freeze solutions if used.
  2. Dry Pipe Sprinkler System: Trip test the dry pipe valve, preferably in the spring.
  3. Cold weather valve, if used, should be closed before freezing weather and piping drained. Valve should be opened in spring.
  4. Low point drains should be drained thoroughly before cold weather and after any system trip.

#### 5. Fire Pump Test

- Every 3 YEAR: Trip test the dry pipe valve – FULL FLOW TEST
- 5 YEAR INSPECTION: Test representative sample of sprinklers with temperature classification of Extra High (325 degrees F) or greater.
- BLOCKAGE INVESTIGATION (Every five years minimum or more often as needed): Ensure that the sprinkler system piping be maintained free of obstructions.
- At any interval, identified problems and needed repairs must be addressed and evidenced/documentated.

NOTE: Assurance that the contracts for inspection and testing include detail of all required activities and by competent parties will be reviewed during the Agency review.

**Select MET if EITHER of the following is verified:**

- The facility has documentation that verifies that required maintenance, testing and inspection of the sprinkler system is occurring with appropriate components included.

**Select NOT MET If ANY of the following are evidenced:**

- There is no documentation of required maintenance, inspection and testing of the sprinkler system
- Documented maintenance/inspection/testing of the sprinkler system indicates a pattern of incompleteness of the expected activities per timelines.

**Select N/A if no sprinkler system is installed at the site.**

8-16 At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.

635-7.4(b)(3)(vi) Fire extinguishers shall be portable and in accordance with the requirements of NFPA 10, and approved and labeled by the Underwriters Laboratories.

*Small IRAs and Small FSR 19-84, 20-14, 20-16*

635-7.4(b)(3)(xvii) Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.

*Small IRAs and Small FSR 19-84, 20-14, 20-16*

635-7.3(h)(4) At least one fire extinguisher equal to Class-1-A-5BC, 2.5 pound unit, approved and labeled by the Underwriters Laboratories, is located in an accessible place on each floor. Extinguishers are tested and recharged in accordance with the recommendations of the manufacturer and the NFPA. 10-10, 19-27, 20-15, 20-17, 20-19, 20-20, 20-21, 31-30, 33-31, 33-33, 34-34, 32-35, 44-44, 50-50, 70-70, 99-99

*Clinic, Large FSR, Large IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u> Site and/or agency staff as needed for clarification</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>documentation of monitoring of extinguisher function and effectiveness</li> </ul>	<p><u>Mandatory:</u> During physical plant tour observe for location, readiness (e.g. charge level) and condition as described below</p>

**Verify:**

- Fire extinguishers must be equal to Class-1-A-5BC, 2.5 pound unit, approved and labeled by the Underwriters Laboratories
- Fire extinguishers are located on each floor of the facility. Small IRAs required extinguishers near kitchen areas.
- Extinguishers are mounted so that their location is fixed so they can be accessed easily
- Function is reviewed through verification that Testing and recharges occur per manufacturer and NFPA recommendations. Minimally, extinguishers should be inspected monthly to ensure that:
  - < There is no obstruction to access
  - < The pressure gauge is in the operable range
- Inspections/testing should be documented to include date and inspector's initials

**Select Met if:** Operable fire extinguishers of the appropriate type and are on each floor and accessible per requirements.

**Select NOT MET if ANY of the following are identified:**

- Fire extinguishers are lacking in any applicable floor or area
- Fire extinguisher are present but not easily accessible
- Any fire extinguisher is inoperable, damaged, not charged

8-17 In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.

633.4(a)(4)(i) No person shall be denied: (i) a safe and sanitary environment 20-15, 20-17, 20-19, 20-21, 70-70  
*Clinic, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

686.16(b)(5) OPWDD shall verify, in facilities of eight beds or less that the alarms of fire detectors installed pursuant to section 635-7.4(b)(3)(v) of this Title are clearly audible in sleeping areas with intervening doors closed.  
*Small IRAs and small FSR*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Site staff regarding how/if they are aware of emergencies in individual apartments</li> <li>• Individuals if needed to assess staff notification and responsiveness</li> </ul>		<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Request demonstration of notification mechanism used on site with activation of the alarm to alert of needs in a particular apartment</li> <li>• Assess likelihood that staff may respond appropriate on site within 1 minute.</li> </ul>

In such supervised apartment living situations, the following must be assured:

- Staff on duty will be automatically notified of a fire alarm activation in the service recipient’s home/apartment

**and**

- Staff must be able to get to the individual within 1 minute of notification of fire or other emergency

**and**

- The service recipient must have a way to notify the staff of his/her need for assistance when the staff is not in the individual’s home,

**and**

- All direct support staff must have a key or other means of immediate access to the Individual’s home.

**Select MET if:** Review activities verify that there is an effective mechanism which assures automatic notification to staff AND 1 minute response AND immediate staff access to the individual's apartment.

**Select NOT MET if any of the following are evidenced:**

- Review activities verify that there is no mechanism to ensure that staff can be summoned to an individual's apartments in an emergency in a supervised apt setting.
- There is a mechanism however in does not assure all three elements: assurance of automatic notification of staff AND 1 minute response AND immediate staff access to the individual's apartment.

**Select N/A only if the site is NOT a setting of individual apartment certified as a Supervised residence.**

8-18 A carbon monoxide alarm is appropriately located in all new and existing residences on sleeping levels, per requirements.

633.4(a)(4)(i) No person shall be denied: (i) a safe and sanitary environment  
*Small IRAs and Small FSR*

635-7.3(h)(8) When required by other State agencies, the facility shall keep records that document compliance with the sanitation, health and environmental safety codes of New York State or the City of New York.  
*Large FSR, Large RA, Apt, CR, Specialty Hospital, Private School*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<u>As needed:</u> Site and/or agency staff as needed for clarification	<u>As needed:</u> regarding maintenance of equipment if concerns are identified	<u>Mandatory:</u> During physical plant tour to assure condition and placement on site as noted in guidance

Facilities should meet ALL the requirements of [Amanda's law requirement for carbon monoxide installations](#) Amanda's Law, in particular, those listed below:

**Carbon monoxide (CO) detectors shall be provided in the following locations:**

1. On any story of a building that contains a carbon monoxide source (a fuel burning appliance)
  - On any story, below the floor (or mezzanine) with a carbon monoxide source, where an interconnecting stair is open to both floors (or not otherwise protected with a smoke barrier), and the space on the lower level is considered habitable  
*(This is a specific clarification to Amanda's Law- location of CO devices in townhomes and similar conditions, like split level homes).*
2. Within each dwelling unit, with a carbon monoxide source; on each level containing a sleeping area, within 15 feet of each sleeping area.
  - a. More than one carbon monoxide detector shall be provided, where necessary, to assure that no sleeping area on any level is more than 15 feet away from a carbon monoxide detector.
3. Health Care Occupancies are required to have a CO detector located within each sleeping area.

4. All new CO detectors shall be hardwired and interconnected with the smoke and heat detection system.
5. A hardwired interconnected CO detector(s) shall be installed if not otherwise appropriately located, when a new fuel burning appliance is installed.
6. A CO detector is recommended to be placed in all vehicular garages which are attached to a home with a common interconnecting door.
7. CO detectors should be maintained as operable.

Carbon monoxide detectors **are not required** in homes where no carbon monoxide source is located within or attached to the building.

**Select MET if EITHER of the following are verified:**

- Review activities verify carbon monoxide alarms are installed in locations in the home as required and operable.

**Select NOT MET If:** Review activities verify that carbon monoxide alarms are NOT installed in locations in the home as required and operable.

**Select N/A Only if:** The home does not have a carbon monoxide source (e.g. room and water heating is electric only)

8-19 The facility, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.

635-7.4(b)(3)(xv) Any hazardous conditions that present a threat to an individual's safety or welfare are repaired in a timely manner.  
*Small IRAs and Small FSR*

635-7.3(h)(7) Any hazardous conditions that present a threat to an individual's safety or welfare shall be repaired in a timely fashion.  
*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u>                      Facility and agency staff and individuals for any questions or concerns they may have regarding the safety of the site</p>	<p><u>As needed:</u>                      Any documentation which co-evidences any other existing hazard which is not addressed in another protocol standard.</p>	<p><u>Mandatory:</u>                      During physical plant tour to observe for any other hazards, not specifically addressed in other protocol standards</p>

During the survey and during the physical plant walk through, surveyors must be vigilant in the assessment of facilities for potential fire hazards.

Possible examples of fire hazards are; but not limited to; as follows:

GENERAL FIRE SAFETY ISSUES may include:

- Overloaded electrical outlets including "piggy-backed" power strips.
- Fixtures or appliances with damaged electrical wiring
- Wiring that is placed so that it is routinely run over such as by bed wheels and may become damaged
- Use of narrow gauge extension cords
- Extension cords draped over doors or under carpets
- Complaints of tripping circuit breakers when certain appliances are turned on
- Smells of gas or the smell of the products of combustion
- Noisy or dust clogged exhaust fans in bathrooms, kitchens etc.
- Improperly stored combustibles in the home i.e. propane tanks, gasoline for mowers etc., oil based paints, charcoal lighter fluid etc. Typically flammable materials are not permitted indoors. If they are kept on premises quantities must be strictly limited and kept either in an exterior shed or a vented metal cabinet within a properly enclosed hazardous area.

- Items such as outdoor grills, backup generators etc. too close to exterior siding such as vinyl or wood. Less than 3 feet clearance around grills. Grills placed under a roof.
- Combustibles such as paper towel or dish towels hung close to or over the stove.
- Significant grease accumulations on stove tops or in ovens
- Halogen lights should be avoided in lamps that can tip over such as torch lamps
- Use of toaster ovens on flammable surfaces such as wooden cutting boards or their observed unattended.
- Unattended lit candles

**CLOTHES DRYERS:**

- The use of a plastic or flexible foil vent duct to vent clothes dryers IS NOT PERMITTED. Clothes dryer vent conduit must be constructed of rigid or flexible solid metal.
- Torn Lint Filter (This leads to extensive lint build up in dryer vent conduits.)
- Extensive kinking in dryer vent conduit
- Extensive lint accumulation on the lint filter in the dryer and/or at the terminus of the dryer vent arrangement (indicative of infrequent cleaning)
- An accumulation of clothes or debris behind the dryer

**Select MET if:** No other fire safety hazards as described above are identified.

**Select NOT MET If:** Other fire safety hazards as describe above are identified and not addressed by the agency prior to identification by DQI staff.

**For situations that present an immediate risk to the safety of an individual, contact your Area Director & require immediate correction.**

## SECTION 9 Site Specific Requirements

9-1 The site/program has a written Quality Assurance Plan that has been implemented.

679.4(m)(1)-(3) OPWDD shall verify that the written plan for the facility's quality assurance program describes the program's objectives, organization, responsibilities of all staff members, scope of the program and procedures for overseeing the effectiveness of monitoring, assessment and problem-solving activities and that the plan has been implemented. The quality assurance process shall define methods for the identification and selection of clinical and administrative problems to be reviewed, and include:

- (1) the establishment of review criteria developed in accordance with current standards of professional practice for monitoring and assessing the appropriateness of treatment and clinical performance;
- (2) regularly scheduled reviews of clinical records, complaints, suggestions from persons served and their collaterals, reported incidents or allegations of abuse, and other documents pertinent to problem identification;
- (3) documentation of all quality assurance activities, including but not limited to the findings, recommendations, and actions taken to resolve identified problems.

*Clinic*

690.6(n)(1)-(3) OPWDD shall verify that the facility's quality assurance process defines methods for the identification and selection of clinical and administrative problems to be reviewed, and includes:

- (1) the establishment of review criteria developed for monitoring and assessing the appropriateness of treatment and clinical performance;
- (2) regularly scheduled reviews of clinical records, complaints, suggestions from persons served, their correspondents and/or advocates, reported incidents or allegations of abuse, and other documents pertinent to problem identification;
- (3) documentation of all quality assurance activities, including but not limited to the findings, recommendations, and actions taken to resolve identified problems.

*Day Treatment*

**GUIDANCE:**

**DISCUSSION**

**DOCUMENTATION REVIEW**

**OBSERVATION**

<p><u>Mandatory:</u> Facility and agency staff and individuals for any questions or concerns they may have regarding the safety of the site</p>	<p><u>As needed:</u> Any documentation which co-evidences any other existing hazard which is not addressed in another protocol standard.</p>	<p><u>Mandatory:</u> During physical plant tour to observe for any other hazards, not specifically addressed in other protocol standards</p>
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- **The written plan for and implementation of the program’s Quality Assurance Plan includes:**
  - the objectives of the Quality Assurance plan/activities;
  - the responsibilities of staff members and assignment of implementation;
  - selection of clinical and administrative criteria/ issues/requirements to be reviewed;
  - procedures for overseeing the effectiveness of the Quality Assurance program; and,
  - review criteria for monitoring and assessing the appropriateness of treatment and clinical performance.
  - regularly scheduled reviews of individual’s records, complaints, suggestions from persons served (and their family/advocates as needed), reported incidents or allegations of abuse; and other documents and standards determined by the program to be pertinent to quality and problem identification
  - Methods for selecting the records to be reviewed
  - the standards against which reviewed areas will be judged
- **There is documentation of all Quality Assurance activities including findings and problems**
- **The summary includes for recommendations for actions to resolve identified problems.**

Select **MET** if **ALL** of the following are present:

- The program has a QA plan ( by whatever name they give it)
- The QA plan includes most of the components included in the bullets above. If there is a missing component to the written plan it does not negatively impact the identification of issues impacting the quality of care or safety of individuals .
- There is adequate documentation to demonstrate implementation of the QA Plan
- Findings from QA activities are summarized/documentated
- Recommendations for corrective actions are identified for any problems identified

Select **NOT MET** if **ANY** of the following are identified:

- The program does not have a QA plan

- The program has a QA plan but it was not implemented per the plan as follows:
  - The plan was not implemented with the frequency stated
  - The plan was implemented but significant activities stated in the plan were omitted, incomplete or poorly implemented. Use judgement to determine the extent of missed activities and impact to identification of significant issues and quality care. (E.g. some slight variation in samples size completion or erroneously missing only one occasion of implementation when multiples of that same activity were also implemented with no negative findings, may still result in surveyor determining that plan was conscientiously implemented).
  - Findings of QA activities are not documented/summarized.

Negative findings do not result in recommendations for remediation.

## 9-2 Corrective actions identified per the QA plan activities are implemented.

679.4(m)(4) OPWDD shall verify that the written plan for the facility's quality assurance program describes the program's objectives, organization, responsibilities of all staff members, scope of the program and procedures for overseeing the effectiveness of monitoring, assessment and problem-solving activities and that the plan has been implemented. The quality assurance process shall define methods for the identification and selection of clinical and administrative problems to be reviewed, and include: 4 the timely implementation of corrective actions and periodic assessments of the results of such actions with adjustments, as appropriate.

### *Clinic*

690.6(n)(4) OPWDD shall verify that the facility's quality assurance process defines methods for the identification and selection of clinical and administrative problems to be reviewed, and includes: the timely implementation of corrective actions and periodic assessments of the results of such actions with adjustments, as appropriate.

### *Day Treatment*

See DISCUSSION, DOCUMENTATION AND OBSERVATION GUIDANCE ABOVE:

Verify:

- The agency/program ensured timely implementation of corrective actions and
- The agency/program actions are effective results of such action
- Corrective actions should be appropriate to the problems identified. They may include:

Select **MET** if:

- The agency/facility implements the corrective actions described
  - The agency/facility has a system to ensure that corrective actions are implemented and effective
- OR
- There were no problems noted during QA activities requiring corrective actions

Select **NOT MET** if:

- The corrective actions are not implemented
- Corrective actions are implemented but QA findings demonstrate repeats of same issues without effective corrections or corrective plans

**SECTION 10**  
**Specialized Risk Factors**

*The information you gather throughout your survey via discussion and observation will allow you to respond to the Qualifier Questions (QQ) in this section. For any Yes response, you must complete review activities to determine whether the standard is met.*

**SECTION 10a: RISK FACTOR - SKIN BREAKDOWN**

**Does anyone currently have, or have a history of skin breakdown?**

If yes, the following standards open up for review:

If yes, ID Individual(s) Name:

10a-1 There is a **written plan** to provide care for wounds and/or prevent worsening & further breakdown.

633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.

*Clinic, FSR, IRA, Apt, CR, Day Treatment, Day Training, Day Hab, Private School and Certified Pre-Voc*

680.7(b)(2)(ii)(a)(1) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD.

*Specialty Hospital*

690.5(b)(2)(v) The administrator of the facility shall be responsible for: ensuring that the services meet the physical, social and developmental needs of all persons attending the facility, that there is adequate protection of each person's health, safety, comfort, well-being, and civil, human and legal rights and that selection takes account of the person's preferences.

*Day Treatment*

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.

*Clinic, FSR, IRA, Apt, CR, Day Training, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

686.16 (b)(4)(i)-(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (i) any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid; (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.

*IRAs only*

ADM#2003-01 additional supportive justification

*IRAs excluding FSR; CRs, Apts.*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• DSP</li> <li>• RN if concerns or questions regarding the plan, DSP implementation, or RN oversight</li> <li>• Site supervisor</li> </ul>	<p><u>Mandatory:</u> Documents that provide instruction to address a person’s health care needs, in this case – skin integrity. E.g.:</p> <ul style="list-style-type: none"> <li>• Plan of Nursing Service (PONS) or Nursing Care Plan (NCP)</li> <li>• IPOP</li> <li>• ISP, Treatment Plan, Program Plan</li> <li>• Safeguards identified in waiver or site specific individualized program plan</li> <li>• Medication Administration Record (MAR)</li> <li>• Illustrative instruction on needed supports, if used, such as               <ul style="list-style-type: none"> <li>▪ Positioning diagrams or descriptions</li> <li>▪ Pictorial examples of skin condition, redness, wound appearance that require staff action</li> </ul> </li> </ul>	<p>N/A</p>

If any person has an active skin breakdown/wound or is at risk for it, there must be a comprehensive, current written plan which clearly describes the care/support to provide to address skin integrity issues. The risk may be due to a history of skin breakdown or the existence of other health issues which put the person in jeopardy of developing a wound or decubitus ulcer. It may be a stand-alone care plan such as a ‘Plan of Nursing Service’ (PONS) or ‘Nursing Care Plan’ (NCP), or may be integrated into the person’s service plan appropriate to the site, such as an IPOP, safeguard section of the habilitation plan, or individualized program plan. The plan should be the resource for staff to know the specific supports to provide in order to prevent, care for and monitor skin integrity and/or wounds.

