

# UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

**GENERAL NOTE:** In all cases when a deficiency is suspected, it is the analyst's responsibility to conduct whatever additional review activities are necessary to identify and substantiate the specific deficient practice.

## **VALUED OUTCOMES**

1. Use Tag Number Y300 (633.4(a)(4)(viii), which is applicable to all program types when survey findings reveal that the ISP does not provide sufficient supports to assist the consumer to live as independently as possible, increase social competency and provide opportunities for community integration that equals consumer interests and choice.

Use Tag Number A669 and Regulatory Reference Number 686.99(ab) for consumers enrolled in the HCBS Waiver *living in supportive or supervised community residences* when there is a discrepancy between the services activities and supports identified in the ISP and those actually occurring, or when the ISP lacks consistency between the personal goals and capabilities of the consumer and related habilitation plans or supports.

Observe activities. Talk to program participants, family members and facility staff as needed. How do people spend their time during the day, evening and weekends? Are they learning new skills? Are they participating in leisure-time activities that they enjoy? Do they participate in the routine chores of the household? Do they have opportunities to do things for other people or for their community?

Review the ISPs/Plans of Service. Observe activities. Talk to staff and participants. Are individuals learning skills that will make them more independent? Even if a person will probably not achieve total independence at a certain activity, such as taking medication, for example, are they learning to be as independent as possible by doing such things as pouring their own water? Are individuals practicing skills (such as cooking, making purchases, table-setting, etc), or do they "learn" a skill never to use it again? Do individuals participate to the extent they are able in the routine tasks of the household, or are things done for them (e.g., breakfast prepared and served by staff when consumers have the ability to participate)? Once individuals learn a skill, are they moving forward and learning additional skills in other areas of identified need? Do individuals receive training in tasks when appropriate (e.g., do staff intervene when a consumer is eating with his/her fingers)?

2. The primary Tag number to use is Y300 (633.4(a)(4)(viii) which requires that every person served by OMRDD has the right to a written individualized plan of services. It is applicable to all programs and services authorized or certified by OMRDD. If the person is receiving MSC, deficiencies should be listed under the requirements for an ISP if possible. Please refer to the MSC protocol.

Use Tag Number MHL I and Regulatory Reference Number MHL 13.07(a), which is applicable to all certified programs and outlines the scope of

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OMRDD's responsibilities with regard to the development of comprehensive plans, programs and services in areas such as care and treatment, habilitation, vocational and other educational and training for MR/DD consumers. Services shall be developed by OMRDD as well as other community organizations and agencies. The Tag Number may be utilized when survey findings reveal systemic problems due to the agency's inability to develop a concise system in which effective, comprehensive, individualized consumer care plans are developed and annual reviews are not conducted in a timely manner. Issues, such as lack of professional staffing to complete assessments or provide services, may also be cited here.

Use Tag Number A151 and Regulatory Reference Number 686.7(a)(3), which is applicable to supervised CRs, when there is a lack of needed assessments and/or clinical services. Appropriate supervision is lacking or staff have not received training in the needs of consumers.

Use Tag Number A153 and Regulatory Reference Number 686.7(b)(1), which is applicable to supervised CRs, when the facility has failed to provide adequate services to the consumer; i.e., an audiological examination requested by the Speech Therapist was never obtained or medical testing requested by a consulting psychologist to rule out flaccid bladder prior to the start of a toileting program was not completed.

Use Tag Number A159 and Regulatory Reference Number 686.7(b)(5)(ii) for supervised CRs when the Service Plan is not revised annually or when the activities do not reflect the consumer's needs, preferences, choices, etc. This Tag Number should also be used if the consumer is already independent in the activities identified in the Service Plan or if the Plan does not address key areas such as maladaptive behavior, "OMRDD shall verify that at least annually there is a review and recommendations are made on the following: that the description of the person's general program activities in and out of the residence and the person's participation in those activities reflects the needs and interests of the person..."

Use Tag Number A665 and Regulatory Reference Number 686.99(x) for IRAs only when survey findings reveal that a consumer does not have a Plan of Protective Oversight, the Plan lacks relevant information regarding supports; i.e., severe medical or behavioral condition, evacuation needs, or has not been updated as required.

Use Tag Number V832 and Regulatory Reference Number 635-10.4(b) for Day Habilitation and Tag Number D475 and Regulatory Reference Number 690.99(z) for Day Treatment programs.

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5. Tag Number Y322 and Regulatory Reference Number 633.4(a)(4)(xxiv) is taken from Part 633.4 (Consumer Rights and Responsibilities) and as such is applicable to all program types. This Tag Number should be used when there is evidence that the facility has failed to promote an environment in which consumers are assisted in developing relationships of their choice; i.e., staffing levels do not permit a consumer to visit an aging parent in Brooklyn nor attend Bingo at a local church. A capable consumer is not taught how to use the telephone so he/she can call family members independently.

Tag Numbers A159 and A160 and Regulatory Reference 686.7(b)(5)(ii-iii) may be used to cite deficiencies found in supervised CRs when there is evidence that the person's general program of activities does NOT reflect their needs or interests and/or the current level of participation in community activities does not meet the persons' needs or capabilities.

Talk to program participants, family members and facility staff. Do participants have social relationships with friends and relatives who are not part of the paid staff of the facility? Can they have friends and family members in to visit? Are any restrictions placed on them? Are they afforded privacy when they have visitors? For people who may not have relationships other than those with peers and paid staff, what is the facility doing to help them to develop such relationships? Are any restrictions placed upon people in terms of who they associate with? If so, what is the rationale? Are individuals provided counseling/training in sexuality, if needed or desired?

6. Tag Number Y300 and Regulatory Reference Number 633.4(a)(4)(viii), which is applicable to all program types, should be used to cite deficiencies when the ISP fails to address issues/needs related to increasing consumer independence, both in and out of the residential environment or increasing social skills.

Use Tag Number Y310 and Regulatory Reference Number 633.4(a)(4)(xii), which is applicable to all program types, when there is evidence that the facility is not assisting individuals in pursuing personal interests such as religious services.

Use Tag Number Y311 and Regulatory Reference Number 633.4(a)(4)(xiii), which is applicable to all program types, when there is evidence that the facility is not providing support or assistance to individuals who wish to vote or pursue other civil activities.

Use Tag Number A160 and Regulatory Reference Number 686.7(b)(5)(iii) for *supervised CRs* when there are deficiencies resulting from a failure on the part of the facility to indicate at least annually whether the consumer's current level of participation in the community is consistent with the persons' needs and interests. This Tag Number may also be utilized when community activities are designed to fill up time rather than foster special interests, activities are infrequent, or boring (such as van rides) or in other ways not consistent with the person's individualized needs and interests.

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Use Tag Number V850 and Regulatory Reference Number 635-10.4(b)(2)(ii) for Day Habilitation when individuals do not receive services in accordance with needs identified in the ISP that provide assistance with the acquisition, retention or improvement in skills that train and assist in developing appropriate social behaviors which are normative in the surrounding community such as conducting oneself appropriately in restaurants, on public transportation vehicles, in recreational facilities, in stores and other public places.

Use Tag Number D069 and Regulatory Reference Number 690.3(b)(1) for Day Treatment when it has been determined that a community integration opportunity is clinically appropriate, in accordance with needs identified in an individual's plan of services, and the facility fails to document that the habilitation activities are being implemented per the plan. NOTE: Each particular community integration opportunity; i.e., the activity and its associated outcome, shall be time-limited as specified by the ITT, but no longer than one year and shall focus on the initiation/enhancement of a specific developmental skill/behavior appropriate for increasing the person's independent functioning in the community.

For Willowbrook Class Members receiving Day Habilitation and Day Treatment services, use Tag Number P199 and Permanent Injunction Reference #21, if community inclusion services are not present as part of the individual's overall plan of services or if aspects of the plan relating to community inclusion are not implemented or documented properly.

**SURVEYOR NOTE:** Permanent Injunction (PI) Reference #21 discusses monitoring and the means in which to ensure that Class Members are receiving services required by the PI. Specifically, paragraph #21 references Appendix N which, in turn, is the Willowbrook Long Form Audit Instrument. The standards and guidelines therein outline the requirements referenced in this question; however, OMRDD and the Willowbrook parties have agreed in subsequent negotiations that frequency, variety and group size of inclusion experiences for individual Class Members must be appropriate based on each person's needs, preferences and capabilities and not measured against any predetermined standard.

Talk to facility staff and individuals/Willowbrook Class Members, if possible; review any offered documentation. How do individuals make use of the community as part of day program activities and at the residence in accordance with individual plans of service? Do they participate in food/clothing shopping, or are these activities done by staff only? Do they make use of recreational opportunities in the community, such as parks, movies, YMCA, restaurants, etc.? How often? Do individuals go out in large groups only, or are opportunities provided for people to go out one-on-one or in small groups of two or three with people of their choosing? If they do arrive together to an activity in a large group, are they encouraged/permitted to split up into smaller groups or individually upon arrival, if appropriate? How are community activities chosen? Do residents participate in any community volunteer-type activities -- local park clean-ups, for example? Develop a sense of how often individuals use community resources and whether or not they use the community in normalized ways or only in large groups participating in some sport or special event. Are individuals able to "opt out" of community activities? If the Class Member refuses community activities, are reasons for the

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refusal documented? Has the team considered alternatives to accommodate choice of experiences?

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## WAIVER SERVICES

*For those Tag numbers beginning with FR, please enter findings on the Waiver database. Ensure that any deficiencies found are communicated on an exit conference form to the agency/ program. Monitor on subsequent Waiver reviews that the agency has taken action to correct the deficiencies. Potential billing disallowances should be communicated to the BCM by the Area or Regional Director as appropriate.*

*Much of the following language is taken from Administrative Memoranda.*

7. For each agency or program that provides a Waiver service, there must be a Waiver Service “Plan”. Waiver Service Plans must specify the Waiver service identified in the ISP. The requirements for the waiver service plan will vary based on the particular Waiver service being implemented. For example, a “plan” to provide respite services only needs to identify that respite services will be provided. No supports or activities need to be specified. However, a Habilitation plan requires particular elements listed below.

It is very important that both the ISP and Waiver service documentation exactly list the correct Waiver services so that the service will be reimbursed.

8. There should be a valued outcome in the ISP that is supported by the Waiver service. The Habilitation plan must relate to at least 1 valued outcome listed in the ISP. The person’s valued outcome(s) are specified in the ISP. The Habilitation Service is “authorized” only where the service relates to at least one of a person’s valued outcomes. The Habilitation Plan writer uses these valued outcomes as a starting point for writing the Habilitation Plan and then goes on to describe the combination of skill acquisition, staff supports and exploration of new experiences that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes.
9. Habilitation Services are those supports and services that assist people to live successfully in their home, work at their jobs and participate in the community. Habilitation Plans describe what staff will do to help the person reach his or her valued outcome(s) that have been identified in the Individualized Service Plan (ISP). The ISP provides the authorization for delivering a particular Habilitation Service (e.g., Day Habilitation). Habilitation Services involve staff teaching a skill and/or helping the person, i.e., providing a support, and new experiences. A Habilitation Plan is individualized by using the person’s valued outcomes as a starting point. The Habilitation Plan should address one or more of the following strategies for service delivery: skill acquisition, skill retention, staff support, and exploration of new experiences. The strategies are discussed below. The Habilitation Service Provider, using professional judgment and in collaboration with the person and his/her service coordinator, decides which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new Habilitation Service staff to know what they must do to implement the person’s Habilitation Plan. It should be noted that the Habilitation Plan provides strategies for habilitation service delivery and is not meant to identify each and every activity that

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occurs throughout the day.

