



**Office for People with
Developmental Disabilities**

Agency Protocol Manual

2/8/2019

Agency Review Overview

- The Agency Review is intended to verify that agencies have procedures and act to facilitate compliance with regulatory requirements, emphasize quality services, and prioritize both compliance and quality organizationally.
- OPWDD-Division of Quality Improvement (DQI) staff activities will include discussion with agency representatives regarding topics and standards included in the protocol. Agency staff may be asked to describe the processes related to standards in the Agency Review Protocol.
- For some areas of review, the agency will be asked to demonstrate implementation and effectiveness of the procedures and/or activities.
- For some standards related to regulatory requirements, surveyors will review documentation demonstrating implementation for a specified sample. This will be identified in each protocol section when applicable. The findings from the sample review will be used to make a reasoned determination of whether the Agency appears to have adequate procedures to meet the regulatory requirement being reviewed.
- Other standards related to best practices for organizations are evaluated through interview and documentation review. Using protocol guidance, surveyors will determine if the agency has mechanisms to address the quality standard.
- The Agency Review will be implemented with each provider agency.
- Agency Review activities will take place primarily at the agency main office where the required documentation and staff necessary for interview can be available. Incident Review using IRMA information may occur off site as able to lessen time on site and travel expenses when applicable. Additional off-site activities may occur as agreed upon with the agency and DQI, when the agency is able to provide information electronically.
- The visit will be announced. Notice will be sufficient to ensure that staff knowledgeable of the agency's systems is available and written materials needed can be gathered, but no greater than two weeks.
- The findings of both the Site Review and Person Centered Review (PCR) activities conducted, will guide decisions on whether certain sections of the protocol should be implemented. Experience from the Site and PCR may also assist DQI staff in directing their questions and review of the agency processes as they are already familiar with some agency practices and outcomes. The Site Reviews and PCRs serve as additional verification that agency procedures are implemented and effective. The findings of all three review types provide the best overall assessment of the agency's competence to deliver quality services.

Note:

- The guidelines in this document cannot be inclusive of every scenario a surveyor may encounter and are not meant to substitute the judgment and knowledge base of experienced DQI staff.
- Procedures identified in this document do not restrict OPWDD's ability to assess any item determined to influence the regulatory compliance of an agency or the safety and welfare of individuals receiving services.

Table of Contents

Information Gathering Overview	8	3	58
Standards Table.....	12	Section 2: Satisfaction.....	59
Guidance & Reference Citations.....	37	Standard #.....	59
Topic 1: Oversight of Services and Outcomes	37	1	59
.....	37	2	60
Section 1: Service Delivery	37	Topic 3: Agency Procedures Regarding Rights Protections	61
Standard #	37	Section 1: Rights Promotion.....	61
1	37	Standard #.....	61
2	39	1	61
3	41	2	62
Section 2: Family Care Sponsoring Agency Activities.....	42	Section 2: Rights Protections	64
Standard #	42	Standard #.....	64
1	42	1	64
2	43	Section 3: Human Rights Committee	66
3	44	Standard #.....	66
4	45	1	66
Section 3: Respite Services	46	2	68
Standard #	46	3	70
1	46	Topic 4: Behavior Intervention Policy and Procedures.....	72
Section 4: Self-advocacy & Personal Outcomes.....	47	Section 1: Written Part 633.16 Policy and Procedures.....	72
Standard #	47	Standard #.....	72
1	47	1	72
2	49	2	74
3	51	3	76
Topic 2: Satisfaction and Complaint Management.....	53	4	78
Section 1: Complaints and Objections Procedures.....	53	5	80
Standard #	53	6	82
1	53	7	84
2	55	8	86
		9	88
		Topic 5: Oversight of Health Care Services ..	91



Sample Guidance	91	3	131
Section 1: RN Oversight All Settings.....	91	4	134
Standard #	91	5	137
1	91	6	140
2	93	7	142
3	96	8	144
Section 2: Medication Administration	98	9	146
Standard #	98	10	148
1	98	11	150
2	100	Section 3: Initial Training	152
3	102	Standard #	152
Section 3: Written Procedures: Delegated Nursing in non-certified settings for community- based waiver services.....	103	1	152
Standard #	103	2	154
1	103	3	156
2	106	4	158
Topic 6: Workforce.....	107	5	160
Sample Guidance	107	6	162
Section Worksheets.....	107	7	164
Section 1: Hiring Practices	108	8	166
Standard #	108	9	168
1	108	Section 4: Annual Training and Other Training Activities	169
2	110	Standard #	169
3	114	1	169
4	116	2	171
5	118	3	172
6	120	4	174
7	122	5	176
8	124	6	177
Section 2: Background Checks	126	7	178
Standard #	126	8	180
1	126	9	182
2	128	10	184
		11	186



12	187	Topic 8: Personal Allowance	230
13	189	Sample Guidance.....	230
14	191	Section 1: Personal Allowance Oversight....	230
Section 5: Evaluation and Competency	192	Standard #.....	230
Standard #	192	1	230
1	192	2	232
2	194	3	233
3	197	4	234
4	201	Section 2: Personal Allowance	
5	204	Policy/Procedure	236
6	206	Standard #.....	236
7	208	1	236
8	210	2	238
Section 6: Staff Management and		3	241
Development.....	211	4	244
Standard #	211	5	246
1	211	Topic 9: Safety and Maintenance	248
2	213	Section 1: Safety and Maintenance.....	248
3	215	Standard #.....	248
4	217	1	248
5	219	2	250
6	221	3	252
Topic 7: Tuberculosis Control	223	4	253
Sample Guidance	223	5	254
Section 1: TB Testing.....	223	6	256
Standard #	223	7	258
1	223	8	259
Standard #	225	9	260
2	225	10	261
3	227	11	263
Section 2: TB Evaluation for Excluded Persons		Topic 10: Incident Management	264
.....	229	Sample Guidance.....	264
Standard #	229	Section 1: Notification of Policy and	
1	229	Procedures.....	264



Standard #	264	7	293
1	264	8	295
2	265	9	296
Section 2: VPCR Reporting.....	267	10	297
Standard #	267	11	299
1	267	12	300
Section 3: IRC – General Requirements.....	268	13	301
Standard #	268	Section 6: IRC – Part 625 Requirements	302
1	268	Standard #.....	302
2	270	1	302
3	272	2	303
4	273	3	305
5	274	4	306
Section 4: IRC – Incident Review Requirements.....	276	Section 7: IMU Measures	307
Standard #	276	Standard #.....	307
1	276	1	307
2	277	2	308
3	278	3	310
4	279	4	312
5	280	Topic 11: Facilitating Connections	313
6	281	Section 1: Natural Supports and Relationships	313
7	282	Standard #.....	313
8	284	1	313
9	285	2	315
Section 5: IRC – Part 624 Reporting and Notification Requirements.....	286	Section 2: Community Engagement.....	317
Standard #	286	Standard #.....	317
1	286	1	317
2	287	2	319
3	288	3	321
4	289	Topic 12: Agency Management.....	323
5	291	Section 1: Agency Mission	323
6	292	Standard #.....	323
		1	323



2	324	6	345
3	325	Section 2: QI Plan Communication	346
4	326	Standard #.....	346
5	327	1	346
Section 2: Agency Leadership	328	2	347
Standard #	328	Section 3: Quality Improvement Actions.....	348
1	328	Standard #.....	348
2	329	1	348
3	330	2	349
4	332	Appendix	350
Section 3: Governing Body	333	Access Guides	351
Standard #	333	How to Access the Compliance Report in Business Intelligence	351
1	333	How to Search for an Authorized Person	353
2	334	Criminal Background Check Guide..	355
3	335	Sample Guidance.....	357
4	337	Topic 6 Worksheets.....	359
5	338	Section 6.1: Workforce – Hiring Practices.....	359
6	339	Section 6.2: Workforce – Background Checks	360
Topic 13: Agency Quality Improvement	340	Section 6.3: Workforce – New Employee Training	361
Section 1: QI Plan Components.....	340	Section 6.5: Workforce – Code of Ethics/DSP Performance Evals	362
Standard #	340		
1	340		
2	341		
3	342		
4	343		
5	344		

Information Gathering Overview

GENERAL TOPIC	DISCUSSION AREAS	DISCUSSION STARTERS	AGENCIES
RIGHTS AND ADVOCACY	SELF-ADVOCACY & PERSON-CENTERED OUTCOMES	Self-Advocacy: Information on Self-Advocacy training available/provided, mechanisms, self-advocacy groups and meetings, activities by or for self-advocates, mentors assigned, etc.	ALL
		Agency activities to assess and address achievement of personal outcomes	ALL
		Policies and Procedures: Person Centered Planning and Service Delivery	ALL
		Policies and Procedures: Conflict of Interest	ALL
		Policies and Procedures: HCBS Settings Rules	Agencies providing Habilitation Services
	RIGHTS ADVOCACY & ADDRESSING CONCERNS	Processes for Notification of Rights and Notification of Grievance Process to Stakeholders and how ensured/monitored	ALL
		Implementation of Formal Grievance Process: Ask if agency has received a formal grievance. Discuss how it was handled and verify through their process was implemented, at what point in the process the grievance was resolved, if it has been resolved, etc.	ALL
		Processes related to informal complaints: Ask about agency handling of inform complaints or concerns expressed by individuals, families or other stakeholders; if and how agency handles - documents, addresses, and tracks resolution	ALL
		Policy and Procedures for Written Informed Consent (WIC): processes for obtaining initial and updated, tracking/monitoring, timeliness	ALL
		Policies, Procedures and Activities re: Rights Protections and Rights Promotion	ALL
		Satisfaction Surveys: Individuals, Family/Advocate, Staff - Are satisfaction surveys implemented, how, with whom? How is input reviewed and addressed?	ALL

HRC and BEHAVIOR INTERVENTION	HUMAN RIGHTS COMMITTEE	Committee membership, committee meetings and review activities	Agencies providing Behavior Support Services
	PART 633.16 POLICY & PROCEDURE	Agency P & P to ensure compliance with behavior intervention requirements (633.16)	As above and directed by Area Director
HEALTH CARE OVERSIGHT	NURSING SUPERVISION	Agency procedures to ensure Registered Nursing coverage; agency on-call strategies	Agencies where DSPs provide delegated nursing services - site or community based
		Procedures for supervision and training of DSPs performing delegated nursing services	Same as above
		Management of Medication Errors: reporting and remediation	Delegated nursing services include medication administration - site or community based
WORKFORCE	PERSONNEL RECORDS	Review of Personnel Records for hiring practices including 633.6 requirements, qualifications and background checks	ALL
		Evidencing employee agreement with conduct requirements	ALL
		Assessment of staff competency/Completion of performance evaluations	ALL
	TRAINING PRACTICES	Required Training: Review of training practices and tracking of training completion	ALL
		Does agency required training in addition to OPWDD required training? What additional training is required as determined by the agency. Tracking	ALL
	AGENCY ENHANCEMENT/RETENTION	Discuss agency specific mechanisms to address staff engagement, staff skill building and development, and facilitate staff retention	ALL
		Agency mechanisms for supervision of staff, expectations of supervisors	ALL
		Agency specific Mechanisms for assignment/deployment of staff	ALL

INFECTION CONTROL	TUBERCULOSIS TESTING	TB testing & results tracking	
PERSONAL FUNDS	PERSONAL FUNDS OVERSIGHT	Practices to ensure that Individuals receive their monthly amount	Agencies with certified residences where individuals receive Personal Allowance
		Completion of required Auditing of PA accounts	Same as above
	PERSONAL FUNDS POLICY & PROCEDURE	Agency procedures per Protocol (safeguarding, amount limit on site, etc.)	Same as above
SAFE ENVIRONMENTS	NOTIFICATION to DQI/OPWDD	Written procedures for notification to DQI/OPWDD of termination of service (e.g. heat, water, alarm system outage, etc.)	Agencies with certified sites
		Written procedures for Safety Plan development and submittal to DQI	Same as above
	SAFE AND OPERATING EQUIPMENT	Mechanism for assessment, testing and replacement of alarm, detection and protection equipment related to fire safety	Same as above
		Mechanism for assurance of vehicle safety	ALL
FAMILY CARE	FAMILY CARE OVERSIGHT	Procedures for completion of Family Care Home recertification activities as required	Agencies with Family Care Homes
		Mechanism to ensure completion of recertification reviews and monthly visits at FCH & correction of issues.	Same as above

INCIDENT MANAGEMENT	EVENTS NOT IN IRMA	Receipt/review of Minor Reportable Documentation when agency policy does not require submittal in IRMA	ALL
		Documentation and Mechanism for reporting and handling Minor Events (i.e. events that are not reportable per 624/625, but rather by agency policy)	ALL
	INCIDENT REVIEW AND TRENDING	Incident Review Committee activities: Discussion with IRC Chair, review of IRC minutes and communication or recommendations	ALL
		Trend Reporting and follow-up	ALL
Quality Improvement	QI ACTIVITIES	Discussion regarding Quality Improvement (QI) processes: e.g. what strategies are in place, targets/goals for the agency, how decision are made regarding what to measure, targets, goals, etc.	ALL
		Quality Improvement Documentation: QI Plan, QI Measures, QI Actions, Tracking	ALL
Agency Management and Governance	GOVERNING BODY	Board Meeting Minutes: review for evidence that they are informed, provide oversight and involved in decision making, participation of members and individuals supported, etc.	Voluntary Agencies
		Board member discussion	Voluntary Agencies
	AGENCY LEADERSHIP	The Agency Mission and how that translates to agency activities and management strategies	ALL
		Executive Leadership discussion	ALL
	OPPORTUNITIES FOR INPUT	Mechanisms for input of service recipient input into agency decision making	ALL
		Mechanism for input from other stakeholders into agency decision making	ALL

Standards Table

TOPIC 1: Oversight of Services and Outcomes

Section 1: Service Delivery

Standard #	Standard Text	Decision
1	The agency implements procedures to ensure that sites where Home and Community Based Services (HCBS) are delivered are not isolating or institutional.	Met/Not Met
2	The agency implements procedures to facilitate and ensure that residential and non-residential settings where HCBS services are provided, comply with HCBS settings requirements.	Met/Not Met
3	The agency implements procedures to oversee and ensure appropriate delivery of services to individuals while in the community, whether provided as part of community based or certified site-based services.	Met/Not Met/NA

Section 2: Family care sponsoring agency activities

Standard #	Standard Text	Decision
1	The sponsoring agency has procedures to ensure the completion of required recertification reviews for family care homes and the submittal of required documents to the DDSO, prior to site expiration date.	Met/Not Met
2	The family care sponsoring agency implements procedures to ensure that recertification review activities are implemented competently.	Met/Not Met
3	The family care sponsoring agency implements procedures to verify that problems/concerns/deficiencies identified during the family care home recertification review or any other review activity, have been corrected.	Met/Not Met
4	The family care sponsoring agency ensures designated staff complete annual visits to each Family Care Home per OPWDD requirements.	Met/Not Met

Section 3: Respite Services

Standard #	Standard Text	Decision
1	The agency implements procedures to monitor that respite services are delivered appropriately in settings that are not personal homes.	Met/Not Met/NA

Section 4: Self Advocacy & Personal Outcomes

Standard #	Standard Text	Decision
1	The agency has a mechanism to support individuals in self-advocacy.	Met /Not Met
2	The agency uses formalized procedures/strategies to facilitate and ensure person centered services.	Met /Not Met
3	The agency has policies and procedures to ensure conflicts of interest do not interfere with person centered services.	Met /Not Met

TOPIC 2: Satisfaction and Complaint Management

Section 1: Complaints and Objections procedures

Standard #	Standard Text	Decision
1	The agency has procedures to ensure that Individuals, family members, guardians and correspondents are informed of what to do if they have an objection, problem, or complaint.	Met /Not Met
2	The agency has procedures to address and resolve objection to services and ensure due process, in accordance with Part 633.12.	Met /Not Met
3	The agency's procedures are effective to address reported objections to services or grievances.	Met /Not Met/NA

Section 2: Satisfaction

Standard #	Standard Text	Decision
1	The agency has a mechanism to determine individuals' satisfaction with the services and supports they receive.	Met /Not Met
2	The agency has a mechanism for addressing/remediating dissatisfaction reported through the mechanism.	Met /Not Met

TOPIC 3: Agency Procedures regarding Rights Protections

Section 1: Rights Promotion

Standard #	Standard Text	Decision
1	The agency has procedures to ensure that individuals, family members, guardians and correspondents are informed of individual rights.	Met /Not Met
2	The agency implements activities for the promotion of the individuals' rights	Met /Not Met

Section 2: Rights Protections

Standard #	Standard Text	Decision
1	The agency has effective written procedures to ensure that individuals' rights are limited only in compliance with regulatory safeguards.	Met /Not Met

Section 3: Human Rights Committee

Qualifier	The agency implements for at least one-person, written plans, services and interventions that include or may include any of the following: modification or limitation of rights, intrusive interventions, and/or administration of medications to modify or control inappropriate behaviors.	Yes/No
Standard #	Standard Text	Decision
1	The agency has a active Human Rights Committee.	Met /Not Met
2	The agency's Human Rights Committee maintains the required membership for review of Behavior Interventions.	Met /Not Met
3	The agency's Human Rights Committee completes reviews of the use of treatments, medications and interventions designed to address a person's behaviors, in accordance with Part 633.16 requirements.	Met /Not Met

TOPIC 4: Behavior Intervention Policy and Procedures

Section 1: Written Part 633.16 Policy and Procedures

<p>Qualifier</p>	<p>In consultation with the Area Director, has it been determined that agency procedures related to behavior supports/interventions must be reviewed.</p> <p>(Note: This determination may be due to findings of other survey activities, complaints, or other known concerns related to behavior supports.)</p>	<p>Yes/No</p>
Standard #	Standard Text	Decision
1	The agency has written Behavior Intervention Policies and Procedures.	Met /Not Met
2	The agency's policies and procedures prohibit the use of behavioral interventions for the convenience of staff, disciplinary purposes or as a substitute for treatment or supervision.	Met /Not Met
3	Agency policies and procedures prohibit the use of aversive conditioning	Met /Not Met
4	Agency policies and procedures prohibit the use of sleep deprivation, food deprivation and food alteration for disciplinary purposes, the convenience of staff, or as a consequence of challenging behavior.	Met /Not Met
5	Agency policies and procedures address the requirements for the use of any intermediate and/or restrictive physical intervention techniques.	Met /Not Met
6	Agency policies and procedures describe the purpose for the development and implementation of behavioral interventions and plans for individuals.	Met /Not Met
7	Agency Policies and procedures require completion of a Functional Behavioral Assessment prior to the development of a Behavior Support Plan.	Met /Not Met
8	Agency policies and procedures address the process for objections to current and proposed Behavior Support Plans.	Met /Not Met
9	Agency policies and procedures address the operation, responsibilities, and membership of the Behavior Plan/Human Rights Committee if a committee is required.	Met /Not Met/NA

TOPIC 5: Oversight of Health Care Services

Section 1: RN Oversight all Settings

Qualifier	<p>Delegated nursing services (e.g. medication administration, treatments, and implementation of plans of nursing services) are delivered by direct support staff in either of the following circumstances:</p> <ul style="list-style-type: none"> To individuals supported in certified sites as permitted by the Nurse Practice Act (NPA) exemption; or To individuals during the delivery of community based waiver services, as permitted by the Nurse Practice NPA expansion MOU, to individuals NOT living in certified residential sites. 	Yes/No
Standard #	Standard Text	Decision
1	The agency implements procedures to ensure that a Registered Nurse (RN) or other acceptable healthcare professional is available to direct support staff, AMAPs, and LPNs during hours of service provision (including 24 hours a day, 7 days a week as needed for residential services).	Met /Not Met
2	The agency has procedures to ensure that an RN or other acceptable health care professional, provides supervision to DSPs performing delegated nursing tasks/activities and LPNs.	Met /Not Met
3	The agency has procedures to ensure that RNs are appropriately trained in OPWDD nursing/health care requirements regarding health care delivery and supervision.	Met /Not Met

Section 2: Medication Administration

Qualifier	Services include medication administration.	Yes/No
Standard #	Standard Text	Decision
1	<p>The agency implements procedures to ensure that all non-licensed staff who administer medications are qualified as follows:</p> <ul style="list-style-type: none"> Direct support staff have current certification; and Family care providers have received OPWDD training (if applicable). 	Met /Not Met/NA
2	The agency has a medication administration error reporting system which includes procedures to address/remediate causes for the errors.	Met /Not Met
3	The agency implements the agency medication administration error reporting and remediation system effectively.	Met/Not Met/NA

Section 3: Written Procedures: Delegated Nursing in non-certified settings for community-based waiver services

Qualifier	DSPs provide nursing services to individuals who live in non-certified settings who receive community based waiver services.	Yes/No
Standard #	Standard Text	Decision
1	The agency providing delegated nursing services to community based individuals, has procedures to ensure that only those certain nursing services which can be delegated per ADM 2015-03 are delegated to trained DSP staff.	Met /Not Met
2	The agency providing delegated nursing services to community based individuals, implements procedures to ensure that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.	Met /Not Met

TOPIC 6: WORKFORCE

Section 1: Hiring Practices

Standard #	Standard Text	Decision
1	The agency ensures verification and documentation that employees hired meet the qualifications for the position for which the person was hired. (excludes Clinic Medical Director, and staff responsible to write and oversee behavior support plans.)	Met/Not Met
2	The agency ensures that employees who are developing and/or monitoring Behavior Support Services meet the educational and experiential qualifications for their positions.	Met/Not Met/NA
3	The agency's certified clinic facility is assigned a qualified Medical Director that is a licensed physician or dentist.	Met/Not Met
4	The agency documents confirmation of applicants' last place of employment or related experience in the personnel file.	Met/Not Met
5	The agency ensures that applicants provide a statement indicating whether or not they had ever been convicted of a misdemeanor or felony in any jurisdiction, or has any pending criminal charge, and a description of same.	Met/Not Met

6	The Agency has an effective procedure to ensure that if the position requires driving, the applicant provides a statement indicating if there have been any convictions of moving violations within the last three years; and any suspension, revocation, alcohol and drug related offenses, driving while intoxicated convictions or any occurrence involving harm to persons or property while driving.	Met/Not Met/NA
7	The Agency procedures ensure that the applicant/employee provides written/signed acknowledgement that information provided on the application is true and acknowledges that false answers are grounds for dismissal.	Met/Not Met
8	There is a mechanism to ensure that people receiving supports are supported to have a role in the hiring process to include candidate recruitment, interview and hiring decisions.	Met/Not Met

Section 2: Background Checks

Standard #	Standard Text	Decision
1	The agency designated an authorized party or parties responsible for the agency's criminal background check information and submitted necessary information to the Justice Center, as required.	Met/Not Met
2	Criminal history background checks are submitted for prospective employees, volunteers, (and family care providers) in accordance with 633.22(d)(2)(i), as required.	Met/Not Met/NA
3	The agency maintains complete and up to date criminal background check records on each subject party, as required.	Met/Not Met
4	The agency has developed and implements procedures that ensure required safeguards are provided to address situations in which staff may be temporarily approved to work pending results of submitted criminal background checks .	Met/Not Met
5	The agency has developed and implements policies and procedures to ensure prompt and appropriate action on criminal history determinations made by the Justice Center.	Met/Not Met
6	The agency has developed and implements procedures that ensure required safeguards to protect individuals receiving services if there is a <u>conviction or impending charge subsequent to a subject party's initial criminal history background check.</u>	Met/Not Met/NA