- Instructions/Plans should be written using language that is understandable to staff who must implement it. If medical/technical terminology is used in the plan, verify that staff understand what it means in relation to their responsibilities. Interview and review of implementation will help you to verify that they understand.

- Verify that there is a written plan that describes care, monitoring and reporting necessary to address skin integrity for individuals who requires care for skin integrity. Such plans must be updated for the person's *current* skin care needs and, at a minimum, updated annually if person is stable for ongoing preventive care. Skin integrity can change rapidly, as wounds can start in the deeper unseen layers of the skin and then appear on the surface, almost suddenly, as an advanced wound, seemingly overnight. Skin care plans *may* need frequent updating as the wound changes, and subsequent staff training and re-training (see standard below.)
- An individualized plan should not be a 'cookie-cutter' set of instructions for general use with anyone. It must specifically address the unique care needs of the person for whom it is written. (E.g. it may contain attention to other chronic conditions and related health care needs of the Individual, as they relate to skin integrity so that, for example, a person who is incontinent may need more frequent assistance with care, or a person who eats poorly may also receive nutritional supplements to assist with skin integrity.) An individualized plan may include supporting documents such as positioning charts or diagrams,
- Plans to address skin integrity/care *must* contain specific directions *appropriate to what should be provided at the particular site and individualized to the person*. Day programs may provide supports to individuals with skin integrity risks. The facility may have personnel qualified to develop an appropriate plan for implementation at the site or may implement a plan provided by the person's physician or residential medical professional. A copy of the person's plan should be available at the site. It should be minimally describe the care and supports to be provided while supported by the day program.
- While no strategy should be considered exclusive to a particular service setting, a person's plan may include more comprehensive care and treatment to be delivered in the residence than expected in the day program. For example: While both settings may be expected to ensure positioning, appropriate cleansing, and monitoring during care; residential strategies may also include administration of prescribed treatments, visual observations by the RN, and other direct care.
- A plan should be specific to the person. For example a person with high needs for physical support and high risk for decubiti will likely have a more complex plan for cleaning, positioning and monitoring; than an individuals with risk factors but is continent and repositions him/herself when a timer set on their cell phone dings.
- Strategies should include as appropriate:
  - What staff are to do to care for affected areas and wounds; (e.g. use a specific cleanser when bathing around the wound or bandage; leave open to air, take body temperature daily, remove AFO's at specific intervals or specific activities or while at rest, etc.)
  - Clear description of positioning requirements if skin integrity risk is pressure related: i.e. in what position the person's body or parts of his/her body are to be in and with what frequency these are to change. E.g. Position person off of his left hip every 2 hours, for 30 minutes, while not in bed; or provide reminders to reposition in wheelchair every 30 minutes and assist as needed.

Pictures of positioning requirements or options are helpful to facilitate alternate positioning, though pictures are not specifically required.

- Instruction of monitoring: i.e. what parts of body to visually inspect and what signs/symptoms to watch for regarding skin condition
  - The frequency and duration care is to be given; (e.g. once per day; at every bathroom break, per the Medication Administration Record, etc.)
  - What to document and where; (e.g. Redness, color and size of wound, drainage, drainage color, person's reported pain level 1-10, or degree of warmth to touch, etc.)
  - What to report to the RN (e.g. a visual increase in wound size beyond the size of a golf ball; hot red skin around the wound; drainage that is opaque and/or foul-smelling; body temperature above 99.3 F) and how soon after observing these things, to contact the RN.
  - The plan *may* contain additional elements to be successful, based on an Individual's specific skin integrity issue, mobility, and diagnoses. These may include medical or nutritional interventions (e.g. prescribed topical treatments or oral medications, protein powder mixed in food).
- While an RN has oversight responsibilities, they as well as other clinical staff, may also have a role in direct provision of treatments/care and monitoring of condition.

**Select MET if:**

- An individualized written plan/instruction for care, support and treatment related to improving or maintaining health skin integrity is present; AND
- The plan includes strategies necessary to provide adequate care per the individuals' needs and comply with standards of care, appropriate to the site

**Select NOT MET if any of the following are present:**

- There is not a written plan/instruction for care, support and treatment related to improving or maintain healthy skin integrity for individuals with the need;
- The plan lacks sufficient clarity to ensure adequate care and the person is not getting adequate care
- The plan for skin integrity is not individualized to a person's specific needs.

**10a-2 Staff implement interventions related to care and monitoring of skin integrity and the prevention of skin breakdown, for which they are responsible.**

633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.

*FSR, IRA, Apt, CR, Day Training, Day Hab, Private School and Certified Pre-Voc*

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. ALL

*FSR, IRA, Apt, CR, Day Training, Day Hab, Private School and Certified Pre-Voc*

686.16 (b)(4)(i)-(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following:(i) any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid;(ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.

*IRAs only*

680.6(d) The individual program plan shall be developed and implemented by an interdisciplinary team (see section 680.13 of this Part) including the providers of medical treatment and active programming and direct care staff. One member of this team who is a qualified mental retardation professional (see section 680.13) shall serve as client coordinator (see section 680.13) with primary responsibility for implementation of the individual program plan, coordination of its components and for arranging movement of the client to a less restrictive environment as soon as the client's handicapping conditions permit.

*Specialty Hospital*

680.7(b)(2)(ii)(a)(2) The objectives of nursing services shall be to evaluate each client's need for nursing care on a continuing basis, and to provide such care directly by or under the supervision of a registered nurse (see section 680.13 of this Part). Such services shall include: participation in preventive, habilitative and rehabilitative services to eliminate, limit or reduce the client's health related problem

*Specialty Hospital*

690.5(b)(2)(v) The administrator of the facility shall be responsible for: ensuring that the services meet the physical, social and developmental needs of all persons attending the facility, that there is adequate protection of each person's health, safety, comfort, well-being, and civil, human and legal rights and that selection takes account of the person's preferences

*Day Treatment*

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP if interventions not occurring during observation or direct observation cannot occur due to respect for individual's privacy</li> <li>• RN if concerns with plan, DSP implementation , or RN oversight</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• family and/or advocate</li> <li>• Site supervisor</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Documents that provide instruction to address a person's skin integrity needs, and documentation of supports and treatments required: E.g.:               <ul style="list-style-type: none"> <li>○ PONS or NCP</li> <li>○ IPOP</li> <li>○ ISP</li> <li>○ Safeguards identified in waiver or individualized program plan</li> <li>○ MAR</li> <li>○ Physician's orders</li> <li>○ Diet orders</li> </ul> </li> <li>○ Documentation/notes on provision of care; e.g. prn notes, daily notes, health care notes, nursing notes, positioning/repositioning charting if used, body check records/documentation if used.</li> </ul>	<p><u>Mandatory:</u> During observation periods be attentive for implementation of required actions, as applicable. E.g.</p> <ul style="list-style-type: none"> <li>• appropriate positioning and repositioning per individualized plans and within required time frames</li> <li>• removal of AFOs or adaptive braces when indicated</li> <li>• provision of equipment related to skin integrity such as special cushions</li> <li>• nutritional supports per the plan as applicable</li> </ul> <p>NOTE: Survey staff should not violate privacy of the individual.</p>

- Verify through discussion, that staff understand what actions they take to provide support and/or care to address the person's skin integrity concerns.

- Via observation as able, verify that individuals are provided specified care/support as described in the written plan.
- During record review of care and the person's condition be alert to evidence of the condition improving, maintaining or deteriorating. If the condition is not improving or deteriorating, verify that appropriate actions are being taken, including RN notification and assessment, and physician notification and progressive treatment as needed. Failure to pursue and secure additional care and treatment when the condition is not improving is unacceptable.
- If staff are unable to adequately describe, and/or are not providing support and care for skin integrity per the plan, request/review documentation of staff training on the plan and individualized interventions for each person's Skin Integrity.
- As appropriate, ask Individuals what they know about the support they require for skin integrity issues; and what role he/she and staff have in the care. (E.g. who takes care of it for/with them; positioning needs, if the care is helping them get better; etc.)
- Documentation of care and monitoring will vary depending on the interventions in the care plan. Some interventions may require documentation, while other required interventions may not. Review the individual's record and documentation to verify that supports that must be documented per the plan are documented. This may include e.g. wound care treatments, monitoring notes re: skin condition, position changes if the plan requires this. Documentation may be part of the MAR or other documentation sources per the written plan and site procedures.
- Diet orders may be part of a care plan addressing skin integrity, and individuals' diets should be followed accordingly. This however may not be included in routine documentation and can be verified through interview and when possible, observation.
- An RN as well as other clinical staff may also have a role in provision of treatments and care. The RN has an active role in monitoring the individual's condition, oversight that the individual receives appropriate care, and communication and advocacy with physicians and wound care professionals.

Select **MET** if:

- Based on observation, discussion and documentation review, the individual(s) is receiving care required to improve/maintain skin integrity.

Select **NOT MET** if the following is present:

Based on observation, discussion and documentation review, any individual is not receiving/not consistently receiving skin integrity care per their written plan and per their needs

**SECTION 10b: RISK FACTOR - DISCHARGE FROM HOSPITAL**

**Has anyone been discharged from the hospital in the past 3 months?**

If yes, the following standards open up for review:

If yes, ID Individual(s) Name:

10b-1 Clear **written instruction** was provided to staff regarding the specific actions to take to provide care and monitoring required by the person discharged.

633.4(a)(4)(x) no person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.

*FSR, IRA, Apt, CR, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.

*IRA, Apt, CR, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School and Certified Pre-Voc*

ADM#2003-01 as additional authority

IRAs excluding FSR; CRs, Apts.

**GUIDANCE:**

**DISCUSSION**

**DOCUMENTATION REVIEW**

**OBSERVATION**

<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP</li> <li>• RN if concerns with plan, DSP implementation , or RN oversight</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• family and/or advocate</li> <li>• Site supervisor</li> </ul>	<p><u>Mandatory:</u></p> <p>Documents that provide instruction regarding the persons needs for health care support, E.g.:</p> <ul style="list-style-type: none"> <li>• prescriber orders;</li> <li>• discharge instruction form; instructions for follow-up appointment</li> <li>• Medication Administration Record (MAR) for meds and treatments</li> <li>• Any written plans of care for health needs such as a Plan of Nursing Service (PONS) or Nursing Care Plan (NCP), guidelines for dining, swallowing, ambulation, seizures, etc. as appropriate to the health status and reason for hospitalization or hospital visit</li> <li>• Documentation on health status</li> <li>• Documentation/notes of provision of care; e.g. prn notes, daily notes, health care notes, nursing notes</li> </ul>	<p>N/A</p>
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- Upon discharge from a hospital, skilled nursing facility, emergency department or rehabilitation center, discharge instructions (usually written by the discharging facility staff) will accompany a person from the hospital or facility. The RN or designated medical professional is responsible to translate and expand as needed, the discharge instructions into the written plan staff must follow to provide any required care, monitoring of condition, notifications, and f/u visits to health care providers. The plan of care should be related to the hospitalization, for instance care after surgery will be different than care after admission for testing and observation after a fall, or supports provided following a psychiatric admission.
- ***While initially the instruction may be conveyed verbally (especially during off hours over telephone). Staff should be instructed to document the direction given by the health care professional (HCP) and asked to repeat what they have written back to the HCP to verify accuracy. The RN should then f/u to ensure the person has a clear and individualized plan of care.***
- The written care plan may include, depending on the health issue:
  - Medications and treatments the person is prescribed to include all the required information and instruction
  - Vital signs monitoring
  - Revised or new therapies such as physical, speech or respiratory therapy

- Changes in level of supervision or supports, mobility support, behavioral supports, ambulation guidelines, etc.
- Revised or new diet order, swallowing guidelines, tube feeding instructions, bowel management regimen, etc.
- Revised or new dressing changes, oral care, seizure precautions, etc.
- The signs and symptoms of disease or concerns (e.g. blood pressure, blood sugar, mental status, fatigue level, breathing difficulties, seizure activity, etc.) of which staff are to be aware and/or respond to. The action to take when response is necessary.
- Description of what symptoms are to be reported to the RN, RN on call, medical prescriber, etc., and within what time frame the report is to be made.
- Time/duration of care and monitoring, e.g. for 10 days following discharge, until notice from the RN to discontinue, etc.
- Instructions/Plans should be written using language that is understandable to staff who must implement it. If medical/technical terminology is used in the plan, verify that staff understand what it means in relation to their responsibilities. Interview and review of implementation will help you to verify that they understand.

Note: For Specialty Hospital reviews, this applies to discharges from hospitals/medical facilities that are not the specialty hospital.

Select **MET** if all of the following are present:

- Clear individualized instruction was developed and provided to staff regarding care, monitoring, services and supports required by a person(s) following hospitalization. Individualized instruction means appropriate to the person's specific condition, diagnoses, needs, and abilities
- The written instruction/plan of care was developed by a qualified medical professional
- The instruction is consistent with the instructions provided by the facility that discharged the person
- Strategies in the plan, if implemented appear sufficient to address the needs of the individual

Select **NOT MET** if any of the following are present:

- Individualized instruction was not provided regarding care and support of an individuals after discharge from a medical facility
- Instruction was provided verbally but not in a written plan
- Instruction was not individualized and appropriate to the person's specific condition, diagnoses, needs, and abilities
- Individualized instruction was provided, but not by a qualified medical professional
- Strategies in the plan are not sufficient to address the needs of the individual as evidenced by preventable health concerns

**10b-2 The written instruction included how and **what to document** regarding required care and monitoring following hospital discharge.**

633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.

*IRA, Apt, CR, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School*

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.

*IRA, Apt, CR, Day Training, Day Treatment, Day Hab, Specialty Hospital, Private School*

ADM#2003-01 (*as additional authority*) The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer’s condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].

*IRAs excluding FSR; CRs, Apts.*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• DSP if questions/concerns with documentation</li> <li>• RN if concerns with plan, DSP implementation , or RN oversight</li> <li>• Site supervisors as needed re: training and oversight</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Written plans of care for health needs such as a PONS or NCP</li> <li>• Documentation of care and monitoring</li> </ul>	<p>N/A – See Standard on implementation, below.</p>

It is imperative that there is an ongoing record of the care and support provided to individuals in the site regarding health care.

Documentation may be entered on paper forms/hard copy or through electronic record keeping, daily notes or other agency specified recording

methods. What, when and where to document care and monitoring required after discharge should be clearly specified in their plan after a hospitalization, rehabilitation or nursing facility, or emergency department stay. For example:

- Any observed signs and symptoms of disease or health related concerns (e.g. Temperature, blood pressure, blood glucose level, skin turgor, mental status, fatigue level, breathing difficulties, seizure activity, and status relative to what is “normal” for the individual, etc.) per the written plan.
- Actions taken by staff *in response to* any of the observed signs and symptoms, if they were outside of the written plan’s recommended limits or if the person was observed to be in distress or acting abnormally. The Individual’s response to staff actions.
- Staff communication of any concerns, symptoms and/or level of distress to the RN, RN on call, medical prescriber, etc.
- The individual response to new medications and/or revised medication orders
- The Individual’s response to new or revised treatments (for example, dressing changes, use of a vagal nerve stimulator, etc.)
- Provision of physical exercises, supported range of motion, and respiratory exercise provided and the Individual’s response;
- The individual’s response to revised or new diet order or feeding methodologies;
- Documentation of any follow-up appointments and communications.
- While new medications and medications orders may occur following discharge from a medical, hospital or rehab facility, evidence of medication administration per orders should be reviewed in Section 3.

Note: For Specialty Hospital reviews, this applies to discharges from hospitals/medical facilities that are not the specialty hospital.

Select **MET** if all of the following are present:

- The plan instructs on the required/expected documentation of care provided and/or status of the individual based on monitoring of the person’s condition (what, where, when).
- The instruction is consistent with the instructions provided by the facility that discharged the person, if applicable.
- Instruction on what/how to document is sufficient to evidence continuity of care

Select **NOT MET** if any of the following are present:

- The plan lacks instruction/does not require documentation of care and monitoring provided following discharge from medical/hospital facility.

- While the plan directs that staff document care and monitoring, it lacks sufficient clarity resulting in insufficient evidence of continuity of care following discharge.

**10b-3 There is evidence that the staff **implement** required care and monitoring following discharge.**

633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.

*Clinic, FSR, IRA, Apt, CR, Day Training, Day Treatment, Day Hab, Specialty Hospitals, Private School and Certified Pre-Voc*

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.

*IRA, Apt, CR, Day Training, Day Treatment, Day Hab, Specialty Hospitals, Private School*

680.6 (j)(1)(iv)-(vi) The specialty hospital shall maintain the following system of records: Client record. The specialty hospital shall maintain a comprehensive record for each client. Each record shall be organized in the manner and contain the information prescribed by OPWDD. Each client's record shall contain the following types of information:(iv) copies of assessments, reassessments, progress notes and previous individual program plans;(v) service plans, description of treatments provided and medications administered;(vi) reports of illness or injury including the date and time of occurrence and action taken regarding each occurrence.

Specialty Hospitals

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP if interventions not occurring during observation or direct observation cannot occur due to respect for individual’s privacy</li> <li>• RN if concerns with plan, DSP implementation , or RN oversight</li> </ul>	<p>Mandatory</p> <ul style="list-style-type: none"> <li>• Documents that provide instruction to address a needs, and supports and treatments required: E.g.:               <ul style="list-style-type: none"> <li>○ PONS or NCP</li> <li>○ MAR</li> <li>○ Physician’s orders</li> <li>○ diet orders</li> </ul> </li> </ul>	<p><u>Mandatory as possible:</u> Attend to what you expect to see occurring based on the post discharge written instructions.</p> <p>Note: Survey staff should not violate privacy of the individual.</p>

<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• family and/or advocate</li> <li>• Site supervisor</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation/notes on provision of care; e.g. prn notes, daily notes, health care notes, nursing notes</li> </ul>	
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Consider the following, when verifying that staff are effectively delivering individuals’ needed care and monitoring as best evidenced by its impact on the Individual and effective response to changing health:

- Observe as able, depending on when care and monitoring is provided, that the person receives care and monitoring per the written plan
- Documentation of care and monitoring will vary depending on the interventions in the care plan. Some may require documentation, while other required interventions may not. Review the individual’s record and documentation to verify that supports that must be documented per the plan are indicated in documentation. Documentation may be part of the MAR or other documentation sources per the written plan and site procedures.
- As appropriate, talk with individuals (and/or family, advocate) what they know about their stay at the facility (e.g. why they had to be there; if they are better or healthier now and if so, what is helping them to feel better; how the staff helps them to get well.
- Verify through discussion that staff understand the person’s health care needs after a stay in the hospital/facility and the care/support they provide. Determine if staff know the signs and symptoms they are to monitor and/or report and to whom. If staff cannot report the care needs adequately, ask them where they would access the needed information. If concerned regarding the staff’s competence, seek information about training provided regarding discharge care.
- The RN is responsible to train staff on any required services to effectively support the newly discharged person and prevent unnecessary readmission.
- While an RN will have oversight responsibilities, they may also have a role in direct provision of treatments/care and monitoring of the person’s condition.
- If a repeat hospitalization, emergency department trip, or another unexpected illness or relapse occurs soon after the discharge, within the 3 month period, evaluate if a lapse in care may have contributed to it.