- a) **Skill Acquisition** describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others that know the person well and/or by data collection.
  - b) **Skill retention** should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, the Habilitation Service can be directed to skill retention.
  - c) **Staff Supports** are those actions provided by the habilitation staff when the person is not expected to independently perform a task without supervision that is essential to preserve the person's health or welfare, or to reach a valued outcome. Examples are assistance with personal hygiene or activities of daily living. Staff oversight of the person's health and welfare is also a part of the Habilitation Service (e.g., when staff accompany people in the community or provide first aid).
  - d) **Exploration of new experiences** is an acceptable component of the Habilitation Plan when based on an appropriate review by the Habilitation Service Provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. This trial and error process eventually enables the person to make informed choices and, consequently, to identify new valued outcomes that then become part of the ISP and the Habilitation Plan.
10. The Waiver Service plan will identify supports or services that are to be delivered to the person. There should be evidence through record review, observation or interview that those supports and/or services are being provided.
  11. The Waiver plan should identify a frequency that services or supports are to be provided. There should be evidence through record review, observation or interview that those supports and/or services are being provided in the frequency listed. It is acceptable for a Waiver plan to state that a service will be provided weekly or 2 times a week, or monthly, etc. The service does not always need to be provided at the same time on the same day.
  12. If the Waiver service plan specifies that a service or support will be provided for 30 minutes, there should be evidence through record review, observation or interview that those supports and/or services are being provided for the duration listed.
  13. The Waiver service plan should identify the objective of the service/support and relate to a valued outcome listed in the ISP. For example, an individual's valued outcome may be to become more independent in his/her home. The residential habilitation plan may state that staff will

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provide support & training to help the person plan a meal, shop for ingredients, and prepare the meal. There should be evidence that those supports/services are occurring.

14. Use Tag Number V832 and Regulatory Reference Number 635-10.4(b), which is applicable to HCBS Waiver participants, when there is a lack of consistency between the consumer's strengths, needs and choices and habilitation plans and supports.

Review the ISP/Habilitation Plan. Observe activities. Speak with the person, facility staff, family member or advocate (if available) and Service Coordinator (if available). The Habilitation Plan and activities should be based on an understanding of the person -- what he/she wants in life, what he/she likes to do. Did the person attend the meeting at which the ISP/Plan of Service was developed? If the person was not in attendance at the meeting or if the person has difficulty in communicating, how was the person's participation obtained? Is the Plan responsive to the person's choices and other input? Are opportunities provided to discover and explore new life experiences? Do staff respond or ignore the person when he/she expresses an interest in the new experience? Do staff members make decisions about activities based upon their own values rather than the choices of the consumers? Does the facility have mechanisms for ascertaining individual preferences for activities? Do staff attempt to learn about and respond to preferences the consumer expresses regarding his/her life in the residence? Do staff encourage and create opportunities for informed choice by the consumer? If the consumer attempts to self-advocate, do the staff and administration recognize and/or respond to reasonable consumer requests? Note that not every need/preference needs to be addressed, but all activities, services and supports provided should have a basis in the person's strengths, interests, choices, aspirations, needs and/or valued outcomes.

15. If the individual's ISP lists allergies that staff who are providing Waiver services need to know in order to keep the person safe, those allergies should be listed or referenced in the Waiver service plan. The key is that staff have the information they need to safeguard the person. For example, if an individual is working at a janitorial job, staff should know if he/she has a latex allergy. It might not be so important that they know that he/she is allergic to golden rod pollen.
16. The **safeguards** delineated in Section 1 of the ISP are used as the starting point for the Habilitation Service Provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff, as appropriate, must have knowledge of the person's safeguards. If the individual has a health need that could impact on the safe provision of Waiver services, that information must be made available to staff who are providing the Waiver services.
  - a) Safeguards for persons receiving IRA Residential Habilitation are addressed in the individual's Plan of Protective Oversight in accord with 14 NYCRR Section 686.16. The individual's Plan of Protective Oversight is *attached* to the IRA Residential Habilitation Plan.

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- b) For all other Habilitation Services (Residential Habilitation in Family Care, CRs and At Home; Day Habilitation; Prevocational Services; and Supported Employment) safeguards are *included* in the Habilitation Plan or the plan may *reference* other documentation that specifies the safeguards. *Information on the safeguards must be readily available to the Habilitation Service Provider staff.*
17. The **safeguards** delineated in Section 1 of the ISP are used as the starting point for the Habilitation Service Provider. The Waiver service plan should document or reference any required assistance, support or equipment that a person will need in order to be safe in a fire emergency. Again, the key is that staff who are providing the Waiver service have the information they need to safeguard the individual.
18. If possible, observe the Waiver service being provided. If not possible to observe, interview the staff who provide the Waiver service and the individual. If the individual has a health need that should be known to staff and addressed during the provision of Waiver services, ensure that staff have the information and are providing the service.
19. To support service claim documentation and quality services, the service provider must assure that at least monthly, or more frequently if the provider so chooses, a narrative note is written that: a) summarizes the implementation of person's Habilitation Plan, b) addresses the person's response to the services provided, and c) states any issues or concerns about the plan or the person.

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## OVERSIGHT & PROTECTIONS

20. **APPLIES ONLY TO CERTIFIED IRAs.** Use Tag Number **A683** and Regulatory Reference Number 686.16(b)(3), if the facility has failed to develop an IPOP, or if the Plan clearly fails to address all areas of need.

When reviewing for this standard, survey staff needs to determine whether there is a current IPOP that meets all of the safeguarding needs of the individual. The Plan should identify areas in which the consumer requires staff assistance and should specify the level of assistance needed. Survey staff will determine if this standard is met through interview, observation and review of documentation.

Each person residing in an IRA must have an Individualized Plan for Protective Oversight (IPOP), which is part of his/her ISP. For individuals who are not enrolled in the HCBS Waiver, there will be no ISP. However, there must still be an IPOP. The reviewer should verify that the consumers are provided adequate protective oversight based on individual needs. Review the ISP. Talk with the Service Coordinator and the consumer/advocate. How were the needs for specific safeguards identified? The ISP should identify what safeguards or protections are wanted or needed by the consumer in order to implement the individualized service environment. Note that not EVERY identified need or preference needs to be addressed, but needs that impact a person's health, safety or welfare must, of course, be addressed. If the person has an identified need for a safeguard, does the IPOP provide staff with specific directions regarding what they need to do to keep the person safe? The reviewer should consider the thoroughness of the protective oversight, weighing the degree of risk versus the protection of the individual. Areas to consider include overall health care (including medications), personal care (including nutrition, hygiene, and clothing) and individual rights. The following components are suggested topics for review only and are not to be construed as a set of requirements and/or mandates:

- Health Care Needs: May include the level of staff assistance required due to specific medical conditions; i.e., diabetes, and may include assessments and follow-up by health care professionals; health education; or, infection control.
- Medications: May include security of medications; administration of medication by staff; sufficiency of medication; medication review; and, staff oversight required if the consumer is self-medicating or on a program to increase skills.
- Behavioral Needs: May include interventions to manage behavior; supervision and follow-up of staff interventions; periodic review of behavior planning, but only as it applies to provider protection of the individual.
- Dental Care: May include planned dental check-ups; dental hygiene education; periodic prophylaxis.
- Nutrition: May include the current diet and restrictions, staff assistance required for menu planning; dietetic assessments and review; provision of adaptive equipment; provision of food preparation and delivery; and, assistance during mealtimes.
- Personal Hygiene: May include staff assistance needed to regulate the water temperature; showering, shaving, nail care, hair care, etc.

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20. (Cont'd.)

- Appropriate/Adequate Clothing: May include the level of staff assistance required to dress and select the appropriate clothing, size, age-appropriate, color, style coordination, cleanliness, quantity, and seasonal-appropriate needs.
- Freedom From Abuse (By Staff Or Other Participants) And An Environment Maintained So As To Prevent Injuries To The Person: May include the specific safeguards in place to protect the individual in the home and community (staffing and adaptive equipment), staff training, consumer training, etc.
- Fire Safety: May include specifics regarding the consumer's response to fire alarm/drills; staff actions/supervision required to safely evacuate.
- Night Safety: May include bed rails/safety; periodic bed checks; use of monitor or the need to leave a wheelchair in the consumer's bedroom, etc.
- Adequate Supervision In The Community: May include staff supervision, travel training, identification card, use of "911" or similar emergency phone system, training on community dangers, assessment of need for supervision/assistance from staff in community.
- Rights: May include identification of rights and need for protection specific to the individual. Examples include: privacy, money-management, voting, etc.
- Need For Periodic Review Of Protective Oversight: May include schedule for review of the Plan, or triggers that prompt review of the Plan.

**SURVEYOR NOTE:        The plan must be reviewed at least once annually.**

21. If the review of the Individual plan of protective oversight listed above identifies deficiencies in the fire safety information included in the person's IPOP, list here and enter the information into the Waiver database.
22. Use Tag Number **A683** and Regulatory Reference Number 686.16(b)(3) if the IPOP has not been renewed at least annually and as needed.

Review the IPOP. Speak to the staff/Service Coordinator. Is there evidence that the person's Plan is reviewed at least annually and more often, if requested by the consumer/case manager? Are appropriate changes made to the Plan as the person's needs, preferences or other conditions change? Is the Plan relevant to the person's current status? Based on observation and interview, surveyors may raise issues that are not included in the IPOP, if the observation/interview reveals that appropriate protective oversight in one or more areas has not been addressed.

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23. Use Tag Number **A687** and Regulatory Reference 686.16(b)(4)(iii) when there are problems found in the provision or implementation of protective oversight.

The main focus of this portion of the review is to ascertain whether and to what extent components of the IPOP have actually been implemented as identified in the Plan. Your review of the implementation of that Plan must recognize that the method to verify implementation shall vary and will depend in large part on observation and interview rather than documentation.

### Examples:

- An RN is not immediately (within 30 minutes) directly available to staff on a 24/7 basis.
- Medical follow-up is lacking.
- A needed Behavior Plan is missing, unclear or not followed and the behavior is a danger to the individual or others; i.e., AWOL, alcoholism, etc.
- A consumer's refusal to evacuate the premises is not adequately addressed.
- An oral hygiene program does not address the dentist's recommendations.
- The hot water temperature is 130° Fahrenheit and the consumer is not trained to regulate it.

This deficiency may also be cited under Question #23.

24. Use Tag Numbers A208 through A213 and Regulatory Reference Number 686.8(b)(1)(ii-vii) to cite the specific admission requirement(s) the facility has failed to meet. If any individuals in the SLF no longer meet the admission requirements, the surveyor should cite it here.

All persons admitted to the supportive living facility are required to meet the following requirements:

- The individual is at least 18 years old unless they are the offspring or legal wards of appropriately admitted individuals; the individual has the capacity to self-administer medication or adequate provisions have been made by the provider to ensure adherence to his/her medication regime; the individual has the ability to evacuate the premises without staff assistance in the event of a fire emergency or take other appropriate action in such emergency; the individual has not evidenced instances of a severe behavior problem within the year previous to admission which threatened the life or limb of themselves or others; the individual has not manifested a chronic health care or self-care need which could not be addressed independently by applicant or by limited oversight and guidance; the individual has the ability to use a telephone or other communication device to obtain assistance; and, the individual has no need for more face-to-face oversight and guidance than can be accomplished within a schedule approximating an average of 21 hours/week. The residence must have a systemic formalized assessment to identify a new admission's need for oversight and guidance. The surveyor will examine the records and observe any individual admitted since the last on-site visit to determine if the admission requirements of 686.6 are met. Please note that 686.8(b)(1)(vii) allows for additional supervision, once a person has met admission criteria, to assist individuals in such situations such as placement, adjustment, and illness recovery or crisis resolution. Also, note that the facility must have in place a mechanism to identify whether consumers continue to have the skills necessary for continued stay in the supportive apartment.

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25. Use Tag Number A220 and Regulatory Reference Number 686.8(b)(8) when oversight and guidance has not been provided per the Plan. Use Tag Number A214 and Regulatory Reference Numbers 686.8(b)(2) when there is no assessment of the need for oversight and guidance.

The facility must have documentation of a formalized assessment to identify each new admission's need for oversight and guidance. Verify that a Plan has been developed and implemented based on the assessment. Please note that 686.8(b)(1)(vii) allows for additional supervision, once a person has met admission criteria, to assist individuals in such situations as placement adjustment, illness recovery or crisis resolution.

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### WILLOWBROOK

26. Use Tag Number PI99 and Regulatory Reference Permanent Injunction – Appendix I(I) if the Case Manager does not meet the definition of a QMRP or if there is a conflict of roles, as described below.

Survey staff should note that MSC and Willowbrook case management educational requirements differ; except in one area, where both accept RN as an educational requirement. Case Managers providing services to Class Members must meet the following criteria: the Case Manager is a QMRP, per 484.430(a)(1)(2) & (b)(5); and, the Case Manager is employed by a state or voluntary agency not providing day or residential services to the Class Member; or, the Case Manager is employed by the same agency, providing day or residential services to the consumer, but is functionally independent from these service areas.

27. Use Tag Number PI99 and Regulatory Reference Permanent Injunction #8 and Appendix I if the Case Manager's workload exceeds the 1:20 ratio.