7	The agency has developed and implements required safeguards applicable to background checks for <u>registered providers</u> .	Met/Not Met/NA
8	The agency ensures that a check of the Staff Exclusion List (SEL) is completed for every subject party before hiring, or allowing that party any regular and substantial contact with an individual receiving services, until the agency has the results of the check.	Met/Not Met
9	The agency ensures that a check of the Statewide Central Register of Child Abuse and Maltreatment is completed, where applicable, for every subject party before that party is allowed any unsupervised contact with an individual receiving services, and until the agency has and reviews the results of the check.	Met/Not Met/NA
10	The agency ensures that a Mental Hygiene Law 16.34 check is completed for each subject party before that party has any unsupervised contact an individual receiving services.	Met/Not Met/NA
11	The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its decision to hire or allow the party to have regular and substantial contact with an individual receiving services.	Met/Not Met/NA

Section 3: Initial Training

Qualifier	The agency has hired staff into a position(s) related to service planning, delivery and/or the management/oversight of service planning/delivery in the past year or since DQI's last review of initial training records.	Yes/No
Standard #	Standard Text	Decision
1	The agency ensures that employees receive training in principles of human growth and development within three months of <u>initial</u> employment.	Met/Not Met/NA
2	The agency ensures that employees receive training in characteristics of the persons served within three months of <u>initial</u> employment.	Met/Not Met/NA
3	The agency ensures that employees receive training in 'Promoting Positive Relationships and Safe Environments for People with Developmental Disabilities' within three months of <u>initial</u> employment.	Met/Not Met/NA
4	The agency ensures that employees receive training in abuse prevention, identification, reporting and processing of allegations of abuse within three months of <u>initial</u> employment.	Met/Not Met/NA

5	The agency ensures that employees receive training in laws, regulations and policies and procedures governing protection from abuse within three months of initial employment.	Met/Not Met/NA
6	The agency ensures that employees receive training in incident reporting and processing within three months of initial employment.	Met/Not Met
7	The agency ensures that employees receive training in the agency's safety and security procedures <u>including fire safety</u> within three months of initial employment.	Met/Not Met
8	The agency ensures that employees receive OPWDD Choking Prevention Initiative training as applicable to their position, within three months of initial employment.	Met/Not Met
9	The agency ensures that Support Brokers have completed the OPWDD-approved Broker training prior to delivering brokerage services.	Met/Not Met

Section 4: Annual Training and Other Training Activities

Standard #	Standard Text	Decision
1	The agency has a mechanism to monitor/track that employees receive required training.	Met/Not Met
2	The agency ensures that <u>all employees</u> receive mandatory annual training in Promoting Positive Relationships.	Met/Not Met
3	The agency ensures that <u>all employees</u> receive mandatory annual training in abuse prevention, identification, reporting and processing of allegations of abuse.	Met/Not Met
4	The agency ensures that <u>all employees</u> receive mandatory annual training in laws, regulations and policies/procedures governing protection from abuse.	Met/Not Met
5	The agency ensures that <u>all employees</u> receive mandatory annual training in incident reporting and processing.	Met/Not Met
6	The agency ensures that <u>all employees</u> receive mandatory annual training in safety and security procedures <u>including fire safety</u> .	Met/Not Met

7	The agency staff participate in development activities for the NADSP Code of Ethics and the DSP Core Competencies per OPWDD requirements and agency policy/procedure.	Met/Not Met
8	The agency staff providing direct services are provided training/learning experiences to develop/maintain the ability to identify, understand, and support the diverse personal outcomes of people they support.	Met/Not Met
9	The agency staff responsible for the design, development, and/or monitoring of services and supports, receive training regarding facilitation of person-centered planning and service delivery.	Met/Not Met
10	The workforce is trained to understand and implement their role in achieving the provider agency's mission.	Met/Not Met
11	The agency ensures that clinicians who complete Functional Behavioral Assessments have training in functional behavior assessment techniques.	Met/Not Met/NA
12	The agency ensures that staff/supervisors responsible to implement behavior support plans that include use of physical intervention techniques completed and are annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques.	Met/Not Met/NA
13	The voluntary provider agency ensures that members of its board of directors receive a one-time mandatory training in incident management within three months of becoming a board member.	Met/Not Met/NA
14	The agency ensures Support Brokers participate in 12 hours of ongoing professional development training annually.	Met/Not Met

Section 5: Evaluation and Competency

Standard #	Standard Text	Decision
1	Documentation indicates that Agency employees, volunteers and family care providers have been advised of conduct requirements, per Part 633.7(b)(2).	Met/Not Met
2	Agency custodians, employees, volunteers and family care providers have read and signed the code of conduct adopted by the Justice Center for People with Special Needs, upon employment and annually thereafter.	Met/Not Met
3	The agency has effective, and ongoing, policy and procedures for use of the National Alliance of Direct Support Professionals (NADSP) Code of Ethics, DSP Core Competencies and the NYS DSP Performance Evaluations.	Met/Not Met
4	The agency completes DSP Core Competency performance evaluations in accordance with OPWDD requirements.	Met/Not Met
5	The agency has established performance expectations, in writing, for positions other than DSP and provided employees with the information appropriate to their position.	Met/Not Met
6	The agency implements a formal mechanism(s) to evaluate the job performance of employees that are not DSPs, to verify they competently implement job tasks and/or provide the services they are responsible to deliver.	Met/Not Met
7	The agency implements informal feedback systems to enhance and reinforce employee competence.	Met/Not Met
8	The agency's performance evaluations/ feedback systems are designed to clearly promote motivation, commitment and career progression for all employees.	Met/Not Met

Section 6: Staff Management and Development

Standard #	Standard Text	Decision
1	The agency uses a mechanism to allocate staff in sufficient numbers to ensure that individuals' health and safety needs are met, planned individualized services/supports are delivered, and the diverse needs, interests, goals and abilities are accommodated.	Met/Not Met
2	The agency, with consideration of the individuals' viewpoint, assigns staff that have the skills/training to meet people's unique needs and accommodate their diverse individualized goals, interests, and abilities.	Met/Not Met
3	The agency has a system in place to monitor staff vacancy rates and staff retention.	Met/Not Met
4	The agency implements strategies to address vacancy and retention to maximize retention and continuity of quality staff.	Met/Not Met
5	The agency provides ongoing staff development opportunities to employees at all levels of the organization.	Met/Not Met
6	The agency implements ongoing employee communication and engagement strategies to support workforce quality.	Met/Not Met

TOPIC 7: TUBERCULOSIS CONTROL

Section 1: TB Testing

Standard #	Standard Text	Decision
1	<p>The agency implements effective procedures to ensure that employees, volunteers, and contractors, family care providers and approved substitute/respite providers have TB testing completed prior to their first day of employment or service provision. (If using the two-step PPD, individuals may begin work if the first test is negative.)</p>	Met/Not Met
2	<p>Exclusions from Testing</p> <p>The agency's implements effective procedures to ensure that persons are only excluded from pre-employment or pre-delivery of services testing, if the agency has documentation of one of the following reasons for the person's exclusion:</p> <ul style="list-style-type: none"> (i) prior documented significant reaction to TB testing; or (ii) adequate treatment for active pulmonary tuberculosis; or (iii) completion of adequate preventive therapy. 	Met/Not Met/NA
3	<p>Contraindication to Testing</p> <p>The agency implements effective procedures to ensure that persons not tested for TB due to a contraindication are only excluded with a statement by a physician, nurse practitioner or physician's assistant that must include:</p> <ul style="list-style-type: none"> (i) a recommendation as to when and if testing would be appropriate at a designated point in the future; and (ii) how the party will be evaluated for active pulmonary tuberculosis in the interim. 	Met/Not Met/NA

Section 2: TB Evaluation for Excluded Persons

Qualifier	Were any employees excluded or contraindicated for TB testing? (i.e. were 2.0 or 3.0 above answered with a met or not met?)	Yes/No
Standard #	Standard Text	Decision
1	The agency implements effective procedures to ensure that persons excluded from TB testing, are evaluated by a registered nurse taking into account any symptomology and history since the person's previous TB test or evaluation.	Met/Not Met

TOPIC 8: PERSONAL ALLOWANCE

Section 1: Personal Allowance Oversight

Standard #	Standard Text	Decision
1	The agency has an effective procedure to ensure the proper amount of personal allowance is provided to individuals monthly	Met/Not Met
2	The agency has an effective procedure to ensure that personal allowance funds are credited to an individual's account within three (3) business days of receipt of the person's income.	Met/Not Met
3	The agency conducts audits of 25% of personal allowance accounts yearly.	Met/Not Met
4	The agency has effective written procedures for the security and safeguarding of Personal Allowance Funds.	Met/Not Met

Section 2: Personal Allowance Policy/Procedure (Has a QQ)

<p>Qualifier</p>	<p>In consultation with the Area Director, has it been determined that agency level practices related to Personal Allowance must be reviewed.</p> <p>(Note: This determination may be due to findings of other survey activities, complaints, or other known concerns regarding the use, handling and accounting for personal allowance and/or personal needs allowance funds.)</p>	<p>Yes/No</p>
Standard #	Standard Text	Decision
1	The agency has written established policies and procedures regarding management of personal allowance, in accordance with OPWDD regulations and guidelines.	Met/Not Met
2	The agency has written policies and procedures regarding the responsibilities of the representative payee, in accordance with OPWDD regulations and guidelines.	Met/Not Met
3	The agency has written procedures regarding determination of an individual's need for a representative payee, in accordance with applicable OPWDD regulations.	Met/Not Met
4	The agency has written procedures to provide required notice to qualified parties when the agency director applies to serve as an individual's representative payee, in accordance with applicable OPWDD regulations.	Met/Not Met
5	The agency has written procedures for the expenditure of and accounting for the Personal Needs Allowance/Clothing Allowance funds, in accordance with OPWDD regulations. Voluntary Agencies Only	Met/Not Met

TOPIC 9: SAFETY AND MAINTENANCE

Section 1: Safety and Maintenance

Standard #	Standard Text	Decision
1	The agency has written procedures in place to ensure that OPWDD is notified immediately of anticipated or actual termination of any service vital to the continued safe operation of the facility or the health of persons receiving services and personnel.	Met/Not Met
2	The agency has written procedures to ensure that safety plans are approved by OPWDD/DQI prior to facility renovations affecting normal operations at the site, and implemented.	Met/Not Met
3	The agency has procedures to assess smoke detectors every 10 years and determine if replacement is necessary.	Met/Not Met
4	The agency has procedures to assess Carbon Monoxide detectors every five years and determine if replacement is necessary or occurs per manufacturer's instruction.	Met/Not Met
5	The agency has procedures to ensure that Smoke Detection and Fire Alarm Systems are properly tested and maintained.	Met/Not Met
6	The agency has procedures to ensure that Sprinkler Systems are properly tested and maintained.	Met/Not Met/NA
7	The agency has a mechanism to ensure that vehicles used in the transportation of service recipients are safe and properly maintained.	Met/Not Met/NA
8	All agency staff receive training in the agency procedures to report site maintenance problems affecting individuals' safety and well-being.	Met/Not Met
9	The agency has and implements procedures for direct observational review of sites to ensure the environment is clean, appropriately maintained, and safe.	Met/Not Met
10	The agency acts to remediate and/or prioritize remediation for any maintenance and cleaning needs identified during environmental review of agency sites.	Met/Not Met
11	The facility has preventative maintenance schedule or review schedule to aid in the routine maintenance of the physical plant on a regular basis.	Met/Not Met

TOPIC 10: INCIDENT MANAGEMENT

Section 1: Notification of Policy and Procedures

Standard #	Standard Text	Decision
1	The agency has procedures to ensure that individuals are offered written information regarding incident reporting policies and procedures when beginning services and annually thereafter.	Met/Not Met
2	The agency has written procedures for providing all staff and applicable associates the policies and procedures on incident reporting when beginning employment and annually thereafter.	Met/Not Met

Section 2: VPCR Reporting

Standard #	Standard Text	Decision
1	The agency has a mechanism to ensure that staff required to contact the VPCR for a particular incident, have done so.	Met/Not Met

Section 3: IRC - General Requirements

Standard #	Standard Text	Decision
1	The agency's IRC membership meets regulatory and agency requirements.	Met/Not Met
2	The IRC guards against conflicts of interest.	Met/Not Met
3	Members of the committee are trained in confidentiality laws and regulations, and comply with section 74 of the Public Officers Law.	Met/Not Met
4	The IRC monitors trends of other events or situations which may be potentially harmful, but do not meet the definition of a reportable incident or notable occurrence	Met/Not Met
5	The IRC reported at least annually to the chief executive officer, chief agency executives, the governing body, and OPWDD concerning its monitoring functions, including trend analysis and response.	Met/Not Met

Section 4: IRC Incident Review Requirements

Standard #	Standard Text	Decision
1	The IRC meets within one month of a report of a reportable incident or serious notable occurrence or (minimally) on a quarterly basis.	Met/Not Met/NA
2	The IRC reviews and monitors the minor notable occurrence, serious notable occurrence, or reportable incident.	Met/Not Met/NA
3	The IRC reviews and monitors investigatory procedures for the reportable incident or serious notable occurrences.	Met/Not Met
4	The IRC makes written recommendations to appropriate staff to improve processes and minimize the prevalence of a reportable incident or notable occurrence.	Met/Not Met/NA
5	The IRC forwards findings and recommendations to the CEO within two weeks of meeting.	Met/Not Met/NA
6	The IRC documents their reviews and recommendations and tracks the conveyance of results and recommendations to appropriate parties within the Agency.	Met/Not Met/NA
7	The IRC monitors implementation of actions taken on recommendations made, including those made by OPWDD or the Justice Center.	Met/Not Met/NA
8	Within three weeks of the IRC meeting, the portion of the minutes addressing Reportable Incidents and Serious Notable Occurrences are entered into IRMA.	Met/Not Met
9	IRC minutes include all of the required information regarding Reportable Incidents and Serious Notable Occurrences.	Met/Not Met

Section 5: Part 624 Reporting and Notification Requirements

Standard #	Standard Text	Decision
1	Minor Notable Occurrences are reported to the CEO within 48 hours of occurrence or discovery.	Met/Not Met/NA
2	Minor Notable Occurrences are either detailed in a written initial incident/occurrence report or entered into IRMA within 48 hours or by close of the next working day, whichever is later.	Met/Not Met/NA
3	Reportable Incidents and Serious Notable Occurrences are reported to the CEO immediately upon occurrence or discovery.	Met/Not Met
4	Reporting updates requested by IMU, are entered into IRMA.	Met/Not Met/NA
5	For an individual residing in a facility certified or operated by OPWDD, MHLS is notified within three working days of all reportable incidents of abuse or neglect.	Met/Not Met
6	For an individual in a State Operated or Sponsored site, the Board of Visitors is notified within three working days of all reportable incidents of abuse or neglect.	Met/Not Met
7	Telephone notification of required information is made to appropriate involved parties for the reportable incident and notable occurrence.	Met/Not Met/NA
8	The Agency provides a written report (OPWDD 148) to any party who received the telephone notification on initial actions taken to address the incident/notable occurrence, within 10 days of completion of the incident report (MNO) or entry into IRMA.	Met/Not Met/NA

9	The Agency provides the written incident/occurrence report (OPWDD 147) to eligible requestor(s) within 10 days of the request.	Met/Not Met/NA
10	The agency releases records and documents pertaining to reportable incidents to eligible requestors in accordance with 624.8 (Jonathan’s Law requirements).	Met/Not Met/NA
11	Deaths are reported to the Justice Center as required.	Met/Not Met
12	Deaths are reported to OPWDD .	Met/Not Met
13	The Coroner/Medical Examiner is notified if the death was a suicide, homicide, accidental death, or death due to suspicious, unusual, or unnatural circumstances. In NYC, the NYC police are also notified.	Met/Not Met/NA

Section 6: Part 625 Requirements

Standard #	Standard Text	Decision
1	All events and situations as defined in Part 625 are reported to OPWDD through IRMA entry.	Met/Not Met
2	The agency takes action to protect the individual when the event or situation meets Part 625 reporting definitions (non-death).	Met/Not Met/NA
3	Subsequent information is provided to OPWDD via IRMA entry.	Met/Not Met/NA
4	Information regarding the death is submitted to the Justice Center as required.	Met/Not Met

Section 7: IMU Measures

Standard #	Standard Text	Decision
1	The Reportable Incident or Serious Notable Occurrence is reported immediately to OPWDD.	Met/Not Met
2	Law Enforcement was notified as required.	Met/Not Met/NA
3	The Incident or occurrence is closed in IRMA within acceptable time frames.	Met/Not Met
4	The agency completed timely submission of an acceptable Reportable Abuse/Neglect investigation record via the WSIR.	Met/Not Met

TOPIC 11: FACILITATING CONNECTIONS

Section 1: Natural Supports and Relationships

Standard #	Standard Text	Decision
1	The agency implements specific strategies to facilitate the creation, development, and continuation of natural support networks for individuals.	Met/Not Met
2	The agency has policies and procedures for regular and timely communication regarding individuals, with the individuals' family/advocates and/or natural supports, per the individual's preferences.	Met/Not Met

Section 2: Community Engagement

Standard #	Standard Text	Decision
1	The agency works collaboratively with other community organizations, to develop the role of the agency in the community, to foster opportunities for individuals.	Met/Not Met
2	The agency implements community outreach intended to increase opportunities and meaningful relationships for the individuals supported (e.g. work, education, associational).	Met/Not Met
3	The agency supports their employees to develop social networks and community connections for individuals and/or to enable individuals to build their own social networks and community connections.	Met/Not Met

TOPIC 12: AGENCY MANAGEMENT

Section 1: Agency Mission

Standard #	Standard Text	Decision
1	The agency has a clearly written mission statement, and related goals/objectives.	Met/Not Met
2	The agency's, written goals, and objectives align its services and supports with achievement of individuals' valued outcomes.	Met/Not Met
3	The agency's mission, goals, and objectives support the vision/outcome priorities of OPWDD.	Met/Not Met
4	The agency's mission and goals are communicated to all people receiving supports and services, their families/advocates; all level of staff; and the governing body.	Met/Not Met

5	Agency leadership engages all agency members in the implementation of the mission and goals of the agency.	Met/Not Met
---	--	-------------

Section 2: Agency Leadership

Standard #	Standard Text	Decision
1	The agency monitors its processes to facilitate compliance with applicable NYS and Federal requirements.	Met/Not Met
2	The agency monitors its processes to facilitate quality services that support individuals' desired outcomes.	Met/Not Met
3	The agency has written conflict of interest policies and procedures.	Met/Not Met
4	The agency actively supports a leadership culturally competent in the diversity of individuals served.	Met/Not Met

Section 3: Governing Body

Standard #	Standard Text	Decision
1	The agency's governing board (Board of Directors) provides active oversight to ensure effectiveness the agency in carrying out its mission and goals.	Met/Not Met
2	The agency Board of Directors has a framework to exercise active governance.	Met/Not Met
3	The Board has a mechanism for active representation of individuals receiving services in agency governance and decision making.	Met/Not Met
4	The Board demonstrates oversight of the Executive Director including adherence to executive compensation requirements.	Met/Not Met
5	The Board's membership has diversity of the appropriate skills and cultural competency to make decisions in alignment with the organization's mission.	Met/Not Met
6	The Board provides fiscal direction and oversight.	Met/Not Met

TOPIC 13: AGENCY QUALITY IMPROVEMENT

Qualifier
(Applies to all Sections)

The agency has a quality improvement plan/strategy.

Yes/No

Section 1: QI Plan Components

Standard #	Standard Text	Decision
1	The quality improvement plan includes measurement, aggregation, and analysis of factors related to the outcomes and quality of life desired by individuals.	Met/Not Met
2	The quality improvement plan addresses person centered planning and service delivery.	Met/Not Met
3	The written quality improvement plan addresses assurance of individuals' health, safety, rights, and freedom from abuse/neglect and exploitation.	Met/Not Met
4	The quality improvement plan includes goal, objectives, and processes to address compliance with OPWDD, state and federal requirements.	Met/Not Met
5	The agency quality improvement plan addresses areas important to stakeholders based on their solicited input.	Met/Not Met
6	The quality improvement plan addresses findings from satisfaction surveys.	Met/Not Met/NA

Section 2: QI Plan Communication

Standard #	Standard Text	Decision
1	The quality improvement plan is reviewed and approved by the board of directors on at least an annual basis.	Met/Not Met
2	There is a mechanism for making the Quality Improvement Plan known to persons supported, staff, agency stakeholders and other interested parties.	Met/Not Met



Section 3: Quality Improvement Actions

Standard #	Standard Text	Decision
1	The agency's QI plan identifies quality improvement actions to be taken during the year.	Met/Not Met
2	The agency's quality improvement activities include an annual progress summary that identifies the quality improvement actions taken and the results/effectiveness.	Met/Not Met

Guidance & Reference Citations

Topic 1: Oversight of Services and Outcomes

Section 1: Service Delivery

Standard #	Standard Text	Decision
1	The agency implements procedures to ensure that sites where Home and Community Based Services (HCBS) are delivered are not isolating or institutional.	Met/Not Met

Guidance

Interview:

Per agency processes and structure, interview agency employees responsible for oversight of delivery of HCBS services such as residential program directors, day services directors, community services directors, and/or other agency management with responsibility to address HCBS requirements.

Documentation dependent on agency process:

- Written policy or procedure to facilitate non-institutional operations;
- Written documentation of agency level processes to facilitate that programs are integrated, flexible, person centered;
- Written documentation of agency level processes to monitor and confirm that programs operate in a manner that is integrated and individualized vs. isolating and institutional;
- Additional information that agency may offer as demonstration of an agency level approach to support agency programs to be compliant.

Guidance:

- This is a QUALITY INDICATOR of organization level processes to ensure that services and settings do not have qualities that are institutional or isolating. That is, there are agency level processes to ensure that programs operate in a manner that is integrated and allows for autonomy and individualization vs. isolating and institutional.
- Through your review activities, determine if the agency has taken measures at the agency level to prevent/avoid institutional or isolating practices.
- Consider whether the agency has taken any of the following actions. These are examples of appropriate approaches and should not be considered as the only effective activities to be taken by the agency:
 - o The agency examined its practices/procedures/policy, directives, approval processes, to ensure they do not result in or may result in practices that are institutional or isolating. Policies, procedures and practices should be amended if there are any blanket rules/restrictions/practices that impose processes or rules that limit individual inclusion, integration, choice, autonomy.
 - o The agency implemented organizational self-assessment practices to observe the day to day operations of service delivery regarding inclusion, integration, choice, autonomy.
 - o The agency reviewed and adopted agency practices to eliminate or reduce risk of isolating or institutional practices and facilitate greater opportunity for inclusion, integration, choice, autonomy; such as: committing to

smaller program sizes; site relocations; no new sites on agency grounds; review of staffing levels; review of transportation opportunities; etc.

- Surveyor experience with reviews associated with heightened scrutiny and HCBS settings is good background regarding qualities desired and not desired to ensure HCBS services are not isolating or institutional. See Site Review Protocol Standard 1-6 if you need a refresher on what is considered institutional or isolating.
- Sites that require particular attention of the agency for systemic actions include IRAs/CRs/Apartments (Residential Habilitation); Day Habilitation sites, Prevocational sites.
- Upon discussion and document review determine if the agency has taken organizational action(s) to impact the prevention of institutional and isolating practices and/or positively impact individualization, integration and autonomy.