Note: For Specialty Hospital reviews, this applies to discharges from hospitals/medical facilities that are not the specialty hospital.

Select MET if both are evident:

- Based on observation, discussion and documentation review, the individual(s) is receiving care necessary to facilitate and monitor their health status and recovery
- Individual's health returns to normal/baseline for them or any relapse/subsequent illness cannot be attributed to inadequate care

Select NOT MET if the following is present:

- Based on observation, discussion and documentation review, any individual is not receiving/not consistently receiving necessary care to facilitate and monitor their health status and recovery
- Individuals relapse in health can be attributed to inadequate implementation of an adequate written care plan following discharge from a health care facility

**SECTION 10c: RISK FACTOR - CURRENT ILLNESS**

**Is any person in the home currently showing signs/symptoms of illness?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

**10c-1 RN or other medical professional has been informed of the signs/symptoms (s/s).**

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. \ *IRAs, CRs, Apts, Specialty Hospitals, Private School*

633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. *IRA, Apt, CR, Day Training, Day Treatment, Day Hab, Specialty Hospitals, Private School*

680.6(j)(1)(vi) The specialty hospital shall maintain the following system of records: Client record. The specialty hospital shall maintain a comprehensive record for each client. Each record shall be organized in the manner and contain the information prescribed by OPWDD. Each client's record shall contain the following types of information (vi) reports of illness or injury including the date and time of occurrence and action taken regarding each occurrence. *Specialty Hospital*

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>DSP</li> <li>Individuals as appropriate</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>family and/or advocate if necessary</li> <li>RN if concerns with communication</li> <li>Site supervisor</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>Daily progress notes and/or daily health care or medical book progress notes</li> </ul> <p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>Medication Administration Record</li> <li>Training records – to evaluate what staff have been trained on regarding signs/symptoms of health concerns</li> </ul>	<p><u>Mandatory:</u></p> <p>Routine observations and conversation occurring may evidence current or emerging changes in any individual's health</p>

- During observation take note of whether staff are aware of individuals and any signs/symptoms of illness that one or more Individuals are exhibiting. At times symptoms may present, at other is may be just an awareness that they are “not themselves”, change in appetite, change in behavior, change in activity level, change in ambulation, etc. Staff may also converse with individuals about how they are feeling.
- Through discussion with staff determine when and in what manner, they reported the s/s of illness to the RN or other medical professional.
- Individuals may report to staff that they are not feeling well or mentions specific symptoms, e.g. head hurts, stomach aches. Individuals may tell surveyor that they are not feeling well and who, if anyone they have told this to. Survey should f/u with staff to determine if they know and what has been done to report and address.
- For the purpose of this standard, notification of health care professional may also include calling 911, taking person to an Urgent Care walk-in or ER; or talking person to an after-hours or 24 hour medical facility.
- There should be evidence through documentation of:
  - The actual communication made, of any concerns about symptoms and/or level of distress related to symptoms, to the RN/RN on call/ physician, etc. This should include what the staff reported and questions asked by the medical professional to gather more information to provide guidance.
  - During “business hours” this communication may occur when an RN is on site, at other times this may occur by telephone (telephone triage)
  - What the staff was directed to do by the health care professional.

Select **MET** if:

- RN or other health care professional was informed of individual’s signs/symptoms and/or change in their usual status/baseline

Select **NOT MET** if either are present:

- Staff did not recognize presenting signs that individuals may be ill or that their status had changed
- Staff did not contact RN or other medical professional despite recognition of change in status and/or sign of illness

10c-2 Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition and notifications required.

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.

*IRA, Apt, CR, Day Training, Day Treatment, Day Hab, Specialty Hospitals, Private School =*

633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. *IRA, Apt, CR, Day Training, Day Treatment, Day Hab, Specialty Hospitals, Private School*

ADM#2003-01 (additional supportive justification) The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer’s condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].

*IRAs excluding FSR; CRs, Apts.*

GUIDANCE:

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP – Mandatory</li> <li>• RN if concerns with plan, DSP implementation , or RN oversight</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Residential management staff</li> <li>• Individual</li> <li>• family and/or advocate if necessary</li> </ul>	<p><u>Mandatory:</u></p> <p>Documents that provide instruction regarding the persons needs for health care support, E.g.:</p> <ul style="list-style-type: none"> <li>• written plans of care for health needs such as a short term plan of nursing service (PONS) or nursing care plan (NCP)</li> <li>• Medication Administration Record (MAR) for meds and treatments</li> <li>• Daily notes and/or daily health care or medical book, nursing notes</li> </ul>	<p>N/A</p>

- The RN (or HC professional designated by agency) is responsible to provide instructions to staff to effectively support individuals who are ill or may be ill, monitor their changing status, provide care to ameliorate illness and/or its symptoms, and prevent transmission of the illness to others. Training may be necessary.
  - ***While initially the instruction may be conveyed verbally (especially during off hours over telephone). Staff should be instructed to document the direction given by the health care professional (HCP) and asked to repeat what they have written back to the HCP to verify accuracy. The RN should then f/u to ensure the person has a clear and individualized plan of care.***

- Instructions/Plans should be written using language that is understandable to staff who must implement it. If medical/technical terminology is used in the plan, verify that staff understand what it means in relation to their responsibilities. Interview and review of implementation will help you to verify that they understand.
- Care, monitoring and support to be provided may include:
  - Administer prescribed prn medication
  - Revisions to routines or scheduled activities if warranted for increased rest (e.g. stay home from work, cancel PT session if too strenuous, or reschedule recreational plans.)
  - Revise diet orders, swallowing guidelines, tube feeding instructions, due to illness (e.g. hold tube feeding for nausea, vomiting or high residual checks; clear or 'BRAT' diet for nausea, vomiting, etc.)
  - Interval measure of vital signs (e.g. Temperature, blood pressure, pulse, respiratory rate), with guidance of person-specific highs and lows that require further action, and the actions to take.
  - More frequent measure of blood glucose level, with guidance of highs and lows that require further action, and the actions to take.
  - Every shift reporting of other observations: e.g. appetite, activity level, mental status, fatigue level, breathing difficulties, seizure activity, etc.
  - Revised supervision levels or mobility support.
  - Inclusive of the above, and any additional description of signs/symptoms to be reported to the RN, RN on call, medical prescriber, etc., and within what time frame the report is to be made. This includes identifying high/low parameters for vital signs expected to be measured, that require RN, RN on call, medical prescriber notification.
  - Care, monitoring, and support may vary based on individual's history, current diagnoses and abilities to reliably communicate symptoms. For example: an individual who may be exhibiting signs of the flu, while requiring care and monitoring related to the flu, may also need heightened monitoring of the blood glucose levels as illness may affect levels unexpectedly.
  - Infection control measures to prevent possible infectious illness from spreading to others.

Select **MET** if all of the following are present:

- Clear individualized instruction was developed and provided to staff regarding care, monitoring, supports and notifications required by a person(s). Individualized instruction means appropriate to the person's specific condition, diagnoses, needs, and abilities.
- The instruction/plan of care was provided by a qualified medical professional (RN, NP, PA, MD)
- Strategies in the plan, if implemented appear sufficient to address the needs of the individual towards health and comply with standards of care

Select **NOT MET** if any of the following are present:

- Individualized instruction was not provided regarding care and support of individuals showing signs of illness or known to be ill.
- Instruction was provided verbally but not documented
- Instruction was not individualized and appropriate to the person's specific condition, diagnoses, needs, and abilities
- Individualized instruction was provided, but not by a qualified medical professional
- Strategies in the plan are not sufficient to address the needs of the individual as evidenced by preventable exacerbation of condition

10c-3 The instruction included how and **what to document** regarding required care and monitoring for identified health concern.

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.

IRAs, CRs, Apts, Specialty Hospitals and Private Schools

633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.

IRAs, CRs, Apts, Specialty Hospitals and Private Schools

ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer’s condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment]. additional supportive justification

IRAs excluding FSR; CRs, Apts.

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>• DSP if questions/concerns with documentation</li> <li>• RN if concerns with plan, DSP implementation , or RN oversight</li> <li>• Site supervisors as needed re: training and oversight</li> </ul>	<p>Documents that provide instruction regarding the persons needs for health care support, E.g.:</p> <ul style="list-style-type: none"> <li>• Written plans of care for health needs such as a PONS or NCP, or other written plan format</li> <li>• Documentation of care and monitoring per instruction and agency mechanism</li> </ul>	<p>N/A</p>

It is imperative that there is an ongoing record of the care and support provided to individuals in the site regarding health care. Documentation may be entered on paper forms/hard copy or through electronic record keeping, daily notes or other agency specified recording methods. What, when and where to document care and monitoring should be clearly specified in the plan/written instruction. For example:

- Observed signs and symptoms or changing conditions to observe and per the written plan. This may be specific measures such as vital signs or staff observations of the individual signs that are *different from their individualized “normal”*.

- Actions taken by staff *in response to* any of the observed signs and symptoms, if they were outside of the written plan's recommended limits or if the person was observed to be in distress or acting abnormally.
- Individual's response to what the staff performed.
- Any subsequent communication made, of any concerns, symptoms, distress, or questions about the individual and their symptoms, to the RN, RN on call, medical prescriber, etc.
- Follow-up actions or communications.
- Individual's response to prn medications or dietary changes made to help the illness or symptoms of illness.
- Any observed worsening or improving of signs and symptoms of health concerns.

Select **MET** if:

- The plan instructs on the required/expected documentation of care provided and/or status of the individual based on monitoring of the person's condition (what, where, when) sufficient to evidence continuity of care.

Select **NOT MET** if any of the following are present:

- The plan lacks instruction/does not require documentation of care and monitoring and individual condition and response;
- While the plan directs that staff document care and monitoring, it lacks sufficient clarity resulting in insufficient evidence of continuity of care

**10c-4 There is evidence that the staff **implement** required care and monitoring.**

633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.

IRAs, Apts, CRs, Specialty Hospitals, Private Schools

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. ALL

IRAs, Apts, CRs, Specialty Hospitals, Private Schools

680.7(b)(2)(ii)(a)(2) The objectives of nursing services shall be to evaluate each client's need for nursing care on a continuing basis, and to provide such care directly by or under the supervision of a registered nurse (see section 680.13 of this Part). Such services shall include: participation in preventive, habilitative and rehabilitative services to eliminate, limit or reduce the client's health related problem.

Specialty Hospital

680.6(j)(1)(v)-(vi); The specialty hospital shall maintain the following system of records: (v) service plans, description of treatments provided and medications administered; (vi) reports of illness or injury including the date and time of occurrence and action taken regarding each occurrence.

Specialty Hospital

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP if interventions not occurring during observation or direct observation cannot occur due to respect for individual's privacy</li> <li>• RN if concerns with plan, DSP implementation , or RN oversight</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• family and/or advocate</li> <li>• Site supervisor</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Documents that provide instruction to address a person's acute health needs, and supports and treatments required: E.g.:                             <ul style="list-style-type: none"> <li>○ Short term PONS or NCP</li> <li>○ MAR</li> <li>○ Physician's orders</li> <li>○ diet orders</li> </ul> </li> <li>• Documentation/notes on provision of care; e.g. prn notes, daily notes, health care notes, nursing notes</li> </ul>	<p><u>Mandatory:</u></p> <p>During observation periods, give attention to what you expect to see occurring based on the written instructions to staff regarding the period of acute illness for one or more persons.</p> <p>Note: Survey staff should not violate privacy of any individual.</p>

Consider the following, when verifying that staff are effectively delivering an individual's needed care and monitoring.

- Verify through discussion and observation as able, that staff understand the support, care and monitoring to provide and that they provide it. For example, if the following supports are to be provided, are they providing offers of additional fluids every hour; inquiring as to pain level least 4x/day; providing a temporarily modified consistency diet; taking body temperature every 4 hours while awake, etc.
  - Determine if staff know what signs and symptoms they are to monitor.
  - Determine if they can explain what they would do if the person's condition was worsening/if they know when to notify the RN/on-call, the primary care physician or 911.
  - If staff cannot report the care needs adequately, ask them where they would access the needed information.
  - If concerned regarding the staff's competence, seek information about training provided regarding care.
- Observe as able, depending on when care and monitoring is provided, that the person receives care and monitoring per the written plan
- There should be documentation of care and monitoring provided. Documentation of care and monitoring will vary depending on the interventions in the care plan. Some may require documentation, while other required interventions may not. Review the individual's record and documentation to verify that supports that must be documented per the plan are indicated in documentation. Documentation may be part of the MAR or other documentation sources per the written plan and site procedures.
- As appropriate, ask Individuals how they are feeling; what is helping them to feel better; how the staff helps them when they are sick, etc.
- The RN has oversight responsibilities, and may also have a role in direct provision of treatments/care and monitoring of the person's condition.

**Select MET if both are evident:**

- Based on observation, discussion and documentation review, the individual(s) is receiving care necessary to facilitate and monitor their health status and recovery
- Individuals health returns to normal/baseline for them or any relapse/worsening illness cannot be attributed to inadequate care

**Select NOT MET if the following is present:**

- Based on observation, discussion and documentation review, any individual is not receiving/not consistently receiving necessary care to facilitate and monitor their health status and recovery from illness
- Individuals' worsening health can be attributed to inadequate implementation of an adequate written care plan

**SECTION 10d: RISK FACTOR - DIABETES**

**Is any person diagnosed with Diabetes?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

10d-1 Clear **written instruction** is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required by the person.

633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.

IRAs, Apts, CRs, Specialty Hospitals, Private Schools

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.

IRAs, Apts, CRs, Specialty Hospitals, Private Schools

686.16 (b)(4)(i)-(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following:(i) any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid;(ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.

IRAs only

680.6(a), Each client of a specialty hospital shall have an individual program plan which describes for the client his or her medical treatment for health-related problems and active programming for developmental disability(ies). Specialty Hospitals

680.6(g) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD...

Specialty Hospitals

680.6(g)(2) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: service plans for each mandatory and selective service which combine into an integrated program of individually designed activities, experiences and programs necessary to achieve the individual client's objectives. These plans shall contain, as appropriate, specific individual medical prescriptions or written direction from the interdisciplinary team for all necessary services.

Specialty Hospitals

680.7(b)(2)(ii)(a)(1) The objectives of nursing services shall be to evaluate each client's need for nursing care on a continuing basis, and to provide such care directly by or under the supervision of a registered nurse (see section 680.13 of this Part). Such services shall include: participation in preventive, habilitative and rehabilitative services to eliminate, limit or reduce the client's health related problem.

Specialty Hospitals

ADM#2003-01 additional supportive justification  
IRAs excluding FSR; CRs, Apts.

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP</li> <li>• RN if concerns with plan, DSP implementation, or RN oversight</li> </ul> <p><u>As needed</u> Individual, Site supervisor, family/advocate</p>	<p><u>Mandatory:</u> Documents that provide instruction regarding the persons needs for health care support, E.g.:</p> <ul style="list-style-type: none"> <li>• Health care records which may include notes and orders from physicians and health care professionals involved in the individuals' diabetic care and oversight</li> <li>• Written plans of care to address diabetes such as a nursing care plan (NCP), plan of nursing services (PONS), specific portion of IPOP, ISP, Treatment Plan or Program Plan</li> <li>• Medication Administration Record (MAR)</li> <li>• Diet order</li> </ul>	<p>N/A</p>

- |  |   |  |
|--|---|--|
|  | <ul style="list-style-type: none"> <li>• Routine documentation e.g. prn notes, progress notes and/or daily health care or medical book, nursing progress notes</li> </ul> |  |
|--|---|--|

- A Written plan must be available that instructs trained staff to effectively support persons with diabetes and to minimize its complications. These written instructions may appear in different documents (e.g. MAR, diet order, PONS, IPOP). If instruction is in more than one document, they all should all provide consistent information so that staff have current, non-contradictory information from all guidance sources to use to provide care. The plan may need to include:
  - Prescribed medications to administer to persons with diabetes (oral, injection, insulin pump) which includes all the required information to accurately administer.
  - Blood sugar checks with a finger stick glycemic monitor (glucometer) with a specific frequency (e.g. before meals and bedtime). This monitoring is very important and sometimes determines the dosage of insulin a person is to receive at any given administration (e.g. 'sliding scale' insulin injections).
  - The plan must identify individual-specific symptoms of both high glucose levels and low glucose levels (aka hyper- and hypo-glycemia) and what staff must do in response to either condition. This should include recheck of glucose levels following intervention to address the highs or lows (determine effectiveness).
  - Description of symptoms of diabetes and/or level of distress that are to be reported to the RN, RN on call, medical prescriber, etc. Staff may need to respond differently to symptoms displayed by a person who has diabetes. For example if a person with diabetes has caught a cold or the flu, in addition to addressing the illness, increased blood sugar monitoring may be necessary as illness can affect the regulation of same, all else being constant.
  - The person's individualized dietary needs and/or modification
  - Other strategies to minimize diabetic complications may be necessary such as: exercise encouragement/support; diabetic foot care; diabetic eye care, etc.

- Care, monitoring, and support may vary based on individual's history, abilities, health status and specific needs. For example: While some individuals require staff to provide all diabetic care and monitoring of blood glucose levels, other individuals may be learning to do their own finger sticks and recording of levels while staff monitor that they are do it when required.
- Plans should describe equipment necessary and information on how to use it should be available to supplement training.
- Day programs may provide services to individuals who require support to manage their diabetes. The facility may have personnel qualified to develop an appropriate plan for implementation at the site or may implement an appropriate plan provided by the person's physician or residential medical professional. A copy of the person's plan should be available at the site. It should be minimally describe the care and supports to be provided while supported by the day program.
- If an individual is independent in their diabetic care and self-monitoring:
  - His/her independence should be documented in their written plan.
  - In Residences the plan should also:
    - include a description of what aspects of their care they are capable and responsible to do;
    - indicate any monitoring of self-care to be provided by direct support staff and the RN;
    - describe direct support staff's role even if limited, in monitoring the person's status;
      - signs/symptoms to be alert to, indicators of hyper and hypoglycemia,
      - sign requiring immediate response and what staff must do,
      - what to report to the RN,
    - The plan should describe roles and responsibilities for the communication of the person's status with the health care provider(s) (i.e. MD, PA, NP) treating and monitoring the person diabetes and overall health.
  - In Day Programs the plan should:
    - describe direct support staff's role even if limited, in monitoring the person's status;
      - signs/symptoms to be alert to, indicators of hyper and hypoglycemia,
      - sign requiring immediate response and what staff must do,
      - what to report and to whom
- Instructions/Plans should be written using language that is understandable to staff who must implement it. If medical/technical terminology is used in the plan, verify that staff understand what it means in relation to their responsibilities. Interview and review of implementation will help you to verify that they understand.