Paragraph 8 and Appendix I of the Permanent Injunction stipulates that Class Members are to receive case management at a ratio equivalent of 1:20. For Willowbrook caseload calculations, the following rules apply:

- Case management FTE (defined as time spent providing case management, not time employed). Staff can be full-time employees, but work only part time as a Case Manager/Service Coordinator. Time spent is prorated and work units adjusted appropriately. For example, a staff person working half-time as a case manager may carry 10 work units; a staff person working quarter-time may carry five work units.
- Individuals served. Individuals living in VOICFs are half-time work unit; all other individuals are one work unit.
- The MSC weighting factor of 1.2 when calculating rations for consumers who live alone, with family or in non-certified settings does NOT apply when calculating ratios for Willowbrook Case Managers/Service Coordinators with mixed caseloads.
- Willowbrook caseload requirement of 1:20 ratio equivalent supersedes MSC caseload ratios of 1:30.

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28. Use Tag Number PI99 and Regulatory Reference Permanent Injunction Appendix H if a non-correspondent is not receiving adequate representation, as needed by the CAB. According to *Appendix H* of the Permanent Injunction, “active representation” is generally defined as participating with the team in planning and evaluating the Class Member’s plan of care and/or visits between the correspondent and the Class Member at least annually. Merely signing mailed consent forms or receiving facility-initiated phone calls with no other involvement does not constitute "active representation." Survey staff should determine if the Case Manager has made reasonable efforts to ensure “active representation” by a correspondent, CAB or correspondent and CAB. "Co-representation" is often requested by an aging parent, or one who lives at a distance, hindering full participation. In gauging the Case Manager’s efforts, reviewers should consider the nature and type of efforts currently required as well as those efforts made in the past and the outcome of such efforts; i.e., were phone calls made, were letters sent, were parties given reasonable notice, was attendance encouraged by scheduling the meeting to accommodate them, etc.? Also, reviewers should consider that if relevant parties were unable to attend, did the Case Manager ensure the necessary information, and issues and concerns were represented at the meetings and what efforts were made to get such parties the information following the meeting.
29. Use Tag Number PI99 and Regulatory Reference Permanent Injunction #10(a) if implementation of the ISP has been adversely affected by lack of transportation services. A good plan for participation in community activities is worth little if there are only very limited means for transporting consumers to those activities and an inadequate number of staff available to assist consumers in participating. This depends on numerous factors such as location of the program site, availability of public transportation, private vans, transport services, staff assigned to conduct the activity, etc. If problems with transportation or staff availability have been identified, determine what, if any, efforts have been made by the provider to improve conditions. There may be circumstances where a “N/A” rating is appropriate for availability of transportation to permit community participation at day program.
30. Use Tag Number PI99 and Regulatory Reference Permanent Injunction #17, if the Willowbrook Notice of Rights is not in the file maintained by all providers of residential and habilitative services.

Paragraph 17 of the Permanent Injunction requires that all providers maintain the “Notice of Rights” statement in each Class Member’s record; i.e., residential, day service coordination, etc. The “Notice of Rights” in the record should be dated 4/00 and printed on heavy gauge paper stock and indicate DO NOT REMOVE on each side. If the “Notice of Rights” is a copy on regular paper, the surveyor should ensure that it is a copy of the current notice.

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31. Use Tag Number PI99 and Regulatory Reference Permanent Injunction – Written Informed Consent – for any plan that restricts rights. Review the record, including the medication records, and any behavior plans. Talk to staff and Service Coordinator (if available). This question addresses the concern of safeguarding the rights of consumers. Written informed consent must be obtained from a consumer (if he/she is capable of giving it), from a parent or guardian (if the consumer is not capable) or from a three-person special committee identified in the Injunction prior to a provider commencing any treatment where such consent is required (e.g., aversive conditioning, experimental treatments, research, etc.). Also refer to 14NYCRR 633.11 -- Consent for Professional Medical Treatment; 633.13 -- Research in Facilities and 681.13 -- Informed Consent for Service Plans Which Involve Untoward Risk to an Individual's Protection or Rights in addition to the Part 483 requirements discussing informed consent (W261, W263) for plans that incorporate restrictive techniques (e.g., restraints, use of psychotropic medication, restriction on community access).

**SURVEYOR NOTE:** For Class Members now living in IRAs that converted from SOICFs, there is a letter of agreement between OMRDD, the CAB and Counsel for the Willowbrook Plaintiffs indicating that for those Class Members who use psychotropic medications and have behavior plans, the Parts 681 and 483 requirements for informed consent in ICFs will continue to apply to those Class Members living in converted IRAs.

32. Use Tag Number PI99 and Permanent Injunction Reference #10(a), if community inclusion services are not present in accordance with the Class Member's ISP. Use Permanent Injunction Reference #21 if aspects of the person's services are not implemented or documented properly. Use Permanent Injunction Reference #12, if there is insufficient staff present and on-duty to ensure the Class Member's community inclusion services are implemented, as appropriate.

**SURVEYOR NOTE:** Permanent Injunction (PI) Reference #21 discusses monitoring and the means in which to ensure that Class Members are receiving services required by the PI. Specifically, paragraph #21 references Appendix N which, in turn, is the Willowbrook Long Form Audit Instrument. The standards and guidelines therein outline the requirements referenced in this question; however, OMRDD and the Willowbrook parties have agreed in subsequent negotiations that frequency, variety and group size of inclusion experiences for individual Class Members must be appropriate based on each person's needs, preferences and capabilities and not measured against any predetermined standard.

Review the Class Member's community inclusion services, as reflected in the ISP. Talk to staff and Class Members. Are activities based upon his/her preferences? Does staff make decisions about activities based upon their own values rather than the choices of the Class Member? Does the facility have a mechanism for ascertaining the Class Member's preferences for activities? Has the Class Member, with the capacity to do so,

## **UNIVERSAL PROTOCOL SURVEYOR GUIDELINES**

been afforded the right to refuse to participate in a community inclusion activity? How do Class Members make use of the community? Is there sufficient staff present and on-duty to ensure the Class Members participate in community inclusion activities? Does staff ensure they make use of recreational opportunities in the community, such as parks, movies, banks, the post office, shopping, YM/YWCA, restaurants, etc.? Do Class Members go out in large groups only, or are opportunities provided for people to go out 1:1 or in small groups of two or three with people of their choosing? If they do arrive together to an activity in a large group, are they encouraged/permitted to split up into smaller groups or individually upon arrival, if appropriate? Are community inclusion activities documented and reviewed for Class Member satisfaction with the services?

# UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

## STAFFING

33. Use Tag Number Y304 and Regulatory Reference Number 633.4(a)(4)(ix), for any staff training issue; use when based on the needs of consumers, staff require certain training, but have not been provided with it (e.g., SCIP-R).  
In order to answer the "staffing" standards, you must spend time observing activities and interactions within the facility. Additionally, you must talk with staff about their job duties, the training they have received and the activities that they engage in with the individuals who reside in the facility. Do staff interact with consumers in a respectful, caring and supportive manner? Are staff respectful of consumers' rights, including privacy rights? Are staff knowledgeable about individuals' needs (including health care and behavioral), preferences and the activities and services included in their ISPs/Plan of Service? Do they provide the needed services/activities in accordance with the ISPs/Plans of Service? Can you verify, through observation and interview, that staff have been trained in the required areas, including principles of human growth and development, characteristics of persons served, abuse prevention and reporting, incident reporting, safety and security procedures, management of individuals at risk for HIV, and any other needed topics that relate to the care and treatment of the particular individuals residing in the facility? For example, if individuals in the facility are assaultive or aggressive, staff need to have been trained in SCIP or other appropriate ways of intervening with them. Are staff that administer medications AMAP-certified?
34. Use Tag Number Y304 and Regulatory Reference Number 633.4(a)(4)(ix), when based on deficiencies found during observations or record review, the facility does not have adequate staff to operate their program safely and effectively; or, when the facility has not based its staffing on the needs of consumers (e.g., the consumers have significant behavior management needs, but there has been inadequate planning because of a lack of clinical input).  
For residential programs only, use Tag Number A230 and Regulatory Reference Number 686.9(a)(2), when the facility does not have a staffing plan based on such considerations as the number of consumers, their functioning level, support staff requirements and physical plant issues. Observe activities in the facility. Review the staffing plan for the facility, including the numbers of staff on duty. Review staff logs/incident reports. Speak to facility administrators. Talk with staff and consumers. Is there scheduled sufficient staff to meet the service needs of the individuals and to provide adequate supervision? Do the numbers of staff present and on-duty correspond to the numbers scheduled? Are the numbers sufficient to supervise individuals and carry out the activities in their ISPs/Plans of Service and sufficient to attend to people's needs for protection from harm? What is the system for replacing staff that may be ill, on vacation or otherwise absent? Do staff and consumers indicate that there are sufficient staff to provide supervision for people both in the facility and during community activities? Do people have to wait for long periods of time to receive attention from staff? Are meal times well organized and do all individuals receive needed supervision while eating? Are community recreational activities and/or medical appointments canceled because of insufficient staffing? Does a 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? Are people's needs for staff intervention for behavioral and health care issues being met? How do individuals look? Is their hygiene adequate? Are they dressed in clean and appropriate clothing? A negative answer to any of these questions may be an indication that staffing is insufficient to meet people's needs for basic care and protection.

## UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

34 (Cont'd.)

Mealtime 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, etc. For a Supervised CR, 24-hour staffing must be scheduled and implemented; for an IRA, the scheduled staffing must conform to that specified in the facility Plan for Protective Oversight; for an SLF, there must be individual plans for oversight and guidance that state how many hours will be provided for each person. Note that in an SLF, if a person requires more than 21 hours of oversight and guidance on a regular basis, then that person is probably inappropriate for placement in a supportive facility.

35. For any staff who have the potential to provide services to children, there is evidence that the person's name was submitted to the Statewide Central Register of Child Abuse and Maltreatment and that the person was cleared prior to working alone and unsupervised with children.

### **QUALIFIED PROVIDER: (Questions # 36 to # 43)**

For newly hired staff who deliver Waiver services, look at the training record. There should be evidence that required trainings were received within 3 months of providing services.

For all other staff who deliver Waiver services, your discussions with them, observations, and review of the individual's record, should indicate whether the staff person is knowledgeable about the person, and the requirements of his/her job. If based on your review, the staff person is doing a competent job for the persons he/she is serving, there is no need to look at a training record.

If the staff who deliver Waiver services are not doing a competent job, the real issue is whether the agency/ supervisor has identified the need for additional training and is providing the training & supervision needed. If the agency is in the process (really) of providing training & supervision to improve the functioning of the staff person(s), do not mark it as deficient, but note the person(s) in the comment section for follow-up at subsequent reviews. If the agency has not identified the need for additional training and development or is not taking action to improve the staff person(s)' performance, he/she should be included under # deficient.

Determine which area of training is deficient for specific knowledge listed in Part 633.8. List the number deficient under the particular training requirement. You may need to do some additional investigation such as reviewing training records or training curricula or agency monitoring systems in order to determine the nature and extent of the deficient practice.

If the staff person's lack of knowledge/training presents an immediate threat to the person being served, contact the regional director & require immediate correction.

# UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

## RIGHTS

44. Use Tag Number M700 and Regulatory Reference Commissioner's Directive, Paul Kietzman Memo of July 19, 2000, if the requirements of the Kietzman memo are not met. Recommendations are summarized below.

Review the record including the medication records and any behavior plans. Talk to staff and Service Coordinator (if available). There are four principal components of this regulation that must be taken into account when assessing this question. Note that written informed consent must be obtained prior to commencement of treatment.

- 1) Each person, for whom medications that modify or control maladaptive or inappropriate behavior are prescribed, must be evaluated for his/her ability to give informed consent. Such evaluation must be in writing and documented in the person's clinical record.
- 2) Before any capable person (or a surrogate decision-maker) gives informed consent to such medication, he/she must be told the purposes, risks and benefits of the medication and any alternatives to the administration of the medication.
- 3) If the person refuses medication that modifies or controls maladaptive or inappropriate behavior, either initially or after informed consent has been given to the administration of such medication, then:
  - a. the administration of that medication must be suspended; and,
  - b. If the provider or the DDSO believes that the administration of such medication is in the person's best interests, the provider or the DDSO must petition the courts for a hearing, which will determine the person's ability to refuse the medication.
- 4) Use of "emergency" medication -- medication that modifies or controls inappropriate or maladaptive behavior -- may be administered over the objection of the person or the objecting authorized party when:
  - a. the person's behavior constitutes a significant danger to the person or others; or,
  - b. the person is engaging in destructive conduct in the facility; or,
  - c. when, in a physician's judgment, an emergency exists creating an immediate need for the administration of such medication, and an attempt to secure informed consent would result in delay of treatment, which would increase the risk to the person's life or health.