Select Met if it is clearly evidenced that the agency implements procedures to ensure that Home and Community Based Services (HCBS) are individualized, support autonomy, and are integrated with people who do not have disabilities. I.e. Services are provided in a manner that is not institutional and/or isolating.

Select Not Met if any of the following are evident:

- The agency has not taken any organizational actions to ensure their certified sites are not isolating and/or institutional, but rather support autonomy and integration;
- The agency has no written procedures applied throughout the agency sites where HCBS services are delivered, to review/evaluate settings, and correct any isolating or institutional practices.

Citations

QI: This standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The agency implements procedures to facilitate and ensure that residential and non-residential settings where HCBS services are provided, comply with HCBS settings requirements.	Met/Not Met

Guidance

Interview:

Per agency processes and structure, interview agency employees responsible for oversight of delivery of HCBS services such as residential program directors, day services directors, community services directors, and/or other agency management with responsibility to address HCBS requirements.

Documentation dependent on agency process:

- Written agency policy or procedure to regarding agency HCBS setting compliance;
- Written documentation of agency level processes to facilitate HCBS setting compliance;
- Written documentation of agency level processes to monitor and confirm that HCBS Services are delivered in a manner compliant with HCBS requirements;
- Additional information that agency may offer as demonstration of an agency level approach to support agency programs to be compliant with HCBS services and settings requirements.

Additional Guidance

- This is a QUALITY INDICATOR of organization level processes to ensure that HCBS services and the settings where they are delivered, are in compliance with HCBS settings requirements.
- Through your review activities, determine if the agency has taken measures at the agency level to facilitation individualization, autonomy and integration, choice, privacy, rights, etc. aligned with HCBS requirements.
- Consider whether the agency has taken any of the following actions. These are examples. There is no specific correct approach(es):
 - o Examined agency practices/procedures/policy, directives, approval processes, to ensure they support compliance with HCBS settings requirements. Policies, procedures and practices should be amended if they impede compliance or make it difficult.
 - o Implemented organizational self-assessment practices to observe the day to day operations of service delivery regarding inclusion, integration, choice, autonomy, rights promotion, etc.
 - o Reviewed and adopted agency practices to promote compliance with the HCBS settings requirements such as supporting person-centered practices, supporting choice in service and living environments, supporting privacy and independence in service environments, promoting right, etc.
 - o Ensured that all organizational policies and procedures, training materials, and other applicable documents are consistent with the HCBS standards.
 - o Implemented policies, procedures, and practices that clearly define its commitment to the promotion and protection of individual rights.
 - o Communicated with stakeholders including staff and individuals served on these principles and soliciting feedback from individuals served and their advocates on how to do better through satisfaction surveys, focus groups, residence meetings, and other applicable forums should be undertaken.

- Surveyor experience with reviews associated with HCBS assessments, Site Review and Person-centered review supports the understanding of HCBS requirements. Refer to guidance in those protocols if you need a reminder of the expectations.
- Upon discussion and document review determine if the agency has taken organizational action(s) expected to promote practices that enhance individual decision making e.g., over schedules, activities, and staff hiring, training, supervising, evaluation, and firing, and in other areas where individual input and autonomy can be promoted and facilitated.

Select Met if it is clearly evidenced that the agency has and implements procedures to facilitate and ensure that residential and non-residential settings where HCBS services are provided, comply with HCBS settings requirements.

Select Not Met if any of the following are evident:

- The agency has not taken any organizational actions to facilitate and ensure that residential and non-residential settings where HCBS services are provided, comply with HCBS settings requirements.
- The agency has no written processes applied throughout the agency regarding compliance with HCBS settings requirements.

Citations

QI: This standard is a Quality Indicator.

Standard #	Standard Text	Decision
3	The agency implements procedures to oversee and ensure appropriate delivery of services to individuals while in the community, whether provided as part of community based or certified site-based services.	Met/Not Met/NA

Guidance

This is a QUALITY INDICATOR.

Interview:

- Interview agency employees responsible for oversight of delivery of services such as residential program directors, day services directors, community services directors, and/or other agency management with such responsibility.

Documentation dependent on agency process, if any, e.g.:

- Written policy/procedure to related to staff supervision and oversight;
- Mechanisms for oversight of service delivery in the community;
- Additional information that agency may offer as demonstration of an agency level approach to support agency programs to be compliant.

Additional Guidance:

- This is a Quality Indicator which reviews whether the agency has an organizational means to supervised community based service delivery.
- Delivery of quality services in community settings may be difficult to ensure. A best practice is to establish agency expectations for oversight of delivery of such services.
- Service delivery in community setting may include:
 - o “community based services” not associated with a certified site, such as community habilitation, supported employment, day habilitation without walls); and/or
 - o off-site services delivered through certified sites, such as day habilitation services delivered for whole or part days off site.
- Agency mechanisms to monitor/oversee community based service delivery may vary from agency to agency, and this standard is not reviewing for one correct way to accomplish this. Mechanism may include periodic observations, unannounced visits, phone checks, contacts with service recipients and/or their advocates, or other agency strategy.
- Regardless of mechanism used by the agency, it should require periodic oversight and verification of services delivered in the community and agency level verification that the oversight is provided.

Select Met if the agency implements periodic active monitoring of service delivery in the community.

Select Not Met if the agency does not implement periodic active monitoring of service delivery in the community.

Select NA only if the agency does not deliver services in the community and only delivers them when located at a certified site.

Citations

QI: This standard is a Quality Indicator.

Section 2: Family Care Sponsoring Agency Activities

Standard #	Standard Text	Decision
1	The sponsoring agency has procedures to ensure the completion of required recertification reviews for family care homes and the submittal of required documents to the DDSO, prior to site expiration date.	Met/Not Met

Guidance

Interview:

Sponsoring Agency Staff responsible to complete and ensure completion and submittal of recertification reviews for family care homes (FCHs).

Documentation Review:

Written agency procedure, tracking and oversight documents, tracking etc. used by the agency related to scheduling, completion, and submittal of FCH recertification reviews.

Guidance:

- Verify that the agency has and implements routine processes for the completion of FCH recertification reviews to include:
 - o scheduling and completion of the review; and
 - o submittal of certification documents to the DDSO prior to the end date of the FCH operating certificate.
- Ask sponsoring agency staff to demonstrate/show the materials used for the agency processes to ensure the above.
- DQI Business Intelligence (BI) offers reports regarding expired programs and sites with upcoming certification expiration. Review status of the family care homes sponsored by the agency and if the sponsoring agency has a pattern of family care homes with expired certifications.

Select Met if both of the following are evident:

- The sponsoring agency implements a process used to ensure completion and submittal of FCH recertification reviews; AND
- The certification dates for the sponsoring agency's family care homes are largely up to date.

Select Not Met if any of the following is evident:

- The sponsoring agency does not have a process to ensure completion and submittal of FCH recertification reviews; AND/OR
- There is a pattern of overdue recertification for the sponsoring agency's family care homes.

Citations

QI: This standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The family care sponsoring agency implements procedures to ensure that recertification review activities are implemented competently.	Met/Not Met

Guidance

Interview:

Sponsoring Agency Staff responsible to complete and ensure completion of recertification reviews for family care homes (FCHs).

Documentation Review:

Written agency procedure and oversight processes, used by the agency, related to implementation of FCH recertification reviews.

Guidance:

- Verify that the agency has and implements routine processes to ensure that family care home recertification reviews are:
 - o completed using the OPWDD approved tool/protocol (Form 638 until xx/xx/2018 and DQI Site protocol beginning xx/xx/2018); and
 - o completed competently.
- Agency processes should include quality monitoring of the completed recertification tool to ensure:
 - o all required recertification review activities have been completed, and
 - o sufficient information explaining issues/concerns identified is documented on the review tool.
- Ask the agency to evidence implementation of the oversight process.
- Agency processes will dictate who will conduct the review.

Select Met if the sponsoring agency implements procedures to ensure family care home recertification review activities are competently completed and documented using the OPWDD approved tool.

Select Not Met if the sponsoring agency does not have or implement procedures to ensure family care home recertification review activities are competently completed and documented using the OPWDD approved tool.

Citations

ADM 2018-03

State and Agency Sponsored Family Care program responsibilities for completing recertification reviews will be standardized statewide. Changes, which are described in the attached Family Care Recertification policy 7.2, include but are not limited to the following:

- All State Sponsored Family Care Homes will be reviewed by designated DDSOO staff. All Agency Sponsored Family Care Homes will be reviewed by designated Sponsoring Agency staff.
- All recertification reviews will be completed by designated Sponsoring Agency staff using the approved OPWDD Family Care Review instrument and the attached Recertification Checklist. The Family Care Home Evaluation and Survey (Form 238) will serve as the approved review instrument until it is replaced by a new standardized instrument later this year.

Standard #	Standard Text	Decision
3	The family care sponsoring agency implements procedures to verify that problems/concerns/deficiencies identified during the family care home recertification review or any other review activity, have been corrected.	Met/Not Met

Guidance

Interview:

Sponsoring Agency Staff responsible to complete and ensure completion of recertification reviews for family care homes (FCHs).

Documentation Review:

Written agency procedure and oversight processes, used by the agency, related to implementation of FCH recertification reviews.

Guidance:

- Verify that the agency has and implements routine processes to ensure that deficiencies/problems identified during family care home recertification reviews are addressed, corrected.
- Agency process should include:
 - o Mechanism to plan corrective actions;
 - o Validation that problems are addressed effectively;
 - o Routine time frame for validation or verification that problems are addressed/corrected; as determined by the agency. For example: one month from review; or 6 months from review, or plan of corrective action accepted then validation at next annual visit.
- Ask the agency to show you examples of their process by showing some examples of the tracking and verification of correction of deficiencies/issues found.
- Agency processes will dictate who will confirm correction and who will oversee that this occurs.

Select Met if the sponsoring agency implements procedures to verify that problems/deficiencies identified during recertification review are corrected.

Select Not Met if the sponsoring agency cannot show that they verify that problems/deficiencies identified during recertification reviews are corrected.

Citations

ADM 2018-03

State and Agency Sponsored Family Care program responsibilities for completing recertification reviews will be standardized statewide. Changes, which are described in the attached Family Care Recertification policy 7.2, include but are not limited to the following:

- All State Sponsored Family Care Homes will be reviewed by designated DDSOO staff. All Agency Sponsored Family Care Homes will be reviewed by designated Sponsoring Agency staff.
- All recertification reviews will be completed by designated Sponsoring Agency staff using the approved OPWDD Family Care Review instrument and the attached Recertification Checklist. The Family Care Home Evaluation and Survey (Form 238) will serve as the approved review instrument until it is replaced by a new standardized instrument later this year.

Standard #	Standard Text	Decision
4	The family care sponsoring agency ensures designated staff complete annual visits to each Family Care Home per OPWDD requirements.	Met/Not Met

Guidance

Interview:

Sponsoring Agency Staff responsible to complete and ensure completion of annual visits to family care homes (FCHs).

Documentation Review:

Written agency procedure and oversight processes, tracking, etc. used by the agency related to completion of annual visits to family care homes.

Guidance:

- The sponsoring agency is responsible to ensure that annual visits to family care homes occur in the years that are not recertification visits.
- These annual visits are operationally different from the routine monthly visits by a family care liaison,
- The annual visits are to be documented using the OPWDD approved form/tool/protocol (Form 638 until xx/xx/2018 and DQI Site protocol beginning xx/xx/2018).
- Verify that the agency has and implements routine processes for the completion of FCH annual visits to include:
 - o scheduling and completion of the reviews; and
 - o use of required tool during the visits and submittal of required documents.
- Ask sponsoring agency staff to demonstrate/show the materials used for the agency processes to ensure the above.

Select Met if both of the following are evident:

- the sponsoring agency implements a process to ensure annual visits/reviews are completed at sponsored family care homes; AND
- the sponsoring agency's process documents/tracking evidence that annual visits are largely being done.

Select Not Met if any of the following is evident:

- the sponsoring agency does not have and or does not implement a process to ensure annual visits/reviews are completed; AND/OR
- it is uncertain whether the annual visits are being done at the family care homes; AND/OR
- there is evidence that annual visits are largely not occurring at family care homes.

Citations

QI: This standard is a Quality Indicator.

Section 3: Respite Services

Standard #	Standard Text	Decision
1	The agency implements procedures to monitor that respite services are delivered appropriately in settings that are not personal homes.	Met/Not Met/NA

Guidance

This is a QUALITY INDICATOR.

Interview:

- Agency employees responsible for oversight of delivery of respite services.
- Additional agency staff or stakeholders as needed.

Documentation dependent on agency process, if any, e.g.:

- Written policy/procedure to related to Respite service delivery and oversight of respite program.
- Written mechanisms for oversight of service delivery of respite programs.
- Additional information that agency may offer as demonstration of respite oversight.

Additional Guidance:

- This is a Quality Indicator which reviews whether the agency oversees group respite services.
- This includes:
 - o Respite services in certified sites (e.g. free standing respite); or
 - o Respite services delivered in other settings to a group of individuals in agency facilities or community settings, but not certified.
- Oversight mechanisms may vary, but should include direct visitation/observation.

Select Met if it is verified that the agency monitors respite programs and the monitoring includes direct visitation and observation.

Select Not Met if either of the following are evident:

- The agency does not implement any monitoring/oversight of respite programs; and/or
- The agency's monitoring does not include direct visitation and observation.

Select NA if the agency only delivers respite services in certified settings (Free Standing Respite, IRAs, ICFs).

Citations

QI: This standard is a Quality Indicator.

Section 4: Self-Advocacy & Personal Outcomes

Standard #	Standard Text	Decision
1	The agency has a mechanism to support individuals in self-advocacy.	Met/Not Met

Guidance

This Standard is a Quality Indicator related to organizational support of advocacy and self-advocacy.

Interview:

Agency staff knowledgeable of centralized self advocacy efforts and self advocacy facilitation in service planning, e.g. self-advocacy mentor, self advocacy group officer, etc.

Documentation:

Available documentation will be unique to agency practices, but may include: policy/procedure, self-advocacy charters, newsletters, meeting minutes, trainings and other evidence of formal self advocacy activities; self-advocacy and/or decision making policy/procedure; or other policy or evidence the agency may offer.

Guidance:

- This Quality Indicator is intended to assess the degree to which the agency supports individuals to take on the role as their own best advocate. This standard reviews for the presence of formal and routinely implemented agency practices. It verifies that mechanisms are available for those capable and willing to self-advocate.
- Agency support of self-advocacy may take many forms and the standard does not require a specific mechanism. Agency support of self-advocacy may occur through different viable mechanisms including but not limited to: organized and agency supported self-advocacy groups and activities; organized educational offerings to individuals on exercising choice, self-advocacy; and/or informed decision making; and formal and required agency procedures for service planning that require the person to be educated and provide information necessary to make informed choices
- Ask if a formal advocacy group exists. If it does, if possible speak to a/some member(s) and staff mentor. Ask about the group's activities and content of its meetings. Discuss how individuals are supported for participation. An educational component is key. Education may include self-advocacy skills (improved confidence to ask questions, communicate concerns, and express choices); providing information to improve individual understanding of service and support options and strategies to consider pros and cons; agency specific issues, etc. Discuss how the agency sponsors self-advocacy activities, supports participation in self-advocacy activities within and external to the agency;
- Discuss any other formal agency approach in place to foster service recipient advocacy and decision making, such as written procedures/processes that require and enable individuals to play a significant role in decisions regarding their life, life planning, and/or agency operations of services/programs.
 - o Ask how individuals are organizationally, encouraged and supported to express specific needs and wants regarding agency services and supports, request changes in agency practices, policy/procedures, and advocacy for peers who may need a voice.
 - o Agency level efforts can be aimed at support and skill development of individuals to be proficient in advocacy and choice making to make a difference at the agency level, personal level or both, so long as the efforts are organizational, and not based simply in the relationship between the individual and people that directly support them or provide their care management.

- Dependent on your conversations and discovery, request to see any supporting documentation/evidence the agency may be able to provide, if any.

Select Met if any of the following are evident:

- The agency has and supports through a designated staff member, a self-advocacy group which meets regularly and includes educational activities; and/or
- The agency enables/ provides resources to participate in local, regional and statewide self advocacy meetings, education, and events; and/or
- The agency requires through policy/procedure and verifies use, of a mechanism that ensures that individuals are provided information necessary to make informed choices and guidance to understand the information; and/or informed choices are made on behalf of individuals based on their known/perceived priorities when ability to self express is limited.

Select Not Met if:

- The agency has no formal process, policy or mechanism aimed in supporting self-advocacy and individual participation in decision making; and/or
- The agency has no expectation that individuals play a significant role in decisions regarding their activities and life planning; and/or
- The agency provides no support of groups, councils, or meetings that provide and encourage individuals to discuss issues of importance to them.

Citations

QI: This standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The agency uses formalized procedures/strategies to facilitate and ensure person-centered services.	Met/Not Met

Guidance

This is a Quality Indicator of organizational support of person centered services.

Interview:

Agency staff knowledgeable of organizational procedures and promotion of person centered services.

Documentation:

Documentation such as policy/procedures, memorandums, instructive guidance, job performance measures, or other policy or evidence the agency may offer that directs or supports person centered services at the agency level.

Guidance:

- Discuss with the agency management, organizational actions taken to ensure that services provided are person centered:
 - o Discuss and review agency written policy/procedures required by the agency specifically to implement consistent actions to address and facilitate person centered service delivery for all settings and individuals;
 - o Discuss whether the agency has reviewed its policies/procedures to ensure that procedures do not create any systemic barriers to person centered service planning and delivery (e.g. cumbersome and delayed approval processes for off-site activities, rigid business office purchasing practices); and the review resulted in revisions aimed to support person centered services, if needed.
 - o Discuss any other regularly implemented organizational approaches such as inclusion of tips for person centered services in agency newsletters, agency posters, agency level goals, agency forums so that service/program teams can share and learn from each other’s successes and challenges related to this topic; etc.
- During your review of any agency documents and policy and procedure, consider whether person centered language is used.
- Person-centered services support people with disabilities to fulfill their needs, wishes, and goals that reflect their individual culture and communication style. The person centered services promote opportunities for social inclusion (e.g., community membership, employment, personalized living arrangements, etc.) through inclusion and participation. Person centered services help individuals with intellectual and developmental disabilities to lead lives that are meaningful and purposeful to them, and that allow them to participate fully in their homes and communities to the extent they are willing and able to do so. Person centered practices ensure individuals receive services in a way they may help them achieve individual goals.
- There is no one universal approach to ensuring person centered services. However, all person-centered services begin with person centered planning. While person centered planning is often ascribed to care manager (currently) and the service coordinator (historically); all service providers must be proficient in and supportive of person centered planning practices and service delivery. This is necessary to execute the agency’s part in the service planning discussions with the individual, in planning meetings, design of program and services operations, and in the design and implementation of services the provider agency is responsible to provide.
- There is no one correct organizational approach to advance person centered services. Some policies and procedures may expect use of a particular approach; e.g. every person has a POMs interview and at least 2 unmet findings important to the person must be addressed; while other agencies may have developed agency specific policy and

practices; and others a combination of externally and internally developed approaches. This standard does not review for one correct approach, but rather for at least a formal, meaningful approach.

Select Met if at least two of the following are evident:

- The agency's written policy/procedures, require that specific actions, intended to facilitate and ensure person centered service delivery, are taken throughout the organization;
- There is evidence that activities/strategies are implemented with regular frequency, intended to promote person centered services as an agency value and improve staff competency and awareness.
- Agency policy and procedures do not inhibit person centered services.

Select Not Met if either of the following is evident:

- The agency, does not have any organizational approach to facilitate and promote delivery of person centered services.
- The agency does not regularly implement activities or strategies, intended to promote person centered services as an agency value and improve staff competency and awareness.

Citations

QI: This standard is a Quality Indicator.

Standard #	Standard Text	Decision
3	The agency has policies and procedures to ensure conflicts of interest do not interfere with person-centered services.	Met/Not Met

Guidance

This is a Quality Indicator of organizational protections against conflict of interest in person-centered planning and service delivery; and what to do if it arises.

Interview:

Agency staff knowledgeable of organizational procedures intended to prevent and address conflict of interest it arises.

Documentation:

Documentation such as policy/procedures, memorandums, instructive guidance, or other policy or evidence the agency may offer that prevents conflict and directs actions when conflict of interest in service planning and/or service delivery occurs.

Guidance:

- Agencies should develop policies that ensure conflicts of interest do not interfere in the person-centered planning process. If available, review agency policy/procedure related to preventing and addressing conflict of interest in service planning and service delivery.
- A conflict of interest means that a member of the person-centered planning team has a competing interest with the interests of the person with a disability which a reasonable person would regard as making it difficult to properly perform their responsibilities to the person with disability.
- Conflicts of interest may include, but are not limited to:
 - o Financial interests in the provision of services, including decisions to offer or deny services;
 - o Administrative interests, e.g. what agency provides services and whether it is in the best interest of the person or the agency; persuasion or emphasis to consolidate services within one agency without justification of need or individual interest;
 - o Personal or familial relationships of agency staff with the circle of support or individual; and/or
 - o Services and activities standpoint, e.g. when the person expresses interest in increased independence and autonomy while the person’s advocate insists on no changes; etc.
- Discuss with the agency management, organizational actions taken to prevent potential conflict of interest scenarios and actions to take if issues of conflict arise.
- Individuals must have access to a clear and accessible dispute resolution process when there are disagreements within the person-centered planning process. There should also be strategies for conflicts and disagreements between person-centered planning team members. Determine if written strategies for handling disagreements among people who participate in the person-centered planning process exist.
- If needed, verify that the policy was effective specific to the individual’s situation. Discuss and request documentation of any situations of conflict of interest that had to be addressed using the agency process; how they were handled and satisfaction of the individual served. As needed follow up with the individual (or their advocate).

Select Met if both of the following are evident:

The agency has a written strategy, process, or policy/procedures regarding:

- conflict-of-interest within person-centered planning, AND
- a clear dispute resolution process pertaining to disagreements between person-centered planning team members.

Select Not Met if any of the following is evident:

- the agency lacks a written strategy, process or policy/procedures that addresses conflict in the person-centered planning; OR
- the agency's written strategy, process, policy/procedure does not address one or both elements required under MET, above.

Citations

QI: This standard is a Quality Indicator.

Topic 2: Satisfaction and Complaint Management

Section 1: Complaints and Objections Procedures

Standard #	Standard Text	Decision
1	The agency has procedures to ensure that Individuals, family members, guardians and correspondents are informed of what to do if they have an objection, problem, or complaint.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Agency policy and procedure related to objections, problems, or complaints.

Interview:

Mandatory: Quality Assurance Staff, Agency Management

Guidance:

- Review the agency policy/procedure to ensure it addresses the following requirements:
 1. Informing individuals, family, guardians, and correspondents of a process to resolve objections, problems, or grievances relative to an individual's rights and responsibilities, upon admission and as changes occur [633.4(2)(ii)];
 2. Informing the same stakeholders of the parties available to receive complaints with contact information [633.4(a) (12) (i)-(v)]
 3. Informing that when an agency proposes to reduce, suspend, or discontinue a person's HCBS service(s), the agency must advise the person, and his or her advocate and care manager of the proposed changes and of the mechanism for resolving an objection to the proposed changes [633.12(a)(5)];
 4. Agency actions/procedures to inform required people (how and when) and staff responsible to complete the task.
- Written procedures should provide specificity sufficient to ensure continuity of actions, regardless of personnel changes.