Select **MET** if all of the following are present:

- Clear individualized instruction was developed and provided to staff regarding care, monitoring, services and supports required by a person(s) related to the diabetes diagnosis.
- The written instruction/plan of care was developed by a qualified medical professional
- Strategies in the plan, if implemented appear sufficient to maintain the person's health relative to diabetes and its complications, and comply with standards of care

Select **NOT MET** if any of the following are present:

- Individualized instruction was not provided regarding diabetic care and support of individuals with diabetes
- Strategies in the plan are not sufficient to address the needs of the individual as evidenced by preventable exacerbation of the diabetes and its associated health complications
- Instruction was provided verbally but not in a written plan
- Instruction was not individualized and appropriate to the person's specific condition, needs and abilities
- Individualized instruction was provided, but not by a qualified medical professional

10d-2 The written instruction includes how and what to **document** regarding required care and monitoring for identified diabetic needs.

633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. IRAs, Apts, CRs, Specialty Hospitals, Private Schools

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.  
IRAs, Apts, CRs, Specialty Hospitals, Private Schools

680.6(j)(1)(iv)-(v) The specialty hospital shall maintain the following system of records: The specialty hospital shall maintain a comprehensive record for each client. Each record shall be organized in the manner and contain the information prescribed by OPWDD. Each client's record shall contain the following types of information: copies of assessments, reassessments, progress notes and previous individual program plans; service plans, description of treatments provided and medications administered.  
Specialty Hospitals

ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment]. additional supportive justification  
IRAs excluding FSR; CRs, Apts.

**GUIDANCE:**

**DISCUSSION**

**DOCUMENTATION REVIEW**

**OBSERVATION**

<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP</li> <li>• RN if concerns with plan, DSP implementation or RN oversight</li> </ul> <p><u>As needed</u> as appropriate: Individual, family/advocate, clinician, site supervisor</p>	<p><u>Mandatory as appropriate to facility and systems:</u></p> <p>Documents that provide instruction regarding the persons needs for health care support, E.g.:</p> <ul style="list-style-type: none"> <li>• Health care records which may include notes and orders from physicians and health care professionals involved in the individuals' diabetic care and oversight</li> <li>• Written plans of care to address diabetes such as a PONS, NCP, specific portion of IPOP, ISP, Treatment Plan or Program Plan</li> <li>• Medication Administration Record (MAR)</li> <li>• Diet order</li> <li>• Routine documentation e.g. prn notes, progress notes and/or daily health care or medical book, nursing progress notes</li> </ul>	<p>N/A</p>
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It is imperative that there is an ongoing record of the care and support provided to individuals in the site regarding health care. Documentation may be entered on paper forms/hard copy or through electronic record keeping, daily notes or other agency specified recording methods. What, when and where to document care and monitoring for those diagnosed with diabetes should be clearly specified in the plan/written instruction.

For example:

- Administration of diabetic medications and treatments the person is prescribed to include all the required information for any prescribed medicine. REVIEW IN SECTION 3 also.
- Checks performed such as blood glucose measures/checks, when and that the reading is
- Signs and symptoms noted in the plan to be aware of: e.g. mental status, fatigue/energy level, lethargy, breathing difficulties, seizure activity, cardiac symptoms such as chest pain or shortness of breath, etc.
- Actions taken by *in response to* any of the observed signs and symptoms, per the plan. Documentation of the Individual's response to what the staff performed to treat the symptoms.

- Communication/notification of any concerns about symptoms, concerns to the RN/RN on call/medical prescriber; and guidance provided.

Select **MET** if:

- The plan instructs on the required/expected documentation of care provided and/or monitoring of the person's diabetes (what, where, when) sufficient to evidence continuity of care

Select **NOT MET** if any of the following are present:

- The plan lacks instruction/does not require documentation of care and monitoring related to diabetes
- While the plan directs that staff document care and monitoring, it lacks sufficient clarity resulting in insufficient evidence of continuity of care

10d-3 There is evidence that the staff **implement** required diabetic care and monitoring.

633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. IRAs, Apts, CRs, Specialty Hospitals, Private Schools

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.  
IRAs, Apts, CRs, Specialty Hospitals, Private Schools

686.16 (b)(4)(i)-(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following:(i) any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid;(ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.  
IRAs only

680.6(d), The individual program plan shall be developed and implemented by an interdisciplinary team (see section 680.13 of this Part) including the providers of medical treatment and active programming and direct care staff. One member of this team who is a qualified mental retardation professional (see section 680.13) shall serve as client coordinator (see section 680.13) with primary responsibility for implementation of the individual program plan, coordination of its components and for arranging movement of the client to a less restrictive environment as soon as the client's handicapping conditions permit.  
Specialty Hospitals

680.6(j)(1)(iv)-(v); The specialty hospital shall maintain the following system of records: The specialty hospital shall maintain a comprehensive record for each client. Each record shall be organized in the manner and contain the information prescribed by OPWDD. Each client's record shall contain the following types of information: copies of assessments, reassessments, progress notes and previous individual program plans; service plans, description of treatments provided and medications administered.  
Specialty Hospitals

680.7(b)(2)(ii)(a)(2) The objectives of nursing services shall be to evaluate each client's need for nursing care on a continuing basis, and to provide such care directly by or under the supervision of a registered nurse (see section 680.13 of this Part). Such services shall include: participation in preventive, habilitative and rehabilitative services to eliminate, limit or reduce the client's health related problem.

Specialty Hospitals

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP</li> <li>• Individual – Highly recommended</li> <li>• RN if concerns with plan, DSP implementation or RN oversight</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Others as appropriate: clinician, family and/or advocate; site supervisor</li> </ul>	<p><u>Mandatory:</u></p> <p>Documents that provide information regarding the persons health care support needs, e.g.:</p> <ul style="list-style-type: none"> <li>• Medication Administration Record (MAR) for diabetic meds and treatments</li> <li>• written plans of care for health needs such as a PONS or NCP</li> <li>• Physician’s consults re: treatment and monitoring of diabetes</li> <li>• Lab values such as A1C and other indicators of diabetic status</li> </ul> <p>Documentation evidencing provision of diabetic care and monitoring, e.g.:</p> <ul style="list-style-type: none"> <li>• Daily progress notes and/or daily health care or medical book, nursing progress notes</li> </ul>	<p><u>Mandatory with knowledge that all aspects of plan may not need implementation:</u></p> <p>During observation periods, give attention to what you expect to see during routine and activities <b><i>based on the written plan</i></b> regarding the care and support of a person with diabetes.</p> <ul style="list-style-type: none"> <li>• It is likely you will see dining to assess adherence to special diets</li> <li>• You may be able to verify that glucose monitoring, if necessary has occurred</li> <li>• You may observe activities related to healthy lifestyle such as exercise, nutritional training, etc.</li> </ul> <p>Note: Survey staff should not violate privacy of any individual.</p>

Consider the following, when verifying that staff are effectively delivering individuals’ needed care and monitoring as best evidenced by its impact on the Individual and effective response to changing health.

- Be attentive to activities that may be related to diabetic health per plan.

- Review whether the person receives support to eat foods aligned with their dietary requirements. When dining occurs, verify appropriateness of the food provided per person's diet. Consider appropriateness from a wider perspective. A treat now and then may be permissible for the maintenance of the person's condition, but frequent variances from a prescribed diet may be problematic. In a residence, consider whether menus accommodate needs of a diabetic and that food choices in the house for meals and snacks allow the person to make choices aligned with dietetic recommendations.
- Verify through discussion that staff understand their role and responsibilities regarding individuals' diabetic care, support and monitoring. If staff cannot report the care needs adequately, ask them where they would access the needed information. If you remain unsure of staff's competence review the documentation of staff training. If the training was provided and the trained staff is still not providing pursue ask staff about how they were trained. Follow-up with RN or medical designee as needed.
- There should be documentation of care and monitoring provided. Documentation of care and monitoring will vary depending on the interventions in the care plan. Some may require documentation, while other required interventions may not. Review the individual's record and documentation to verify that supports that must be documented per the plan are indicated in documentation. Documentation may be part of the MAR or other documentation sources per the written plan and site procedures.
- Documentation should include interventions taken for high or low glucose levels and the result/response, and RN and physician notifications, as needed.
- Through discussion and observation verify that the equipment needed for monitoring and supplies needed for intervention are available on site, working and maintained.
- If they are amenable, ask Individuals what they know about their diabetes, what they are doing to take care of themselves (such as exercise, diet, stress reduction techniques); and how the staff supports them to keep their diabetes under control.
- The RN has oversight responsibilities, and may also have a role in the plan for direct provision of care.
- If your review identifies problems and/or errors with implementation of diabetic care an support, consider verifying that staff who are delegated diabetic care/support have been may want to verify that the staff responsible for implementation were appropriately trained by a Certified Diabetic Trainer.

Select **MET if both** are evident:

- Based on observation, discussion and documentation review, the individual(s) is receiving the care and monitoring necessary for management of diabetes per the plan and standards of care
- Individuals are maintaining health/stability related to their diabetic condition and any problems with the condition are not attributed to inadequate care

Select **NOT MET** if **either** of the following is present:

- Based on observation, discussion and documentation review, any individual is not receiving/not consistently receiving necessary care per the plan and standards of care to facilitate and monitor their health status and recovery
- The Individual's diabetic condition is not well stabilized as indicated by physician's reports, lab values, signs and symptoms, that can be inadequate implementation supports necessary to address diabetes

**SECTION 10e: RISK FACTOR - FLUID INTAKE**

**Is any person prescribed a specific daily level of fluid intake?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

**10e-1 The amount of fluid to be consumed by the person is clearly indicated in a written plan.**

633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.

FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

686.16 (b)(4)(i)-(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following:(i) any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid;(ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.

IRAs and FSRs only

680.6(a), Each client of a specialty hospital shall have an individual program plan which describes for the client his or her medical treatment for health-related problems and active programming for developmental disability(ies).

Specialty Hospital

680.6(g) Specialty Hospital

680.6(g)(2), Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: service plans for each mandatory and selective service which combine into an integrated program of individually designed activities, experiences and programs necessary to achieve the individual client's objectives. These plans shall contain, as appropriate, specific individual medical prescriptions or written direction from the interdisciplinary team for all necessary services.

Specialty Hospital

680.7(b)(2)(ii)(a)(1) The objectives of nursing services shall be to evaluate each client's need for nursing care on a continuing basis, and to provide such care directly by or under the supervision of a registered nurse (see section 680.13 of this Part). Such services shall include: development of a written nursing services plan for each client as part of the individual program plan.

Specialty Hospital

ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment]. additional supportive justification

IRAs excluding FSR; CRs, Apts.

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• DSP</li> <li>• RN if concerns with plan, implementation or RN oversight</li> <li>• Others as appropriate: Individual, Site Supervisor</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Documents that provide instruction regarding the persons needs for health care support, E.g.:               <ul style="list-style-type: none"> <li>○ Plan of Nursing Services (PONS) or Nursing Care Plan (NCP)</li> <li>○ IPOP</li> <li>○ ISP</li> </ul> </li> </ul>	<p>N/A</p>

- |  |   |  |
|--|---|--|
|  | <ul style="list-style-type: none"> <li>○ Safeguards identified in waiver or site specific individualized program plan (treatment or program plans)</li> <li>○ MAR</li> <li>○ Physician's orders</li> <li>○ dining guidelines</li> </ul> |  |
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People may require a plan related to fluid intake for different reasons. For example: A person on dialysis may require a plan to ensure they do not drink more liquid than their body can safely manage, while another person may require a plan to ensure that they drink at least a designated amount to assist with infection, bowel management or to address a medication side effect. The need for support to monitor fluid intake may be written as a stand-alone care plan, or may be one strategy in a larger plan addressing a particular diagnosis/health need.

When an Individual is prescribed/requires monitoring of their daily fluid intake, their plan must clearly identify the threshold amount of fluid the person is to receive. The plan should specify amount as a total minimum or maximum (depending on the issue) for the day; i.e. no more than X ounces/cc per day or at least X ounces/cc per day. Plans should go further and guide staff on how to provide/distribute liquids through the day. See the next Standard.

If the information is in more than one (1) written plan ensure that there is consistent information so that all staff who work with the Individual implement the fluid prescription correctly.

Select **MET** if all of the following are present:

- The amount of total fluid a person is to receive daily is identified in the written plan that includes this intervention
- The instruction is consistent with a physician's order if applicable, particularly in the case of ensure limitations on fluid intake

Select **NOT MET** if any of the following are present:

- The individual has a health need/physician's order requiring specificity of fluid intake and the person's plan does not specify the target minimum or maximum (as applicable)
- Instruction was provided verbally but not in a written plan

10e-2 Clear written instruction is provided to further guide staff in how to **implement** the fluid intake requirements.

633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.  
A FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

680.6(g)(3) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: progress notes describing the client's response to programs and services  
Specialty Hospitals

680.6(j)(1)(v) The specialty hospital shall maintain the following system of records: The specialty hospital shall maintain a comprehensive record for each client. Each client's record shall contain the following types of information: copies of assessments, reassessments, progress notes and previous individual program plans; service plans, description of treatments provided and medications administered.  
Specialty Hospitals

ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment]. additional supportive justification  
IRAs excluding FSR; CRs, Apts.

**GUIDANCE:**

**DISCUSSION**

**DOCUMENTATION REVIEW**

**OBSERVATION**

<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• DSP</li> <li>• RN if concerns with plan, implementation or RN oversight</li> <li>• Others as appropriate: Individual, Site Supervisor</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Documents that provide instruction to address a person’s skin integrity needs, and documentation of supports and treatments required: E.g.: <ul style="list-style-type: none"> <li>○ PONS or NCP</li> <li>○ IPOP</li> <li>○ ISP</li> <li>○ Safeguards identified in waiver or site specific individualized program plan</li> <li>○ MAR</li> <li>○ Physician’s orders</li> <li>○ diet orders</li> </ul> </li> </ul>	<p><u>N/A</u></p>
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**The plan should be sufficiently detailed to ensure that the fluid requirement/order is followed:**

- When an Individual is prescribed a daily fluid intake, staff across all of his/her service settings must know how to support the individual to adhere to fluid amounts. The plan requires details to instruct the individual and staff. A RN, a Registered Dietitian, or other medical/clinical professional should translate how the fluid requirements are to be provided throughout the daily routines: meals, medication administration, intermittent snacks, etc. to meet the individuals health needs regarding fluid intake.  
For example: 8 oz. per each medication session at 6a, 3p, and HS; 8 oz. with each meal; and 6 oz. mid-morning and upon arrival home from work.
- The plan should require that a shift and/or setting communicate with other shifts/settings serving the person as necessary to maintain compliance. E.g. if an individual drank 8 oz. extra while dining out as part of a day habilitation activity, the residence should be told so they can make needed adjustments.
- The plan should identify what to “count” as a fluid. Anything fluid at body temperature is a fluid; including popsicles, gelatin, ice-cream, and sherbet.

- Any role the individual has if any, in the monitoring and tracking of their fluid intake.
- What staff are to do if the person doesn't consume the prescribed amount of fluids, i.e. if they consume too few fluids, when the plan is to 'push' fluids (e.g. to prevent dehydration) or if they consume more than a prescribed fluid restriction (e.g. to prevent total body fluid overload, edema, water intoxication, etc.)
  - Signs and symptoms of body fluid status concerns, either over-hydration or under-hydration, of which staff are to be aware and/or respond to. (E.g. changes in consciousness or seizures related to over-hydration; skin tone, constipation or low blood pressure, with dehydration.)
  - Description of what symptoms and/or level of distress related to symptoms are to be reported to the RN, RN on call, medical prescriber, etc., and within what time frame the report is to be made.
- How, what and where to document fluid intake
- Information on fluid requirements if referenced in more than one of the person's plans should all describe consistent accurate information.

Select **MET** if all of the following are present:

- Clear written individualized instruction was developed and provided to staff regarding implementation of fluid restriction/requirement
- Strategies in the plan, if implemented appear sufficient to address the needs of the individual

Select **NOT MET** if any of the following are present:

- Clear written individualized instruction was not provided regarding implementation of fluid restriction/requirement
- Strategies in the plan are not sufficiently clear to ensure that the person receives the fluid appropriately per their health concerns

**10e-3 There is documentation/tracking of the person’s fluid consumption.**

633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. ALL FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

680.6(j)(1)(v) The specialty hospital shall maintain the following system of records: The specialty hospital shall maintain a comprehensive record for each client. Each client's record shall contain the following types of information: copies of assessments, reassessments, progress notes and previous individual program plans; service plans, description of treatments provided and medications administered.  
Specialty Hospitals

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• DSP</li> <li>• RN – if concerns with plan, DSP documentation or implementation of plan</li> <li>• Others as appropriate: Clinician, site supervisor</li> </ul>	<p><u>Mandatory:</u></p> <p>Documents used for recording the individual’s fluid intake, e.g.:</p> <ul style="list-style-type: none"> <li>• Medication Administration Record</li> <li>• Fluid intake record/sheet</li> <li>• health care, prn, or progress notes to record fluid consumption</li> <li>• Food/fluid intake record at meal times.</li> </ul>	<p><u>As needed:</u></p> <p>After observations of persons on fluid prescription occur, check documentation to see if tracking of fluid intake is done.</p>

When verifying this standard, note that the documentation may take place on hard copy or electronic tracking forms, clinical progress notes or other agency specified documentation methods. Whatever the format, the written plan should specify who, what, when and where to document fluids consumed. When a person has a plan that requires that fluid intake is monitored, every consumption of beverages must be tracked. It

cannot be assumed that the individual consumed the exact amount written into the plan for every medication pass, meal, snack. This also means that if 8 ounces is planned for dinner, but the person refuses the beverage, that zero intake is noted. It cannot be assumed that no documentation or blanks means no intake as no documentation could also mean a missed documentation. In some situations, this information may need to be provided to their physician or dialysis center, etc. Staff should also document any concerns or difficulties encountered in assisting the person to comply with fluid plan, including individual's resistance to drink sufficient fluids or frustration with having to limit their intake, as well as any other observations specified in the written plan.