The administration of such medication may only continue for as long as the above condition(s) exists. If an "emergency" medication is used more than three times in a 30-day period or four or more times in a six-month period, then there shall be a comprehensive review of the situation by the Program Planning Team within five days of the second administration. Refer to Section 681.13 -- Informed Consent for Service Plans that involve untoward risk to an individual's protection or rights and to Part 483, requirements discussing informed consent for plans that incorporate restrictive techniques. The restrictive technique relevant to this Protocol question is the use of psychotropic medication to control or modify maladaptive or inappropriate behavior (W261, W263).

## UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

45. Tag Number Y289 and Regulatory Reference Number 633.4(a)(1) is applicable to all program types and should be cited if consumers are not being afforded all civil and legal rights, including all rights guaranteed by OMRDD Regulations.

Talk with consumers, family members and staff. Review the ISP/Plan of Service. Observe activities in the facility. Review "house rules." You can review written information regarding the consumer's rights, but do not make a judgment on whether or not people are afforded their rights solely on the basis of the facility providing a written list of rights to the consumers.

Do your conversations with staff/consumers and your observations show that individuals are both allowed and encouraged to exercise their rights. Rights guaranteed by regulation include: a safe and clean environment; freedom from abuse; freedom from corporal punishment; freedom from unnecessary physical and/or chemical restraint; freedom from exploitation; confidentiality with respect to information in the record; a written Plan of Service; the opportunity to participate in the Plan's development; the opportunity to object to and/or appeal any aspect of the Plan; provision of meaningful and productive activities; services from staff who are adequately trained; appropriate and humane health care; freedom to express sexuality; participation in religious activities; the right to vote; freedom from discrimination based on HIV status; use of personal money and property; a balanced and nutritious diet; an adequate and appropriate supply of clothing and hygiene supplies; a reasonable degree of privacy; storage space for belongings; the opportunity to request an alternative residential setting; the opportunity to make complaints/express grievances; the opportunity to have visitors and to communicate freely with others; and, the opportunity to execute a DNR order/health care proxy. Note that the concept of "protective oversight" as found in the regulations for IRAs is really the provision of a number of the rights listed above, including rights to appropriate and humane health care; services including assistance and guidance from staff who are properly trained; a safe environment; freedom from abuse; protection from exploitation; a balanced and nutritious diet; an adequate supply of clothing and hygiene supplies; etc. If you are reviewing an IRA and find a pattern of these rights not being provided, you must also make a judgment as to whether or not protective oversight is being provided and notify the provider, as appropriate.

46. Tag Number Y365 and Regulatory Reference Number 633.4(b)(5) is applicable to all program types and should be cited if the facility has failed to take affirmative steps to make persons at the facility aware of their rights to the extent that the person is capable of understanding them.

Tag Number Y352 and Regulatory Reference Number 633.4(b)(2)(i) is applicable to all program types and should be cited if the facility has failed to provide rights information to individuals/parents/guardians/correspondents.

Talk with individuals/family members and facility staff. How are individuals informed of their rights? Are they able to articulate some of their rights? Are there training programs in place to teach people to exercise their rights? Do your observations show that people know and exercise their rights? Do people confirm that they have visitors; that they have telephones available for their use? Do they attend religious activities, as desired? Are meals adequate and appetizing? Do people participate in the development of their ISP/Plan of Service, etc.? How does the facility handle notification of rights for people whose primary language is not English?

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47. Use Tag Number Y364 and Regulatory Reference Number 633.4(b)(4), if staff are not aware of the civil, legal and regulatory rights guaranteed to individuals.

Talk with facility staff. Are they able to articulate individuals' rights? Can they tell you how they train and assist people in exercising their rights? Does observation of activities show that people are encouraged to exercise their rights?

48. Use Tag Number Y353 and Regulatory Reference Number 633.4(b)(2)(ii), if individuals/parents/guardians/correspondents have not been provided information regarding the process for resolving objections, problems or complaints.

Use Tag Number Y362 and Regulatory Reference Number 633.4(b)(3)(ii) ONLY if instances of this question being not met are limited to persons admitted to the facility since the last survey.

Speak with consumers/family members. Review available documentation. Do individuals know to whom they can make a complaint? Is there information in the record showing that such information has been provided in writing to the correspondent/family of the individual? Information should include the current address/telephone number of the Commissioner of OMRDD/CQC and the local DDSO Director, at a minimum.

49. Use Tag Number Y304 and Regulatory Reference Number 633.4(a)(4)(ix), if staff do not interact with participants humanely and with full respect for the individual's dignity and personal integrity. Note that if this behavior rises to the level of abuse, neglect or intimidation, the surveyor should cite this under Question #30, not here.

Also use Tag Number Y364 and Regulatory Reference Number 633.4(b)(4), if the reason for the inappropriate interaction is that staff are not aware of the civil, legal and regulatory rights guaranteed to individuals.

Assess this standard after observing activities and interactions among staff and program participants.

50. Use Tag Number W294 and Regulatory Reference Number 633.4(a)(4)(ii), if individuals do not appear to be free from abuse, neglect or intimidation or if there is evidence of past instances of this, which were not reported and investigated.

Talk with residents/family members and staff. Observe activities and the manner in which staff and individuals interact. Review incidents/allegations of abuse and staff logs. Observe people's appearances. Do individuals appear to be clean, healthy, well dressed? Is there any indication that individuals are frightened of any of the staff? Are staff caring and supportive in their interactions with individuals? Are individuals free to talk to you and others? Do they have communications with people outside the facility? Are there patterns of injuries that may indicate abuse? Do individuals express their choices/opinions? This may be a difficult standard to judge; surveyors must be sensitive to the

## UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

overall atmosphere of the house; look for any indications that consumers are afraid of the staff or are hesitant to express opinions, preferences, etc.

### **RIGHTS RESTRICTIONS:**

51. This is a federal Waiver requirement and findings will need to be documented on the Waiver database. Use Tag Number Y366 and Regulatory Reference Number 633.4(b)(6), if rights are being limited without written clinical justification.

Tag Number Y291 and Regulatory Reference Number 633.4(a)(3) is the related principle of compliance for the above standard.

Are any consumer's rights limited for any reason? If the answer is "YES," is there a written clinical justification for the rights limitation, is it individualized? Note that blanket limitations of rights, such as restrictive "house rules," which limit rights, are not allowed.

52. This is a federal Waiver requirement and findings will need to be documented on the Waiver database. Use Tag Number Y366 and Regulatory Reference Number 633.4(b)(6), if rights are being limited without a specific time period for such limitation.

Tag Number Y291 and Regulatory Reference Number 633.4(a)(3) is the related principle of compliance for the above standard.

Are any consumer's rights limited for any reason? If the answer is "YES," is there a time limit to the limitation? Note that limitations with no time limit for review of the continued appropriateness of the limitation, are not allowed.

53. This is a federal Waiver requirement and findings will need to be documented on the Waiver database. As a condition of the Waiver approval, OMRDD has agreed to monitor that no rights restrictions occur in the absence of a plan that is directed toward eliminating the need for the restriction. The Waiver provider must be notified on an exit conference form if a deficiency is found. The deficient practice must be monitored for correction by the agency at subsequent Waiver reviews. If no correction is noted, please contact your regional to discuss any necessary remediation activities.

### **RESTRAINT:**

54. This is a federal Waiver requirement and findings will need to be documented on the Waiver database. As a condition of the Waiver approval, OMRDD has agreed to monitor that no restraint occurs in the absence of a plan that contains clear guidelines for its use. Restraint includes restrictive physical interventions (unless used in an emergency), mechanical restraints (except as a physician ordered medical support), and PRN

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chemical restraints. The plan must specify the conditions when the restraint should be used, staff's responsibility when the restraint is in use, the specific time limit for the use of the restraint, and required documentation when the restraint is used. The Waiver provider must be notified on an exit conference form if a deficiency is found. The deficient practice must be monitored for correction by the agency at subsequent Waiver reviews. If no correction is noted, please contact your regional to discuss any necessary remediation activities. For situations that present an immediate risk to the safety of an individual, contact your regional director & require immediate correction.

55. This is a federal Waiver requirement and findings will need to be documented on the Waiver database. As a condition of the Waiver approval, OMRDD has agreed to monitor that no restraint occurs in the absence of required approvals. Approvals are required from the individual's program planning team, and the agency's executive director or designee (often a human rights committee.) Approvals must be based on an assessment of the individual, and review of the plan. Approvals for the use of restraint must be reviewed no less than annually. The use of restraint without appropriate approvals is an allegation of abuse and should be so reported.

# UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

## PERSONAL ALLOWANCE

The Personal Allowance questions apply to residential facilities only. The purpose of these questions is to determine whether or not: consumers have access to and receive Personal Allowance (PA) monies; consumers are allowed to spend their money as they choose; PA funds are safeguarded and accounted for; and, expenditures made with PA funds are appropriate. Positive responses and/or outcomes to the survey questions should provide reasonable assurance that there are no PA problems existing at the site surveyed. It is not DQA policy to do a detailed review to ascertain whether or not individual consumers received every dollar to which they are entitled. However, should there be any indication of serious and/or systemic problems with receipt of PA funds, then it would be expected that BPC, through its Regional and Area Directors, would make a request for a fiscal audit from MPE, which would then determine down to the specific dollar whether or not each consumer has received all PA that they are entitled to. The surveyor should review the PA accounts of three persons whose PA the agency is responsible for managing and from that review and conversation with staff and (whenever possible) consumers, have a sense as to whether the agency's "system" for the management of PA monies is working effectively for the consumers in the home. NOTE: The agency must manage a person's PA account in the following cases: the CEO of the agency is the Representative Payee or the Representative Payee has requested that the agency manage the PA account. (The agency is required to extend to the Representative Payee an offer in writing to manage the PA account. The offer must be documented and it must be made within three business days of admission.)

56. Use Tag Numbers **Y2129**-Y2130 and Regulatory Reference Number 633.15(i)(11-12) (Tag Number **Y2130** if the representative payee is other than the agency; Tag Number **Y2129** if the representative payee is the agency), when PA monies were not deposited to the person's account within three working days of receipt.  
Use Tag Number **Y2164**-**Y2166** and Regulatory Reference Number 633.15(k)(1-3), if the agency did not immediately address requests for withdrawal of PA monies.  
Requests for spending money are addressed immediately if there is cash in the residence or, if the request goes to the agency's Business Office, a check is issued and money credited to the account of the consumer within three working days of the Business Office receiving the request.
57. Use Tag Numbers **Y2053** and Regulatory Reference Number 633.15(c)(5) when PA expenditures do not reflect the person's preferences and needs. To the extent of their capabilities, do individuals have control over the use of their money? Check the ISP for evidence of evaluation of money-handling ability.

## UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

58. Use Tag Number **Y2110** and Regulatory Reference Number 633.15(h)(4)(i) when the ledger cards do not document receipt and disbursement of all monies.  
Check the house ledger for evidence of a routine for logging in of consumer income funds brought in to the house. The ledgers should also list the disbursement of any PA funds at the time the disbursement occurs.  
  