Select Met if both of the following are evident:

- The agency has a policy and procedures in place that address the information regarding objections, problems, or complaints as described in 1-3 in above guidance; and
- The agency policy and procedure describes how the information is provided to individuals, parents, guardians and correspondents, per #4 in guidance above.

Select Not Met if either of the following are evident:

- The agency does not have a policy and procedures in place that address the information regarding objections, problems, or complaints as described in 1-3 in above guidance; or
- The agency policy and procedure does not describe how the information is provided to individuals, parents, guardians and correspondents, per #4 in guidance above.

Citations

633.4(b)(2)(ii)

OPWDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):

(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities

633.4(a) (12) (i)- (v)

(12) There shall be a means to advise individuals and/or and their parents, guardians or correspondents, on admission and as changes occur, of the availability of the following parties to receive complaints and concerns, with current addresses and telephone numbers:

(i) The director of the B/DDSO.

(ii) The commissioner of OPWDD.

(iii) The Justice Center for the Protection of People with Special Needs (see glossary, section 633.99 of this Part).

(iv) The Mental Hygiene Legal Service (see glossary, section 633.99 of this Part), for developmental center residents and persons in the community on conditional release from developmental centers only.

(v) The board of visitors, for developmental center residents and persons in the community on conditional release from developmental centers only.

633.12(a)(1)

The agency has procedures to ensure that Individuals, family members, guardians and correspondents are informed of what to do if they have an objection, problem, or complaint.

633.12(a)(5)

(5) The person receiving services, and his or her parent, guardian, correspondent and advocate, as applicable, shall be advised of the mechanism to resolve an objection: upon admission to a facility or enrollment in HCBS waiver services, as changes occur, and upon any substantive amendment to this section. In addition, when an agency proposes to reduce, suspend, or discontinue a person's HCBS waiver service(s), the agency shall, in a form and format approved by the commissioner, advise the person, and his or her advocate and service coordinator (see section 633.99 of this Part) as applicable, of the proposed changes and of the mechanism for resolving an objection to the proposed changes.

Standard #	Standard Text	Decision
2	The agency has procedures to address and resolve objection to services and ensure due process, in accordance with Part 633.12.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Agency policy and procedure related to agency actions regarding objections, problems, or complaints and their resolution.

Interview: Mandatory:

The agency's systems will influence who will be interviewed, but may include Agency Program Directors/Management, Agency Leadership, and/or Quality Assurance Staff.

Guidance:

The following agency processes should be written and describe agency procedures/actions to resolve an objection:

- In facilities and for HCBS waiver services, when the objection is not related to a proposal to reduce, suspend or discontinue HCBS waiver service(s) the procedures must include the following:
 - o A mechanism for informal resolution between the objecting party and relevant staff of the agency, including the chief executive officer or his or her designee. The person's coordinator and advocate must be included, as applicable.
 - o Means for written confirmation of resolution or inability to reach a resolution to be sent to the objecting party by the chief executive officer.
 - o If a resolution cannot be reached through the informal mechanism, the objecting party must be given the opportunity to submit a formal written objection requesting a hearing to the appropriate DDSO director.
 - § Within five days of receipt of a formal written objection, a hearing to take place before a hearing officer appointed by the DDSO Director, must be scheduled with no less than 10 days' notice to the involved parties.
 - § A written decision by the hearing officer must be sent to the involved parties within 14 days of that hearing.
 - o If any party to the proceeding is not satisfied with the decision, it may be appealed within 10 days to the commissioner, who will issue a final written decision to all parties within 14 days of receipt of the appeal. The commissioner may, at his or her discretion, send the matter back to the hearing officer for further review.
 - o During the period that an objection is undergoing administrative review:
 - § A person will participate in programming mutually agreeable to the objecting party, the agency, the person, and his or her parent, guardian, correspondent or advocate;
 - § Every effort feasible shall be made to maintain the person in at least his or her current level of programming; and
 - § In order to protect a person's health, safety, or welfare or the health, safety, or welfare of others, nothing must preclude a change in programming for, or the relocation or discharge of a person.

However, while an objection to placement or discharge is undergoing administrative review, relocation or discharge shall only take place with the commissioner's approval.

- Related to the reduction, suspension, or discontinuance of HCBS waiver services, agency procedures must include:

- o A mechanism for informal resolution between the objecting party and relevant staff of the agency, including the chief executive officer or his or her designee. The person's coordinator and advocate must be included, as applicable.

- § The agency shall include documentation of the result of the process in the person's record.

- o Written notice of the parties' inability to resolve the objection must be sent to the objecting party by the chief executive officer. The notice must be in a form and format approved by the commissioner and sent by certified mail, return receipt requested, or such other means so that the time of receipt of the information can be documented.

- o The objecting party may submit a written objection to the DDSO director requesting administrative review of the reduction, suspension or discontinuance, within 14 days after the receipt of the notice.

- § The agency must not reduce, suspend or discontinue the HCBS waiver service(s) at issue during such 14-day period, unless otherwise agreed to by the parties.

- § Upon receipt of a written objection requesting an administrative review, the DDSO director or his or her designee must contact the objecting party and the agency providing the service(s) to mediate resolution of the objection.

- ∅ If there is no resolution within 14 days of receipt of the objection, a hearing must be scheduled, with no less than 10 days' notice to the involved parties.

- ∅ The hearing shall be conducted by a hearing officer appointed by the DDSO director.

- ∅ The objecting party and the agency may mutually agree to extend the time periods noted in this clause.

- o The hearing officer shall issue a written decision to the objecting party and the agency within 14 days after the conclusion of the hearing.

- o Either party may appeal the decision to the commissioner and submit a written reply to the decision within 14 days of its receipt. The commissioner will issue a final written decision to all parties within 14 days of the last date to appeal. The commissioner may, in his or her discretion, send the matter back to the hearing officer for further review.

- o During the period that an objection is undergoing administrative review (including an expedited review), the agency must not reduce, suspend or discontinue the HCBS waiver service(s) at issue, unless otherwise agreed to by both parties.

- o When an agency proposes to reduce, suspend or discontinue the provision of a HCBS waiver service(s) to prevent immediate risk to the health or safety of the person or others: the agency shall make reasonable efforts to alleviate the health and safety risks at issue, and the agency or the objecting party may request an expedited hearing by the following process:

- § A written request for the hearing must be sent by the agency or objecting party to the commissioner. The agency must also immediately notify the person, parent, guardian, correspondent and advocate, as applicable, of such request.

- § If the commissioner determines that an expedited hearing is warranted, the appropriate DDSO director will schedule a hearing within seven days of the commissioner's determination. The hearing will

be held before a hearing officer appointed by the DDSO director. Absent good cause, the parties involved in the objection will receive at least three days' notice of the hearing.

§ The hearing officer's recommendation must be sent to the parties and sent to the commissioner within five days of the conclusion of the hearing. The hearing officer must advise the parties of their opportunity to send a written reply to the recommendation directly to the commissioner. The commissioner will issue a final written decision as soon as practical thereafter.

- Written procedures should provide specificity sufficient to ensure continuity of actions, regardless of personnel changes.

Select Met if the following is evident:

- The agency has written procedures in place to resolve objection to services and ensure due process as outlined above.

Select Not Met if either of the following is evident:

- The agency does not have procedures in place to resolve objection to services and ensure due process; or
- The agency has procedures in place; however, they do not minimally contain the information outlined above.

Citations

633.12(a)(1)

(1) Every agency/facility (see section 633.99 of this Part) and sponsoring agency (see section 633.99 of this Part) providing facilities (see section 633.99 of this Part) or home and community based (HCBS) waiver services (see section 633.99 of this Part) shall develop policies and procedures which establish mechanisms to resolve objections to services, in conformance with this section.

Standard #	Standard Text	Decision
3	The agency's procedures are effective to address reported objections to services or grievances.	Met/Not Met/NA

Guidance

Interview, Mandatory:

Agency Management and/or Quality Assurance Staff to discuss objections to services reported by an individual or on behalf of an individual.

Documentation Review, Mandatory:

Agency documentation maintained on received grievances, informal and formal processes implemented, steps taken in the hierarchy of actions, resolutions and decisions, and communication to required parties.

Guidance:

- Discuss with Agency Management any objections to services received by the agency and how they were resolved.
- In the first agency review, if no objections occurred in the past year, extend the past time frame to up to 3 years to review the agency process in practice. During agency reviews in following years, review all objections and actions taken in the past year/since the previous agency review.
- Review the documentation available on the objections received, actions taken by the agency, grieving party, and the resolution. The agency should retain records related to such events and documentation is required for formal complaints.
- Surveyors may have knowledge of grievances reported, based on their review activities throughout the year. Previous gathered information regarding grievance and resolution should be applied to this standard.
- This standard is not a validation that the decision or resolution was exactly what the objecting/grieving party wanted and/or requested as the resolution. The standard reviews that the agency is responsive to grievances; takes timely and appropriate action to work with the parties; and adheres to the requirements of 633.12 objections, described in the standard above.
- If there is any question or concern about agency information and documentation, follow-up with the parties filing the objection or grievance.

Select Met if the following is evident:

- Agency procedures were effective to manage and address received complaints, grievances and/or objections; ensuring that each is appropriately reviewed as needed, resolved when able, and per regulatory requirements if it is an objection to service per 633.12.

Select Not Met if:

- Agency procedures were NOT effective to manage and address received complaints, grievances and/or objections; and/or DID NOT ensure that each is appropriately reviewed as needed, resolved as able and per regulatory requirements if it is an objection to service per 633.12.

Select NA if:

- No grievances or objections to service were reported to the agency for the time period being reviewed by DQI.

Citations

QI: This standard is a Quality Indicator.

Section 2: Satisfaction

Standard #	Standard Text	Decision
1	The agency has a mechanism to determine individuals' satisfaction with the services and supports they receive.	Met/Not Met

Guidance

Interview:

Discuss with appropriate staff, e.g. agency management and/or quality improvement staff, regarding agency-wide processes to gather information regarding satisfaction.

Documentation:

If any, review satisfaction surveys or other means to solicit satisfaction from individuals and their family, guardian, advocate and agency review and aggregation of information gathered through the satisfaction surveys.

Guidance:

- This standard is a quality indicator to identify if the agency has a formal mechanism to solicit and review information from people receiving services regarding satisfaction with services.
- Determine whether the agency uses a satisfaction survey or another mechanism to uniformly solicit information from the individuals receiving services regarding satisfaction. The satisfaction assessment should be focused on the individual's input and/or the individual's point of view. The agency may also have satisfaction assessments for other stakeholders, but this standard addresses one from the view of the service recipient. Individuals however, may be supported to give input on satisfaction by family/someone close to them.
- Discuss how the satisfaction survey is administered, how often, whether sampling is used and how the information received is reviewed by the agency. To meet this standard, in addition to administering a satisfaction survey in a routine manner, not just one time (e.g. every year, every 2 years, etc.), the agency must demonstrate that the information is reviewed.
- This mechanism must be separate from individualized discussion of services and satisfaction that may occur during person centered planning.

Select Met if both of the following are evident:

- The agency implements a satisfaction survey or other satisfaction mechanism with individuals with periodic regularity, AND
- There is a focused review of the feedback provided.

Select Not Met if any of the following is evident:

- The agency does not implement a satisfaction survey or other satisfaction mechanism with individuals with periodic regularity, AND/OR
- The agency has a satisfaction assessment mechanism but does not review the input provided.

Citations

QI: This standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The agency has a mechanism for addressing/remediating dissatisfaction reported through the mechanism.	Met/Not Met

Guidance

Interview:

Discuss with proper staff, e.g. agency management and/or quality improvement staff, regarding agency-wide processes to review information received through the satisfaction mechanism.

Documentation:

If any, review a sample of the satisfaction surveys or input received by the agency, any aggregation and/or summary of the information that may have been made, and any actions taken by the agency in response to input.

Guidance:

- This standard is a quality indicator to verify whether the agency acts to address or remediation dissatisfaction identified via the satisfaction mechanism implemented.
- It verifies that the agency has processes to review the input given regarding satisfaction and determine if any of the specific input needs to be addressed and how. The agency process should address:
 - o Patterns/trends in the responses that must be addressed (e.g. agency-wide or site/service specific);
 - o Individual concerns that must be addressed if responder is not anonymous;
 - o Documentation of the decisions and actions taken.

Select Met if both of the following are evident:

- The agency has a process to determine satisfaction input that must be addressed, AND
- The agency can demonstrate that follow-up was taken or referred for action.

Select Not Met if any of the following is evident:

- The agency does not have a process to determine satisfaction input that must be addressed, AND/OR
- The agency cannot demonstrate that follow-up was taken or referred for action.

Citations

QI: This standard is a Quality Indicator.

Topic 3: Agency Procedures Regarding Rights Protections

Section 1: Rights Promotion

Standard #	Standard Text	Decision
1	The agency has procedures to ensure that individuals, family members, guardians and correspondents are informed of individual rights.	Met/Not Met

Guidance

Documentation:

Review agency policy and procedures to determine mechanisms used to notify required parties of their rights per Part 633.4

Interview agency staff as needed for clarification.

Guidance:

- Verify that the agency has written procedures for the informing parties of their rights and responsibilities and that they minimally address:
 - o Informing people of rights upon admission or initial receipt of service from the agency;
 - o Informing of rights when they are revised or amended;
 - o How the information will be communicated to the varied parties;
 - o Timeframes for informing of rights;
 - o Staff (by title) responsible for actions identified in procedures;
 - o Documentation required;
 - o How the agency verifies that parties have been informed.
- Written procedures should provide specificity sufficient to ensure continuity of actions, regardless of personnel changes.

Select Met if:

The agency has written procedures that address informing individuals of their rights inclusive of the information identified in the guidance above.

Select Not Met if any of the following is evident:

- The agency does not have written procedures to address informing individuals of their rights;
- The agency has written procedures related to informing individuals of their rights, but they lack specificity and/or the minimal components identified in the guidance above.

Citations

633.4(b)(1)

There are written policies/procedures on notifying individuals and/or their parents, guardians or correspondents of the person's rights:

- on (or prior to) admission; and
- (ii) as changes are made.

Standard #	Standard Text	Decision
2	The agency implements activities for the promotion of the individuals' rights	Met/Not Met

Guidance

Quality Indicator

Documentation Review:

Agency policy/procedures, process documents, forms, mechanisms, written plans that may demonstrate promotion of rights as described below in guidance.

Interview:

Agency staff, as needed for clarification

Guidance:

- This Standard is a Quality Indicator to identify whether there are organizational approaches to work with individuals and other agency members to understand and facilitate expression of the rights afforded to individuals as service recipients and human beings. This standard is separate from other standards focused on regulatory compliance regarding informing of rights (above), ensuring rights protections (below), and basic informing/training staff on what the rights are.
- Determine whether the agency has written policy/procedures, mechanisms, routines related to rights promotion.
- Provide the agency opportunity to demonstrate there are mechanisms implemented by the agency to increase individual competency in understanding and exercising rights and/or staff competency in understanding and facilitating individuals to exercise their rights.
- If strategies are not written, verify implementation of some of the strategies the agency staff state are routinely executed.
- There is no one acceptable strategy. To be met, the expectation is that strategy(ies) are implemented as an agency practice and not specific to one team, one location or a specific service plan; and not simply the act of informing people of their rights, reviewed in the above standard.
- Strategies may include enhancement of staff's understanding of individuals' right and their support of same.
- To be met, more than just the absence of overt rights violations is required. There should be evidence that agency promotes rights awareness and practice of rights; that people are given opportunities to practice their rights; and/or the agency offers an ongoing educational component whereby people are encouraged to learn about their rights.
- Agency strategies may include:
 - o Offering of activities that enable individuals to learn more about their rights and/or practice exercising their rights. Examples include but are not limited to:
 - o As opportunities for rights expressions arise, provide occasions and mentoring for that expression;
 - o Providing information agency wide to be reviewed through venues such as program or house meetings, training, or other activities;
 - o Organized strategies to help individuals to "practice" expression of rights;
 - o Formal informational sessions offered by the agency;

o Agency sponsored newsletters that include a topic related to rights that are reviewed with/ given to appropriate stakeholders;

o Topics may include but are not limited to:

Ø Voting: learn about government, elections and issues, platforms, and the mechanics of voting at a polling station or absentee ballot;

Ø Health and Health Care: Understanding what to expect during a medical appointment, asking questions, choosing another practitioner if not happy, seeking second opinions;

Ø Education about other specific 633.4, HCBS, or civil rights.

Select Met if the agency demonstrates implementation of at least one organizational mechanism designed to promote individuals' understanding and expression of their rights.

Select Not Met if the agency does evidence any organizational mechanism designed to promote individuals' understanding and expression of rights.

Citations

QI: This standard is a Quality Indicator.

Section 2: Rights Protections

Standard #	Standard Text	Decision
1	The agency has effective written procedures to ensure that individuals' rights are limited only in compliance with regulatory safeguards.	Met/Not Met

Guidance

Interview:

Staff responsible for oversight and assurance of rights protections, which may include quality improvement staff, staff responsible for human rights committee activities or other agency staff knowledges of agency procedures.

Documentation Review:

Agency Policy/Procedures related to rights limitations and restrictions.

Guidance:

- This standard ensures that the agency has policy and procedure regarding the protection of individual's rights by ensuring limitations and restrictions only under the protective conditions identified in regulation.
- This standard reviews that the agency has written procedures regarding rights limitations under any rights limitation condition applicable to the agency's services as specifically reviewed through this standard. All requirements to meet 633.16 (behavior interventions) and HCBS services (Part 636) are not reviewed in this standard. They are reviewed through other activities.
- The agency's written policy/procedure should:
 - o Define rights limitations;
 - o Define clinical justification;
 - o Describe the determination of time period for limitations;
 - o Define rights limitations and restrictions;
 - o Identify rights limitations and restrictions needing written informed consent.
 - o Identify right limitations and restrictions requiring agency committee approval;
 - o Describes actions to take when limitations/restrictions in place impact individuals who do not require the intervention;
 - o Describes the actions necessary to obtain consents;
 - o Identifies documentation required;
 - o Identifies staff (by title) responsible to ensure rights are limited only per regulatory requirements;
 - o If applicable to the agency's service, references that there are additional requirements for rights limitations/restrictions related to behavior interventions and HCBS services, and where the related policy/procedure can be found.
- Review agency compliance summary in Business Intelligence for the past year's (Site and Person Centered Reviews, for standards addressing assurance of rights protections to determine if the agency procedures are effective and implemented. If there is not a pattern of deficiencies related to meeting requirements for justification, consents, and approvals, p/p will be considered effective.

- If the agency states that the limitation or restriction of rights is not permitted as a strategy in the agency; there must be written agency policy stating that.
- Written procedures should provide specificity sufficient to ensure continuity of actions, regardless of personnel changes.

Select Met if both of the following are evident:

- the agency has written policy/procedure to ensure that rights limitations/restrictions occur only per requirements and generally include the information above; AND
- Site and Person Centered review results evident the agency as generally compliant in standards related to justification, consent, approval, time period for limitations/restrictions of rights.

Select Not Met if either of the following are evident:

- The agency has no written policy procedure addressing the limitation/restriction of rights per requirements.
- The agency has written policy/procedure regarding rights limitations/restrictions but two (2) or more content areas noted above are not addressed.
- The agency states it has a “no rights limitation/restriction policy”, however this is not documented and described.
- Site and Person Centered review results evidence the agency has a pattern of non-compliance with standards related to justification, consent, approval, time period for limitations/restrictions of rights.

Citations

633.4(b)(6)

For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)

633.2(b)

To provide the basis to agencies whereby they shall develop and implement written agency/facility (see glossary) specific policies/procedures (see glossary), which reflect compliance with this Part. Such policies/procedures shall become part of the agency/facility policy and/ or procedure manual(s). Upon development, such policies/procedures shall be implemented and the agency/facility shall be responsible for ensuring ongoing compliance with said policies/procedures.

If applicable to rights limitations/restrictions part of behavior interventions: 633.16(c)(9) Additional requirements apply to behavioral interventions which impose a limitation on a person's rights as specified in section 633.4 of this Part, including behavioral consequences negatively impacting the person's dignity (see paragraph [j][2] of this section), and, where applicable, as specified in section 636-1.4 of this Title concerning requirements for documentation of rights modifications in the person-centered service plan.

If applicable to rights limitations/restrictions related to HCBS service settings: 636-1.4(b) Modifications to the rights identified in paragraphs (1) -(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan:

Section 3: Human Rights Committee

Qualifier	The agency implements for at least one person, written plans, services and interventions that include or may include any of the following: modification or limitation of rights, intrusive interventions, and/or administration of medications to modify or control inappropriate behaviors.	Yes/No
Standard #	Standard Text	Decision
1	The Agency has an active Human Rights Committee.	Met/Not Met

Guidance

Interview:

- Agency Human Rights Committee (HRC) chair
- Agency staff responsible for coordination of HRC activities

Documentation Review:

- Documentation of HRC activity and membership.

Guidance:

- Through discussion and documentation review, verify that the agency has a Human Rights Committee by whatever name used, IF NEEDED.
- A behavior plan/ human rights committee is the committee which has the responsibility to protect the rights of persons whose behavior support plan incorporates the use of any restrictive/intrusive intervention and/or limitation on a person's rights to prevent, manage and/or control challenging behavior, and which exercises this responsibility through the process of reviewing and approving (or refusing to approve) proposed behavior support plans strategies described in the plans.
- The agency must use a Behavior Plan/Human Rights Committee if any person's plan includes restrictive/intrusive intervention and/or limitation on the person's rights. The agency may form its own committee or may coordinate with other agencies in the creation of a shared behavior plan/human rights committee.
- NOTE: An agency is not required to have a behavior plan/human rights committee if:
 - (i) No individual served is in need of a behavior support plan that includes a restrictive/intrusive intervention; and
 - (ii) No individual served is in need of a behavior support plan that includes a limitation on the person's rights.

Select Met if:

- The agency requires and has a Human Rights committee to review plans incorporating the use of any restrictive/intrusive intervention and/or limitation on a person's rights.

Select Not Met if:

- The agency need to have a Human Rights committee to review plans incorporating the use of any restrictive/intrusive intervention and/or limitation on a person's rights, but does not have one.

Citations

633.16(f)(1)- (2)

(f) Behavior plan/human rights committee.

(1) Every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans that include restrictive/intrusive interventions and/or rights limitations shall establish a behavior plan/human rights committee to protect the rights of persons whose behavior support plans incorporate the use of restrictive/intrusive interventions and/or a limitation on a person's rights. It may be a separate committee created solely for the purpose of meeting the requirements of this section, or it may be part of another committee. An agency is not required to have a behavior plan/human rights committee if:

(i) no individual served is in need of a behavior support plan that includes a restrictive/intrusive intervention; and

(ii) no individual served is in need of a behavior support plan that includes a limitation on the person's rights.

(2) Agencies shall create their own behavior plan/human rights committee or may coordinate with other agencies in the creation of a shared behavior plan/human rights committee.