Select **MET** if both of the following are present:

- Daily documentation/tracking of all fluid intake is evident and per the plan
- Documentation/tracking mechanism facilitate monitoring of daily totals

Select **NOT MET** if any of the following are present:

- Daily documentation/tracking of all fluid intake is not evident/not occurring
- Daily documentation/tracking is incomplete with missing information
- Documentation/tracking mechanism does not enable monitoring of daily totals

10e-4 The written plan for fluid consumption is **implemented** correctly.

633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.  
FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

686.16 (b)(4)(i)-(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid; any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and each person's plan for protective oversight is being implemented as specified in the person's individualized service plan IRAs and FSRs only

680.6(d) The individual program plan shall be developed and implemented by an interdisciplinary team (see section 680.13 of this Part) including the providers of medical treatment and active programming and direct care staff. One member of this team who is a qualified mental retardation professional (see section 680.13) shall serve as client coordinator (see section 680.13) with primary responsibility for implementation of the individual program plan, coordination of its components and for arranging movement of the client to a less restrictive environment as soon as the client's handicapping conditions permit.  
Specialty Hospitals

ADM#2003-01 Adequate nursing supervision is the provision of guidance by an RN for the accomplishment of a nursing procedure, including: initial training of the task or activity; and periodic inspection of the actual act of accomplishing the task or activity. additional supportive justification  
IRAs excluding FSR; CRs, Apts.

**GUIDANCE:**

**DISCUSSION**

**DOCUMENTATION REVIEW**

**OBSERVATION**

<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• RN if concerns with plan, DSP implementation or RN oversight</li> <li>• As appropriate: clinician, family and/or advocate; Site Supervisor</li> </ul>	<p><u>Mandatory:</u></p> <p>Documents used for recording the individual's fluid intake for the past month/4 weeks, e.g.:</p> <ul style="list-style-type: none"> <li>• Medication Administration Record</li> <li>• Fluid intake record/sheet</li> <li>• health care, prn, or progress notes to record fluid consumption</li> <li>• Food/fluid intake record at meal times.</li> <li>• Communication mechanisms between service settings/providers</li> </ul> <p>Physician's consults related to health conditions requiring fluid plan</p>	<p><u>Mandatory:</u></p> <p>During observation periods, give attention to what you expect to see occurring, based on the written instructions, regarding the fluid consumption.</p> <p>Dining and snacking, will be likely times to verify that the fluid prescription, but other routine observations dependent on individuals' independence might also provide information.</p>
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- As indicated above, for individuals with health needs requiring fluid parameters, tracking of the individual's fluid intake is necessary and vital to maintain their health. Review the tracking documents of the fluid intake for the past 4 weeks.
  - If certified residence: Review the documentation across all shifts and written communication that is used to inform of intake from other service providers and/or settings; so that there is a record of intake over 24 hours.
  - If day service setting with responsibility to monitor intake: Review documentation of fluid intake while served by the program and written communication of intake used to inform those supporting the individual in their home.
- Verify through discussion with staff that they understand the person's written plan for fluid intake and how they are to support the person to comply with fluid intake requirements. Ask where they can reference the plan if needed.
- During meals, snacks, or requests for beverages, observe how/if the plan is followed and if staff document intake.
- If staff are unable to adequately describe the plan and/or are not implementing, you may request verification that training has occurred, and/or that specific staff received training.

- As appropriate, ask Individuals about their fluid intake levels, what they are doing to take care of themselves, and how the staff support them to keep their fluid balance under control.

**Select MET if both are evident:**

- Based on observation, discussion and documentation review, the individual(s) is consistently receiving the support and monitoring they require for fluid intake management
- Individuals are maintaining health/stability related to their need for fluid intake monitoring and any problems with the condition are not attributed to errors in fluid intake

**Select NOT MET if either of the following is present:**

- Based on observation, discussion and documentation review, any individual is not receiving/not consistently receiving the support and monitoring they require for fluid intake management
- The individual's condition that requires fluid intake plan is not well stabilized as indicated by physician's reports, lab values, signs and symptoms linked to fluid intake issues per documentation.

**SECTION 10f: RISK FACTOR - OXYGEN USE**

**Does any Individual have an order for Oxygen Use?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

**10f-1 Clear written instruction** is provided to guide staff in when and how to implement the order for oxygen.

633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.  
FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

680.6(g) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD...  
Specialty Hospitals

ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment]. IRAs excluding FSR; CRs, Apts.

**GUIDANCE:**

**DISCUSSION**

**DOCUMENTATION REVIEW**

**OBSERVATION**

<p><u>As Needed Routine:</u></p> <ul style="list-style-type: none"> <li>• DSP</li> <li>• RN</li> </ul> <p>Others As Needed:</p> <ul style="list-style-type: none"> <li>• Individual, Site supervisor, family</li> </ul>	<p><u>Mandatory:</u></p> <p>Documents that provide medical orders and instruction regarding the persons needs for health care support, E.g.:</p> <ul style="list-style-type: none"> <li>• Notes and orders from both a Primary Care physician, Pulmonologist, or other practitioner</li> <li>• The written plans of care for health needs such as a nursing care plan (NCP), plan of nursing service (PONS); guidelines for oxygen use during dining, ambulation, etc.</li> <li>• Medication Administration Record (MAR) for meds and treatments</li> <li>• IPOP, ISP, Safeguards in habilitation plans</li> </ul>	<p>N/A</p>
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- Oxygen (O<sub>2</sub>) can only be administered with a medical/physician's order
- The physician/medical practitioner will write the order/prescription for oxygen:
  - The order will describe routine or 'as needed' (PRN) use; with guidance for prn use
  - The amount, i.e. the proper concentration of oxygen to be administered - how many liters;
  - Device/method for oxygen administration (e.g. concentrator, tank)
  - Method it will be administered (e.g. nasal cannula or face mask)
- The prescribed instructions should be "translated" into the written plan/instruction that staff must implement to effectively support the person with O<sub>2</sub> use. This may include:
  - The O<sub>2</sub> order with details for how much, how, and when to administer
  - If prn order, describe specific conditions, signs and symptoms that indicate the need to administer. Signs and symptoms of respiratory or O<sub>2</sub> health related concerns (e.g. blood pressure, blood O<sub>2</sub> saturation levels, mental status, fatigue level, breathing difficulties, etc.) of which staff are to be aware and/or respond to.
  - Description of the symptoms and/or level of distress symptoms to be reported to the RN, RN on call, medical prescriber, etc., and within what time frame the report is to be made.

- Any role the individual has in oxygen administration and use
- Talk with staff about the person's O<sub>2</sub> care needs and how the support/care they provide. If staff cannot report the care needs adequately, ask them where they would access the needed information.
- Instructions/Plans should be written using language that is understandable to staff who must implement it. If medical/technical terminology is used in the plan, verify that staff understand what it means in relation to their responsibilities. Interview and review of implementation will help you to verify that they understand.

Select **MET** if all of the following are present:

- Clear individualized instruction was developed and provided to staff regarding care, monitoring, services and supports required by a person for oxygen use/administration
- The written instruction/plan of care was developed by a qualified medical professional
- The instruction is consistent with the physician's order
- Strategies in the plan, if implemented appear sufficient to address the needs of the individual

Select **NOT MET** if any of the following are present:

- Individualized instruction was not provided regarding oxygen use/administration
- Instruction was not individualized and consistent with the physician's order

10f-2 The written instruction includes how and what to **document** regarding required oxygen administration and monitoring.

633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. FSRs, IRAs, CRs, Apts, Day Treatment, Day Training, Day Hab, Specialty Hospitals, Private Schools, Cert. Pre-Voc

680.6(g) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD...  
Specialty Hospitals

ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].  
IRAs excluding FSR; CRs, Apts.

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As Needed Routine:</u></p> <ul style="list-style-type: none"> <li>• DSP</li> <li>• RN</li> </ul> <p>Others As Needed:</p> <ul style="list-style-type: none"> <li>• Individual, Site supervisor, family</li> </ul>	<p><u>Mandatory:</u></p> <p>Documents that provide instruction regarding the person's oxygen administration and the associated health issues and supports, e.g.:</p> <ul style="list-style-type: none"> <li>• prescriber orders</li> <li>• The written plans of care, across all service settings, for health needs such as a NCP, PONS, for direction of how to document and monitor oxygen (O<sub>2</sub>) use</li> <li>• Respiratory therapy notes, if person receives it</li> </ul>	<p>N/A</p>

It is imperative that there is an ongoing record of the care and support provided to individuals in the site regarding health care. Documentation may be entered on paper forms/hard copy or through electronic record keeping, daily notes or other agency specified recording methods. What, when and where to document administration of oxygen and monitoring for effectiveness (especially for prn administrations) should be clearly specified in the plan/written instruction.

When verifying this standard, the documentation may take place on hard copy or electronic tracking forms, clinical progress notes or other agency specified communication methods but whatever the specified format is, it should be clear in the written plan what, when and where to document it. Documentation of the following types of activities and information would be appropriate to include in the written plan for individuals prescribed O<sub>2</sub>:

- O<sub>2</sub> administration as specified by the form use and plan instructions
- O<sub>2</sub> tolerance: For example, the staff may be required to note how the person is tolerating the O<sub>2</sub> by noting the color around their lips, fingernail beds, dry skin around nose, etc.
- Provision of guidance and support provided to the individual for oxygen administration, and the individual's response if relevant;
- Documentation of any observed worsening of signs and symptoms of health concerns related to O<sub>2</sub> administration (e.g. shortness of breath, pale or bluish lips, nail beds, skin tone, mental status, fatigue level, unable to easily rouse from a nap, dry mouth or skin around the nose.
- Documentation *of what staff did in response to* any of the observed worsening of signs and symptoms of health concerns related to O<sub>2</sub> therapy per the plan, including notifications to RN and or physician.

Select **MET** if:

- The individual's plan of care instructs on the required/expected documentation of oxygen administration
- The individual's plan clearly instructs on required/expected documentation of other associate care provided and/or the status of the individual
- Documentation required meets service standard for evidence of continuity of care

Select **NOT MET** if any of the following are present:

- The individual's plan of care lacks instruction/does not require documentation of oxygen administration
- The plan lacks instruction on other types of information to document related to oxygen administration and/or the condition addressed by oxygen administration;
- While the plan directs that staff document care and monitoring, it lacks sufficient clarity resulting in insufficient evidence of continuity of care

**10f-3 Necessary equipment is available per the medical order for oxygen.**

633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion  
ALL

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.  
ALL

633.10(a)(6) Facilities which have emergency medical equipment on hand shall ensure that such equipment is maintained in accordance with a written agency/facility plan. Such a plan shall incorporate maintenance requirements that are in accordance with manufacturer recommendations and which includes provisions for inspection/replenishment subsequent to each use. Facilities with such equipment shall ensure that there are staff appropriately qualified to use it. ALL

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>DSP – as necessary to ascertain routine availability of necessary and properly working equipment.</li> <li>Individual – as necessary to ascertain routine availability of necessary and properly working equipment.</li> <li>RN –if concerns re: equipment.</li> <li>Others as appropriate: site supervisor, clinician</li> </ul>	<p><u>Mandatory:</u></p> <p>Documents that provide instruction regarding oxygen use and delivery/equipment, E.g.:</p> <ul style="list-style-type: none"> <li>Health care records, such as: prescriber orders;</li> <li>MAR for O<sub>2</sub> prescription and administration</li> <li>Documents/plan that identifies O<sub>2</sub> equipment including tanks and tubing to be used</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>To verify if oxygen concentrator and/or adequate amount of tanks of O<sub>2</sub> are available in the site, within date, of the correct concentration, properly stored and in good working order.</li> <li>Clean and usable oxygen delivery tubing, cannula tubing, face masks, etc. per person’s needs.</li> </ul>

Determine the O<sub>2</sub> equipment is needed by the person and verify that it is available and on site, and that there have been no issues with always having it available and operational through observation, conversation and documentation review.

**Select Met if:**

- Evidence supports that equipment to administer oxygen to the individual(s) per their order is routinely available and operational

**Select NOT MET if either situation** is discovered:

- Documentation, discussion and/or observation indicate that equipment necessary to deliver oxygen to the individual(s) is not available at time of survey, resulting in inability to administer

Documentation and/or interview indicate that there have been occasions when individual(s) did not receive needed oxygen due to lack of supply/equipment or malfunctioning equipment.

**10f-4 There is documentation evidencing ordered administration of oxygen and monitoring of their condition.**

633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion ALL

633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.  
ALL

680.6(g)(3) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: (3) progress notes describing the client's response to programs and services  
Specialty Hospitals

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• RN – mandatory if concerns with plan or DSP implementation, documentation of plan</li> <li>• DSP – As needed to confirm their understanding of what they are to document regarding a person’s O<sub>2</sub> therapy</li> <li>• Individual – As needed to confirm administration of O<sub>2</sub></li> <li>• Others as appropriate: Site Supervisor</li> </ul>	<p><u>Mandatory:</u></p> <p>Documents that provide written order and instruction for oxygen administration to individual(s), e.g.:</p> <ul style="list-style-type: none"> <li>• Prescription for O<sub>2</sub></li> <li>• MAR for O<sub>2</sub></li> <li>• Nursing plan of care or plan of nursing services, or other written plan to address O<sub>2</sub> administration and/or the health condition(s) requiring its administration</li> </ul>	<p>N/A – See Standard on implementation, below.</p>

	Documentation/notes on provision of care; e.g. prn notes, daily notes, health care notes, nursing notes	
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There should be documentation to evidence that orders for O<sub>2</sub> administration and related supports are implemented as written. Documentation sources noted above, may take place on hard copy or electronic tracking forms, clinical progress notes or other agency specified documentation methods. A MAR or Treatment record be the document used for this purpose. Review the document sources to validate that oxygen is correctly administered per orders and supports provided per the care plan.

- Discussion with staff responsible should be the additional verification that there are no problems, concerns, omissions in providing oxygen and support. If there are any questions regarding the documentation of O<sub>2</sub> administration, talk with relevant people as indicated above.
- Through discussion and observation verify that the equipment needed for oxygen administration, monitoring, and storage are available on site, working and maintained. (E.g. oximeter, tanks as needed, concentrators as needed, appropriate delivery mask/cannula, wrench as needed, etc.)

**Select MET if both are evident:**

- Based on observation, interview and documentation review, the individual(s) is consistently receiving O<sub>2</sub> as prescribed and the related support and monitoring they require
- Individuals are maintaining health/stability related to their need for oxygen use and any problems with the condition are not attributed to errors/omission in oxygen administration

**Select NOT MET if either of the following is present:**

- Based on observation, interview and documentation review, any individual is not receiving/not consistently receiving O<sub>2</sub> as prescribed and the related support and monitoring they require
- The individual's condition that requires O<sub>2</sub> is not well stabilized as indicated by physician's reports, oxygen saturation values, signs and symptoms linked to errors/omissions in O<sub>2</sub> administration per documentation.

**SECTION 10g: RISK FACTOR - SUPERVISION**

**Enhanced supervision levels are required by one or more person supported by the site?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

10g-1 There are sufficient staff on duty to maintain the supervision levels required by the Individuals.

686.9(a)(2) There shall be a staffing plan based upon such considerations as the number of clients and their levels of functioning and need, support staff requirements, and physical plant demands.

IRAs including FSR, CRs, Apts.

686.16 (a)(6)(i) The assessment of each person's need for the amount and type of supervision necessary including both staff and/or technology as appropriate to the person and circumstance.

All IRA Types including FSR

633.4(a)(ix) No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity

All other program types

**GUIDANCE:**

**DISCUSSION**

**DOCUMENTATION REVIEW**

**OBSERVATION**

<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP to ascertain their perception of staffing adequacy to maintain supervision requirements.</li> <li>• Individuals – to understand their perception staff attentiveness and ability to assist them when needed</li> <li>• Site management: re: staffing to ensure supervision levels and needs of all individuals are met, site staff minimums, staff coverage, staff vacancies, staff turnover</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Clinicians as necessary, if any health or clinical concerns regarding staffing</li> <li>• Family members re their observations or concerns</li> <li>• MSC re their observations or concerns</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Current staff schedule</li> <li>• Communication Logs if used</li> <li>• Incident reports</li> <li>• For people reported to require enhanced supervision, plan(s) indicating supervision level, e.g.: IPOP, Habilitation Plan, ISP, Behavior Support Plan (BSP)</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Documentation that identifies minimum and routine staffing levels such as Site protective oversight plan in IRAs</li> <li>• Staff schedules for recent weeks/months if concerns</li> <li>• If concerns that accurate information was not provided in the entrance conference regarding enhanced supervision needs, review for OTHERS, <ul style="list-style-type: none"> <li>○ Individual safeguarding documents (e.g. IPOP)</li> <li>○ Behavioral support plans</li> <li>○ ISP and Habilitation plans for person supported.</li> </ul> </li> <li>• PRN notes, daily notes, service notes</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Observe routines to get the sense of individuals' needs requiring enhanced supervision</li> <li>• By observing routines, activities and service delivery in the site, verify whether staffing is adequate to ensure that individuals requiring enhanced or specialized supervision receive it continuously AND the needs of others in the site are also met</li> <li>• Be attentive to times of transition, such as morning preparation for daily activities, arrival and departure times, meal times, medication administration times, staff breaks and shift changes.</li> </ul>
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For this standard, **enhanced supervision levels** refers to a level of routine supervision and assistance that requires consistent staff attentiveness to an individual and ability to respond immediately to a situation involving the person without distraction. This may include enhanced staff ratios and/or specifics as to proximity and visual supervision (e.g. 1:1 within arm's length, 1:1 with contact guard while ambulating, continuous "eyes

on", line of sight within 10 feet). It is not meant to mean supervision levels that allow for intermittent staff intervention with individuals (30 minute visual checks, 2 hour visual checks, etc.). However, this standard does require consideration of whether a person's need for enhanced supervision can be maintained, given needs of other people served by the site/residence/program. Enhanced supervision may be a consistent part of a person's plan or a recent addition and temporary (e.g. for one month during medication taper/reduction); or reactive/prn per the written plan (e.g. for remainder of day until hours of sleep following assaultive behavior).

Verify this standard through observation while considering any increased supervision required by individuals and needs for behavior supports described during your info gathering/entrance conference. If needed verify that you received accurate information as explained above under Documentation Review.