*Use Tag Number Y2111 and Regulatory Reference Number 633.15(h)(4)(ii) for all non-residential programs, i.e. day treatment, day habilitation.*
59. Use Tag Number **Y2099** and Regulatory Reference Number 633.15(h)(1)(iii) if there are inconsistencies among the cash-on-hand, the ledger balance and/or the bank balance.  
Check the actual cash on hand for the sample with the ledger balance for the sample.
60. Use Tag Number **Y2005** and Regulatory Reference Number **633.15(a)(4)** if the cash-on-hand exceeds monthly Congregate Care level plus \$20.00.  
Check the actual cash on hand for the sample with the ledger balance for the sample.  
*Use Tag Number Y2112 and Regulatory Reference Number 633.15(h)(4)(iii) if the Personal Expenditure Plan sets an upper limit that can be maintained under the control of the staff at the residence in excess of the monthly Congregate Care Level III plus \$20.00.*
61. *Use Tag Number Y2186 and regulatory Reference Number 633.15(h)(4)(iii) if there was no documentation specifying the specific amount, time, and purpose for the cash balance on hand exceeding the routine upper limit.*
62. *Use Tag Number Y2186 and Regulatory Reference Number 633.15(a) if the agency did not maintain complete records for four(4) years.*
63. Use Tag Number **Y2121** and Regulatory Reference Number 633.15(i)(6) if the consumer has not signed/initialed the ledger card once per month and there has been no determination of their capacity in this regard. Look in the ISP and talk to the consumer to determine if an assessment has been done to document the extent to which the consumer is able to handle his/her own money or understand and approve the use of his/her money.
64. Use Tag Number **Y2110** and Regulatory Reference Number 633.15(h)(4)(i) if the ledger entries do not state the general purpose/description and amount of each disbursement.
65. Use Tag Number **Y2191** and Regulatory Reference Number 633.15(p)(4) if PA monies were used for any expense, supplies or services the agency is required to provide. Use Tag Number **Y2191** and Regulatory Reference Lisa M. Kagan Memorandum of March 11, 2002 for deficiencies involving use of PA funds for staff expenses.

## UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

In general, these would be items normally provided as part of a residential/day program planned activity or Medicaid-covered expenses. If something looks questionable, refer to the attached 14NYCRR 635-9 for specific guidance regarding the type of program being reviewed, the Medicaid-eligibility of the consumer in question and the areas for the exercise of personal selection on the part of a consumer.

If PA funds were used to pay for staff expenses incurred while the consumer was on a vacation or a recreational outing, the agency must have obtained prior written approval from the Social Security Administration (SSA) for this use of PA funds. This approval is required in all such cases and must be on file at the agency, if prior approval was obtained. Staff expenses for which PA funds may be used are as follows:

- The resident's PA funds may only be used to cover staff expenses that are not normally reimbursed by the voluntary agency. A resident's PA funds may not be substituted for 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.
- The use of a resident's PA funds for staff expenses (with prior SSA approval) applies to voluntary provider agencies only. Under no circumstances may residents' PA funds be used to pay for expenses incurred by state employees, even if prior SSA approval was obtained, since this practice is prohibited by the New York State Ethics Law.

66. Use Tag Number **Y2168** and Regulatory Reference Number 633.15(**l**)(**l**) if receipts for expenditures made by staff other than routine recreational activities and related expenditures are not available.

Check for appropriate receipts and match them to the ledger for the sample. Remember that where appropriate documentation exists for money-handling capability, consumers are not required to produce receipts for normal purchases.

67. Use Tag Number **Y2058** and Regulatory Reference Number 633.15(**d**)(**3**) if the cash-on-hand is not secure. This includes past instances of inadequate security (e.g., missing monies). Is money secured? Is access limited?

68. *Use Tag Number 2113 and Regulatory Reference 633.15(h)(4)(iv) if the agency did not reimburse any loss of cash at either the residence or at the non-residential program.*

*As of January 1<sup>st</sup>, 2008, all residential programs must formally assess the individual's ability to independently manage money. This assessment should be part of the Annual Meeting and result in a Personal Expenditure Plan (PEP). Starting April 1<sup>st</sup>, 2008, the following Tag Numbers and Regulatory References will be used to insure compliance.*

69. Use Tag Number **Y2142** and Regulatory Reference 633.15(**j**)(**3**)(**i**) if there is no formal assessment of the individual's money management ability.

70. Use Tag Number **2139** and Regulatory Reference 633.15(**j**)(**1**) if the Agency has not developed a PEP for each individual who had an

## **UNIVERSAL PROTOCOL SURVEYOR GUIDELINES**

**Annual Meeting since January 1st, 2008.**

- 71. Use Tag Number Y2152 and Regulatory Reference 633.15(j)(5) if the PEP has not been reviewed annually or as needed to insure flexibility in spending or to reflect updated priorities in spending.**

# UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

## CLOTHING/PERSONAL NEEDS ALLOWANCE

**Questions 72 & 73 apply only to voluntary-operated Community Residences (CRs) and Individualized Residential Alternatives (IRAs).**

The purpose of the following two questions is to ensure that clothing/personal needs allowance, i.e., Mental Hygiene Law Section 41.36(n) Funds, are safeguarded. The glossary of NYCRR Subpart 635-9.1(*as*) defines Section 41.36(n) Funds as a payment of up to \$250 per year, disbursed semi-annually as \$125, per person residing in a VOCCR/IRA. These funds are available to the provider to meet one or more of the following needs of the individual:

- replacement of necessary (basic) clothing, as defined in Subpart 635-99.1(*as*);
- personal requirements and incidental needs; and
- recreational and cultural activities.

72. Surveyors should determine through interview and documentation review that the provider is using these funds as intended for all eligible individuals

Determine the amount to which individuals in the sample are entitled based upon discussion with staff responsible for managing/accounting for these funds; review appropriate documentation. Individuals who receive SSI and/or are enrolled in Medicaid are eligible for the full \$250 paid in \$125 semi-annual installments. Please note that voluntary providers of CR/IRAs assume the cost of basic clothing except where Section 41.36(n) Funds are available and personal allowance (PA) monies, not required for an individual's current and foreseeable needs, are available. In all cases, a \$100 PA balance must be reserved for purposes other than basic clothing purchases.

Basic Clothing is defined in the glossary of NYCRR Subpart 635-99.1(*as*) as: "A clothing supply for a person which is in good repair and which ensures that he/she is outfitted daily in clean clothing, appropriate to the season, to the occasion and to his/her age, sex and size. Appropriate sleep wear is also required."

73. Are the clothing/personal needs funds accounted for separately from the individual's personal allowance? Surveyors should speak with staff who are responsible for managing clothing/personal needs funds. The accounting for these funds must be separate and distinct from personal allowance (PA) monies. Review documents that account for the disbursement of these funds. Check expenditures to ensure they are appropriate and meet individual's needs. Verify further, through conversation with staff and individuals, if possible, to determine that items documented as having been obtained are in the individual's possession, etc. Observe items, if available.

**SURVEYOR NOTE:** Funds remaining in an individual's account at the time of transfer to another CR or IRA site must be forwarded to the individual's new residence.

# UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

## HEALTH SERVICES AND MEDICATIONS

74. Use Tag Number Y864 and Regulatory Reference Number 633.17(b)(6) if consumers did not receive all medications/treatments including OTCs that were ordered/prescribed (e.g., blank boxes on MAR, script not filled, etc.). *Use Tag Number Y123 and Regulatory Reference Number 635-11.2(d) if the medication is not available because of difficulty with the consumer becoming enrolled in the Medicare prescription plan (PDP)(e.g. consumer is enrolled in a plan that does not cover the medication, is unable to change plans by himself and the facility did not proactively have the plan changed)*. Tag Number Y765 and Regulatory Reference Number 633.17(a)(7) is the related principle of compliance for the above standards.

For each individual in the sample, review the ISP/Plan of Service to determine what, if any, medications have been ordered for him/her. Review the medication administration records for these people to determine if there is documentation that all medications are administered as ordered. If you are reviewing an SLF where people are self-medicating, talk to them about taking their medications. It is not mandatory that you observe a medication pass, but you may wish to do so if you have questions about whether or not staff are properly administering individuals' medications.

75. Use Tag Number Y875 and Regulatory Reference Number 633.17(b)(10) if any medications including treatments, OTCs and syringes are not properly stored. Tag Number Y876 and Regulatory Reference Number 633.17(a)(19)(ii) is the related principle of compliance for the above standard. Tag Number Y765 and Regulatory Reference Number 633.17(a)(7) is a related principle that requires medications to be safeguarded in accordance with federal and state statutes.

Review the medication storage areas of the facility. Are syringes and controlled substances in double-locked storage? Are *used syringes that are maintained in a tamper-resistant sharps container as well as* all other medications at least single-locked? Who has access to keys for the medication storage areas? Access should be limited to AMAP staff and health care professionals on staff. If medications are stored in a refrigerator in which food is stored as well, are the medications in a locked box? Are external and internal medications stored together or separately, as required?

76. Use Tag Number Y878 and Regulatory Reference Number 633.17(b)(13) if there are any outdated medications or treatments, including OTCs being stored at the facility. Tag Number Y842 and Regulatory Reference Number 633.17(a)(19)(iii) is the related principle of compliance for the above standard. Tag Number Y845 and Regulatory Reference Number 633.17(a)(20) is the related principle that addresses proper disposal of outdated medications.

In reviewing the medication storage areas, observe whether or not there are outdated or discontinued medications in the area. It is not acceptable to continue to store outdated or discontinued medications in the facility. Talk to AMAP staff or others having responsibility for medication storage. How are outdated and discontinued medications disposed of? For consumers who control their own medications, is storage appropriate? Is the

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section of the medication cabinet used to store controlled medications/syringes secured to the larger medication cabinet?

77. Use Tag Number Y852 and Regulatory Reference Number 633.17(b)(3) for all facilities EXCEPT supportive CRs and family care homes. Use Tag Number Y857 and Regulatory Reference Number 633.17(b)(4) for supportive CRs and family care homes. Tag Number Y809 and Regulatory Reference Number 633.17(a)(17) is the related principle for both of the above standards.

Review the medication administration records for individuals in the sample. Are they properly completed? Do they accurately reflect the medications prescribed? Are they free from the use of whiteouts? Are medication errors properly noted?

78. Use Tag Number Y862 when the staff administering medication certification as an AMAP has lapsed during the time that the medication was administered.
79. Use Tag Number Y867 and Regulatory Reference Number 633.17(b)(9) when consumer-specific written information for each medication and treatment, including OTCs is not present. Tag Number Y809 and Regulatory Reference Number 633.17(a)(17)(iii) is the related principle of compliance for the above standard.

Review medications for individuals in the sample. Is there available for each medication prescribed information for the medication including dosage, intended effects, possible side effects, etc.? The information must be specific for the individual for whom the medication is prescribed. Is this information readily available to facility staff?

80. Use Tag Number Y851 and Regulatory Reference Number 633.17(b)(2) if annual evaluations are not present for all individuals regardless of whether they are currently receiving medications. Tag Number Y791 and Regulatory Reference Number 633.17(a)(16) is the related principle of compliance for the above standard.

Review the individual's record. Is there a current (within one year) evaluation of the person's ability to self-medicate? Please note that evaluation of the ability to self-medicate is generally done residentially at OMRDD-operated or -certified programs and other providers of service shall be informed of the person's designation. A Day Service provider that assumes the responsibility for the consumer's medication administration while the person is in attendance shall accept the determination made by the person's residence or evaluate the person and evaluate all persons who do not reside in an OMRDD-operated or -certified facility [633.17(a)(16)(ii)(a-c); 633.17(b) (1)&(2)].

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81. Use Tag Number Y866 and Regulatory Reference Number 633.17(b)(8) if the semi-annual medication regimen reviews were not completed by a health care professional. Use Tag Number Y826 and Regulatory Reference Number 633.17(a)(18) if the reviews are present but incomplete/inadequate OR if actions identified as a result of the reviews were not taken. Residential facilities shall ensure that a review of the person's medication regimen occurs at least semi-annually by a health care professional and that any needed action is taken [633.17(a)(18)(I); 633.17 (b)(8)].

**NOTE:** This requirement is applicable to **RESIDENTIAL** facilities **ONLY**; N/A for Day Services and Clinics. Review the records for the individuals in the sample. For individuals receiving medications, is there at least a semi-annual review of their medication regimens by a physician, pharmacist, physician's assistant or registered nurse? If changes are recommended based on the reviews, are such changes implemented as needed?

82. Use Tag Number Y305 and Regulatory Reference Number 633.4(a)(4)(x) when survey findings indicate that health care plans/protocols are not implemented appropriately (e.g., bowel movement plans are not followed, decubiti is present, but there are no guidelines for prevention). Tag Number Y504 and Regulatory Reference Number 633.10(a)(1) may be utilized when survey staff finds significant/egregious examples of poor medical follow-up and/or unmet medical/dental needs.

Review the ISP. Discuss with staff and the individual, if reasonable, to ascertain if the basic health care needs of the individual are assessed annually, monitored and/or delivered in a safe and humane fashion. Are physician's orders being carried out, appointments with health care professionals being met and are necessary consents acquired for delivery of professional medical treatments warranting informed consent? Reviewers should also sample house logs and/or daybooks to see if accidents/health care emergencies are addressed and followed up in appropriate fashion.