Standard #	Standard Text	Decision
2	The Agency's Human Rights Committee maintains the required membership for review of Behavior Interventions.	Met/Not Met

Guidance

Interview as appropriate to agency mechanism for membership:

- Agency Human Rights Committee (HRC) chair
- Agency staff responsible for coordination of HRC activities

Documentation Review:

- Documentation of HRC activity and membership; e.g.:
 - o List of HRC members with annotation of their role (e.g. professional or clinical role, family member, board member, etc.)
 - o 6 month of HRC meeting minutes

Guidance:

Through a review of committee meeting minutes, verify that the committee has the required representation and that there are at least 3 persons who meet the representation requirements involved in any committee deliberations. Sampling of minutes is dependent on the frequency of committee meetings/review of behavior support plans. Minimally, review minutes for the past 6 months.

- A behavior plan/human rights committee must have a minimum of four members including:
 - (a) a licensed psychologist or a Behavioral Intervention Specialist, with training in assessment techniques and behavioral support plan development;
 - (b) a clinician, currently licensed, certified, or registered in New York State as one of the following: social worker, physician, physician assistant, nurse practitioner, registered nurse, speech pathologist, occupational therapist, physical therapist, or pharmacist; and
 - (c) an additional party, preferably with no ownership, employment relationship, or other interest in the agency. This party may be, but is not limited to:
 - (1) someone charged with the responsibility for advocating for a person's rights (e.g., an ombudsperson, a volunteer, or an advocacy organization representative); or
 - (2) someone with a developmental disability, or a guardian or family member of someone with a developmental disability.
- A committee member must recuse himself/herself from reviewing a plan for a person for whom he/she is actively involved in the delivery of services.
- The committee must have a minimum of three members present to proceed with its deliberations.
- NOTE: Agencies may comply with requirements through a collaborative relationship with other agencies; e.g. a joint committee serving more than one agency. If this approach is used, the agency must still be able to show that the committee and meeting deliberations comply with membership requirements.

Select Met if both of the following are evident:

- The HRC membership of the committee used by the agency meets minimum requirements; AND
- Deliberations for which the HRC is responsible, occur only with the minimum participation of 3 required members.

Select Not Met if any of the following are evident:

- The HRC membership of the committee used by the agency does not meet minimum requirements; AND/OR
- Deliberations for which the HRC is responsible, occur without the required minimum parties participating.

Citations

633.16(f)(8) (i-iii)

(8) Behavior plan/human rights committee membership.

(i) A behavior plan/human rights committee must have a minimum of four members including:

(a) a licensed psychologist or a behavioral intervention specialist, with training in assessment techniques and behavioral support plan development;

(b) a clinician, currently licensed, certified, or registered in New York State as one of the following: social worker, physician, physician assistant, nurse practitioner, registered nurse, speech pathologist, occupational therapist, physical therapist, or pharmacist; and

(c) an additional party, preferably with no ownership, employment relationship, or other interest in the agency. This party may be, but is not limited to:

(1) someone charged with the responsibility for advocating for a person's rights (e.g., an ombudsperson, a volunteer, or an advocacy organization representative); or

(2) someone with a developmental disability, or a guardian or family member of someone with a developmental disability.

(ii) A committee member must recuse himself/herself from reviewing a plan for a person for whom he/she is actively involved in the delivery of services.

(iii) The committee must have a minimum of three members present to proceed with its deliberations.

Standard #	Standard Text	Decision
3	The Agency's Human Rights Committee completes reviews of the use of treatments, medications and interventions designed to address a person's behaviors, in accordance with Part 633.16 requirements.	Met/Not Met

Guidance

Interview:

Agency Human Rights Committee (HRC) chair

Documentation Review:

- Documentation of HRC activity/review deliberations including 3-6 months of HRC meeting minutes that reflect review of behavior support plans, interventions and medications used, and documentation supporting the interventions in the submitted plan. Surveyor decision regarding how many months of minutes/documentation to review, should consider what is needed to determine effectiveness of HRC review. This may include weighing frequency of HRC meetings and number of individuals' plans/interventions needing to be reviewed.
- Business Intelligence review of the agency compliance summary related to HRC approval of restrictions, limitations, and modifications.

Guidance:

- Through a review of HRC meeting minutes, verify that the committee deliberations of behavior support plans and the interventions (including medication) included are competently and thoroughly executed. This includes but is not limited to vetting of clinical justification, e.g.:
- Consideration of the history of use of interventions whether they are evidenced as effective in reducing the targeted behaviors,
- Assurance that less restrictive measures are proven ineffective,
- Require that behavioral data and explanation are presented to the committee as part of their considerations,
- Assurance of inclusion of fading plan and review of reasonableness of thresholds/targets,
- Assurance of reasonable time frames for review of continued need of interventions.
- Review agency compliance summary in BI for the past year's Site and Person Centered Reviews for HRC approval. If there is not a pattern of deficiencies related to inadequate HRC review. The discovery of this pattern will occur through repeated finding of plan inadequacy. E.g.:
- Repeated findings during separate reviews conducted within a short time frame
- Aggregation of Review findings over the survey year, when it is discovered that problems with behavior support plans have sustained over time.
- Discovery of a pattern of implementation of Behavior Support Plans that have been approved by the committee but do not meet the Behavior Support Plan requirements identified in 633.16(e)(2)-(3).

Select Met if all of the following are evident:

- The HRC meets to fulfill its review responsibilities; AND
- Review of Human Rights Committee meeting minutes show comprehensive and adequate review of plans and interventions included; AND
- Site and Person Centered review results evident the agency as generally compliant in standards related to content of behavior support plans and review/approval of behavior support plans.

Select Not Met if either of the following are evident:

- The HRC does not meet to fulfill its review responsibilities; AND/OR
- Review of Human Rights Committee meeting minutes show limited and incomplete review of plans and interventions included; AND/OR
- Site and Person Centered review results show the agency as generally non-compliant in standards related to content of behavior support plans and review/approval of behavior support plans.

Citations

633.16(f)(3)- (6)

(3) Prior to the implementation of the proposed behavior support plans, the committee shall approve or refuse to approve, in writing, proposed plans which contain a limitation on a person's rights (see paragraph [c][9] of this section) and/or utilize one or more restrictive/intrusive interventions specified in paragraph [c][8] of this section, except for monitoring plans in which medication is used solely for the treatment of a co-occurring diagnosed psychiatric disorder. The term psychiatric disorder means those psychiatric disorders which are recognized as such by the American Psychiatric Association or World Health Organization. For the purposes of this section, the term co-occurring psychiatric disorder does not refer to the following: mental retardation, learning disorders, motor skills disorders, communication disorders, pervasive developmental disorders, attention-deficit and disruptive behavior disorders, and impulse control disorders.

(4) The committee must review the behavior support plans identified in paragraph (3) of this subdivision to verify that all required components are included (see subdivision [e] of this section).

(5) The committee chairperson must verify that:

(i) the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person; and

(ii) written informed consent is obtained prior to the implementation of the approved behavior support plan. If written informed consent cannot be obtained within a reasonable period of time prior to the initiation or continuance of a plan, verbal consent may be accepted only for the period of time before written informed consent can be reasonably obtained. Verbal consent must be witnessed by two members of the staff, and documented in the person's record. This verbal consent is valid for a period of up to 45 days and may not be renewed.

(6) The committee must specifically approve (or refuse to approve):

(i) the use of a mechanical restraining device that is not commercially available or is not designed for human use (e.g., modification of a commercially available device) pursuant to sub clause (j)(4)(ii)(a)(2) of this section; and

(ii) modification of intermediate and restrictive physical intervention techniques, and new intermediate and restrictive physical intervention techniques, consistent with the provisions of subparagraph (j)(1)(iii) of this section.

Topic 4: Behavior Intervention Policy and Procedures

Section 1: Written Part 633.16 Policy and Procedures

Qualifier	In consultation with the Area Director, has it been determined that agency procedures related to behavior supports/interventions must be reviewed. (Note: This determination may be due to findings of other survey activities, complaints, or other known concerns related to behavior supports.)	Yes/No
Standard #	Standard Text	Decision
1	The Agency has written Behavior Intervention Policies and Procedures.	Met/Not Met

Guidance

Interview:

- Mandatory:
 - o Agency leadership/management staff of Behavioral Services (by whatever name known)
 - o Agency provider staff responsible to provide behavioral supports/services (clinical and direct support)
- As Needed:
 - o Agency Executive Director
 - o Agency Board Chair or other member(s)

Documentation Review

- Mandatory:
 - o Agency wide policy and procedures manual(s) and/or related documents

Additional Guidance:

- Upon review of the quality and compliance of agency behavioral support services through the person-centered review, site review or other agency visits (e.g. monitoring visits, complaint visits) either, or both, serious, systemic deficiencies were identified. The agency is required to have current, compliant policies and procedures which guide agency provider staff to provide behavioral supports and services per 14 CRR-NY 633.16 person-centered behavioral intervention regulations.
- Written procedures should provide specificity sufficient to ensure continuity of actions, regardless of personnel changes.
- Interview of agency staff responsible for the development and dissemination of these policies and procedures and review of these documents should evidence if the agency has these in place. Observation will ensure that being 'in place', means that the policies and procedures are written, current, and disseminated such that staff responsible to implement these person-centered procedures know where to, and are able to, access them.

Select Met if both are present:

- Agency wide policy and procedures are in place which contain sufficient information to guide provider staff to implement behavioral supports and services compliant with 14 CRR-NY 633.16.
- Agency provider staff responsible to provide behavioral supports know where to, and can access, these policies and procedures.



Select Not Met if either are present:

- Current policies and procedures, compliant with regulations in 14 CRR-NY 633.16, do not exist.
- The 14 CRR-NY 633.16 compliant and current policies and procedures exist, but responsible staff do not know where to, or are unable to, access them.

Citations

633.16(c)(1)

General provisions;

(1) Every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans shall develop behavior intervention policies and procedures that are in conformance with this section.

Standard #	Standard Text	Decision
2	The agency's policies and procedures prohibit the use of behavioral interventions for the convenience of staff, disciplinary purposes or as a substitute for treatment or supervision.	Met/Not Met

Guidance

Interview:

• Mandatory:

- o Agency leadership/management staff of Behavioral Services (by whatever name known)
- As Needed:
 - o Agency Executive Director
 - o Agency Board Chair or other member(s)
 - o Agency QA/QI administrator
 - o Agency provider staff responsible to provide behavioral supports/services (clinical and direct support)

Documentation Review

Mandatory:

- Agency wide policy and procedures manual(s) and/or related documents
As Needed:
- o Currently active Behavioral Support Plans (BSP)
 - o IRMA review
 - o RIA review

Guidance:

Upon review of the quality and compliance of agency behavioral support services through the person-centered review, site review or other agency visits (e.g. monitoring visits, complaint visits) either, or both, serious, systemic deficiencies were identified. The agency is required to have current, compliant policies and procedures which guide agency provider staff to provide behavioral supports and services per 14 CRR-NY 633.16 person-centered behavioral intervention regulations.

These policies and procedures must include guidance and direction, to staff responsible to provide behavioral supports and services, regarding the absolute prohibition of the use of behavioral interventions as punishment, for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes, or as a substitute for treatment or supervision.

Select Met if:

- Agency wide policy and procedures are in place which contain sufficient information to direct provider staff against the use of behavioral interventions as punishment, for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes, or as a substitute for treatment or supervision.

Select Not Met if:

- Current agency policies and procedures do not explicitly prohibit the use behavioral interventions as punishment, for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes, or as a substitute for treatment or supervision.

Citations

633.16(c)(1)

(c) General provisions;

(1) Every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans shall develop behavior intervention policies and procedures that are in conformance with this section.

633.16(c)(3)

(c) General provisions;

(3) Behavioral interventions shall be designed and implemented for the purpose of developing or increasing adaptive behaviors (a.k.a. replacement behaviors) that support more independent and personally successful living, and eliminating or decreasing the frequency of challenging behaviors, but never employed for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes, or as a substitute for treatment or supervision.

Standard #	Standard Text	Decision
3	Agency policies and procedures prohibit the use of aversive conditioning	Met/Not Met

Guidance

Interview:

- Mandatory:
 - o Agency leadership/management staff of Behavioral Services (by whatever name known)
- As Needed:
 - o Agency Executive Director
 - o Agency Board Chair or other member(s)
 - o Agency QA/QI administrator
 - o Agency provider staff responsible to provide behavioral supports/services (clinical and direct support)

Documentation Review:

- Mandatory:
 - o Agency wide policy and procedures manual(s) and/or related documents
- As Needed:
 - o Currently Active Behavioral Support Plans (BSP)
 - o IRMA review
 - o RIA review

Additional Guidance:

Upon review of the quality and compliance of agency behavioral support services through the person-centered review, site review or other agency visits (e.g. monitoring visits, complaint visits) either, or both, serious, systemic deficiencies were identified. The agency is required to have current, compliant policies and procedures which guide agency provider staff to provide behavioral supports and services per 14 CRR-NY 633.16 person-centered behavioral intervention regulations.

These policies and procedures must include guidance and direction, to staff responsible to provide behavioral supports and services, regarding the absolute prohibition of the use of aversive conditioning. Regulation defines aversive conditioning as, “the contingent application of a physical stimulus or device to a person's body or senses in order to modify or change behavior. Such a stimulus or device must be reasonably considered to be uncomfortable, painful, or noxious to the person when applied. Examples of such stimuli may include, but are not limited to: water and other mists or sprays, noxious odors (e.g., ammonia), noxious tastes (e.g., hot sauce), corporal punishment (e.g., slapping, spanking, hitting, or pinching), air blasts, blindfolds, white noise helmets, and electric skin shock (see paragraph [15] of this subdivision).”

Select Met if:

- Agency wide policy and procedures are in place which contain sufficient information to direct provider staff against the use of aversive conditioning.

Select Not Met if:

- Current agency policies and procedures do not include sufficient information on the prohibition of use of aversive conditioning.



Citations

633.16(c)(1)

(c) General provisions;

(1) Every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans shall develop behavior intervention policies and procedures that are in conformance with this section.

633.16(c)(6)

(c) General provisions;

(6) The use of aversive conditioning methods is prohibited.

Standard #	Standard Text	Decision
4	Agency policies and procedures prohibit the use of sleep deprivation, food deprivation and food alteration for disciplinary purposes, the convenience of staff, or as a consequence of challenging behavior.	Met/Not Met

Guidance

Interview:

- Mandatory:
 - o Agency leadership/management staff of Behavioral Services (by whatever name known)
- As Needed:
 - o Agency Executive Director
 - o Agency Board Chair or other member(s)
 - o Agency QA/QI administrator
 - o Agency provider staff responsible to provide behavioral supports/services (clinical and direct support)

Documentation Review:

- Mandatory:
 - o Agency wide policy and procedures manual(s) and/or related documents
- As Needed:
 - o Currently Active Behavioral Support Plans (BSP)
 - o IRMA review
 - o RIA review

Additional Guidance:

Upon review of the quality and compliance of agency behavioral support services through the person-centered review, site review or other agency visits (e.g. monitoring visits, complaint visits) either, or both, serious, systemic deficiencies were identified. The agency is required to have current, compliant policies and procedures which guide agency provider staff to provide behavioral supports and services per 14 CRR-NY 633.16 person-centered behavioral intervention regulations.

These policies and procedures must include guidance and direction, to staff responsible to provide behavioral supports and services, regarding the absolute prohibition of the use of sleep deprivation and/or the alteration of a healthy and nutritious diet, timing of meals/snacks, withholding of food/drink for purposes of: punishment or behavioral control; for the convenience of staff; as a threat; as a means of retribution; for disciplinary purposes; or as a substitute for treatment or supervision.

Select Met if:

- Agency wide policy and procedures are in place which contain sufficient information to direct provider staff against the use of sleep deprivation and/or the alteration of a healthy and nutritious diet, timing of meals/snacks, withholding of food/drink for purposes of: punishment or behavioral control; for the convenience of staff; as a threat; as a means of retribution; for disciplinary purposes; or as a substitute for treatment or supervision.

Select Not Met if:

- Current agency policies and procedures do not include sufficient information on the prohibition of use of sleep deprivation and/or the alteration of a healthy and nutritious diet, timing of meals/snacks, withholding of food/drink for purposes of: punishment or behavioral control; for the convenience of staff; as a threat; as a means of retribution; for disciplinary purposes; or as a substitute for treatment or supervision.

Citations**633.16(c)(1)**

(c) General provisions;

(1) Every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans shall develop behavior intervention policies and procedures that are in conformance with this section.

633.16(c)(7) (i-iii)

(c) General provisions;

(7) There shall be sufficient safeguards and supervision to ensure that the dignity, safety, health, welfare, and civil rights of a person have been adequately protected. No behavior support plan shall:

(i) incorporate sleep deprivation as a consequence of challenging behavior; or

(ii) deprive a person of a balanced and nutritious diet;

(a) meals shall be served at appropriate times and in as normal a manner as possible;

(b) the composition or timing of regularly served meals shall not be altered for disciplinary (punishment) purposes, or for the convenience of staff;

(c) restrictions of the amount of food or type of diet that a person consumes may be made for clinical reasons, pursuant to documentation by a qualified healthcare professional, which shall specify the clinical justification for the restriction and the time period that such restriction shall be in effect, and which shall be included in the individual's written service plan; or

(iii) incorporate the use of food such that the form of the food served is altered as a consequence of challenging behavior.

Standard #	Standard Text	Decision
5	Agency policies and procedures address the requirements for the use of any intermediate and/or restrictive physical intervention techniques.	Met/Not Met

Guidance

Interview:

- Mandatory:
 - o Agency leadership/management staff of Behavioral Services (by whatever name known)
- As Needed:
 - o Agency Executive Director
 - o Agency Board Chair or other member(s)
 - o Agency QA/QI administrator
 - o Agency provider staff responsible to provide behavioral supports/services (clinical and direct support)

Documentation Review:

- Mandatory:
 - o Agency wide policy and procedures manual(s) and/or related documents
- As Needed:
 - o Currently Active Behavioral Support Plans (BSP)
 - o IRMA review
 - o RIA review

Additional Guidance:

Upon review of the quality and compliance of agency behavioral support services through the person-centered review, site review or other agency visits (e.g. monitoring visits, complaint visits) either, or both, serious, systemic deficiencies were identified. The agency is required to have current, compliant policies and procedures which guide agency provider staff to provide behavioral supports and services per 14 CRR-NY 633.16 person-centered behavioral intervention regulations.

Specific to the use of intermediate and/or restrictive physical intervention techniques, the agency must have policies and procedures which direct the design and implementation of BSPs to be compliant with 633.16(c)(8) (i-v). Therefore, agency policies and procedures must provide direction for the compliant inclusion of:

- intermediate and/or restrictive physical techniques [see 633.16(j)(1)]
- use of time out [see 633.16(j)(3)]
- the use of mechanical restraining devices to control behavior [see 633.16(j)(4)]
- the use of medication solely to control challenging behavior [see 633.16(j)(5)]
- the use of other, professionally accepted, behavioral methods to modify behavior, but which are considered restrictive or intrusive by agency policy due to the potential to risk a person's protection or to unduly impact a person's 'normal' activities (examples include the behavior mod techniques of 'response cost', 'overcorrection', 'negative practice', and 'satiation').

Select Met if:

- Agency wide policy and procedures are in place which contain sufficient information to address the use of intermediate and/or restrictive/intrusive physical interventions; use of time-out; use of mechanical restraining devices; use of medication solely to control challenging behavior; use of other professionally accepted but potentially restrictive or intrusive behavior modification methods.

Select Not Met if:

- Current agency policies and procedures do not include sufficient information to address the use of intermediate and/or restrictive/intrusive physical interventions; use of time-out; use of mechanical restraining devices; use of medication solely to control challenging behavior; use of other professionally accepted but potentially restrictive or intrusive behavior modification methods.

Citations**633.16(c)(1)**

(c) General provisions;

(1) Every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans shall develop behavior intervention policies and procedures that are in conformance with this section.

633.16(c)(8) (i-v)

(c) General provisions;

(8) Additional requirements apply to the use of “restrictive/intrusive interventions.” These interventions include the following:

(i) any intermediate and/or restrictive physical intervention techniques (see paragraph [j][1] of this section);

(ii) the use of time-out (exclusionary and non-exclusionary) (see paragraph [j][3] of this section);

(iii) the use of any mechanical restraining device with the intent to modify or control challenging behavior (see paragraph [j][4] of this section);

(iv) the use of medication solely to prevent, modify, or control challenging behavior (see paragraph [j][5] of this section); and

(v) other professionally accepted methods to modify or control behavior which are determined by agency/facility policy to be restrictive/intrusive interventions because they impose a risk to a person’s protection or encroach unduly on a person’s normal activities (e.g., response cost, overcorrection, negative practice, and satiation).

Standard #	Standard Text	Decision
6	Agency policies and procedures describe the purpose for the development and implementation of behavioral interventions and plans for individuals.	Met/Not Met

Guidance

Interview:

- Mandatory:
 - o Agency leadership/management staff of Behavioral Services (by whatever name known)
- As Needed:
 - o Agency Executive Director
 - o Agency Board Chair or other member(s)
 - o Agency QA/QI administrator
 - o Agency provider staff responsible to provide behavioral supports/services (clinical and direct support)

Documentation Review:

- Mandatory:
 - o Agency wide policy and procedures manual(s) and/or related documents

Additional Guidance:

Upon review of the quality and compliance of agency behavioral support services through the person-centered review, site review or other agency visits (e.g. monitoring visits, complaint visits) either, or both, serious, systemic deficiencies were identified. The agency is required to have current, compliant policies and procedures which guide agency provider staff to provide behavioral supports and services per 14 CRR-NY 633.16 person-centered behavioral intervention regulations.

Agency wide policies and procedures must contain information and direction which is sufficient for responsible provider staff to know why they have developed, or need to develop and implement, behavior support plans for persons with challenging behaviors. Policy and procedure must inform and direct staff that these plans must contain and be implemented in ways:

- Ø be in conformance with applicable regulation and agency specific policies and procedures;
- Ø be individualized to the person;
- Ø be designed to enhance the person's quality of life, in ways meaningful to him or her;
- Ø be designed to enhance his/her relationships with others;
- Ø be designed to enhance his/her independence;
- Ø contain positive approaches; and
- Ø include strategies and/or supports designed to establish or increase the person's adaptive (i.e. replacement) behaviors.

Select Met if:

- Agency wide policy and procedures are in place which contain sufficient information to responsible staff to ensure that they know why and how to design and implement BSP's of persons supported, by including the information, summarized under 'Additional Guidance' above and per 633.16(c)(2).

Select Not Met if:

- Current agency policies and procedures do not include sufficient information directing responsible staff to ensure that they know why and how to design and implement BSP's of persons supported, by including the information, summarized under 'Additional Guidance' above and per 633.16(c)(2).

Citations**633.16(c)(1)**

(c) General provisions;

(1) Every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans shall develop behavior intervention policies and procedures that are in conformance with this section.

633.16(c)(2)

(c) General provisions;

(2) All behavioral interventions designed to prevent or modify challenging behaviors shall be in conformance with applicable laws and regulations and agency-specific policies/procedures. Interventions and intervention plans must be individualized and designed for the purpose of enhancing the individual's quality of life, relationships with others, and ability to function as independently as possible. Such interventions shall actively include positive approaches, strategies and/or supports designed to establish or increase the person's adaptive (replacement) behaviors.