During your observations and discussions with appropriate parties:

- Consider the number of people at the site that require enhanced supervision, the number of total people served by the site, and the number of staff on duty and routinely scheduled.
- Assess whether individuals requiring enhanced supervision (1:1, arm's length, line of sight, etc.) receive the level of supervision consistently during the survey
- Assess whether there are sufficient number of staff on duty to maintain enhanced supervision to individual(s) and to address the needs and requests of other individuals served by the site.
- Review the staff schedule. Verify that the number of staff on duty during the site visit is as scheduled and not supplemented for purposes of survey visit. If supervisors, management and/or clinical staff appear to be providing direct supports and assistance to individuals, ask question of individuals, DSPs and the assisting staff, and use observations to evaluate this is normal or due to the survey visit.
- Verify that Individuals who will be out in the community during the observation periods, desire to be and/or had planned to be out as opposed to occurring to make the observation appear more favorable
- Gather staff input regarding their ability to competently provide the specialized supervision levels with the number of staff on duty; that they know the staffing minimum requirements and how the increased levels are to be met in periods of high need (e.g. what to do if an Individual needs restrictive intervention which will take some staff out of the support of others).
- Via discussion and observation verify that individuals, both those with and those without the need for the higher supervision levels feel supported and safe in their program site and/or home with the number of staff on duty. Validate this with family members/advocates as needed.
- Consider incidents reviewed that may indicate events with the contributing factor of inadequate staffing.

Select **MET if all** of the following are met:

- There is sufficient staffing to maintain individuals' enhanced supervision levels during site visit.
- Findings evidence that staffing levels are routinely adequate to ensure that individuals' enhanced supervision levels can be maintained while also meeting needs for supervision, support and assistance of others served by the site.

Select **NOT MET if any** of the following are met:

- There is insufficient staffing to maintain individuals' enhanced supervision levels during site visit.
- Findings evidence that staffing levels are often too low to ensure that individuals' enhanced supervision levels can be maintained while also meeting needs for supervision, support and assistance of others served by the site.

**10g-2 Required enhanced supervision and staffing ratios are maintained per people’s individualized plans.**

686.16 (b)(4)(i)-(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid; any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.  
All IRA Types including FSR

633.4(a)(ix) No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity  
All other program types

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP to ascertain their perception of staffing adequacy to maintain enhanced supervision requirements.</li> <li>• Site management: re: staffing to ensure enhanced supervision levels are maintained</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Individuals – to understand their perception staff presence ability to assist them when needed</li> <li>• Clinicians if any health or clinical concerns regarding staffing</li> <li>• Family members regarding their observations or concerns</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Communication Logs if used</li> <li>• Incident reports</li> <li>• For people reported to require enhanced supervision, plan(s) indicating supervision level, e.g.: IPOP, Habilitation Plan, ISP, Behavior Support Plan (BSP)</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Documentation that identifies minimum and routine staffing levels such as Site protective oversight plan in IRAs</li> <li>• Staff schedules if concerns</li> <li>• If concerns that accurate information was not provided in the entrance conference</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Observe routines to verify that the individuals requiring enhanced supervision are consistently receiving same</li> <li>• Be attentive to times of transition, such as morning preparation for daily activities, arrival and departure times, meal times, medication administration times, staff breaks and shift changes.</li> </ul>

regarding enhanced supervision needs, review:

- Individual safeguarding documents (e.g. IPOP)
- Behavioral support plans
- ISP and Habilitation plans for person supported.
- PRN notes, daily notes, service notes

The previous standard requires a decision whether staffing levels were sufficient to create an environment where **enhanced supervision** is provided. **This standard reviews that the individual actually consistently receives the enhanced supervision they require.**

This focuses on delivery of enhanced supervision as described in the above standard. Routine adequacy of supervision is reviewed in Section 6. Verify this standard through observation with attention to increased supervision required by individuals and needs for behavior supports described during your info gathering/entrance conference. Verify that you received accurate information as explained above under Documentation Review as needed.

- Verify that the individual(s) receive the enhanced supervision per their plan through the course of the visit as you complete observations during site review.
- Review whether recent incidents involving the person(s) reviewed in IRMA have identified failure to maintain required supervision as an issue or factor in the reported event contributing to negative outcomes. E.g. If there are injuries, LWOC, assaults, or other events reported with investigations citing. Verify that adequate corrective actions have been implemented.
- Verify that staff understand their role in providing the supervision, and procedures to maintain supervision during transitions, breaks, (e.g. transfer of supervision processes, etc.)

Select **MET if both** of the following are met:

- Individuals receive the enhanced supervision they require per their plan during observations
- There is no evidence of supervision breaches
- If there have been documented supervision breaches, the facility as implemented effective corrective measures to prevent further supervision errors.

Select **NOT MET if any** of the following are evident:

- You observe any interruption of enhanced supervision to an individual
- Issues that contributed to documented supervision breaches have not been addressed/corrective actions not determined or implemented

### **Section 10h: RISK FACTOR - ALL RIGHTS LIMITATIONS/RESTRICTIONS:**

**Are there any observed, reported, or documented limitations, restrictions or intrusions to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

10h-1 Limitation or restriction of rights due to behaviors occur only as part of a written behavior support plan.

633.16(c)(5) & (8) &(9) OPWDD discourages the use of restrictive/intrusive interventions. General and specific requirements regarding the use of restrictive/intrusive interventions are imposed in order to limit the use of these interventions to those situations when necessary. Unless there is a clear risk to the health or safety of the person or others, or a violation of others' basic personal rights, any restrictive/intrusive intervention or limitation on a person's rights as specified in a behavior support plan shall be employed only after less intrusive or more positive interventions have been tried and have not been sufficiently successful.

Additional requirements apply to the use of "restrictive/intrusive interventions." These interventions include the following: any intermediate and/or restrictive physical intervention techniques (see paragraph [j][1] of this section);the use of time-out (exclusionary and non-exclusionary) (see paragraph [j] [3] of this section);the use of any mechanical restraining device with the intent to modify or control challenging behavior (see paragraph [j][4] of this section);the use of medication solely to prevent, modify, or control challenging behavior (see paragraph [j][5] of this section); and other professionally accepted methods to modify or control behavior which are determined by agency/facility policy to be restrictive/intrusive interventions because they impose a risk to a person's protection or encroach unduly on a person's normal activities (e.g., response cost, overcorrection, negative practice, and satiation).Additional requirements apply to behavioral interventions which impose a limitation on a person's rights as specified in section 633.4 of this Part, including behavioral consequences negatively impacting the person's dignity (see paragraph [j][2] of this section). All but Clinic and FSR

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p>As needed if limitations and/or restrictions are in place:</p> <ul style="list-style-type: none"> <li>• DSP</li> <li>• Individual</li> <li>• Site supervisor</li> </ul> <p>Clinician/psychologist</p>	<ul style="list-style-type: none"> <li>• Behavior Support Plan</li> <li>• Service notes as needed</li> </ul>	<p>Take note of any observed limitations or restrictions so you may f/u with interview and documentation review to ensure requirements are met.</p>

***Review for 1 person. If concerns are raised that limitations/restrictions occur without a written plan, consider sample expansion.***

Upon discovery that any individual is subject to restrictions or limitations to their rights due to behaviors that they exhibit that need to be addressed, verify that there is a written Behavior Support Plan (BSP) in place and implemented that identifies the restrictions as strategies.

The written plan is the means to provide instruction in how to support the person to function most effectively and/or minimize challenging behaviors and/or symptoms. A Behavior Support Plan (BSP) outlines specific interventions designed to support, develop or increase replacement or alternative behaviors and/or modify or control a person’s challenging behavior. Agencies may use other equivalent unique and agency specific terms for such plans. The intent, content, strategies and characteristics of the plans determine whether it is a Behavior Support Plan, not the moniker.

NOTE: This is not a comprehensive review of 633.16 requirements regarding an individual’s behavior plan and behavior supports. That review occurs via the Person Centered Review and may be used if necessary.

Select **MET** if:

- A written BSP is in place for the individuals subject to a rights limitation or restriction due to behaviors.

Select **NOT MET** if:

An individual is subject to a rights limitation or restrictions due to behaviors, but a written BSP is not in place.

**10h-2 The Individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention or limitation is to be documented.**

633.16(e)(2)(i-ix) All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan; be developed on the basis of a functional behavioral assessment of the target behavior(s); include a concrete, specific description of the challenging behavior(s) targeted for intervention; include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports; include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success; include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others; provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated; and include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.

IRA (excluding FSR); Apt, CR, PS, SH, Day Tx, Day Training, Day hab, Prevoc

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p>As needed:</p> <ul style="list-style-type: none"> <li>• DSP: to determine if staff understand documentation requirements</li> <li>• Clinician/psychologist on documentation expectations, especially if you have questions/concerns regarding documentation available for review</li> </ul>	<p>Mandatory:</p> <ul style="list-style-type: none"> <li>• Behavior Support Plan</li> <li>• RIA for restrictive physical interventions and/or Time Out use</li> <li>• Review IRMA for any incidents which have occurred for persons in relation to documented or undocumented rights restrictions.</li> </ul> <p>Documentation of behavior and behavioral interventions</p>	<p>If implementation is observed or discussed, this may lead to decisions regarding discussions to have and documentation review.</p>

***Review for 1 person minimum.***

This applies to BSPs with restrictive, intrusive or right limiting interventions.

The BSP should clearly describe what needs to be documented for each intervention and limitation, the format for this documentation, the frequency of the documentation, and the expected content/details to be documented (e.g. exhibited behavior, strategies attempted prior to restrictive/intrusive/limiting intervention, the specific intervention, durations as applicable, individual's response). The documentation may be hard copy or electronic.

The BSP must also include description of requirements for mandated reporting of physical interventions and time out use in the RIA application.

Select **MET** if:

- The BSP provides clear instruction on documentation necessary when staff implement a restriction, limitation or intrusive intervention to address an individual's behavior.

Select **NOT MET** if **either** of the following are evident:

- The BSP does not provides instruction on documentation necessary when staff must implement a restriction, limitation or intrusive strategy to address an individual's behavior.
- Instruction in the BSP is incomplete, inadequate or unclear regarding documentation required when staff implement a restriction, limitation or intrusive intervention to address an individual's behavior.
- A BSP is not in place.

**10h-3 Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.**

633.16(e)(4)(ii) Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.  
IRA (excluding FSR); Apt, CR, PS, SH, Day Tx, Day Training, Day hab, Prevoc

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
As needed: <ul style="list-style-type: none"> <li>• Individual and/or DSP: To determine if rights limitations may be in place</li> <li>• Individuals – to understand their perception of written informed consent to rights restrictions in their BSP. Clinician/psychologist: if you have questions or concerns about WIC</li> </ul>	Mandatory: <ul style="list-style-type: none"> <li>• Behavior Support Plan</li> <li>• Document evidencing Written Informed Consent (WIC)</li> </ul>	No requirement

**Review for 1 person. If limitations/restrictions occur without a WIC, consider sample expansion.**

There should be documentation that written informed consent was obtained prior to implementing a restrictive plan. Written informed consent must be documented with the consenting party's signature and their relationship to the person and a date. Guidance regarding parties who may provide informed consent is found in regulatory references below, but when appropriate should first be sought from the individual.

- 633.16(g)(6) - Hierarchy of parties appropriate to provide consent
- 633.16(g)(7) – Determination of an individual's capacity to give informed consent
- 633.16(g)(8) – Informed Consent Committee

**Time Limited Verbal Consent:** Per 633.16(f)(5)(ii) If written informed consent cannot be obtained within a reasonable period of time prior to the initiation or continuance of a plan, *verbal consent* may be accepted only for the period of time before written informed consent can be reasonably obtained. Verbal consent must be witnessed by two members of the staff, and documented in the person's record. This verbal consent is valid for a period of up to 45 days and may not be renewed.

The specific requirements that must be followed to obtain appropriate written informed consent can be found in section 633.16(g), including involved parties that can provide the consent, starting with the individual receiving supports, when appropriate.

**Select MET if any** of the following is present:

- Written Informed Consent to the BSP and its strategies is evident from the individual or other appropriate consenting party prior to plan implementation
- Written Informed Consent is current (within 12 months of previous consent)
- If strategy/plan is new or recently amended to meet a need, verbal consent is documented as described above, but not exceeding the 45 day period.

**Select NOT MET if any** of the following are present:

- Written Informed Consent to the BSP and its strategies is not evident
- Written Informed Consent is not current
- Verbal consent has been received but has met its time limit and the site has not taken adequate action to receive WIC.
- A BSP is not in place.

**10h-4 Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.**

633.16(e)(4)(i) Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section  
IRA (excluding FSR); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert Prevoc

633.16(f)(3) Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section  
IRA (excluding FSR), Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert Prevoc

633.16(f)(5)(i-ii) The committee chairperson must verify that :(i) the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person; and(ii) written informed consent is obtained prior to the implementation of the approved behavior support plan. If written informed consent cannot be obtained within a reasonable period of time prior to the initiation or continuance of a plan, verbal consent may be accepted only for the period of time before written informed consent can be reasonably obtained. Verbal consent must be witnessed by two members of the staff, and documented in the person’s record. This verbal consent is valid for a period of up to 45 days and may not be renewed.  
IRA (excluding FSR); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert Prevoc

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION	
As needed: <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family Clinician/psychologist</li> </ul>	Mandatory: <ul style="list-style-type: none"> <li>• Behavior Support Plan</li> <li>• Documents evidencing Human Rights Committee (HRC) review and approval</li> </ul>	No requirement	

***Review for 1 person. If concerns are raised that limitations/restrictions occur without Human Rights Committee review and approval, consider sample expansion.***

A behavior support plan which incorporates a limitation on a person’s rights and/or a restrictive/intrusive intervention must be approved by the behavior plan/human rights committee.

- Verify that the committee has reviewed the plan prior to implementation and annually.
- The approval process must ensure that the plan includes required information necessary for implementation of limiting, intrusive and/or restrictive interventions. This includes clinical justification, other strategies attempted, hierarchy of use and documentation requirements when such interventions are implemented.
- Written informed consent must be obtained prior to committee approval. [For guidance regarding verbal consent acceptable to the committee see 633.16(f)(5)(ii)]
- Committee approval must be provided prior to implementation or renewal of the BSP.

- Determine if the HRC approval process is robust and takes into consideration all the unique aspects of the person's behavior it is meant to support. Evaluate if they fully consider the environment and precipitating events related to the behavior or if the approvals appear to come as a rubber stamp of whatever the clinician asks for. Evaluate if the HRC reviews the fading plan associated with the rights restriction to ensure if it is realistic, reasonable, and individualized to the person whose rights are being restricted.

**Select MET if all** of the following are met:

- Acceptable (per above) HRC approval of the BSP and its strategies is documented/evident prior to plan implementation
- HRC approval is current based upon review of the BSP annually

**Select NOT MET if any** of the following are present:

- HRC approval of the BSP and its strategies is not evident
- HRC approval of the BSP is not current (greater than 12 months)
- HRC approval is present but not provided with adequate review of the justification and prerequisites necessary for inclusion of restrictions, intrusions, limitations in the BSP
- A BSP is not in place.

**10h-5 Rights limitations that are not part of a Behavior Support Plan, comply with HCBS requirements for justification and documentation of rights limitation.**

HCBS 636-1.4 (c)(1)-(8) The service coordinator must ensure documentation of the following in the individual’s person-centered service plan: a specific and individualized assessed need underlying the reason for the modification; the positive interventions and supports used prior to any modifications; less intrusive methods of meeting the need that were tried but did not work; a clear description of the condition that is directly proportionate to the specific assessed need; a regular collection and review of data to measure the ongoing effectiveness of the modification; established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; an assurance that interventions and supports will cause no harm to the individual; and the informed consent of the individual.

IRAs, Day Habs, Cert. Prevoc sites

633.4(b)(6) For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect.

ALL

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
As needed: <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> <li>• Clinician</li> </ul>	Mandatory: <ul style="list-style-type: none"> <li>• Written protective oversight, habilitation, treatment or service plans</li> <li>• ISP as applicable</li> </ul> Documents evidencing required consents	Take note of any observed limitations or restrictions so you may f/u with discussion and documentation review to ensure HCBS requirements are met.

***Review for 1 person if rights as limited/restricted but addressed in a plan other than BSP. If concerns are raised, consider size of sample expansion.***

**This standard applies to limitations/restrictions in place for reasons other than behavior, for example health and safety.**

**A person's rights include:**

- Civil rights as a US citizen;
- Rights guaranteed under NYCRR Part 633.4;

- Rights that apply to provider-owned or controlled Settings, as stated in the HCBS Settings regulations issued by CMS – 441.301(C)(4)(vi)(B)-(F).

When assessing this standard, consider all routine aspects of a person's life, access, and opportunities. **Rights restrictions** and **rights modifications** include alterations to any personal rights identified above, including rights limitations, restrictions, and intrusive interventions as defined in NYCRR Part 633.16. Rights restrictions and modifications may or may not require an individualized behavior support plan. This standard addresses those that are not addressed via a BSP. Any modification of rights **must** be supported by a specific assessed need and justified in the person-centered service plan. CMS Regulations identify standards related to **any** modification or restriction of rights in HCBS settings.

**The following requirements must be documented in the person-centered service plan (or behavior support plan). For further guidance of the following requirements, refer to the HCBS Assessment Guidance Document using the crosswalk to find specific pages:**

1. Identification of a specific and individualized assessed need;
2. Documentation of the positive interventions and supports used prior to any modifications to the person-centered service plan;
3. Documentation of less intrusive methods of meeting the need that have been tried but did not work;
4. Includes a clear description of the condition that is directly proportionate to the specific assessed need;
5. Includes a regular collection and review of data to measure the ongoing effectiveness of the modification;
6. Includes established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
7. Includes the informed consent of the individual;
8. Includes an assurance that interventions and supports will cause no harm to the individual.

**For Rights Restrictions and Limitations due to Health or Safety Concerns:**

In the event that any of the person's rights are limited or modified for a person because of **health or safety concerns** (such as using a bed rail or helmet because of Epilepsy), it may not be necessary or appropriate to develop a behavior support plan. However, the requirements in #'s 1-8 still apply and need to be documented. In those instances, the information regarding limitation/restriction may fit appropriately into an Individualized Plan of Protective oversight (IPOP), habilitation plan, or safeguard section of the ISP.