**SURVEYOR NOTE:** Survey staff should consult their Regional Director prior to use of this Regulatory Reference.

83. Use Tag Number Y789 and Regulatory Reference 633.17(a)(15)(i) if medical or nursing supervision of AMAP staff was not provided.

Use Tag Number Y790 and Regulatory Reference Number 633.17(a)(15)(ii) if the facility has failed to follow their own policies/procedures regarding nursing supervision.

Tag Number Y862 and Regulatory Reference Number 633.17(b)(5)(ii) may also be used if AMAP staff administering medications did so without 24/7 RN availability at the time of administration.

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Talk with any nursing staff on-site, talk with facility staff and review the physician's orders, the medication administration records (MARs) and any other relevant documentation (e.g., policy/procedures). The facility must have implemented a procedure to meet the requirements of this question. This procedure should include a back-up strategy for staff to use should the nurse not respond. If you have any indication that the system the agency has developed may not function effectively, test the system by using it. A registered nurse should respond within a reasonable time (30 minutes maximum). If not, the requirements of this question are not met. Guidelines referenced to each phrase of the question are as follows:

- 1) RN: Registered Nurses or Nurse Practitioners (NPs) meet this requirement; however, Licensed Practical Nurses (LPNs) do not meet this requirement.
- 2) Present at the site or immediately available by telephone: This means present or immediately available by telephone at all times that staff are rendering nursing services. This includes all times medications, treatments or nursing services are or can be reasonably anticipated to be provided. In instances where consumers are receiving nursing services, this means 24/7 coverage/availability. One reason for this is the ongoing responsibility of staff to monitor consumers for both the expected effects of medications and treatments as well as adverse reactions.
- 3) To staff rendering: Only nurses and currently certified AMAP staff can render nursing services.
- 4) Professional nursing services: This includes:
  - a. administration of all treatments and medications, both prescription and over-the-counter medications;
  - b. all treatments ordered by a licensed practitioner (e.g., physicians, nurse practitioners, physician's assistants and/or registered nurses);
  - c. all nursing services (e.g., taking vital signs, postural drainage, catheter care, observation of physical status).

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## INFECTION CONTROL

84. Use Tag Number Z141 and Regulatory Reference Number 633.19(b)(4) when staff, including volunteers, are not knowledgeable about the confidentiality requirements of HIV-related information.

Use Tag Number Y420 and Regulatory Reference Number 633.7(a)(2)(vi) if staff failed to maintain confidentiality of HIV-related information.

Use Tag Number Z138 and Regulatory Reference Number 633.19(b)(1) if the facility does not have policies/procedures addressing confidentiality of HIV-related information.

Talk with staff. Have they been trained in and can they articulate the requirements for maintaining information regarding a person's HIV status confidential? Do they know the agency's policy in this regard? Can they explain who in a facility is authorized to have information regarding a person's HIV status? (i.e., information may be kept in the individual's main file but may NOT be red-flagged).

85. Use Tag Number Z139 and Regulatory Reference Number 633.19(b)(2) if the facility does not have adequate mechanisms in place to address HIV-related illness/exposures.

Use Tag Number Z142 and Regulatory Reference Number 633.19(b)(4)(i) if staff are not knowledgeable of the above procedures.

Talk with staff. Review policy/procedures, if needed. Does the agency have a program for the prevention of transmission of HIV, which includes appropriate staff training, training for consumers, supervision of individuals who pose a risk for transmission of HIV, use of protective equipment, use of protective practices in the handling of bodily fluids or in the handling of instruments that may cause puncture injuries, etc.? Is there a program for the management of anyone thought to have been exposed to HIV including reporting, testing, counseling, and appropriate follow-up, etc.?

86. Talk to staff. Can they identify risk circumstances for the transmission of HIV including unprotected sex, handling of contaminated needles, etc.?

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87. Tag Number Z142 and Regulatory Reference Number 633.19(b)(4)(i) is applicable to all program types and should be cited if staff are not aware of universal precautions and when they are to be applied.

Tag Number Z123 and Regulatory Reference Number 633.19(a)(5)(i) is applicable to all program types and should be cited if staff have not received training in infection control including use of protective equipment.

Talk to staff. Have they been trained in the use of universal precautions in preventing skin and mucous membrane exposure to blood, other bodily fluids or other significant risk bodily substances? Have they been trained in preventive practices while handling equipment and instruments that may cause puncture injuries?

88. Tag Number Z139 and Regulatory Reference Number 633.19(b)(2) is applicable to all program types and should be cited if the agency has failed to develop procedures, including training for sexually active individuals, to prevent the transmission of HIV.

Tag Number Z125 and Regulatory Reference Number 633.19(a)(5)(iii) is applicable to all program types and should be cited and is the related principle of compliance for the above standard.

Talk with individuals and staff, as appropriate. Have individuals with a need been trained in HIV awareness and safe sex practices?

89. Tag Number V690 and Regulatory Reference Number 635-8.2(b)(1) is applicable to all program types and should be cited if the facility has no Tuberculosis Control Plan.

Tag Number V691 and Regulatory Reference Number 635-8.2(b)(1)(i) is applicable to all program types and should be cited if the plan does not address staff training.

Tag Number V692 and Regulatory Reference Number 635-8.2(b)(1)(ii) is applicable to all program types and should be cited if the plan does not address Tuberculosis testing/evaluation OR if Tuberculosis testing did not take place. Staff should be tested twice at the time of hire, prior to working with individuals.

Tag Number V693 and Regulatory Reference Number 635-8.2(b)(1)(iii) is applicable to all program types and should be cited if the plan does not address maintenance of testing records.

**SURVEYOR NOTE:** The facility does not need to maintain individual records for contract employees if the contractor has provided an

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attestation that all his employees have been tested at the time of hire and no systems of tuberculosis have been evidenced since testing.

Review records to determine if individuals are tested on an annual basis (Mantoux Test) with documentation of test dates and results being maintained.

90. Survey staff may cite the following unsanitary conditions under this Regulatory Requirement:

- Food found thawing on the kitchen counter.
- Staff observed passing through the kitchen on the way to the laundry with soiled laundry not fully contained in a laundry bag or a sealed, non-absorbent container. Laundry cannot be transported through the kitchen during food preparation or service.
- Trip hazards are found within the facility.
- Evidence of mice/roach droppings is found.
- Frayed wires on electrical appliances or octopus electrical outlets are found.
- Bathrooms do not have proper ventilation (window or a mechanical ventilation system).
- Bathroom facilities have hardware appropriate to the needs of the consumers (grab bars near toilet or tub).
- Survey staff observe soiled carpets/floors and/or odors.
- Dryer filters are covered with lint.
- Walls are soiled and general condition of furniture is below standard (furniture is dirty and/or upholstery is ripped).

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## **INCIDENT MANAGEMENT - GENERAL REVIEW PROCEDURES**

### ***Questions 91 to 109***

Incident/allegation reviews will be reviewed using the on-site protocols. For site-based programs, the incident review may take place totally at the site or partially at the site and partially at the agency office. For non-site-based programs, such as Waiver Services, the Incident Management review may take place when the services are reviewed or when all non-site-based programs and services are reviewed at once at a central agency location. Incident Management for each non-site-based program will be reviewed annually. For every program reviewed, the surveyor will answer the *Quality Review Questions* for all allegations of abuse and for the completed reportable incidents and the completed serious reportable incidents since the last review. For every program reviewed, the surveyor will answer the *Process Review Questions* for the completed reportable incidents, the completed serious reportable incidents and the completed allegations of abuse. The reviewer must complete the protocols to record findings and information. The incident review worksheet and the summary of review findings sheets are included for the surveyor's convenience to help organize information for the exit briefing and for data entry. Their use is not mandatory. Not every Part 624 requirement is included in this review. In addition, every incident will not be reviewed as part of this review. If the surveyor finds deficiencies that lead him/her to consider conducting a full regulatory review of all incidents/allegations, he/she should refer to the previously issued policy for when/how to conduct a full regulatory review.

### **NOTE:**

***On October 1<sup>st</sup>, 2007, Emergency Regulations implementing Jonathan's law took effect. As part of these regulations, OMR 147 (I) and OMR 147 (A) have been combined into a new form, OMR 147, which is the only form to be used effective October 1<sup>st</sup>, 2007. The terms "initial Incident Report" and "initial Allegation of Abuse Report" have been substituted for OMR 147 (I) and OMR 147 (A) respectfully in the questions to reflect the use of this form.***

***The Regulations have also included the "spouse" and "adult child" as "qualified persons" to be notified of an incident. These categories have been added to the questions as appropriate.***

***The Regulations mandated that the Report on Actions Taken be provided for each incident and allegation of abuse that meets the criteria established by law. Question Number 82 and Tag Numbers I261, I260, and I262 have been added to address the provisions of this requirement.***

***On January 1<sup>st</sup>, 2008, additional Emergency Regulations implementing Jonathan's law took effect. The Regulations eliminated the need for Preliminary Investigation Report to be written within 24 hours. The Question addressing this has been removed from the Protocol.***

***The Regulations included serious reportable incidents classified as "missing persons" as subject to the notification process.***

***The regulations amended the definition of reportable incidents to exclude diagnostic procedures (e.g. x-ray) when the results are negative.***

# UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

## INCIDENT MANAGEMENT - QUALITY REVIEW SUMMARY

110. In order to evaluate this standard, it will be necessary for you to speak with staff about their understanding of what events are to be reported as incidents/allegations of abuse. Additionally, as part of your normal review of consumers' records (ISPs, etc.), be alert to documented occurrences that may in fact be incidents/allegations of abuse that may not have been reported as such. For example, if you see in a record that a consumer sustained an injury that required medical treatment following a positive diagnostic procedure (x-ray indicated a fracture of the bone), cross check the occurrence to the incident report to make sure that the event was handled as an incident. Look for injuries noted in physician and nursing notes. The staff log is another source to review for events that may not have been reported as incidents/allegations of abuse when they should have been. Do *NOT* evaluate this question simply by asking "have you had any serious reportable incidents/allegations of abuse in the past year"?
111. Review the guidelines for the standard on reporting above. As you speak with staff and review documentation, be alert to events/occurrences that, though they may have been reported or a form filled out, are not properly classified and, consequently, are not investigated and handled properly. It is common, for example, to see that sexual activity among individuals served, who are not capable of consent, is classified as a "sensitive situation" rather than abuse as required.
112. Review the investigations that have been completed for all incidents. Consider the seriousness of the event and review the components of the investigation. Did the investigator establish the circumstances (timeframe, place, people present, etc.) of the event? Were written statements taken from all relevant staff/consumers or others present? Did the consumer receive an evaluation from a health care professional, if indicated by the event;  
i.e., physical abuse? Was physical evidence examined? Was appropriate documentation (staff log, Behavioral Management Plans and data, medication records, etc.) reviewed based on the nature of the event? Were health care professionals providing treatment to the consumer interviewed? Were records from outside sources, such as hospitals, obtained? Use your investigations training to evaluate this question, but use judgment in determining whether or not a particular investigation was adequate. There may be situations/events for which not every component need be completed. Is the investigation *FULLY* documented, as required?
113. & 114 (Two standards.) Review documentation; talk to all relevant staff and/or consumers. Was immediate and appropriate action taken in all cases of an incident/allegation of abuse to protect the consumer and others in the facility? (Refer also to Part 633.9 for examples of actions that can be taken.) Did consumers receive prompt and necessary medical attention? If it is alleged that a staff person abused a consumer, was the person removed from the care of consumers or properly supervised? Were hazardous conditions repaired in a timely fashion? Was needed staff training/supervision provided promptly?