Standard #	Standard Text	Decision
7	Agency Policies and procedures require completion of a Functional Behavioral Assessment prior to the development of a Behavior Support Plan.	Met/Not Met

Guidance

Interview

- Mandatory:
 - o Agency leadership/management staff of Behavioral Services (by whatever name known)
- As Needed:
 - o Agency Executive Director
 - o Agency Board Chair or other member(s)
 - o Agency QA/QI administrator
 - o Agency provider staff responsible to provide behavioral supports/services (clinical and direct support)

Documentation Review

Mandatory:

Agency wide policy and procedures manual(s) and/or related documents

As Needed:

- Current FBA documents
- Currently active Behavioral Support Plans (BSP)

Guidance:

Upon review of the quality and compliance of agency behavioral support services through the person-centered review, site review or other agency visits (e.g. monitoring visits, complaint visits) either, or both, serious, systemic deficiencies were identified. The agency is required to have current, compliant policies and procedures which guide agency provider staff to provide behavioral supports and services per 14 CRR-NY 633.16 person-centered behavioral intervention regulations.

Agency wide policies and procedures must contain information and direction which is sufficient to direct responsible staff to the requirement to develop a Functional Behavioral Assessment (FBA) to be included in and the basis for a Behavior Support Plan to prevent and address challenging behavior (not occurring solely as the result of a co-occurring psychiatric disorder.) The policies and procedure must ensure the following information is known as required in the development of the FBA:

- It must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning;
- identify/describe the challenging behavior in observable and measurable terms;
- include identification and consideration of the antecedents for the behavior(s);

- identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior;
- identify the likely reason or purpose for the challenging behavior;
- identify the general conditions or probable consequences that may maintain the behavior;
- include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s);
- include an evaluation of preferred reinforcers;
- consider multiple sources of data including, but not limited to:
 - o information gathered through direct observations of the individual;
 - o information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and
 - o a review of available clinical, medical, behavioral, or other data from the individual's record and other sources;
- not be based solely on an individual's documented history of challenging behaviors; and
- provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.

Select Met if:

- Agency wide policy and procedures are in place which require and describe actions to ensure that a Functional Behavioral Assessment is completed, prior to the development of a Behavioral Support Plan, per regulatory requirements.

Select Not Met if:

- Current agency policies and procedures do not require and/or describe actions to ensure that a Functional Behavioral Assessment is completed, prior to the development of a Behavioral Support Plan, per regulatory requirements.

Citations

633.16(c)(1)

(c) General provisions;

(1) Every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans shall develop behavior intervention policies and procedures that are in conformance with this section.

633.16(d)(1)

(d) Functional behavioral assessment;

(1) Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning.

Standard #	Standard Text	Decision
8	Agency policies and procedures address the process for objections to current and proposed Behavior Support Plans.	Met/Not Met

Guidance

Interview:

- Mandatory:
 - o Agency leadership/management staff of Behavioral Services (by whatever name known)
- As Needed:
 - o Agency Executive Director
 - o Agency Board Chair or other member(s)
 - o Agency QA/QI administrator
 - o Agency provider staff responsible to provide behavioral supports/services (clinical and direct support)

Documentation Review:

- Mandatory:
 - o Agency wide policy and procedures manual(s) and/or related documents

Additional Guidance:

Upon review of the quality and compliance of agency behavioral support services through the person-centered review, site review or other agency visits (e.g. monitoring visits, complaint visits) either, or both, serious, systemic deficiencies were identified. The agency is required to have current, compliant policies and procedures which guide agency provider staff to provide behavioral supports and services per 14 CRR-NY 633.16 person-centered behavioral intervention regulations.

Agency wide policies and procedures must:

- contain information and direction which is sufficient to direct responsible staff to inform persons supported and/or their family/advocate on the process they can access to object to proposed or current BSP's;
- contain information necessary for responsible staff to implement the mechanisms in place to resolve objection to the BSP;
- describe the process by which the person who gives informed consent for restrictive or intrusive interventions in a BSP (which is different from the requirement of 633.12 for objection to a BSP) may access to object to restrictive or intrusive interventions [see 633.16(h)(2)(ii)]; and,
- describe the process which an individual may refuse to take a medicine designed to prevent or eliminate a challenging behavior, whether or not the behavior is considered the result of a co-occurring psychiatric disorder [see 633.16(h)(3).]

Select Met if:

- Agency wide policy and procedures are in place which contain sufficient information on the process for the person and/or their family/advocate or person providing written informed consent may object to a BSP, restrictive/intrusive interventions and/or medication designed to prevent or treat challenging behaviors.

Select Not Met if:

- Current agency policies and procedures do not include sufficient information on the process for the person and/or their family/advocate or person providing written informed consent may object to a BSP, restrictive/intrusive interventions and/or medication designed to prevent or treat challenging behaviors.

Citations**633.16(c)(1)**

(c) General provisions;

(1) Every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans shall develop behavior intervention policies and procedures that are in conformance with this section.

633.16(c) (10)

(c) General provisions;

(10) Any objection to a person's current or proposed behavior support plan or to a proposed revision of a current plan must be made following the process as outlined in section 633.12 of this Part, except for objections to the use of restrictive/intrusive interventions by the party providing informed consent and objections to medication use by an individual receiving services. (See subdivision [h] of this section.)

Standard #	Standard Text	Decision
9	Agency policies and procedures address the operation, responsibilities, and membership of the Behavior Plan/Human Rights Committee if a committee is required.	Met/Not Met/NA

Guidance

Interview:

- As Needed:
 - o Agency Human Rights Committee Chair and/or other member(s)
 - o Agency leadership/management staff of Behavioral Services (by whatever name known)
 - o Agency Executive Director
 - o Agency Board Chair or other member(s)
 - o Agency QA/QI administrator

Documentation Review:

- Mandatory:
 - o Agency wide policy and procedures manual(s) and/or related documents
- As Needed:
 - o Currently Active Behavioral Support Plans (BSP)

Additional Guidance:

Upon review of the quality and compliance of agency behavioral support services through the person-centered review, site review or other agency visits (e.g. monitoring visits, complaint visits) either, or both, serious, systemic deficiencies were identified. The agency is required to have current, compliant policies and procedures which guide agency provider staff to provide behavioral supports and services per 14 CRR-NY 633.16 person-centered behavioral intervention regulations.

When the following criteria are met, provider agencies must have policies and procedures informing and directing the existence and function of a Behavior Plan/Human Rights Committee. A Behavior Plan/Human Rights Committee is required when BSP's created by the agency for persons supported who have challenging behavior contain any of the following:

- limitations on persons' rights
- utilization of one or more restrictive/intrusive interventions (i.e. intermediate and/or physical interventions, time-out, mechanical restraining devices, medication exclusively to prevent or control challenging behavior, other professionally accepted methods which may unduly restrict normal activities or impose risk.) [See 633.16(c)(8)]
- The provider agencies' policies and procedures must also inform and direct the required membership of its Behavior Plan/Human Rights Committee. Summarizing 633.16(f)(8), the required minimum 4-person membership, must at least include the following member roles:
 - licensed psychologist or a behavioral intervention specialist
 - a NYS sanctioned social worker, physician, physician assistant, nurse practitioner, registered nurse, speech pathologist, occupational therapist, physical therapist, or pharmacist
 - an additional party, preferably with no ownership, employment relationship, or other interest in the agency

Select Met if:

- Agency wide policy and procedures are in place which contain sufficient information on the operation, responsibilities, and membership of the Behavior Plan/Human Rights Committee if a committee is required.

Select Not Met if:

- Current agency policies and procedures do not include sufficient information on the operation, responsibilities, and membership of the Behavior Plan/Human Rights Committee when this committee is indeed required.

Select NA if the agency's policies and procedures prohibit use of restrictive/intrusive interventions; limitation of rights; and/or medication to prevent or control challenging behaviors.

Citations

633.16(c)(1)

(c) General provisions;

(1) Every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans shall develop behavior intervention policies and procedures that are in conformance with this section.

633.16(f)(3)- (8)

(f) Behavior plan/human rights committee;

(3) Prior to the implementation of the proposed behavior support plans, the committee shall approve or refuse to approve, in writing, proposed plans which contain a limitation on a person's rights (see paragraph [c][9] of this section) and/or utilize one or more restrictive/intrusive interventions specified in paragraph [c][8] of this section, except for monitoring plans in which medication is used solely for the treatment of a co-occurring diagnosed psychiatric disorder. The term psychiatric disorder means those psychiatric disorders which are recognized as such by the American Psychiatric Association or World Health Organization. For the purposes of this section, the term co-occurring psychiatric disorder does not refer to the following: mental retardation, learning disorders, motor skills disorders, communication disorders, pervasive developmental disorders, attention-deficit and disruptive behavior disorders, and impulse control disorders.

(4) The committee must review the behavior support plans identified in paragraph (3) of this subdivision to verify that all required components are included (see subdivision [e] of this section).

(5) The committee chairperson must verify that:

(i) the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person; and

(ii) written informed consent is obtained prior to the implementation of the approved behavior support plan. If written informed consent cannot be obtained within a reasonable period of time prior to the initiation or continuance of a plan, verbal consent may be accepted only for the period of time before written informed consent can be reasonably obtained. Verbal consent must be witnessed by two members of the staff, and documented in the person's record. This verbal consent is valid for a period of up to 45 days and may not be renewed.

(6) The committee must specifically approve (or refuse to approve):

(i) the use of a mechanical restraining device that is not commercially available or is not designed for human use (e.g., modification of a commercially available device) pursuant to sub clause (j)(4)(ii)(a)(2) of this section; and

(ii) modification of intermediate and restrictive physical intervention techniques, and new intermediate and restrictive physical intervention techniques, consistent with the provisions of subparagraph (j)(1)(iii) of this section.

- (7) The committee shall review and make suggestions to the agency's management and/or governing body about its policies, practices, and programs as they relate to topics addressed by this section.
- (8) Behavior plan/human rights committee membership.
- (i) A behavior plan/human rights committee must have a minimum of four members including:
 - (a) a licensed psychologist or a behavioral intervention specialist, with training in assessment techniques and behavioral support plan development;
 - (b) a clinician, currently licensed, certified, or registered in New York State as one of the following: social worker, physician, physician assistant, nurse practitioner, registered nurse, speech pathologist, occupational therapist, physical therapist, or pharmacist; and
 - (c) an additional party, preferably with no ownership, employment relationship, or other interest in the agency. This party may be, but is not limited to:
 - (1) someone charged with the responsibility for advocating for a person's rights (e.g., an ombudsperson, a volunteer, or an advocacy organization representative); or
 - (2) someone with a developmental disability, or a guardian or family member of someone with a developmental disability.
 - (ii) A committee member must recuse himself/herself from reviewing a plan for a person for whom he/she is actively involved in the delivery of services.
 - (iii) The committee must have a minimum of three members present to proceed with its deliberations.

Topic 5: Oversight of Health Care Services

Sample Guidance

Applicable sections:

- Section 2 – Medication Administration

Agency Reportables

Medication Errors: 10%

Section 1: RN Oversight All Settings

Qualifier	Standard Text	Decision
	<p>Delegated nursing services (e.g. medication administration, treatments, and implementation of plans of nursing services) are delivered by direct support staff in either of the following circumstances:</p> <ul style="list-style-type: none"> ○ To individuals supported in certified sites as permitted by the Nurse Practice Act (NPA) exemption; or ○ To individuals during the delivery of community based waiver services, as permitted by the Nurse Practice NPA expansion MOU, to individuals NOT living in certified residential sites. 	Yes/No
Standard #	Standard Text	Decision
1	The agency implements procedures to ensure that a Registered Nurse (RN) or other acceptable healthcare professional is available to direct support staff, AMAPs, and LPNs during hours of service provision (including 24 hours a day 7 days a week as needed for residential services).	Met/Not Met

Guidance

Documentation Review:

- Agency Policy/Procedure, RN coverage agreements (if contracted), agency RN assignments, RN coverage schedules and after hours monitoring as applicable;
- Incident/IRMA history, trends;
- Survey History regarding health care and availability of RN support.

Interview: Agency staff responsible for clinical/nursing oversight and assignments.

Guidance:

- Verify through interview and documentation review that the agency has procedures for RN triage and consultation to staff providing delegated professional nursing services (e.g. medication administration, tube feeding). These procedures need to minimally address:
 - Availability of the services of an RN on site or by telephone during hours of service delivery. This includes 24/7 availability for certified residences.
 - The services may be given by agency RNs, Consulting RNs, or external RN service agencies
 - Providing the information and training to staff regarding the procedure and how to access the RN help, including back up strategies if the RN does not respond.

- o Determining number of people necessary to respond to the typical needs that arise and may be dependent on type of programs/services given and individuals served.
 - o Documentation required to record the communications,
 - o The RN must be either on site or immediately available by telephone when needed.
- As needed, consider whether findings from current survey cycle indicate deficiency trends related to accessing an RN as needed, that remain unaddressed.
 - Consider whether there are recent (past six months) incident trends regarding accessing the RN as needed which remain unaddressed.
 - NOTE: If the system includes the accessibility of a medical professional who may also triage and oversee health care, that is acceptable. An RN is typically assigned, but system may also include an M.D., nurse practitioner or physician's assistant.

Select Met if the agency demonstrates a practical system to maintain availability of RNs during times of service delivery, inclusive of elements described in guidance above.

Select Not Met if ANY of the following are evident:

- The agency does not have a system to maintain availability of RNs during times of service delivery.
- The agency's system does not address the minimum elements described in guidance;
- Based on review of contemporary incidents and/or recent survey history, the agency mechanism is ineffective in ensuring RN availability staff responsible to provide delegated nursing services.

Citations

633.17(a) (15) (i)-(ii)

Supervision and monitoring of staff.

- (i) Medical or nursing supervision of those staff responsible for administering medication shall be provided.
- (ii) Supervision and monitoring shall be in accordance with agency/facility policies/procedures.

ADM 2003-01

Applies to Certified Residences excluding Family Care Homes
Professional Nursing Availability:

There shall be an RN available to unlicensed direct care staff 24 hours a day, 7 days a week. The RN must be either on site or immediately available by telephone. The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.

ADM 2015-03

Applies to providers of HCBS waiver services and services provided by registered professional nurses and direct support professionals to individuals with I/DD in their private homes and while accompanying the individuals in the community, in settings not certified by OPWDD.

Availability of RNs to DSPs

The approved provider shall ensure that one or more qualified RNs are available to provide adequate supervision of DSPs in the provision of nursing tasks when DSPs are performing such tasks on behalf of the individual, 24 hours a day, 7 days a week. The RN must be either on site or immediately available by telephone when necessary to ensure that the individual is safe and to prevent unnecessary emergency room visits.

Standard #	Standard Text	Decision
2	The agency has procedures to ensure that an RN or other acceptable health care professional, provides supervision to DSPs performing delegated nursing tasks/activities and LPNs.	Met/Not Met

Guidance

Documentation Review:

Agency Policy/Procedure, RN supervision requirements, agency RN assignments, RN job duties and performance expectations, etc.

Interview: Agency staff responsible for nursing supervision and oversight.

Guidance:

About Delegated Nursing Services: An MOU between OPWDD and SED allows certain tasks related to an individual's health care may be delegated to direct support staff. The RN may to determine, using professional nursing judgment, whether any and which nursing tasks can be delegated to direct support staff and which of those staff will be authorized and trained to perform the delegated tasks. An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities. Please see ADM #2003-01 and ADM #2015-03 for additional details regarding Delegated Nursing services.

- Direct Support staff are often responsible to provide health care services, supports and administrations that in other settings would be delivered by licensed staff. Therefore, an agency must have procedures to facilitate and ensure competent RN supervision and oversight for the correct delivery of services by DSPs and LPNs to support individuals' health.

- The agency's written procedures must describe general supervision expectations and actions and may need added structure based on specific characteristics of the agency, agency programs/services, and/or of the individuals supported.

- The agency's procedures to ensure adequate provision of guidance and supervision by an RN to staff implementing health supports and delegated tasks should address:

- o Initial training of the task or activity; and

- o Minimum periodic inspection, observation of staff's actual completion of the task or activity to ensure it is consistent with standards of care and their training;

§ Agency procedures regarding the amount and type of nursing supervision required, may allow for determination by the RN responsible for supervising the task or activity, dependent upon the complexity of the task; the skill, experience and training of the staff; and the health conditions and health status of the individuals.

§ If the agency written procedure does not prescribe the amount and type of supervision required for specific tasks, the agency policy/procedure must require that the RN develop a written plan for supervision of the staff performing tasks or as part of RN oversight specifically described in Plans of Nursing Services (PONS).

§ RN activities of supervision regarding delegated nursing services should address RN assurance of the following:

- Ø adequate equipment, supplies, and medications are available, to perform the delegated nursing tasks appropriately;

- Ø the DSPs has been given training sufficient to deliver delegated nursing services;

- Ø the DSPs have demonstrated to the RN that the DSP can perform the delegated nursing tasks safely and competently in the individual's home or in the community setting, if applicable;
- Ø the individual's medical condition is stable and predictable as to allow for delegation.

o The frequency of visits to service delivery sites, at RN discretion but minimally as follows:

- § Certified community-based residences with two or more consumers: RN visit frequency can occur no less than once a week;
- § Non-certified settings where HCBS waiver services are delivered and nursing tasks are delegated: RN visit can occur no less than once in each month in which such nursing tasks are delivered.
- § Other certified settings (e.g. day programs), per agency policy; and
- § Other required visits per policy, i.e. conditions requiring on-site direct assessment of an individual by the RN, e.g. post ED visit, post hospital discharge, post ambulatory surgery, specific signs/symptoms or diagnosis, etc.

o RN documentation requirements related to their on-site visits, and supervision and oversight activities.

o Training of RNs regarding policy/procedures related to supervision and the specific actions required of the RN in their supervision of nursing tasks provided by DSPs and LPNs.

o Review that RN staffing ratios and assignments are sufficient to enable adequate supervision, based on the number of individuals requiring nursing services and the number of direct support staff and LPNs to be supervised.

§ Note: At a minimum, RN to individual ratios must be as follows. The agency may determine the need to reduce the ratio based on factors such as individuals' health needs, staff skills, and travel.

Ø Certified residences: 1 RN to 50 individuals

Ø Community services: 1 RN to 35 individuals

o Oversight and monitoring activities to verify RN required visits and oversight activities are occurring.

Select Met if the agency has written procedures describing RN supervision of staff implementing delegated nursing services to individuals that minimally address the elements described in guidance.

Select Not Met if ANY of the following are evident:

- The agency does not have written procedures addressing RN supervision of DSPs and LPNs.
- The agency's written procedures do not address the minimum elements described in guidance.

Citations

ADM 2003-01

Applies to Certified Residences excluding Family Care Homes

A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities. It is the responsibility of the employing agency to ensure that all staff is adequately trained regarding the elements of clinical nursing supervision, and the difference between clinical nursing supervision and administrative supervision.

Adequate nursing supervision is the provision of guidance by an RN for the accomplishment of a nursing procedure, including:

- initial training of the task or activity; and

- periodic inspection of the actual act of accomplishing the task or activity.
- The amount and type of nursing supervision required will be determined by the RN responsible for supervising the task or activity, and will depend upon:
- the complexity of the task;
- the skill, experience and training of the staff; and
- the health conditions and health status of the consumer.

ADM 2015-03

Applies to providers of HCBS waiver services and services provided by registered professional nurses and direct support professionals to individuals with I/DD in their private homes and while accompanying the individuals in the community, in settings not certified by OPWDD.

RN Supervision of DSPs

An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities. The approved provider shall ensure that each RN who supervises the performance of nursing tasks shall be:

- (1) thoroughly familiar with each individual's health status and nursing care plan and care needs;
- (2) informed of the approved provider's policy and procedures relating to the delegation of and supervision of nursing tasks performed by DSPs;
- (3) in receipt of required training relating to the supervision of nursing tasks provided by the DSPs;
- (4) authorized to oversee and direct care rendered by DSPs; and
- (5) capable of personally visiting the individual whenever necessary to protect the health and safety of the individual and prevent unnecessary emergency room visits.

Standard #	Standard Text	Decision
3	The agency has procedures to ensure that RNs are appropriately trained in OPWDD nursing/health care requirements regarding health care delivery and supervision.	Met/Not Met

Guidance

Documentation Review:

Agency Policy/Procedure, RN training requirements, RN training documents, RN job duties and performance expectations, etc.

Interview: Agency staff responsible for RN training, supervision, and oversight.

Guidance:

- Verify that the agency has procedures for the training of agency and/or contracted RNs responsible for supervision of DSPs and LPNs delivering delegated services.
- The agency's procedures regarding RN training must minimally address:
 - o actions to ensure that any RN with no I/DD experience, hired to supervise the delegated nursing services receive OPWDD RN Orientation/Training;
 - o RN understanding of the OPWDD Medication Administration approved curriculum, and competency in providing the training if so assigned;
 - o identification and actions to ensure RNs receive any other training needed to appropriately support the specific health needs of individuals (e.g. OPWDD diabetic care training);
 - o identification and actions of training the agency has determined necessary for the RNs to receive (e.g. Telephone Triage, Plans of Nursing Service);
 - o Review of OPWDD Medically oriented Safety Alerts)
 - o Verification that the RNs have completed required training.
- Best practice would include procedures that require RNs with I/DD experience, to receive OPWDD Nursing Orientation/Training, if they have not yet attended.

Select Met if the agency procedures minimally address all the following:

- the training requirements for RNs responsible for the supervision of individuals' health care; AND
- assurance of OPWDD orientation training to RN's new to ID/DD services;
- RN training regarding medication administration.

Select Not Met if any of the following are evident:

- The agency does not have policies and procedure to address training requirements for RNs/registered nurses; and/or
- The agency's policy/procedures do not address or inaccurately address OPWDD Nursing Orientation/Training;
- The agency's policy/procedure does not address RN competency in the Medication Administration curriculum.

Citations

ADM 2003-01

Applies to Certified Residences excluding Family Care Homes

RNs who do not have previous experience in the field of mental retardation/developmental disabilities (MR/DD) nursing will be required to complete an orientation for registered nurses in MR/DD nursing within three months of being hired.

ADM 2015-03

Applies to providers of HCBS waiver services and services provided by registered professional nurses and direct support professionals to individuals with I/DD in their private homes and while accompanying the individuals in the community, in settings not certified by OPWDD.

The approved provider shall ensure that all RNs who do not have previous experience in the field of nursing for individuals with intellectual/developmental disabilities complete an orientation for registered nurses in developmental disabilities nursing within three months of being hired. The approved provider shall ensure that the new RN completes such orientation before being assigned to supervise or delegate the performance of nursing tasks to DSPs without clinical oversight by a qualified RN with experience in provision of nursing services to individuals with intellectual/developmental disabilities.

Section 2: Medication Administration

Qualifier	Services include medication administration.	Yes/No
Standard #	Standard Text	Decision
1	<p>The agency implements procedures to ensure that all non-licensed staff who administer medications are qualified as follows:</p> <ul style="list-style-type: none"> • Direct support staff have current certification; and • Family care providers have received OPWDD training (if applicable). 	Met/Not Met/NA

Guidance

Documentation Review:

- Agency Policy/Procedure, Medication Course Completion Tracking, Certification Tracking and Oversight Mechanisms; as appropriate to agency systems
- Agency compliance history related to medication administration by appropriate parties (site protocol).

Interview: Agency staff responsible for agency oversight of medication administration qualifications.