**Note:** *If the IPOP is selected by the provider as the document source for required information, ensure that the information is documented in a manner or location that does not confuse staff's ability to identify **current** strategies to be implemented. (This note is made as requirements #2 and #3 above may provide historic strategies no longer used and determined not to currently be effective.*

**Exceptions due to emergency situations involving an immediate, serious, and credible threat to health and safety:**

The only exception to meeting the rights modifications requirements #1-8, above, is if there is an emergency situation where the person places themselves or others around them in serious jeopardy (i.e., there is an immediate, serious, and credible threat). In this case, the provider/staff must take immediate and appropriate action necessary to address the crisis situation, regardless of documentation present. Once the immediate crisis is over, the provider/staff is expected to reassess the person's preferences and needs using the a person-centered planning process, determine strategies to address health and safety threats determined to be recurring/likely to recur, and update the person's habilitation/service plan accordingly<sup>[1]</sup>.

**Select MET if all of the following are present:**

- **All eight (8) requirements for rights limitations noted above are met**
- **For documentation of positive and less-intrusive approaches:**
  - The service plan documents the description of positive and less intrusive approaches that were tried but were not successful, prior to inclusion of the current restrictions or intrusive interventions.
- **For documentation of a specific, individualized assessed need:**
  - The person's service plan includes the individualized description of each behavior or need requiring/justifying each restrictions or intrusive interventions; and
  - The use of the restrictive strategies in relation to the behavior/need appears justified.
- **For documentation of written informed consent:**
  - Written informed consent is evidenced through signature of consenting party for all limitations, restrictions, modifications. This may be through consent to the person's BSP (when required) or another component of their service plan that identifies the limitations; **OR:**
  - Verbal consent is documented for a restriction implemented fewer than 45 days; and
  - There is no indication that the process used to obtain consent was insufficient per 483 guidance noted above.
- **For documentation of periodic review for effectiveness:**
  - Documentation regarding implementation of strategies and resultant effect is collected as described in the plan, AND
  - This information is reviewed to determine effectiveness of strategies, AND
  - The review of implementation and effectiveness is conducted regularly per the time period identified in the plan, AND
  - Decisions regarding the continuation of a limitation, restriction, intrusion appear appropriate based on the documentation provided.

**Select NOT MET if any of the following are evident:**

- **For documentation of positive, less-intrusive approaches:**
  - The person's service plan does not include the required information.
  - There is no evidence that positive and less intrusive measures have been implemented and tested.
- **For documentation of a specific, individualized assessed need:**
  - The person's service plan does not include the required information; and/or
  - The use of the restrictive strategies in relation to the behavior/need does not appear justified and/or proportionate.
- **For documentation of written informed consent:**
  - Written informed consent is not present.
  - Written informed consent is incomplete.
  - Consent is evident for some but not all limitations, restrictions, modifications.
  - There is evidence that the process used to obtain consent was insufficient per 483 guidance noted above.
- **For documentation of periodic review for effectiveness:**
  - Any of the three components above (data collection, data review, or time period for review) is absent either in planning or implementation; and/or
  - The implementation of any component is inconsistent, incomplete or untimely; and/or
  - Decisions regarding the continuation of a limitation, restriction, intrusion are not justified based on the documentation provided.

10h-6 When environmental protections (that are in place due to an individual's needs) restricts other individuals in the facility, action is taken to ensure that they are not negatively affected.

636-1.4 (d) In the event that a rights modification affects another individual receiving services in the setting who does not require a rights modification, the service coordinator must ensure documentation of the following in such individual's person-centered service plan: the impact that the rights modification has on the individual; the efforts taken to lessen the impact on the individual; and the informed consent of the individual.  
IRAs, Day Habs, Cert. Prevoc sites

633.4(b)(4) OPWDD shall verify that staff are aware of the rights of persons in the facility.  
ALL

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Individuals receiving services</li> <li>• Program staff</li> <li>• Clinical staff</li> <li>• Site supervisors</li> </ul> <p><u>As needed:</u> Families &amp; advocates</p>	<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• Service Plans addressing specific environmental limitations</li> <li>• IPOP</li> <li>• ISP</li> </ul>	<p><u>Mandatory:</u> Observe for any environmental limitations and use to guide discussions and documentation review</p>

In the event that a rights modification affects another person in the setting **who does not require a rights modification**, documentation of the following is required in the individual's person-centered service plan (or attachments):

1. The **impact** that the rights modification has on the person not requiring the modification
2. The **efforts taken to lessen the impact** on the person, **and**:
3. The written **informed consent** of the person (advocates as needed)

**Example:**

When one person requires a locked refrigerator for clinical reasons, this can impact the access and right of everyone in the residence to having food at any time. Steps must be taken to allow others in the facility access to the fridge, such as having their own key; or an alternate location to access the food.

**Select MET if all the following are evident:**

- If there are justified rights modifications are the residence implements active measures to ensure that others' rights are accommodated; AND
- Individuals not requiring the rights modification are not negatively impacted by modifications required by their peers; AND
- Written informed consent has been provided.

**Select NOT MET if any of the following are present:**

- Rights modifications in place for a peer restrict individuals who do not require the modification;  
Written informed consent has not been received from affected individuals

**SECTION 10i: RISK FACTOR - BEHAVIOR SUPPORTS – GENERAL**

Is a behavior support plan or medication monitoring plan required/in place for any Individual(s)?

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

10i-1 Behavior supports are provided per the written plan.

633.16(b)(28) A written plan that outlines specific interventions designed to support, develop or increase replacement or alternative behaviors and/or modify or control a person's challenging behavior. The plan is a component of a person's overall plan of services. Agencies may use other equivalent terms for such plans. (See subdivision [e] of this section.)

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• DSP and program management staff – to determine their knowledge of the written Behavioral Support Plan (BSP).</li> <li>• Individuals – to understand their perception of the BSP written to support their unique behavioral needs and to which they, or their agent, has given consent.</li> </ul> <p><u>As needed:</u></p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Review IRMA for any incidents which may have occurred related to a person BSP or Medication Monitoring Plans (MMP).</li> <li>• RIA review to gather information about implemented physical and time out interventions</li> <li>• BSP</li> <li>• MMP</li> <li>• IPOP as needed</li> <li>• Daily notes, progress notes</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• to verify if staff are providing the supports outlined in the BSP and</li> <li>• Documenting on behavior as directed in the BSP and/or Med Monitoring Plan.</li> <li>• <u>See below</u> for additional considerations during observations.</li> </ul>

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Licensed Psychologist or Licensed Clinical Social Worker (LCSW) and Behavioral Intervention Specialist (BIS)</li> <li>• Others – Family members and/or advocates</li> </ul> | <ul style="list-style-type: none"> <li>• clinical notes as needed</li> <li>• BSP implementation documentation</li> <li>• Behavioral data tracking</li> </ul> |  |
|--|--|--|

**Review for 1 person minimum. If concerns with implementation, consider whether sample expansion is warranted.**

Consider the following, when verifying that staff are effectively delivering both the proactive and reactive behavioral supports outlined in the BSP and monitoring the person’s response to these supports or to those in the MMP

- **Observation, interview and documentation review should indicate that the positive, instructive, and supportive interventions described in the plan are routinely provided.**
- **Observation, interview and documentation review should indicate that restrictive, intrusive interventions and/or rights limitations are only implemented as indicated for circumstances identified in the plan and per the described methodology (hierarchy used, time limitations, safeguards and monitoring provided during and after the implementation.**
- Review the daily notes and behavioral tracking data to see if staff are implementing and documenting strategies as defined by the plan, both positive and supportive strategies as well as reactive interventions. Documentation of both positive and untoward behaviors which will enable the clinicians to evaluate the effectiveness of the plan.
- IRMA review may reveal that inadequate implementation of the BSP may have played a role the occurrence of untoward incident(s). If so, evaluate if resultant recommendations were generated and if these were implemented and effective to prevent further incidents.
- Through discussion with staff, verify that all who support the Individual with a BSP or a MMP can describe their responsibilities to implement it, record on it and report it.
- As needed, ask the person supported, family member/advocate their impression of the BSP or MMP. Discuss whether they think that the plan is helping to make his/her life better and what activities are implemented as part of the plan, trying to focus on proactive interventions.

**Select MET if:**

- Observations, discussions and documentation review result in no concerns with appropriate plan implementation
- Implementation occurs as described in the plan

- There is evidence of implementation of positive strategies designed to guide person to alternative behaviors and/or to prevent behaviors from occurring
- Staff understand the behavior plan(s) and their role in implementation

**Select NOT MET if:**

- Observations, discussions and documentation review result in examples of inappropriate plan implementation
- Implementation is inconsistent with strategies described in the plan
- Implementation of positive strategies designed to guide person to alternative behaviors and/or to prevent behaviors from occurring is inconsistent or not occurring
- Staff are unable to explain the behavior plan(s) and their role in implementation

10i-2 Behavior supports are **reviewed** for effectiveness by clinical staff responsible for the plan.

633.16(e)(2)(ix) All behavior support plans must: include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>DSPs regarding the plan’s effectiveness in addressing the person’s behavior</li> <li>Licensed Psychologist or LCSW and Behavioral Intervention Specialist (BIS) on how they review the effectiveness of the strategies in the plan (when not evident in summary of review)</li> </ul>	<p><u>Mandatory as applicable:</u></p> <ul style="list-style-type: none"> <li>BSP</li> <li>MMP</li> <li>Daily notes</li> <li>Documentation by Licensed Psychologist or LCSW and (BIS) of their (minimum every six months) thorough and thoughtful review of the behavioral tracking</li> <li>Behavioral data tracking records to include staff-generated data on behaviors, antecedents, fading plan requirements and proactive supports being implemented</li> </ul>	<p>N/A</p>

**Review for 1 person minimum. If concerns with implementation, consider whether sample expansion is warranted.**

Verify that the appropriate clinician (licensed psychologist or LCSW and the BIS) is effectively reviewing, minimally every six months, documentation regarding the person’s target behaviors and the delivery of both the proactive and reactive behavioral supports outlined in the BSP. The review should include:

- Review of the notes and behavioral tracking data documented by staff implementing the plan
- Evaluation of the effectiveness of the strategies in the plan to reduce/maintain unwanted behaviors and improve appropriate adaptive behaviors

- Evaluation if any restrictive interventions can be faded, liberalized or eliminated, based on behavioral data if BSP. (Restrictive techniques)
- If a person receives more than one service, review includes review for consistent implementation and effectiveness across his/her service environments.
- Discussion with support staff and the individual regarding effectiveness of the plan
- The plan's effectiveness in helping the person live successfully in their home and community, socially and functionally should be part of the review

**Select MET if all of the following are present:**

- There is documentation of review of the plan by the clinician
- The review thoroughly addresses effectiveness of the BSP/MMP plan and its strategies to assist the person to live more successfully
- The review occurs at least every six months

**Select NOT MET if any of the following are present:**

- There is not documentation evidencing review
- The plan's effectiveness is reviewed but duration between reviews significantly exceeds every six months
- Review of the plan is not thorough/components of the review are not evident; e.g.
  - Does not include review of documentation/data of behaviors; and
  - circumstances regarding the behavior (e.g. antecedents, environment)
  - Does not include review of strategies implemented, correct use of hierarchy
  - Does not include person's response to strategies

10i-3 Behavior supports are **revised** as needed.

633.16(e)(2)(ix) All behavior support plans must: include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>If concerns Licensed Psychologist or LCSW and BIS to learn how they review the recorded tracking data to make decisions about the effectiveness of the plan which result in revision of the plan supports, as appropriate.</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>Individuals – Highly recommended to learn what they think about the plan’s effectiveness</li> <li>Others – Discussions with family members and/or advocates, and other clinicians</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>BSP</li> <li>MMP</li> <li>Daily notes</li> <li>Behavioral data tracking records to include data on fading plan requirements and proactive supports being implemented, in addition to untoward behaviors.</li> <li>Documentation by Licensed Psychologist or LCSW and (BIS) of their (minimum every six months) review of the behavioral tracking data which demonstrates thoughtful assessment and subsequent plan revisions, if necessary.</li> </ul>	<p>N/A</p>

Verify that clinicians responsible for the plan are reviewing documentation related to BSP, to determine whether a **revision of the plan is necessary**:

- Verify that the responsible clinician(s) is/are reviewing the totality of the information recorded to get a holistic picture of how the BSP or MMP is effectively meeting the Individual's behavioral support needs throughout his day. This includes monitoring that both the proactive and reactive behavioral supports are effective.
- Evaluate if the clinician uses information to identify elements which can be revised to maximize the effectiveness of the plan. E.g. Retaining strategies that are effective but removing strategies proven to be ineffective; or including a new intervention for implementation in the evening after discovery that the strategy is highly effective during the daytime, but ineffective when the person is more tired in the evening.
- Review the daily notes and behavioral tracking data to see that strategies staff are using and report as effective become part of the plan if not already included. This will assist in identifying the most effective strategies, including those that may not be in the plan but staff are finding effective. E.g. If staff discover that a certain activity presented calmly has a positive effect in redirecting an individual's agitation, this should be considered as a strategy in the plan.
- If recorded behavioral data demonstrates a successful trend in behavior, determine if it has resulted in the fading or modification of restricting/intrusive/limiting restrictive interventions. If not, verify that the decision not to modify/reduce the restriction is based on a reasoned decision.
- New behaviors or changes in behavior that negatively impact the individual's quality of life are identified and included in the plan.

**Select MET if:**

- The plan is revised when there is evidence of:
  - sustained improvement in behavior; or
  - sustained increase in behaviors that negatively impact the person's life; or
  - new strategies not included in the plan are discovered to be effective ; or
  - new behaviors are occurring/sustained; or
- The plan is not revised when the above conditions are noted, but the failure to revise is based on a reasoned appropriate decision

**Select NOT MET if:**

- The plan is not revised even though there is evidence of:
  - Improved behavior allowing for reductions of restrictions, intrusions, or limitations
  - Ineffective strategies and/or increase in undesirable behaviors; or
  - Input from others regarding effective and ineffective strategies is not considered; or
  - Behaviors that negatively impact the person's quality of life

**SECTION10j: RISK FACTOR - MECHANICAL RESTRAINTS**

Are Mechanical Restraints used for at least one person at the Site?

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

10j-1 Criteria for the application, removal and duration of mechanical restraint device use is described **in the written** behavior support plan.

633.16(j)(4)(ii)(e) Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: (1) the facts justifying the use of the device; (2) staff or family care provider action required when the device is used; (3) criteria for application and removal and the maximum time period for which it may be continuously employed, see clause (i) of this subparagraph; (4) the maximum period of time for monitoring the person's needs, comfort, and safety, see clause (j) of this subparagraph; and (5) a description of how the use of the device is expected to be reduced and eventually eliminated.

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed</u>, with any questions about the plan's implementation of mechanical restraints:</p> <ul style="list-style-type: none"> <li>DSP and other site staff re: application, removal and use duration of mechanical restraints as part of a BSP.</li> <li>Psychologist or LCSW and BIS to verify their understanding of content requirements of the BSP and the application, removal and use duration of mechanical restraints in the</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>Review IRMA for any incidents which have occurred for persons in relation to use of mechanical restraints.</li> <li>Prior to the visit a review of RIA will provide the surveyor information about mechanical interventions that have been implemented.</li> <li>BSP</li> </ul>	<p>Not required for this standard.</p>

<p>BSP and staff understanding/implementation of the plan</p> <ul style="list-style-type: none"> <li>• Individual – re: their experience of mechanical restraints.</li> <li>• RN: if any questions regarding mechanical restraint use and impact to health, skin integrity, etc.</li> <li>• Family members and/or advocates as needed</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation that tracks/records the application, removal and duration of use of mechanical restraints.</li> </ul>	
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**Review for 1 person minimum**

The BSP must clearly describe why use of mechanical restraints is necessary. A mechanical restraining device is any physical apparatus or equipment used to limit or control challenging behavior. The apparatus or equipment cannot be easily removed by the person and may restrict the free movement, or normal functioning, or normal access to a portion or portions of a person’s body, or may totally immobilize a person.

The BSP should include clear criteria and instruction for use of mechanical restraints as follows :

- All alternative strategies or actions to be implemented by staff prior to using the device
- A description of the individual’s behavior and/or behavior progression that indicates the need to use the mechanical restraining device
- Clear criteria and the conditions for application of device
- Clear instruction for monitoring of the person’s condition during use
- Clear individualized behavioral criteria for when device should be removed
- Other conditions for removal of the mechanical restraint/device: e.g. Events/Routines: hours of sleep, meal times, personal hygiene; or certain durations of use
- Instruction regarding maximum duration of device application.
- Circumstances for reapplication
- Documentation required related to use and monitoring of person’s well-being

Note: Regarding maximum duration of device application: Per 633.16(j)(4)(ii)(i) In the absence of a physician's order for a shorter time period for release, the individual must be released from the device at least once every hour and fifty minutes for not less than ten (10) minutes. They must be provided opportunities for movement, eating, drinking and toileting. In the absence of a physician's order specifying otherwise, this is not applicable if the person is asleep, however the opportunities describe above must be offered immediately upon waking. If an individual requests release for movement or toileting prior to specified time period per plan, the opportunity should be provided asap.

*The following are types of mechanical restraining devices that require a specific written Behavior Support plan (which must meet all reviews, consents and approvals). However the specific devices do not need OPWDD central office approval:*

- (1) mittens, helmets, face masks, goggles, sleeve boards (by whatever name known), clothing (e.g., jumpsuit, leotard, or custom-designed clothing such as shirts or pants made of non-shredable HW cloth), bolsters, and mats used to safely contain a person;*
- (2) lap trays, seatbelts, and harnesses; only when used to maintain an ambulatory person in a fixed location for the purpose of enhancing services; and*
- (3) the use of a seatbelt, harness, or mechanical brake to maintain a non-ambulatory person in a fixed location for the purpose of preventing risk to health or safety resulting from challenging behavior.*

*Any other mechanical devices or modifications of the above require specific review and approval by OPWDD-Central Office. Verify this has been received by the agency. If approved, the provider agency will have documentation via email or letter from OPWDD Statewide Services Division. For state operated services, the Area Director will verify through the Statewide Services Division.*

**NOTE:** *Mechanical restraining devices used as a support to achieve proper body position, balance, or alignment, as part of a medical or dental procedure or as a medical or dental safeguard are not subject to the requirements of this section.*

*The use of devices to limit movement for the safe transport of the individual in vehicles, wheelchairs, etc., is not considered to be the use of a mechanical restraining device, and is not subject to the requirements of this section.*

**Select MET if all of the following are evident:**

- The BSP provides clear instruction on the individual's behaviors necessitating application of mechanical restraints and the interventions that must be provided prior to application if applicable;
- The BSP provides clear instruction for appropriate application of mechanical restraints;
- The BSP provides clear criteria and instruction for removal of mechanical restraints
- The BSP provides clear instruction of the supervision and monitoring that staff must provide while mechanical restraints are worn by an individual

**Select NOT MET if any of the following are evident:**

- Mechanical restraints not meeting the exceptions above, are used with an individual but not included as strategy in a behavior support plan;
- The BSP does not provide clear instruction for one or more of the following: behaviors that must be exhibited for mechanical restraint application; how to apply; criteria for removal; required supervision and monitoring of the individuals while mechanical restraints are used.