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115. Review the minutes of the SRC. Review the investigations that have been completed for all incidents. Were there injuries requiring medical attention, which upon review or investigation, were determined to be of unknown origin? Did each investigation document an effort to determine the origin of the injury? Are all such injuries reviewed on at least an annual basis? Are injuries of unknown origin monitored, with particular attention given to repetitive injuries, either to a person or within a program? Is there documentation that findings and recommendations were acted upon?
116. Use Tag Number I131 and Regulatory Reference Number 624.7(b)(1), when the SRC has not ascertained whether appropriate action was taken.
- Use Tag Number I132 and Regulatory Reference Number 624.7(b)(2), when the SRC has not ascertained whether appropriate action was taken specific to protecting consumers from further harm and/or to safeguard against a reoccurrence.
- Review the minutes of the Special Review Committee. Did the Committee review the incident/allegation of abuse to make certain consumers were safeguarded; that all process requirements were met; and that any other needed action was taken at the *TIME* of the incident? If consumers were inadequately safeguarded and the Committee failed to identify that, this standard as well as 624.5(c)(3) would be deficient. If staff failed to complete process requirements (notifications, e.g.) and the Committee failed to identify that as a problem, this standard would likewise be deficient.
117. Review the minutes of the SRC; talk to staff members as needed. Did the Committee, as part of its review, review the quality and completeness of investigations done? Did they seek more information if the investigation was inadequate? If the answer to 624.5(b)(6) is “NO,” did the Committee also identify that the investigation was inadequate? If the answer to 624.5(b)(6) is “NO,” and the Committee failed to identify the inadequacies of the investigation, this standard is deficient as well. Did the SRC have the appropriate composition to review the investigation? For example, in a case of physical abuse, the health care professional available to the Committee should be present. Did any members of the Committee reviewing the incident/allegation have a conflict of interest? For example, a staff person should not both conduct an investigation and review it as a member of the Committee.
118. Review the SRC minutes. Talk to agency staff and Committee members as needed. Did the Committee make recommendations to lessen the likelihood that an event would recur? Are the recommendations clear, specific, relevant and able to be monitored? If the recommendations are implemented, are they likely to prevent recurrence? Be suspicious of such recommendations as "retrain staff," "counsel staff." Such recommendations may be too vague to be useful in addressing the event.

## UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

119. Review SRC minutes, interview staff and Committee members, as needed. How does the Committee ensure that its recommendations are implemented and are effective? Is there evidence of follow-up in the Committee minutes?
120. Tag Number I134 and Regulatory Reference Number 624.7(b)(4) is applicable to all program types and should be cited if the SRC failed to identify trends in reportable incidents.

Tag Number I146 and Regulatory Reference Number 624.7(c)(10) is applicable to all program types and should be cited if the SRC failed to identify trends in other potentially harmful situations.

Tag Number I147 and Regulatory Reference Number 624.7(c)(11) is applicable to all program types and should be cited if the SRC failed to report on the identified trends annually to the appropriate people.

Review the minutes of the SRC. The Committee must not only identify trends in reportable incidents, they must also monitor trends in other events or situations which may be potentially harmful, but do not meet the definition of a reportable incident (e.g., non-reportable bruises, scratches, falls or other minor injuries). The Committee must also recommend appropriate corrective, preventative and/or disciplinary action to safeguard against such recurring situations/incidents from occurring. The Committee must, at least annually, report to the Executive Director, chief agency executives, the Governing Body (Board of Directors) and the local DDSO concerning the Committee's monitoring functions, identified trends, and recommendations regarding corrective/preventative actions.

121. This is a federal Waiver requirement and findings will need to be documented on the Waiver database. As a condition of the Waiver approval, OMRDD has agreed to report the percentage of allegations of abuse involving Waiver recipients that had completed investigations. For the sample of allegations of abuse reviewed that involved individuals who receive Waiver services or MSC from the agency, there was a thorough and timely investigation of the allegation.
122. This is a federal Waiver requirement and findings will need to be documented on the Waiver database. As a condition of the Waiver approval, OMRDD has agreed to report the percentage of allegations of abuse involving Waiver recipients for which corrective actions were identified and implemented. This questions pertains only to the sample of allegations of abuse reviewed that involved individuals who receive Waiver services or MSC from the agency.

# UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

## PHYSICAL PLANT

123. If a Supervised CR was established prior to the requirement that such facilities meet the requirements of NFPA Chapter **33**, can all residents evacuate the premises in 2.5 minutes or less? Review fire drill records to determine this. For consumers who have not evacuated properly, has intensive training been provided to bring the person's performance up to standard and/or has the facility now met the requirements of Chapter **33**? During the retraining, what actions has the agency taken to ensure the safety of the individuals who reside there?
124. For all certified sites that provide Waiver services, there should be an assessment of the individual's ability to evacuate the facility in the event of a fire or other emergency. The assessment should be specific and take into account the person's cognitive ability, any physical limitations, impact of medication, physical plant of the facility, etc. The assessment must be based on actual performance of the person evacuating the facility and not just on the opinion of staff. This information may be found in the ISP or a separate document maintained by the facility. For an IRA, the assessment information may be found in the IPOP, which should be attached to the ISP.

This is a federal Waiver requirement and findings will need to be documented on the Waiver database. As a condition of the Waiver approval, OMRDD has agreed to report the percentage of Waiver recipients that have been assessed for fire safety needs.

125. IRAs of nine beds and over must comply with the NFPA LSC requirements; a Chapter **33** (or Chapter **19**, if applicable) review must be completed. For small IRAs (eight beds and less), individuals fire safety needs must be met. Talk to staff; review fire drills. Are individuals being trained to safely evacuate the residence? Are evacuation times for the facility reasonable (three minutes or less), and if not, what is the agency doing to address the problem? In facilities in which people have difficulty evacuating because of physical limitations or other issues, are there sufficient staff on all shifts so that people can be evacuated safely? (Please reference Commissioner's memo of July 18, 1997.)

In order to ensure consistency among all IRA types, as well as compliance with the regulations, the following will apply: All large IRAs, all small IRAs with evacuation times in excess of three minutes and all former ICFs converted to IRAs shall meet the **2000** version of the Life Safety Code. Use the **2000** LSC booklets when performing these surveys and we must use Chapter **19** (Existing Health Care) for all IRAs (large and small) which were previously certified using either the 1967 or 1981 LSC.

For all other sites that provide Waiver services, there should be evidence that assessed fire safety needs are being addressed. Verify that individuals' fire safety needs are met through supervision and training. The level and type of supervision and training will vary from site to site according to environmental characteristics and the individuals' skills and needs. Review the evacuation plan.

Talk to staff & individuals, asking them to describe what they would do in the event of a fire. Verify that staff and individuals understand the plan as written and to determine whether revisions to the plan need to be made or whether staff & individuals require additional training.

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Ask who needs support, what kind, who is independent, who needs supervision once outside the site, etc. Review fire/evacuation drill documentation. Does it show that staff & individuals are able to follow the evacuation plan and that evacuation is safe & timely?

Please reference Commissioner's memo of July 18, 1997.

**This is a federal Waiver requirement and findings will need to be documented on the Waiver database**

126. This is a federal Waiver requirement and findings will need to be documented on the Waiver database for each site that provides Waiver services. For each site that provides Waiver services, there should be a plan for the safe evacuation of individuals in the event of a fire emergency. Review the site's evacuation plan and verify that the plan includes the following:
- It is clearly written and understandable
  - It is site-specific
  - Describes how to notify the site of the need to evacuate due to fire/smoke.: Sound the alarm, etc
  - Identifies evacuation routes and exit doors
  - Identifies areas of refuge and defend in place
  - Describes actions to be taken upon: actual discovery of the fire; smelling smoke; and/or hearing the alarm
  - Describes how to safely check and enter rooms during the evacuation process
  - Describes how to evaluate evacuation priority
  - Clear assignment and description of individual staff responsibilities for protection, rescue, and evacuation, designated by staff role on the shift, not by name or title
  - Instruction to staff to call 911/Fire Department
  - An identified meeting place for head count
  - Updates and revisions when new individuals are admitted to the site
  - Updates and revisions when individuals' abilities and needs for support change

### Review agency practices for holding drills

- Drills should be held at unexpected times and under varying times and conditions
- Drills are a realistic rehearsal, e.g. Normal staffing levels, level of darkness/light, unexpected, blocked exits, etc.

The Waiver provider must be notified on an exit conference form if a deficiency is found. The deficient practice must be monitored for correction by the agency at subsequent Waiver reviews. If no correction is noted, please contact your regional to discuss any necessary remediation activities. For situations that present an immediate risk to the safety of an individual, contact your regional director & require immediate correction.

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127. This is a federal Waiver requirement and findings will need to be documented on the Waiver database for each site that provides Waiver services. There should be evidence of on-going review of the fire evacuation plan for effectiveness and /or need for revisions. If the plan is current and appropriate, no documentation of review would be necessary. Talk to staff, supervisors and program administrators. Ask how they monitor that the evacuation plan will work and how often they do so. Verify that the facility/agency has procedures for unannounced, management observed drills, and that the results and any corrective actions are documented. Verify that the facility/agency has procedures for administrative review of fire drill documentation and actions taken for follow-up/correction. Ensure that if problems occurred during drills, the facility consistently and aggressively addressed them to ensure the safety of all.

This is not a regulatory requirement but it is a requirement of the HCBS Waiver renewal approval. The Waiver provider must be notified on an exit conference form if a deficiency is found. The deficient practice must be monitored for correction by the agency at subsequent Waiver reviews. If no correction is noted, please contact your regional to discuss any necessary remediation activities. For situations that present an immediate risk to the safety of an individual, contact your regional director & require immediate correction.

128. Safe exiting includes the exterior of the building (street and/or -- in New York City -- courtyard, which shall be a minimum of 30 feet unless there is an unlocked gate with access to adjacent yard or open public space). Are doors (except in Supportive CRs, Self-Preserving CRs and small IRAs) provided with single-function locks? Are the aisles/corridors unobstructed? Is there a hard surface path to a public way? Are occupants able to use a dual-function locking arrangement if one exists at small IRAs or Supportive and Self-Preserving CRs?

This is a federal Waiver requirement and findings will need to be documented on the Waiver database for each site that provides Waiver services.

129. Is there at least one Class 1A5BC, two and one-half pound fire extinguisher on each floor? Have extinguishers been tested on a periodic basis as required? Are extinguishers located so that they are accessible to staff and consumers?

Use the following Tag Number when the deficiency relates to fire extinguishers:

- Tag Number **V2154** and Regulatory Reference Number **635-7.3(h)(4)** for Supportive CRs, Supervised CRs, Large IRAs, Day Treatment, Clinics and Day Training; or,
- Tag Number **V2206** and Regulatory Reference Number **635-7.4(b)(3)(v)** for Small IRAs.

Use the following Tag Numbers when the deficiency relates to other fire protection/detection equipment (e.g., fire alarm system, emergency lighting, and exit signs):

- Tag Number **V2131** and Regulatory Reference Number **635-7.3(e)(1)** for Supervised CRs and Large IRAs;
- Tag Number **V2202** and Regulatory Reference Number **635-7.4(b)(3)(v)** for small IRAs; or,

## **UNIVERSAL PROTOCOL SURVEYOR GUIDELINES**

- Tag Number **V2233** and Regulatory Reference Number **635-7.5(f)** for Day Habilitation sites.

This is a federal Waiver requirement and findings will need to be documented on the Waiver database for each site that provides Waiver services.

## UNIVERSAL PROTOCOL SURVEYOR GUIDELINES

The following table provides an outline of the **basic** fire protection/detection equipment required of each facility listed below. Surveyors should note that a facility may upgrade the level of fire protection equipment, but may not downgrade if the type of programming at the site changes.

### REQUIRED FIRE PROTECTION EQUIPMENT BY FACILITY TYPE

| TYPE OF FACILITY | FIRE EXTINGUISHERS | HARD-WIRED SMOKE DETECTORS | BATTERY-POWERED SMOKE DETECTORS* | EMERGENCY LIGHTING  | EXIT SIGNS   | FIRE ALARM PULL BOX  | HEAT DETECTORS | SPRINKLERS                                     |
|------------------|--------------------|----------------------------|----------------------------------|---|--|--|----------------|--|
| Supportive CR    | R                  | R                          | NP                               | NR  | NR   | NR   | NR             | NR   |
| Supervised CR    | R                  | R                          | NP                               | NR (except in LSC Chapter 19)                                 | NR (except in LSC Chapter 19)                            | NR (except in LSC Chapter 19 & 33)                                   | R              | NR (except in LSC Chapter 18 & 33 Impractical) |
| Small IRA        | R                  | R                          | NP                               | NR  | NR   | NR (except in LSC Chapter 18/19 & 32/33)                             | NR             | NR (except in LSC Chapter 32)                  |
| Large IRA        | R                  | R                          | NP                               | NR (except in LSC Chapter 19)                                 | NR (except in LSC Chapter 19)                            | NR (except in LSC Chapter 19 & 33)                                   | R              | NR (except in LSC Chapter 32 & 33 Impractical) |
| Day Treatment    | R                  | NR                         | NP                               | Emergency lighting required in buildings four stories or more | R  | R  | NR             | NR   |
| Clinics          | R                  | NR                         | NP                               | Emergency lighting required in buildings four stories or more | NR (except in buildings over 2,500 sq. ft. on any story) | NR (except in buildings over two stories or more than 30' in height) | NR             | NR   |
| Day Training     | R                  | NR                         | NP                               | Emergency lighting required in buildings four stories or more | NR (except in buildings over 2,500 sq. ft. on any story) | NR (except in buildings over two stories or more than 30' in height) | NR             | NR   |
| Day Hab          | R                  | NR (except in exit ways)   | NP                               | Emergency lighting required in buildings four stories or more | NR (except in buildings over 2,500 sq. ft.)              | NR (except in buildings over two stories or more than 30' in height) | NR             | NR   |

*NR = Not Required*

*NP = Not Permitted*

\*Battery-operated smoke detectors allowed by exception. For exceptions to battery-operated smoke detectors ban, see Administrative Memorandum No. 97-01 dated January 22, 1997 from Mr. Richard Johnson to Executive Directors of Voluntary Agencies and DDSO Directors.