Guidance:

- Verify through interview and documentation review that the agency has procedures and implements actions to:
 - o track medication administration certification dates;
 - o remind responsible RNs and program supervisors of upcoming recertification needed;
 - o verify that medication administration recertification procedures are conducted within the year;
 - o ensure prompt notification to staff responsible for direct support assignments, of any DSP with overdue certification, with reminder that the DSP may not be assigned medication administration; and
 - o track successful completion of the OPWDD approved Medication Administration training/curriculum by family care providers, if a family care sponsoring agency.
- Review Certification tracking to verify timely certification and evidence that delayed certifications were noted and handled appropriately.
- As needed, consider whether findings from current survey indicate trends in failure to ensure medication administration only by certified parties, that have not been adequately and systemically addressed.
- The agency must ensure that DSPs are separately certified for medication administration, tube feeding and insulin administration by the RN.

Select Met if the agency demonstrates procedures and tracking that appear effective to:

- manage and maintain certification of parties administering medication;
- ensure medication is not administered by parties not currently certified.

Select Not Met if ANY of the following are evident:

- The agency does not have procedures and tracking related to medication administration certification; and/or

- The agency's procedures and tracking do not effectively manage and maintain certification of parties administering medication; and/or
- The agency's procedures will not ensure managers responsible to assign staff duties are aware of staff without current medication administration certification.

Select NA if the agency does not permit non-licensed staff to administer medications.

Citations

633.17(a) (14) (iii)(c)- (d)

(iii) Medication shall be self-administered or administered only by the following:

(c) staff (see glossary) providing direct care services (see glossary), as documented by job description, who have:

- (1) successfully completed an OPWDD approved training course in medication; and
- (2) successfully completed the required practicum; and
- (3) been certified or recertified within the year to administer medication; or (d) a family care provider whose name appears on the operating certificate for the family care home, and who has received training in medication administration in conformance with an OPWDD approved curriculum; or a sponsoring agency approved substitute, in the absence of the family care provider.

633.17(b)(5)(ii)-(iii)

There is documentation that any person who assisted in the administration of medication, or administered a medication was either:

- (ii) a staff person providing direct care services, as documented by job description, who was certified to administer medication at the time of the administration; or
- (iii) a family care provider whose name appears on the operating certificate for the family care home and who received training in conformance with an OPWDD approved curriculum, or a sponsoring agency approved substitute.

ADM 2015-03

Applies to providers of HCBS waiver services and services provided by registered professional nurses and direct support professionals to individuals with I/DD in their private homes and while accompanying the individuals in the community, in settings not certified by OPWDD.

"...The approved provider shall ensure that all DSPs complete all OPWDD required training relating to nursing tasks. It is the responsibility of the delegating and supervising RN to provide initial and on-going individual-specific training to DSPs for all nursing tasks that DSPs will perform. The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications.

The approved provider shall ensure that medication administration, tube feeding and diabetic care is taught utilizing a standard curriculum approved by OPWDD....

The RN shall conduct annual clinical performance evaluations for unlicensed DSPs for procedures that include, but are not limited to, medication administration, insulin administration, and tube feeding. This evaluation shall become part of the employee's annual performance evaluation."

Standard #	Standard Text	Decision
2	The agency has a medication administration error reporting system which includes procedures to address/remediate causes for the errors.	Met/Not Met

Guidance

Documentation Review:

Agency Policy/Procedure related to medication administration errors

Interview: Agency staff knowledgeable of the agency’s medication administration error processes.

Guidance:

- Verify through documentation review and interview, that the agency has standardized procedures to report and address medication administration errors. The procedures should minimally include:
 - o A standardized format to document medication administration error information. The reporting form should generally include:
 - § Name of staff administering medication in error;
 - § Name of service recipient involved;
 - § Prescribed Medication name(s) and dosages involved in the error (what the individuals should receive as ordered);
 - § Date(s) and Time(s) of error;
 - § Description of type(s) of error, e.g. medication omission; wrong medication(s), wrong dosage, wrong time, wrong route
 - § Specifics related to the type(s) of error, e.g. wrong medication – name and dosage of the wrong medication; wrong dosage – specific dosage given;
 - § Effect error had on the individual;
 - § Immediate actions taken and/or monitoring implemented if discovery was within timeframe to make this possible.
 - o Assessment of causes or factors contributing to the medication error and documentation of the findings;
 - o Determination of necessary corrective and/or preventative action to be taken to address the contributing factors and prevent reoccurrences and implementation.
 - o Verification that corrective/preventative actions were implemented.
- A best practice would include trending activities to address systemic issues if identified.

Select Met if the agency has written procedures for the standardized reporting and management of medication administration errors, that includes:

- A reporting form/format inclusive of most of the fields elements described in guidance;
- Expectation to assess and document cause, determine corrective/preventive actions, and verify implementation of corrective/preventive action.



Select Not Met if ANY of the following are evident:

- The agency does not have written procedures for the standardized reporting and management of medication administration errors; or
- The agency's procedures do not include a standardize reporting document; and/or
- The agency's procedures do not address the minimum elements described in guidance.

Citations

ADM 2017-02, Handbook Commentary for 624.3(b)(9)(ii)(b)(3)

If errors involving medication do not meet the definition of a medication error with adverse effect as defined in Part 624, the agency is to ensure that the errors are recorded and addressed appropriately according to agency policy.

Standard #	Standard Text	Decision
3	The agency implements the agency medication administration error reporting and remediation system effectively.	Met/Not Met/NA

Guidance

Documentation Review:

- Documentation evidencing implementation of the agency medication administration error reporting, review and management process; trending if completed;
- Agency compliance history related to correctly medication administration to individuals per physician’s orders (site protocol and person centered review protocol)

Interview: Agency staff knowledgeable of the agency’s medication error processes.

Guidance:

- Review agency documentation related to the medication administration error reporting and management process. This should include medication administration error reporting forms (by whatever name), and documentation of review of reported errors and follow-up actions taken.
- Sample medication error reports and subsequent actions based on the following sample size: 10% of medication errors with minimum all and maximum 10. Sample sizes may be increased as needed based on initial findings.
- Verify that the medication administration errors reported were competently reviewed and addressed.
- Consider whether findings from current survey cycle indicate multiple occurrences of individuals not receiving their medications as prescribed, and if similar issues are now being identified and addressed via the agency system.

Select Met if based on the sample of medication errors reviewed, the agency implements an effective system to review, address and remediate medication administration errors.

Select Not Met if ANY of the following are evident:

- The agency does not have a system for the standardized reporting and management of medication administration errors, i.e. the preceding standard was NOT MET; or
- Based on the sample of medication errors reviewed, the agency does not adequately report, review and/or address and remediate medication administration errors; or
- Based on review survey findings, the agency mechanism is still ineffective to address and remediate medication administration errors.

Select NA if there are no known errors in medication administration to individuals.

Citations

ADM 2017-02, Handbook Commentary for 624.3(b)(9)(ii)(b)(3)

If errors involving medication do not meet the definition of a medication error with adverse effect as defined in Part 624, the agency is to ensure that the errors are recorded and addressed appropriately according to agency policy.

Section 3: Written Procedures: Delegated Nursing in Non-Certified Settings for Community-Based Waiver Services

Qualifier	DSPs provide nursing services to individuals who live in non-certified settings who receive community based waiver services.	Yes/No
Standard #	Standard Text	Decision
1	The agency providing delegated nursing services to community based individuals, has procedures to ensure that only those certain nursing services which can be delegated per ADM 2015-03 are delegated to trained DSP staff.	Met/Not Met

Guidance

Applies only to delegation of nursing services in as part of the delivery of HCBS services in community settings.

Documentation Review:

Agency Policy/Procedure addressing delegated nursing services in non-certified settings.

Interview:

Agency staff knowledgeable of the agency's processes for oversight of delegated nursing services.

Guidance:

- The agency must have oversight procedures to ensure that the only types of nursing activities delegated to DSPs to deliver to individuals in community settings, are those allowed per ADM 2015-03 as agreed with NYSED (NYS Education Department).
- The agency's written procedures regarding these services need to include a review of the specific nursing services that are delegated. The agency may determine its own process. This may range from an approval process of all written Nursing Care Plans or PONS prior to implementation, to a periodic monitoring of services and service plans of individuals for whom (delegated) nursing services are part of their HCBS waiver service delivery. Assess whether they appear reasonably adequate to result in verification of appropriateness of services and to identify whether services were wrongly delegated.
- While this standard addresses procedures for agency oversight to ensure nursing services delegated are appropriate, the tasks allowed and not allowed are identified below to assist discussion with the agency.
 - o Nursing tasks/activities/services that may be delegated by an RN and performed by a DSP include the following:
 - § bladder catheterization care (except for the insertion or removal of indwelling catheters or procedures requiring sterile technique);
 - § non-sterile dressing changes;
 - § glucose monitoring tests using medical devices approved by the FDA for over-the-counter use, if used for a single individual;
 - § respiratory care tasks, such as basic spirometry, oxygen administration, and nebulizer treatments;
 - § permanent gastrostomy or jejunostomy tube feedings;
 - § colostomy care that does not require sterile technique.
 - § basic medication administration tasks (e.g., topical, eye/ear/nose drops, enemas, suppositories, and some routinely administered oral medications); and

§ subcutaneous injections of diabetes-related medications and emergency injections (including, but not limited to, epinephrine, narcan, glucagon).

o Nursing tasks/activities/services that may not be delegated by an RN and performed by a DSP include:

§ any activity that is outside the scope of practice of a licensed practical nurse;

§ the administration of medications or fluids parenterally (except for subcutaneous injections of diabetes-related medications or emergency injections [including but not limited to epinephrine, narcan, glucagon, as described above]);

§ any services that are inconsistent with care ordered or prescribed by a physician, physician assistant, nurse practitioner, dentist, or podiatrist;

§ the administration of controlled substances, except for federal Schedule IV and Schedule V controlled substances prescribed to treat seizure disorders or another developmental disability;

§ the insertion or removal of indwelling catheters;

§ any services requiring sterile technique; and,

§ any nursing care that requires professional nursing judgment, including the assessment of the medication needs of an individual served by OPWDD.

Select Met if both of the following are evident:

- The agency has written policy/procedures to ensure/verify that only allowable nursing services are delegated for delivery as part of community based HCBS waiver services.
- The policy/procedures address most of the elements described in the guidance of above.

Select Not Met if any of the following are evident:

- The agency does not have written policy/procedures to ensure that only allowable nursing services are delegated for delivery as part of community based HCBS waiver services.
- The policy/procedures are not clear and/or do not describe activities allowed and not allowed to be delegated.

Citations

ADM 2015-03

Section- Nursing Tasks

For the purposes of this ADM, nursing tasks are tasks that may be delegated in writing by an RN to a DSP, and may include the following:

- bladder catheterization care (except for the insertion or removal of indwelling catheters or procedures requiring sterile technique);
- non-sterile dressing changes;
- glucose monitoring tests using medical devices approved by the FDA for over-the-counter use, if used for a single individual;
- respiratory care tasks, such as basic spirometry, oxygen administration, and nebulizer treatments;
- permanent gastrostomy or jejunostomy tube feedings;
- colostomy care that does not require sterile technique.
- basic medication administration tasks (e.g., topical, eye/ear/nose drops, enemas, suppositories, and some routinely administered oral medications); and
- subcutaneous injections of diabetes-related medications and emergency injections (including, but not limited to, epinephrine, narcan, glucagon);

For the purpose of this ADM, the following activities and services shall not be delegated to a DSP and shall not be performed by a DSP:

- any activity that is outside the scope of practice of a licensed practical nurse;
- the administration of medications or fluids parenterally (except for subcutaneous injections of diabetes-related medications or emergency injections [including but not limited to epinephrine, narcan, glucagon, as described above]);
 - any services that are inconsistent with care ordered or prescribed by a physician, physician assistant, nurse practitioner, dentist, or podiatrist;
 - the administration of controlled substances, except for federal Schedule IV and Schedule V controlled substances prescribed to treat seizure disorders or another developmental disability;
 - the insertion or removal of indwelling catheters;
 - any services requiring sterile technique; and,
 - any nursing care that requires professional nursing judgment, including the assessment of the medication needs of an individual served by OPWDD.

Standard #	Standard Text	Decision
2	The agency providing delegated nursing services to community based individuals, implements procedures to ensure that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.	Met/Not Met

Guidance

Applies only to delegation of nursing services in as part of the delivery of HCBS services in community settings.

Documentation Review:

Agency Policy/Procedure addressing delegated nursing services in non-certified settings.

Interview:

Agency staff knowledgeable of the agency's processes for oversight of delegated nursing services.

Guidance:

- Given the individualized nature of community based waiver services, the associated delivery of delegated nursing services, it is more vulnerable to and must be responsive to changes in levels and availability of trained staff, that are not as vulnerable in congregate settings.
- Therefore, the agency must have written processes to monitor and ensure that there are enough staff trained to deliver the needed delegated nursing services to individuals.
- This requires that the agency procedures address how to ensure:
 - o a pool of trained/qualified staff that can meet the specific nursing needs of individuals who they may not routinely be assigned to work with, and/or
 - o backup strategies to ensure assignment of substitute staff to deliver delegated during services during community based services, and/or
 - o that a trained RN will serve as back up when the direct support staff cannot deliver services due to scheduled and unplanned absences, vacancies, etc.

Select Met if both the following are evident:

- The agency has procedures to ensure that there is sufficient staffing and backup strategies in place to ensure that delegated nursing services will be delivered to individuals.
- The agency's procedures address the elements described in guidance.

Select Not Met if any of the following are evident:

- The agency does not have procedures to ensure that there is sufficient staffing and backup strategies in place to ensure that delegated nursing services will be delivered to individuals.
- The agency's procedures are unclear and/or do not address the elements described in guidance.

Citations

ADM 2015-03

"... In cases of staffing shortages where a qualified DSP is not available, an approved provider may assign an LPN or RN to perform the nursing tasks.... "

Topic 6: Workforce

Sample Guidance

New Employees and/or Employees Hired for New Positions

Applicable sections:

- Section 1 – Hiring Practices
- Section 2 – Background Checks
- Section 3 – Initial Training)

OF New Employees, Contractors, Students, Volunteers

SAMPLE SIZE

≤10

All New Hires - maximum 3

11-50

15%, minimum 4, maximum 7

51+

10%, minimum 8, maximum
20

- **New Employees or Employees in New Positions:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a rule, choose the sample from new hires and agency staff appointed to new positions in in the past one to two (1-2) years or since last review of hiring practices. Increase the time frame beyond 2 years for sample selection or sample size if necessary to ensure review of personnel requirements.

Veteran Employee Sample

Applicable sections:

- Section 1 - Hiring Practices
(*related to licenses and credentials*)
- Section 4-Annual Training and Other Training Activities

of on-going Employees, Contractors, Students, Volunteers

SAMPLE SIZE

≤10

All – maximum 3

11-50

15%, minimum 4, maximum 7

51+

10%, minimum 8, maximum
20

Other Notes

- **Clinical Staff:** Many clinical positions require licensure through the New York State Education Department (NYSED). Select a sample of licensed clinical staff not included in the “new” sample and verify that licensure necessary for their position is current. Discuss with personnel, the agency process for ensuring and verifying that licensure/certification is up to date.

Section Worksheets

Please use the bookmarks below to access worksheets for the following sections:

[Section 6.1: Workforce – Hiring Practices](#)

[Section 6.2: Workforce – Background Checks](#)

[Section 6.3: Workforce – New Employee Training](#)

[Section 6.5: Workforce – Code of Ethics/DSP Performance Evals](#)

Section 1: Hiring Practices

Standard #	Standard Text	Decision
1	The agency ensures verification and documentation that employees hired meet the qualifications for the position for which the person was hired. (excludes Clinic Medical Director, and staff responsible to write and oversee behavior support plans.)	Met/Not Met

Guidance

Guidance:

Interview: As needed- Personnel / HR staff to clarify procedures and documents that may be unclear.

Documentation Review:

List of new employees for whatever timeframe necessary for sample.

Personnel records including:

- Agency Job descriptions
- Employment application
- Resumes
- Degrees/Diplomas/Transcripts
- Training course completion certificates
- Licenses
- Interview notes
- Agency Policy and procedure
- Agency job descriptions and qualification documents
- As needed, agency written procedures related to verifying that applicants/employees are qualified for the positions they hold.

Note: Do not include review of Clinic Medical Director, and psychologists and other staff responsible to write and oversee behavior support plans. Verification of their qualifications is reviewed through other standards.

Choosing your sample:

- **New Employees or Employees in New Positions:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires and agency staff appointed to new positions in in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- **Clinical Staff:** Many clinical positions require licensure through the New York State Education Department (NYSED). Select a sample of licensed clinical staff not included in the “new” sample and verify that licensure necessary for their position is current. Discuss with personnel, the agency process for ensuring and verifying that licensure/certification is up to date.
- **Sample Sizes** are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Additional Guidance:

- Review documentation in the sample of agency personnel records to verify that employees hired meet the minimal job qualifications established by the agency or required by the functions of the position (e.g. An employee hired as an RN must be appropriately licensed).
- Review agency job descriptions and the documented education and experience requirements for the position.
- Necessary information to verify the employee meets those requirements should be in the employee’s personnel record, as other regulations require the following:
 - o Experience and Job History: A summary of employment history/related experience documented via the application, resume or through documented interview and supported by documentation of communication with last place of qualifying employment/related experience through telephone or written correspondence; 633.5(b)(1) and (4);
 - o Special Skills and Training: Information verifying that special skills or completed training/courses required by the position; 633.5(b)(5);
 - o Education: Supporting documentation of required academic credentials including official transcripts, diploma, and certificates. 633.5(d)(3)
 - o Licensure: A copy or documented verification of an employee’s current certification or licensure if it is a condition of employment or verification of current licensure completed on-line. 633.5(d)(3)

Select Met if the agency hires and reassigns appropriately qualified employees as evidenced by the following:

- Review findings indicate that the agency has hired employees that meet the qualifications or licensure for the position they hold and the job duties they are expected to perform;
- If the agency has hired an employee that does not meet the agency only qualifications for the position, there is documentation of a reasoned decision to hire the person anyway. (Does not apply to positions that require licensure, such as RN, Physical Therapist, etc.)

Select Not Met if any one of the following is evident:

- The agency has hired employees that do meet the job qualifications, including licensure if needed;
- The agency has hired employees that do not meet agency job qualifications and there is no reasoned and acceptable justification;
- Regardless of applicant qualifications, the agency does not verify or keep documentation that verifies that applicants meet the qualifications for their position prior to the performance of the duties of the position;
- More than one employee does not have a current license/certification (expired) for the position they hold and duties they perform, but had it at the time their start date.

Citations

633.5(d)(3)- (4)

Personnel records shall:

- (3) include a copy or documented verification of an employee's, volunteer's or family care provider's academic credential and/or current certification or licensure, if such an academic credential, certification or licensure is a condition of employment or participation; and
- (4) include documented confirmation of an applicant's last place of employment or related experience.

Standard #	Standard Text	Decision
2	The agency ensures that employees who are developing and/or monitoring Behavior Support Services meet the educational and experiential qualifications for their positions.	Met/Not Met/NA

Guidance

Documentation Review:

- Mandatory as appropriate to position:

List of new employees assigned responsibilities for Behavior Supports, for whatever timeframe necessary for sample. Personnel files: Employment application, Resume, College Degree and/or Transcript, Specialized Course completion certificate.

- As needed: Waiver application and written response

Additional Guidance:

- Discuss verification activities with personnel staff and review employee personnel files maintained by the agency to verify that staff assigned to develop or supervise behavior support plans, meet the required educational, experiential and/or licensure requirements.
- This includes the following roles/positions: Behavior Intervention Specialist Level 1 and Level 2, Licensed Psychologist, Licensed Clinical Social Worker, and for agencies that are DDSOs, the civil service titles responsible for behavior supports.
- The sample of employee files reviewed must include at least one (1) employee serving as a BIS; and if any BSP includes restrictions/intrusions/limitations; at least (1) employee fulfilling the licensed Psychologist or licensed Clinical SW supervision role.
- If these roles are fulfilled by contracted staff, the agency must still verify that the contractor meets qualifications for the position and maintain documentation of qualifications. Review documentation for contracted staff.
- If the agency's services include Behavior Support Plans (BSPs) with a restrictive/intrusive intervention and/or a limitation on a person's rights, verify that the agency has a licensed psychologist or licensed clinical social worker available on staff or contracted to write and oversee plans or to provide supervision to the Behavior Intervention Specialist(s).
- Note: A person lacking the specific educational and experiential credentials may be approved to complete the activities of a BIS, licensed psychologist or licensed clinical social worker if OPWDD has approved a waiver of a specific requirement for that particular person. If such waiver has been granted the agency has been provided documentation via letter or email from OPWDD Central Office approving the waiver. Verify that any person not directly meeting the qualifications but performing the functions of the position has had the qualification exception waived by OPWDD.
- See regulatory reference 633.16(b)(32) for the specific qualifications of Level 1 and Level 2 Behavior Intervention Specialists.

Select Met if the following is evident as applicable to the agency's Behavior Support Services staffing:

- Sampled personnel files of employees writing and/or supervising behavior support plans include documentation demonstrating that requirements for experience, education and/or licensure per their assigned responsibilities, are met as follows:

- o Employees functioning as Behavior Intervention Specialists 1 or 2 meet requirements outlined above and in 633.16(b)(32)
- o Employees responsible to develop or supervise BSPs with restrictions, intrusions, or limitations, are licensed as described above;
- o Employees responsible for behavior support plans and/or supervision in State Operated agencies are in civil service titles permitted for their functions; OR
- o There is documentation that OPWDD approved the waiver of specific requirement(s) for each employee responsible for developing and supervision BSPs, that does not meet the required qualifications.

Select Not Met if there is not documentation to evidence that employees involved in developing and supervision of BSPs either:

- o Meet the educational, experiential, or licensure requirements for the position; or
- o Have OPWDD-approved waiver of the educational, experiential, or licensure requirements for the position.

Select NA if the agency does not implement behavior supports through functional behavior analysis and behavior support plan development and implementation.

Citations

633.16(e)(1)

Level 1 Behavioral Intervention Specialists (BIS) may develop and/or provide supervision for behavioral support plans or services that do not include restrictive/intrusive interventions. Level 2 BIS may develop behavioral support plans or services that do not include restrictive/intrusive interventions under the supervision of Level 1 BIS. Behavior support plans or services which include restrictive/intrusive interventions may be developed by a Level 1 or a Level 2 BIS under the supervision of a licensed psychologist or licensed clinical social worker (LCSW) (see paragraph [3] of this subdivision).

633.16(e)(2)(i)

All behavior support plans must:

- (i) be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques;

633.16(e)(3)(1)

(i) Level 1 and Level 2 BIS who develop and/or provide behavior support services to implement behavior support plans which include restrictive/intrusive interventions shall function under the supervision of a licensed psychologist or licensed clinical social worker.

633.16(b) Definitions (32)

Specialist, behavioral intervention (BIS).