**10j-2 Restraints are applied only per the specific criteria described in the written plan.**

633.16(j)(4)(ii)(g) Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months.

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

633.16(j)(4)(i)(b) Mechanical restraining devices shall only be used in a manner consistent with the provisions of this section. Any other use shall be reported as a reportable incident in conformance with Part 624 of this Title.

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>DSP to determine their understanding and competency in implementation of use of mechanical restraints</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>Responsible clinician: Psychologist, Behavioral Intervention Specialist (BIS), LCSW: re: their monitoring for appropriate implementation of mechanical restraint intervention</li> <li>Site supervisors: re appropriate implementation</li> <li>RN if concerns about negative health impact because of use of mechanical restraints</li> </ul> <p>Family members and/or advocates</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>IRMA for any incidents which have occurred in relation to use of mechanical restraints.</li> <li>RIA to identify implementation of mechanical restraints noted in the online application</li> <li>Other documentation regarding restraint use and monitoring</li> <li>BSP</li> </ul> <p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>Staff training records if concerns regarding mechanical restraint implementation and staff competency</li> </ul>	<p>Mandatory if opportunity arises to verify use of any mechanical restraint/device is compliant with application criteria.</p>

**GUIDANCE:**

Observe, converse with relevant parties and review BSP and documents and reports of behaviors and interventions to determine:

- Required preliminary interventions were provided by staff prior to use of mechanical restraints in the hierarchy of interventions in the plan; e.g. when an individual exhibits eye poking, the plan states to interrupt the behavior through touch control, calming prompts and redirection to a preferred supervised activity, but when the person persists after 5 minutes of the behavior and is not responsive to redirection, a helmet with face guard should be applied.

- Target behaviors were exhibited by the individuals precipitating use of mechanical restraints; e.g. the plan allows for use of helmet for eye poking, it cannot be used for hand mouthing.

NOTE: The use of mechanical restraining devices in an emergency is not permitted.

**Select MET if:**

- Documentation and discussion evidence that mechanical restraints/devices are applied to the individual only in accordance with the strategies and hierarchy in the BSP.

**Select NOT MET if any of the following are evident:**

- Mechanical restraints/devices are applied without following the hierarchy of interventions in the plan
- Mechanical restraints/devices are applied for reasons other than the target behavior(s) for which they are necessary;
- Documentation regarding use of mechanical restraints/devices is lacking
- Mechanical restraints are not identified as a strategy in the BSP

10j-3 Restraints are **removed per the criteria and duration** described in the written plan.

633.16(j)(4)(i)(b) Mechanical restraining devices shall only be used in a manner consistent with the provisions of this section. Any other use shall be reported as a reportable incident in conformance with Part 624 of this Title.

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>DSP to determine their understanding and competency in implementation of use and removal of mechanical restraints</li> </ul> <p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>Responsible clinician: Psychologist, Behavioral Intervention Specialist (BIS), LCSW: re: their monitoring for appropriate implementation of mechanical restraint intervention</li> <li>Site supervisors: re appropriate implementation</li> <li>RN if concerns about negative health impact because of use of mechanical restraints</li> <li>Family members and/or advocates</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>IRMA for any incidents which have occurred in relation to use of mechanical restraints.</li> <li>RIA to identify use and removal of mechanical restraints noted in the online application</li> <li>Other documentation regarding restraint use and monitoring</li> <li>BSP</li> </ul> <p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>Staff training records is concerns regarding mechanical restraint use and staff competency</li> </ul>	<p>Mandatory if opportunity arises to verify use of any mechanical restraint/device is compliant with removal criteria and duration.</p>

Observe, converse and review the BSP and documents and reports of behaviors and interventions to determine whether mechanical restraining devices were used in accordance with BSP instruction and criteria for removal of devices:

- Documentation must evidence that when mechanical restraints are used, they are worn by the individual for the minimum time required per the plan’s criteria for removal and the person’s exhibited behavior at the time. That is, the devices are removed as soon as the individual

meets behavioral criteria per the BSP. E.g. if the plan states that the helmet is removed after 10 minutes of calm as defined as no screaming, agitation and attempts to poke eyes, the helmet is removed.

- The duration mechanical restraints are worn does not exceed the maximum duration written in the plan. The plan must not allow a person to wear restraint devices longer than 1 hour and 50 minutes.

Note: Regarding maximum duration of device application: Per 633.16(j)(4)(ii)(i) In the absence of a physician's order for a shorter time period for release, the individual must be released from the device at least once every hour and fifty minutes for not less than ten (10) minutes. They must be provided opportunities for movement, eating, drinking and toileting. In the absence of a physician's order specifying otherwise, this is not applicable if the person is asleep, however the opportunities describe above must be offered immediately upon waking. If an individual requests release for movement or toileting prior to specify time period per plan, the opportunity should be provided asap.

**Select MET if:**

- Documentation and discussion evidence that mechanical restraints are removed in accordance with the criteria described in the BSP for removal.

**Select NOT MET if any of the following are evident:**

- Mechanical restraints/devices are NOT removed when criteria for removal is met per the BSP;
- Mechanical restraints/devices are worn by the individual longer than described in the BSP;
- Documentation regarding use of mechanical restraints/devices is lacking
- Mechanical restraints are not identified as a strategy in the BSP

10j-4 There is a **current physician's order** for the use of the Mechanical Restraining device.

633.16(j)(4)(ii)(g)(1-3) A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u> RN, Psychologist, BIS, LCSW – As necessary, if any concerns about the current prescription for use of the mechanical restraint.</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Physician or prescriber's orders</li> <li>• BSP</li> </ul>	<p>Mandatory if opportunity arises to verify use of any mechanical restraint/device is compliant with the physician's order.</p>

The BSP instruction/guidance for use of the mechanical restraint/device should be consistent with the physician's order. The order must be in the person's clinical record.

The physician's order must specify:

- the type of device to be used,
- an expiration date for the order,
- Any special considerations related to the use of the device based on the person's medical condition, including the monitoring which is required during and after use of the device. This must incorporate specific components such as checking of vital signs and circulation if needed.
- The order must be renewed with the frequency specified in the plan but no less frequently than every 6 months.

**Note:** *If the device is used solely to maintain an ambulatory person in a fixed location or position for the purpose of enhancing the delivery of care or services (e.g. medical interventions), a physician's order is not required. This use must conform to all other requirements regarding use of mechanical restraints.*

**Select MET if:**

- The BSP includes use of a mechanical restraint/device and there is a current physician's order for use of the device. Current means within 6 months or more frequently if required by the BSP or physician.

**Select NOT MET if either of the following are evident:**

The BSP includes use of a mechanical restraint/device and there is NOT a current physician's order for use of a mechanical restraint/device. Current means within 6 months or more frequently if required by the BSP or physician.

**10j-5 There is **documentation** that is a “full record” of the use of the Mechanical Restraining device.**

633.16(j)(4)(ii)(g)(4) A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: be retained in a person's clinical record with a full record of the use of the device.

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u> Direct Support Staff, RN, Psychologist, BIS – if any questions about the use of the mechanical restraint.</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• IRMA for any incidents which have occurred in relation to use of mechanical restraints.</li> <li>• RIA to identify use and removal of mechanical restraints noted in the online application</li> <li>• Other documentation regarding restraint use and monitoring</li> <li>• BSP</li> </ul>	<p>Mandatory if opportunity arises in which the mechanical restraint is implemented during the visit to verify the documentation of its full record of use.</p>

Review documentation to verify that there is a ‘full record’ must be documented for each use of a mechanical restraint. A ‘full record’ means:

- a description of the event that caused the device to be applied (precipitation events, behavior exhibited by the person and other strategies attempted)
- the time it was applied
- the times when monitoring occurred
- the findings of monitoring activities and any actions taken
- the time of release
- Any other information required by the BSP

**Select MET if:**

- There is a “full record” documenting the implementation of the mechanical restraint strategy: as described in the six (6) bullets above.

**Select NOT MET if:**

- There is not a “full record” documenting the implementation of the mechanical restraint strategy: as described in the six (6) bullets above.  
Any one of the items is lacking.
- Mechanical restraints are not included in the BSP as a strategy.

**SECTION 10k: RISK FACTOR - TIME OUT**

**Is 'Time-out' used for any Individuals?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

10k-1. Time-out is **used only in accordance with** the written Behavior Support Plan.

633.16(j)(3)(iv)(a)(1) The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>DSP staff - to ascertain their knowledge of the criteria needed to implement time-out as part of a BSP.</li> <li>Licensed Psychologist or LCSW and BIS to verify their determination of the functional need for time out and how staff implement time-out in the plan.</li> <li>Individuals – to understand their perception of the use of time-out.</li> <li>Family members and/or advocates</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>Review IRMA for any incidents which have occurred for persons in relation to use of time-out.</li> <li>RIA for documentation of time out interventions that have been implemented with individuals.</li> <li>Other documentation and notes that describe use of time-out.</li> <li>BSP</li> </ul> <p>As Needed:</p> <ul style="list-style-type: none"> <li>Staff training records if concerns regarding their competence on the use of time-out</li> </ul>	<p>Mandatory if opportunity arises in which the use of time-out occurs during the visit, to verify its use is based on the criteria which the plan specifies.</p>

***Review for 1 person minimum***

**Guideline:**

- Based on observation, interview and review of documents and reports, determine whether use of the Time Out strategy was implemented safely and in accordance with the BSP criteria and instruction. An account of time out use will also be documented in RIA.
- Documentation should evidence that the plan is followed regarding circumstance for initiation of Time Out per the BSP
- Documentation should also evidence adherence to the BSP criteria and time frames for release from Time Out
- NOTE: Time-out cannot be used in an emergency in the absence of a written plan. It cannot be used as a form of punishment or retribution or for the convenience of staff.
- NOTE: Time away, when a person is redirected to a quieter or less stimulating area of the program and where staff do not actively prevent egress from that area, is not considered a form of time-out.

**Select MET if:**

- Documentation and discussion evidence that Time Out interventions are implemented in accordance with the criteria described in the BSP for initiation and release.

**Select NOT MET if any of the following are evident:**

- Time Out interventions are implemented when unwarranted, for behaviors other than describe in the BSP
- Time Out interventions are implemented prior to implementation of previous strategies in the hierarchy per the BSP
- The individuals is required to remain in time out longer than required per the BSP
- Documentation regarding use of Time Out is lacking
- Time Out is not identified as a strategy in the BSP

10k-2 The use of a time out room is reported electronically to OPWDD.

633.16(j)(3)(iv)(d) Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u> If any questions about the electronic reporting to OPWDD:</p> <ul style="list-style-type: none"> <li>DSP, site supervisor or, Licensed Psychologist or LCSW and BIS to verify their oversight of the need to electronically report time-out as part of a BSP.</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>Review IRMA for any incidents which have occurred for persons in relation to use of time-out.</li> <li>RIA for documentation of time out interventions that have been implemented with individuals.</li> <li>Other documentation and notes that describe use of time-out.</li> <li>BSP</li> </ul> <p><u>As Needed:</u></p> <ul style="list-style-type: none"> <li>Staff training records if concerns regarding their competence on the use of time-out</li> </ul>	<p>N/A</p>

The use of time-out is to be reported in RIA (Restrictive Intervention Application). Review RIA to verify that each use of time-out was reported and all required information was entered into RIA and is consistent with other information available regarding the use of Time Out, as available in behavior tracking and documentation in the person's record.

**Select MET if all of the following are evident:**

- All required Time out use is entered into RIA with required fields completed.

**Select NOT if any of the following are evident:**

- All events of Time out use is not entered into RIA.
- Many events of time out use are not entered into RIA

Information entered into RIA is inaccurate based on discussion with staff and/or documentation of Time Out use elsewhere.

**10k-3 Constant auditory and visual contact** is maintained during time-outs to monitor the Individual's safety.

633.16(j)(3)(iv)(a)(2) The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

**GUIDANCE:**

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u></p> <ul style="list-style-type: none"> <li>• DSP staff - to ascertain their knowledge of the monitoring required when implementing time-out as part of a BSP.</li> <li>• Licensed Psychologist or LCSW and BIS to verify their oversight of how staff implement time-out in the plan</li> <li>• Individuals – to understand their perception of the use of time-out.</li> <li>• Family members and/or advocates</li> </ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Review IRMA for any incidents which have occurred for persons in relation to use of time-out.</li> <li>• RIA for documentation of time out interventions that have been implemented with individuals.</li> <li>• Other documentation and notes that describe use of time-out.</li> <li>• BSP</li> </ul> <p>As Needed: Staff training records if concerns regarding their competence on the use of time-out</p>	<p>Mandatory if any time-out is used during the review to verify if there is constant auditory and visual contact.</p>

Constant auditory and visual contact is mandated to ensure that if the Individual engages in behavior that poses a risk to their health or safety, staff intervenes to prevent injury. Guidance to provide this monitoring should be clearly indicated in the BSP. Documentation for implementation of time

out should indicate that visual and auditory supervision is provided. Review documentation provided through onsite notes and RIA to verify that it is provided and appropriate.

**Select MET if the following are evident:**

- There is documentation to support the provision of visual and auditory supervision during Time Out.
- Interview evidences that appropriate monitoring occurs.
- There is no evidence to raise doubt that appropriate auditory and visual monitoring is maintained during time out.
- The time out room/location physical characteristics allow for the proper provision auditory and visual monitoring during time out.

**Select NOT MET if any of the following are evident:**

- There is no documentation to support that visual and auditory supervision is maintained during time out.
- Discussion with staff or individuals or family reveal that appropriate supervision is not maintained during time out interventions.
- Incident reports or other information indicate that required supervision is not maintained during time out interventions and this issue has not been addressed by corrective actions
- The time out room/location does not allow for proper maintenance of auditory and visual monitoring during time out interventions based on physical characteristics

**SECTION 10I: PHYSICAL INTERVENTIONS**

**Are physical interventions used for any Individuals?**

If yes, ID Individual(s) Name:

If yes, the following standards open up for review:

**10I-1 Physical interventions are used only in accordance with the written Behavior Support Plan.**

633.16(j)(1)(i)(a-d) The use of any physical intervention technique shall be in conformance with the following standards: the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; the technique must be applied in a safe manner; the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

**GUIDANCE:**

<b>DISCUSSION</b>	<b>DOCUMENTATION REVIEW</b>	<b>OBSERVATION</b>
<p><u>As needed:</u></p> <ul style="list-style-type: none"><li>• DSP staff - to ascertain their knowledge of the criteria needed to implement physical interventions as part of a Behavioral Support Plan (BSP).</li><li>• Licensed Psychologist or LCSW and BIS and site supervisor to verify their oversight of staff implementation of physical interventions per the plan.</li></ul>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"><li>• Review IRMA for any incidents which have occurred for persons in relation to use of physical interventions</li><li>• RIA for documentation of physical interventions that have been implemented with individuals.</li><li>• Other documentation and notes that describe use of physical interventions.</li><li>• BSP</li></ul>	<p>Mandatory if opportunity arises to verify its use is based on the criteria which the plan specifies.</p>

- Individuals – to understand to understand their perception of the use of physical interventions.
- Others – Family members and/or advocates

As Needed:  
Staff training records if concerns regarding their competence on the use of physical interventions.

***Review for 1 person minimum***

Based on observation if opportunity presents, discussion with relevant parties and review of documents and reports of behaviors and interventions, determine whether:

- Physical interventions were used safely and in accordance with OPWDD approved interventions. The technique must be applied safely, with the minimal amount of force necessary to safely interrupt the challenging behavior
- Physical interventions were implemented only in accordance with behavioral criteria for use in the BSP and in accordance with BSP guidelines. Physical Interventions used must be the same interventions listed in the Behavior Support Plan, and used in the same hierarchy as put forth in the plan (least restrictive used first).

**Select MET if:**

- Documentation and interview indicate that physical interventions are used appropriately and only per the written BSP;
- Observation (if possible) indicates that physical interventions are implemented only when necessary and per the plan;
- Physical interventions implemented are OPWDD approved

**Select NOT MET if:**

- Documentation and interview indicate that physical interventions are NOT used appropriately and and/or are not implemented per the written BSP;
- Observation (if possible) indicates that physical interventions are implemented for behaviors or circumstances different that those identified as justifiable in the written plan
- Interventions implemented are not OPWDD approved.
- The BSP does not include physical interventions as a strategy.

10I-2 The use of restrictive physical interventions is reported electronically to OPWDD.

633.16(j)(1)(vii) Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.

IRA (excluding FSRs); Apt, CR, Day Tx, Day Training, Day hab, Specialty Hospitals, Private Schools, Cert. Prevoc

DISCUSSION	DOCUMENTATION REVIEW	OBSERVATION
<p><u>As needed:</u> If any questions about the electronic reporting to OPWDD: DSP, site supervisor or, Licensed Psychologist or LCSW and BIS to determine oversight of electronic reporting of the physical intervention.</p>	<p><u>Mandatory:</u></p> <ul style="list-style-type: none"> <li>• Review IRMA for any incidents which have occurred for persons in relation to use of time-out.</li> <li>• RIA for documentation of time out interventions that have been implemented with individuals.</li> <li>• Other documentation and notes that describe use of time-out.</li> <li>• BSP</li> </ul> <p><u>As Needed:</u> Staff training records if concerns regarding their competence on the use of time-out</p>	<p>N/A</p>

The report of the use of physical interventions with individuals should be available in RIA with all appropriate fields completed. Through documentation review, verify:

- That the information entered in RIA is accurate for each physical intervention as compared to other documentation available on site.
- For services provided *in non-certified sites*, documentation may occur via paper documentation. RIA entry is not required.

The use of physical interventions to assist a person to more effectively cope must be reported in RIA (Restrictive Intervention Application). Review RIA and documentation available on site to verify that each use of interventions was reported and all required information was entered into RIA and is consistent with other information such as behavior tracking and documentation in the person's record.

**Select MET if all of the following are evident:**

- All required physical intervention use is entered into RIA with required fields completed.

**Select NOT if any of the following are evident:**

- All events of physical intervention use is not entered into RIA.
- Many events of physical interventions use are not entered into RIA
- Information entered into RIA is inaccurate based on discussion with staff and/or documentation of physical interventions elsewhere.