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130. This is a federal Waiver requirement and findings will need to be documented on the Waiver database for each site that provides Waiver services. Review for inspections of the fire alarm systems. If problems have been identified, have they been corrected? If possible, ask that the alarm system be activated. The Waiver provider must be notified on an exit conference form if a deficiency is found. The deficient practice must be monitored for correction by the agency at subsequent Waiver reviews. If no correction is noted, please contact your regional to discuss any necessary remediation activities. For situations that present an immediate risk to the safety of an individual, contact your regional director & require immediate correction.
131. This is a federal Waiver requirement and findings will need to be documented on the Waiver database for each site that provides Waiver services. The Waiver provider must be notified on an exit conference form if a deficiency is found. The deficient practice must be monitored for correction by the agency at subsequent Waiver reviews. If no correction is noted, please contact your regional to discuss any necessary remediation activities. For situations that present an immediate risk to the safety of an individual, contact your regional director & require immediate correction. During physical plant review and documentation review, perform the following activities:
- Test and verify that alarms/alarm systems function properly. See FRFS03.
  - Through review of alarms/alarm system test reports, sprinkler system test reports and other related documentation, ensure that the agency/facility is responsive to alarm system problems/failures in a timely fashion.
  - Complete a Life safety Code booklet, if applicable, to verify that Life Safety Code requirements are met.
  - Verify that smoking policies are consistent with safe practices and followed: Smoking is allowed at least 50 feet from the site. Appropriate ash tray/cigarette receptacles are used.
  - Observe that there are no obstructions/barriers to exits and exit pathways.
  - Through documentation review and observation, verify that problems identified during fire drills and/or the agency's inspection of the facility have been addressed and corrected.
  - Through documentation review and observation, verify that problems identified during inspections of the facility by external agencies, including previous DQM visits, have been addressed and corrected.
  - Conduct a walk-through of the facility and observe for common fire hazards such as frayed electrical cords, overloaded light sockets, lint accumulation in dryer vents, etc.
131. During physical plant review, observe for the following:
- The building is free from trip hazards, sharp edges, or any other potential threat to consumers.
  - Water temperature is not greater than 110 degrees in sites where any individual cannot and/or is not being trained to control water temperature. Water temperature is less than 140 degrees in sites where all individuals are capable of controlling water temperature and/or are being trained to do so.
  - Beds and bedrail arrangements are safe and without gaps as described in OMRDD's "Bed Safety Checklist and User's Guide" (March

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1999)

**NOTE:** If hot water, unsafe bedrails, or any immediate threat to the safety of an individual(s) is identified, the Regional Director for the Survey Team should be consulted for further guidance.

Clarification regarding appropriate use of bedrails can be found in OMRDD's "Bed Safety Checklist and User's Guide," dated March 1999.

132. Does the residence provide a home-like environment? Are furnishings clean, in good repair and age-appropriate? Have individuals been involved in the choices made in decorations, wall hangings, etc. Does the décor reflect the individual's tastes and preferences; e.g., including personal possessions, such as pictures of friends or family? Is the physical plant appropriately adapted to meet the needs of consumers with physical disabilities (ramps, strobes, bed shakers, turnaround space in toilets, etc.)? Is the temperature comfortable? Is lighting adequate? Is equipment in proper working order? Is all needed adaptive equipment available to consumers and in good working order? Does the facility provide a reasonable amount of privacy for the individuals who live there? Is there an adequate amount of space for planned activities? Is the noise level too high?
133. When reviewing for this standard, survey staff should adhere to the revisions outlined in DQA Administrative Memo No. 96-02; "Revised Testing Standards for Private Wells" dated April 8, 1996. The memo is applicable to all OMRDD-certified facilities that have wells as their source of potable water. The testing requirement reduces the number of required parameters from 16 to the following four, annually: chloroform; standard plate count; chlorides; and, nitrates. Testing parameters exceeding the maximum contaminant level for that substance in drinking water will require corrective action. Additional testing may be required if the well is located near potential sources of contamination, such as lead, unspecified organic contaminants, heavy metals, or sodium.
134. Use Tag Number Y293 and Regulatory Reference Number 633.4(a)(4)(i) if the facility has not maintained a safe or sanitary environment.

Use Tag Number **V2156** and Regulatory Reference Number **635-7.3(h)(6)** or Tag Number **V2219** and Regulatory Reference Number **635-7.4(b)(3)(xix)** (as appropriate for the type of facility being surveyed) for maintenance issues other than those affecting cleanliness or safety.

Are walls, floors, rugs, furniture, bathroom fixtures, etc. cleaned and in good repair and is the facility free from rodent- and/or insect-infestation? Are all appliances/equipment, etc., used by consumers clean and in good working order?

In addition to basic maintenance and cleaning of the physical environment, the agency is required to ensure that fire protection equipment is in good working order.

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135. Review the plan. Do staff know what is in the plan? Does the plan include a communication system for the prompt contacting of responsible personnel in the event of an emergency? Does the plan seem effective? Does the plan address CPR, first aid and access to emergency medical services? Is the outcome of implementing the plan likely to effectively handle the emergency?
136. Water temperature can be up to 139° F if all consumers are trained in controlling water temperature. Temperatures in excess of 139 F are considered to be imminent danger whether or not consumers have been or are being trained and regardless of program type. Is the hot water temperature no more than 110° F unless consumers have been or are being trained to regulate water temperature?
137. Review the system and policies. Do staff know what the system is or how to access it?

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The table below provides a cleaning and maintenance schedule for fire protection equipment by program type:

### MAINTENANCE/INSPECTION SCHEDULE

| TYPE OF FACILITY | FIRE EXTINGUISHERS | HARD-WIRED SMOKE DETECTORS   | BATTERY-POWERED SMOKE DETECTORS* | EMERGENCY LIGHTING | EXIT SIGNS | FIRE ALARM PULL BOX     | HEAT DETECTORS          | SPRINKLERS               |
|------------------|--------------------|--|----------------------------------|--------------------|------------|-------------------------|-------------------------|--------------------------|
| Supportive CR    | Monthly            | Quarterly  | Per manufacturers' instructions  | Monthly            | NR         | Annually (if installed) | Annually (if installed) | Quarterly (if installed) |
| Supervised CR    | Monthly            | Quarterly  | Per manufacturers' instructions  | Monthly            | NR         | Quarterly               | Quarterly               | Quarterly                |
| Small IRA        | Monthly            | Per manufacturers' instructions  | Per manufacturers' instructions  | Monthly            | NR         | Annually                | Annually (if installed) | Quarterly (if installed) |
| Large IRA        | Monthly            | Quarterly  | Per manufacturers' instructions  | Monthly            | NR         | Quarterly               | Quarterly               | Quarterly                |
| Day Treatment    | Monthly            | Per manufacturers' instructions (if installed)                                 | Per manufacturers' instructions  | Monthly            | NR         | Annually                | Annually (if installed) | Quarterly (if installed) |
| Clinics          | Monthly            | Per manufacturers' instructions (if installed)                                 | Per manufacturers' instructions  | Monthly            | NR         | Annually                | Annually (if installed) | Quarterly (if installed) |
| Day Training     | Monthly            | Per manufacturers' instructions (if installed)                                 | Per manufacturers' instructions  | Monthly            | NR         | Annually                | Annually (if installed) | Quarterly (if installed) |
| Day Hab          | Monthly            | N/A if building is sprinklered; per manufacturers' instructions (if installed) | Per manufacturers' instructions  | Monthly            | NR         | Annually                | Annually (if installed) | Quarterly (if installed) |

**NOTE:** When a facility does not require specific fire protection equipment, a maintenance/inspection schedule should be followed in facilities where fire equipment is installed.

\*All smoke detectors should be replaced every 10 years.

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## CLINICS

**GENERAL STATEMENT:**        **Referenced documentation must be on-site at the residence. NOTE: Any deficiencies found for this section, are deficiencies for the Clinic Treatment Program.**

138. The standard is considered met if the Article 16 clinic operator has submitted a letter to the executive director/designee of the residential provider which includes a written description of the clinic services to be delivered in the residence, identifies the specific services to be delivered to each person, and includes a justification for providing the clinic services in the residence. The letter must be current (dated within the past year) and include all consumers in the residence receiving off-site clinic services at the time it was written. The justification must identify the CLINICAL benefit of providing the services to the consumer in the residence rather than at the main clinic site. NOTE: A LACK OF RESIDENTIAL STAFF TO TRANSPORT INDIVIDUALS TO A CLINIC WOULD NOT BE AN APPROPRIATE JUSTIFICATION FOR PROVIDING SERVICES AT THE HOUSE.

Surveyors must review a copy of the letter to make sure that it includes the necessary elements.

139. A copy or summary of each person's clinic treatment plan must be available at the residence. Review the plan or summary. Is it consistent with the description of services referenced in Question #104 above? Based upon observation of services, documentation and/or interview with staff, consumers, families, are the clinic services being delivered in accordance with the person's plan?

140. For clinic services delivered after August 15, 2003, the standard is considered met if there is a current (within the year) letter on file from the executive director of the residential provider agreeing to the provision of Article 16 clinic services at the agency's residences. The letter must be renewed annually.

141. It is not necessary for the residential agency to generate a new approval letter each time a new clinic service is implemented for a person or a new person begins to receive clinic services at the IRA. The standard is considered met if the Article 16 clinic operator has submitted a letter to the executive director/designee of the residential provider, which includes a written description of the clinic services to be delivered in the residence and includes all the information required in Questions #104 and #106 above.

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## ATTACHMENT A

### QUALIFIED MENTAL RETARDATION PROFESSIONAL (QMRP)

1. Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and,
2. Is one of the following:
  - (i) A doctor of medicine or osteopathy;
  - (ii) A registered nurse; or,
  - (iii) An individual who holds at least a Bachelors Degree in a professional category specified below and is licensed, registered or certified as applicable, to provide professional services by the State of New York:
    - a. An Occupational Therapist or an Occupational Therapy Assistant eligible to be certified by the American Occupational Therapy Association or another comparable body. NOTE: Must also possess a Bachelors Degree in a Human Services Field;
    - b. A Physical Therapist eligible for certification by the American Physical Therapy Association or another comparable body.;
    - c. A Physical Therapy Assistant eligible for registration by the American Physical Therapy Association or be a graduate of a two-year College-level program approved by the American Physical Therapy Association or another comparable body. NOTE: Must also possess a Bachelors Degree in a Human Services Field.;
    - d. A Psychologist with at least a Masters Degree in Psychology from an accredited school; or,
    - e. A Social Worker who must:
      - hold a Graduate Degree from a school of Social Work accredited or approved by the Council on Social Work Education or another comparable body; or,
      - hold a Bachelor of Social Work Degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.
    - f. A Speech/Language Pathologist or Audiologist who must:
      - be eligible for a Certificate of Clinical Competence in Speech/Language Pathology or Audiology granted by the American Speech/Language-Hearing Association or another comparable body; or,
      - meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.
    - g. A professional recreation staff member who must have a Bachelors Degree in Recreation or in a specialty area such as art, dance, music or Physical Education;
    - h. A professional dietician eligible for registration by the American Dietetics Association; or,
    - i. A human services professional who must have at least a Bachelors Degree in a human services field, including but not limited to: Sociology, Special Education, Rehabilitation Counseling and Psychology.