- (i) Level 1 BIS. In order for a party to be a Level 1 BIS, the party must:

(a) have the following educational background:

(1) at least a Master's degree from a program in a clinical or treatment field of psychology, social work, school psychology, or applied psychology as it relates to human development and clinical interventions, and documented training in assessment techniques and behavior support plan development; or

(2) a national board certification in behavior analysis (BCBA) and a Master's degree in:

(i) behavior analysis; or

(ii) a field closely related to clinical or community psychology that is approved by OPWDD; or

- (3) a New York State license in mental health counseling; and
 - (b) have at least five years of experience:
 - (1) working directly with individuals with developmental disabilities, including the development, implementation, and monitoring of behavior support plans; and/or
 - (2) providing supervision and training to others in the implementation of behavior support plans.
- (ii) Level 2 BIS. In order for a party to be a Level 2 BIS, the party must meet the qualifications outlined in clauses (a), (b), or (c) of this subparagraph:
 - (a) The party must have a BCBA and a Master's degree in:
 - (1) behavior analysis; or
 - (2) a field closely related to clinical or community psychology that is approved by OPWDD; or
 - (b) The party must:
 - (1) have either:
 - (i) a Master's degree in a clinical or treatment field of psychology, social work, school psychology, applied psychology as it relates to human development and clinical intervention, or a related human services field; or
 - (ii) a New York State license in mental health counseling; and
 - (2) have or obtain OPWDD-approved specialized training or experience in functional assessment techniques and behavior support plan development; or
 - (c) The party must:
 - (1) have a Bachelor's degree in a human services field; and
 - (2) have provided behavioral services for an agency in the OPWDD system as of, and continuously since, December 31, 2012; and
 - (3) either:
 - (i) is actively working toward a Master's degree in an applied area of psychology, social work, or special education; or
 - (ii) completes at least one graduate-level course in an applied health service area of applied psychology, social work, or special education each year.
 - (iii) The qualifying Master's degrees referenced in this paragraph, including any degree obtained through an online educational or distance learning program, must have been awarded by a regionally accredited college or university, or one recognized by the NYS Education Department as following acceptable educational practices. If the Master's degree was awarded by an educational institution outside the United States and its territories, the party must provide independent verification of equivalency from one of the approved entities used by the NYS Department of Civil Service for educational equivalency reviews.
 - (iv) Notwithstanding any other provision of this section, parties who are employed by New York State and function in a title included in a New York State Civil Service title series shall provide behavioral services or supervision of such services described in this section as included in their job descriptions.



(v) Notwithstanding any other provision of this paragraph, a party may be considered a BIS in the event that OPWDD has approved a waiver of a specific required qualification upon application of a provider (see paragraph [c] [12] of this section).

Standard #	Standard Text	Decision
3	The agency's certified clinic facility is assigned a qualified Medical Director that is a licensed physician or dentist.	Met/Not Met

Guidance

Documentation Review:

- Mandatory - Personnel records:
 - Medical license
 - Board certification
 - Resume
 - Agency policy for position qualifications
- As needed:
 - Agency policies for verification of licensure and certifications.

Interview: HR/Personnel, and management staff as needed

Additional Guidance:

Verify through review of documentation in personnel records, that the agency has confirmed that the person hired as clinic (Article 16, Treatment Clinic) Medical Director, is qualified for the position as follows:

- Physician:
 - Is currently licensed to practice in NYS; and
 - Has or is eligible for American Board of Medical Specialties certification in pediatric, adult medicine, neurology family practice medicine or internal medicine; OR with OPWDD approval to hire, has or is eligible for an alternative board-certified specialty such as psychiatry; and
 - Meets agency specific qualifications per agency policy.
- Dentist:
 - Is currently licensed to practice in NYS; and
 - Meets agency specific qualifications per agency policy; and
 - If engaged in any amount of specialized dental practice under clinic auspices, has or is eligible for board certification in an appropriate specialty.

Agency verification of current licensure and board certification may occur through online activity so long as details of the actions and findings are documented.

Select Met if the agency maintains documentation evidencing the clinic Medical Director's current licensure, certification/eligibility and agency qualifications. If board certification/eligibility is other than those required in the regulation (such as psychiatry or other) OPWDD written approval must also be present.

Select Not Met if documentation of one or more of the following is lacking for the clinic Medical Director:

- Current medical license;
- board certification or eligibility;
- agency required educational and experiential requirements.

Citations

679.3(h)

An appropriately qualified physician shall be responsible for the ongoing direction of all clinical services. The medical director shall be licensed to practice medicine in New York State and shall be designated as responsible for maintaining the general health conditions and practices of the program. If the clinic provides dental care, the medical director may be a dentist.

679.4(l) (1)- (3)

(l) OMRDD shall verify that there is a licensed physician or dentist, as appropriate, assigned responsibilities as the medical director for the facility who shall:

- (1) If a physician, be board certified by the American Board of Medical Specialties in pediatrics, adult medicine, neurology, family practice medicine, or internal medicine, or be eligible for said certification. Given documentation of the unique or specialized needs of the majority of persons to be served, the clinic, subsequent to OMRDD approval, may employ a candidate with, or eligible for, an alternative board certified specialization such as psychiatry; or
- (2) If a dentist, be board certified in an appropriate specialty (if engaging in any amount of specialized dental practice under the clinic treatment facility's auspices), or be eligible for said certification; and
- (3) Be qualified pursuant to agency policy for the position by training, experience, and administrative ability.

Standard #	Standard Text	Decision
4	The agency documents confirmation of applicants' last place of employment or related experience in the personnel file.	Met/Not Met

Guidance

Documentation Review:

- List of new employees for whatever timeframe necessary for sample. Personnel records, documentation of contact with the previous employer, employment application, and/or correspondence; agency policy/procedure if needed.
- As needed, agency written procedures related to verification of employment/experience.

Choosing your sample:

- **New Employees or Employees in New Positions:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires and agency staff appointed to new positions in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- **Sample Sizes** are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Additional Guidance:

Verify that the agency contacted the last place of employment, and that they also contacted other employers if the related work experience is a requirement for the position. The verification must be documented.

Documentation of communication with the last place of qualifying employment/related experience through telephone or written correspondence includes:

- Date of the verification contact;
- Name, position/job title, and contact information of the previous employer's representative that provided verification of the work history and related experience;
- Name and position/job title of the agency HR staff that contacted the previous employer.

Select Met if the sampled personnel record have documentation to evidence that prior employment and/or related experience for the position has been verified; or there is documentation of satisfactory documentation of why this could not be verified and the justification for hiring without it. The required documentation will be accepted for purposes of the agency review if all but one of the documentation requirements identified under ""additional guidance"" is present; e.g. The person contacted at previous employer is identified by their specific job title was not documented.

Select Not Met if the sampled personnel records lack adequate documentation related to verification of prior employment and/or related experience for the position, as described above.

Citations

633.5(b)(2)

In accordance with the agency's policies/procedures, the application process for employees, volunteers (see section 633.99 of this Part) or prospective family care providers shall include, but need not be limited to, the following requirements:

- (2) Names, addresses and, where available, telephone numbers of references who can verify the applicant's history of employment or related experience, work record and qualifications.

Standard #	Standard Text	Decision
5	The agency ensures that applicants provide a statement indicating whether or not they had ever been convicted of a misdemeanor or felony in any jurisdiction, or has any pending criminal charge, and a description of same.	Met/Not Met

Guidance

Documentation Review:

- List of new employees for whatever timeframe necessary for sample.
- * Personnel records such as Employment application or application supplement
- * Criminal Background Check information
- As needed, agency written procedures related to applicant crime statement

Interview: Discuss any inconsistencies or questions that arise during review of personnel records.

Choosing your sample:

- **New Employees:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- **Sample Sizes** are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Additional Guidance:

Verify that the Agency has an effective procedure to ensure that the employees, during the application process, provide a response to the requested information indicating whether they had ever been convicted of a misdemeanor or felony in any jurisdiction, or has any pending criminal charge, and a description of same.

- For the employees chosen for the sample, review personnel files to verify that they have answered a statement indicating whether they have ever been convicted of a crime or have any criminal charges pending against them. If the response indicates that they have a criminal conviction or pending criminal charges, the statement must include a description of all convictions and pending criminal charges.
- Response within the application or supplement document that includes this information is acceptable.
- If a document separate from the application is used by the agency, ensure staff provided responses and signed the document.
- **Note:** This statement is required even though the agency must submit a criminal background check.
- The agency best practice is to compare the applicant's statement with the criminal history background check results to verify the statement.

- If DQI staff note that the application information differs from the criminal history background check results review the information to determine if the agency was aware, actions taken regarding the discovery, and if they have processes to validate responses on the application with background check reports.

An appropriate statement by the applicant/employee of criminal conviction or pending charges should provide as much detail as possible regarding the dates/ time frame, the offenses charged, disposition and/or status of the case. If information documented appears too vague for agency follow-up, discuss with personnel staff, how this is/was handled and whether there is further documentation to support their response.

Select Met if sampled personnel records include:

- Employee responses regarding whether they have any criminal convictions or pending criminal charges; AND
- If the employees have any pending charges or convictions, a description is provided; AND.
- The employee responses do not contradict the criminal history report, or if they do, the agency has documented follow-up regarding the discrepancy.

Select Not Met if:

- The application/application process does not include inquiry regarding criminal history; OR
- Sampled personnel records lack employee responses to the required criminal history inquiry; OR
- If the employees respond that they have any pending charges or convictions but do not provide: information regarding the offenses; and there is no evidence of agency follow-up regarding omitted description.

Citations**633.5(b)(6)**

A statement by the applicant, indicating whether or not he or she has ever been convicted of a misdemeanor or a felony in any jurisdiction, and whether there is any pending criminal charge against the applicant. The statement shall include a description of all convictions and pending criminal charges.

Standard #	Standard Text	Decision
6	The Agency has an effective procedure to ensure that if the position requires driving, the applicant provides a statement indicating if there have been any convictions of moving violations within the last three years; and any suspension, revocation, alcohol and drug related offenses, driving while intoxicated convictions or any occurrence involving harm to persons or property while driving.	Met/Not Met/NA

Guidance

Documentation Review:

- List of new employees for whatever timeframe necessary for sample.
- *Personnel records such as Employment application or application supplements
- As needed, agency written procedures related to applicant driving history information

Choosing your sample:

- New Employees or Employees in New Positions: The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires and agency staff appointed to new positions in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Additional Guidance:

Verify that the employee whose position requires driving, provided a response to the requested information on the application or separate document. This statement is required even if the agency has procedures to obtain a driving abstract for prospective employees.

- This statement must be obtained for an employee that may have been originally hired for a non-driving position and transferred to a position that requires driving. Therefore, the employee sample should include employee transferred to new positions.
- Responses to questions regarding driving history are either “yes”, with an explanation or “no”.
- Response within the application or supplement document that includes this information is acceptable.
- If a document separate from the application is used by the agency, ensure staff provided responses and signed the document.

Select Met if the sampled personnel records include documented responses regarding required driving history information, including specific information on any suspension, revocation, or occurrence involving harm to human beings or property while driving, when applicable.



Select Not Met if sampled personnel records lack acceptable documented responses regarding required driving history information:

- There is no response to driving history inquiry; or
- The employee response lacks necessary details regarding suspensions, revocations, or harm.

Select NA if there are no positions in the agency for which driving is required.

Citations

633.5(b)(7)

In accordance with the agency's policies/procedures, the application process for employees, volunteers (see section 633.99 of this Part) or prospective family care providers shall include, but need not be limited to, the following requirements:

- (7) A statement by an applicant for a position for which driving is required, indicating whether he or she has ever been convicted of a motor vehicle moving violation, including, but not limited to, alcohol and drug-related offenses. The statement must also indicate any suspension, revocation, or occurrence involving harm to human beings or property while driving.

Standard #	Standard Text	Decision
7	The Agency procedures ensure that the applicant/employee provides written/signed acknowledgement that information provided on the application is true and acknowledges that false answers are grounds for dismissal.	Met/Not Met

Guidance

Documentation Review:

- List of new employees for whatever timeframe necessary for sample.
- * personnel records such as Employment Application or application supplements
- As needed, agency written procedures related to truthful application completion and consequences for falsehoods.

Choosing your sample:

- **New Employees:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- **Sample Sizes** are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Additional Guidance:

Ensuring application information is truthful is necessary to sound screening and hiring practices.

Verify through review of applications, application attachments in personnel records, that the agency has informed the applicant that information provided must be true and the consequences for being untruthful.

Required information includes:

- A statement on the employment application informing applicants that a false answer to any question in the application process is grounds for immediate dismissal. An acknowledgement of this statement must be signed by the applicant.
- A statement by the applicant stipulating that all information provided on the application is true. This may be accomplished by the applicant's signature acknowledging this statement on the employment application, or on a separate attestation.
- These two separate statements may be acknowledged as a unit by one signature by the applicant on an employment application (as in a boxed or highlighted area containing both statements) or separate attestation.
- Acknowledgement at the end of the application or supplement that includes this information is acceptable.
- Although one signature may be used, both statements must be present immediately preceding the signature for the standard to be met.

Select Met when sampled personnel records include a statement noting that all information provided on the application is true and the application (or other appropriate form) informs the applicant that a false answer to any question in the application process is grounds for immediate dismissal, and there is signed acknowledgement by the applicant.

Select Not Met if:

- o The sampled personnel records lack statement noting that all information provided on the application is true and/or the application (or other appropriate form) does not inform the applicant that a false answer to any question in the application process is grounds for immediate dismissal; and/or
- o The sampled personnel records lack employees' signature/acknowledgement of the statements.

Citations**633.5(b)8)**

(b) In accordance with the agency's policies/procedures, the application process for employees, volunteers (see section 633.99 of this Part) or prospective family care providers shall include, but need not be limited to, the following requirements: ...

- (8) A statement that all information provided on the application is true

633.5(b)9)

(b) In accordance with the agency's policies/procedures, the application process for employees, volunteers (see section 633.99 of this Part) or prospective family care providers shall include, but need not be limited to, the following requirements: ...

- (9) An application form or other appropriate form that informs the applicant that a false answer to any question in the application process is grounds for immediate dismissal

Standard #	Standard Text	Decision
8	There is a mechanism to ensure that people receiving supports are supported to have a role in the hiring process to include candidate recruitment, interview and hiring decisions.	Met/Not Met

Guidance

THIS IS A QUALITY INDICATOR focused on best practices for service recipient participation in agency hiring activities.

Suggested Interviews, dependent upon agency organizational structure, agency hiring process, advocacy mechanisms, etc.:

- Personnel staff
- Executive / Management staff
- Advocacy or advocate group members; individuals involved in hiring

Documentation Review:

- Agency written procedures and/or management plans related to employee recruitment and/or hiring processes
- Personnel, program, and/or advocacy group documentation evidencing participation/input from individuals receiving supports and/or family members.
- Personnel records if applicable

Additional Guidance:

This standard reviews whether the agency has implemented any routine procedures to facilitate participation of individuals supported by the agency in employee hiring/recruitment activities.

- Converse with appropriate agency staff to determine if individuals supported by the agency take part in employee recruitment and hiring or to develop skill in preparation for their participation in employee hiring and recruitment.

If after enough discussion on the subject, the agency reports that individuals do not have any role in such activities, there is no need to conduct further review.

o If the agency does report that there are processes in place for individuals' participation and/or input in hiring, request documentation and have discussions with individuals and staff than will provide more information.

§ Review documentation of the mechanism (e.g. written procedures) for individuals' involvement and its implementation. Best practice would include agency written procedures so that mechanisms in place are clearly established and sustainable. Likewise, the agency best practice would be to maintain documentation of individuals' participation in hiring recruitment, to enable review and reporting of the implementation of the procedures and their effectiveness.

§ Converse with individuals selected to participate in hiring/recruitment processes, personnel, and other agency staff to understand the strategies to involve individuals:

- how individuals are invited to take part in recruitment/hiring;
- how/if individuals have input in deciding qualifications and characteristics desired for staff positions, especially Direct Support staff;
- how individuals interact with interested people and applicants,
- how input is solicited from individuals and used in hiring decisions,
- how individuals are aided to complete the activities assigned to them;
- how individuals are supported competently exercise their role in hiring and/or develop the skills necessary.

- If the agency has procedures for individual involvement, but there is no evidence of individual involvement, determine whether the agency has taken consistent and ardent action to invite, encourage, and promote individual participation. Request information showing actions taken.
- Agencies should support Individuals' participation through facilitation of natural or paid supports, transportation and reasonable accommodations.
- Examples of possible individual involvement include: Assisting at job fairs by interacting with interested job seekers, conducting job interviews in whole or part, meeting with applicants chosen by the agency as a final vetting mechanism, explaining the expected role of the applicant in the service or service environment where they may be working, etc.

Select Met if:

- Documentation and detailed interview provide evidence that individuals who receive services from the agency, routinely have an active and meaningful role in employee recruitment and or hiring activities, that includes at least 2 of the following:
 - o Active participation in the interview process;
 - o Opportunities to spend time with applicants prior to hire and offer feedback/impressions;
 - o Playing an active part in recruitment activities by engaging with people interested in employment to help the interested parties to understand the job, developmental disabilities, key qualities needed in an employee, etc.

OR

- Documentation and detailed interview provide sufficient evidence that the agency conscientiously and routinely provides, offers, invites, encourages, and teaches individuals to be active participants in hiring and recruitment activities; and the agency initiates strategies to improve/increase voluntary participation in such activities.

Select Not Met if any of the following are evident:

- Individuals do not take part in agency hiring/recruitment activities;
- The agency has no mechanism for active participation of individuals in hiring and/or recruitment;
- The agency has a plan/written procedure for participation of individuals in hiring/recruitment, but it is not implemented and/or supported to be implemented (e.g. staff support, transportation or other resources are not available to support individuals to participate);
- Individuals are present during hiring/recruitment activities but have no active role.

Citations

QI: This Standard is a Quality Indicator.

Section 2: Background Checks

Standard #	Standard Text	Decision
1	The agency designated an authorized party or parties responsible for the agency’s criminal background check information and submitted necessary information to the Justice Center, as required.	Met/Not Met

Guidance

Documentation Review:

- Justice Center Website: CBC and authorized party information is available on the Justice Center website in the Criminal Background Check Section. Explanation is below. The information can be reviewed in advance of or during the agency review visit.
- As needed
 - Agency policies and procedures related to Criminal Background Checks

Interview: During the entrance conference, ask who the agency has designated as authorized parties with the Justice center. Interview with at least one of the authorized parties about the agency’s processes as appropriate.

Additional Guidance:

- The agency must designate at least one person as designee as responsible for the agency’s CBC information.
- Review information on the Justice Center website, Criminal Background Check section. The information can be reviewed in advance of or during the agency review visit.
 - Log in with your ny.gov user name and password
 - Hover mouse over Reports
 - Click on “Authorized Person Update Report”
 - For State Agency Group, select “OPWDD-Providers”
 - For File Format select format you prefer to use.
 - For AP Status, most routinely you will select “Active”. Select pending separately as needed if the agency reports they have submitted new/additional staff members to be authorized for information.
 - The pdf and Excel reports provided include all providers so it is recommended that you use the “Find” tool to search for agency’s name. E.g. if the county name is in the name of the agency, searching the word “Onondaga” will find the agencies with that in the title, and when you hit next, bring you to each agency with the word in it in succession.
- Ensure that the individuals who the agency reports as designees have an “Active” Status in the report, or if recently submitted and not yet active in the role “Pending” status.
- Verify that all names on the report as active are still assigned this role within the agency. The agency must keep designee information up to date with the Justice Center by informing when an employee is no longer assigned to the CBC task, so that they do not receive criminal background information. These employees would be indicated as “Inactive” on the report. If not indicated as inactive on the JC report, verify that the agency has submitted documentation to the JC to update the former designee’s status.

Select Met when the following are evident:

- The agency/provider of services has designated one or more authorized parties;
AND
- Authorized party or parties named by the agency are “Active” per the Justice Center report;
AND
- Authorized party or parties listed on the Justice Center report is current/up-to-date.

Select Not Met when any of the following is evident:

- The agency/provider of services has not designated an authorized party; and/or
- Authorized party or parties named by the agency are not “Active” per the Justice Center report;
- Authorized party or parties listed on the Justice Center report is not accurate/up-to-date

Citations

633.22(c)(1)

Each agency, sponsoring agency and provider of services shall designate one or more authorized parties and shall submit the name, position and contact information for the authorized party or parties to the Justice Center in the form and format required by the Justice Center.

Standard #	Standard Text	Decision
2	Criminal history background checks are submitted for prospective employees, volunteers, (and family care providers) in accordance with 633.22(d)(2)(i), as required.	Met/Not Met/NA

Guidance

Documentation Review:

- A list of all new employees, volunteers, contractors, and family care providers who were hired, taken on, contracted with, or certified since (respectively), for sampled time period described below.
- Justice Center Website: Review Criminal Background Check information found on the Justice Center website as instructed.
- As needed, agency policy and procedures

Interview:

- Personnel Manager/Administrator and/or Agency Designated Authorized Party

Additional Guidance:

- Survey staff will compare the list of employees, volunteers, contractors, who will have regular and substantial unsupervised or unrestricted physical contact with people receiving services, and family care providers with CBC information on the Justice Center website.
- Survey staff will discuss/resolve any discrepant information with the designated authorized party
- Note that a staff member may be temporarily approved to work pending CBC results, in accordance with 633.22(f)(1)(i)-(ix), but not before the background check is submitted.
- Review information on the Justice Center Website Criminal Background Check section. The information can be reviewed in advance of or during the agency review visit.
- If it is discovered that an employee who must undergo CBC has not been subject to a background check, verify the employee's current assignment. They must not have regular and substantial unsupervised or unrestricted physical contact with persons receiving services.

Choosing your sample:

- New Employees: The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met when criminal history background checks were submitted for all new prospective employees and volunteers who will have or have regular and substantial unsupervised or unrestricted physical contact with people receiving services, and family care providers.

Select Not Met* when criminal history background checks were NOT submitted for all new prospective employees and volunteers who will have or have regular and substantial unsupervised or unrestricted physical contact with people receiving services, and family care providers.

*DQI staff must immediately contact a Bureau of Program Certification Area Director when the survey staff determine that a party who has regular and substantial unsupervised or unrestricted physical contact with persons receiving services has not been subject to a criminal background check, as required. A plan of correction will have to be taken during the visit to ensure that individuals receiving services are provided with appropriate protection, as required.

Select NA (Not Applicable) if no new employees, volunteers, contractors, and family care providers were hired, taken on, contracted with, or certified since the time of the last agency review

Citations

633.22(d)(2)

Regulatory Reference: 633.22(d)(2). See applicability notes 1-3, below*.

(2) Criminal history record checks are required for the following parties:

(i) prospective employees and operators who will have regular and substantial unsupervised or unrestricted physical contact with people receiving services, according to the criteria established by policies and procedures. Unless the agency or provider of services has documented the grounds for determining that the party does not have such contact, the following employees and operators are presumed to have regular and substantial unsupervised or unrestricted physical contact:

(a) a party providing direct care services to people in facilities and non-certified settings authorized, funded, or approved by OMRDD, including but not limited to:

- (1) residential facilities (ICFs, CRs and IRAs);
- (2) home and community-based waiver habilitation services (including residential habilitation, day habilitation, community habilitation, pathway to employment, supported employment, and pre-vocational services);
- (3) day treatment facilities;
- (4) day training facilities;
- (5) sheltered workshops;
- (6) respite services;
- (7) recreational services;
- (8) authorized demonstration programs (e.g., NYS-Options for People Through Services [NYS-OPTS]); and
- (9) any service like those specified in sub clauses (1) -(8) of this clause;

(b) a party providing line or onsite supervision of direct care staff;

(c) a party providing transportation services, whether driving or accompanying people while they are being transported;

(d) a job coach (or equivalent) providing supported employment services;

(e) a clinician providing clinical services to people receiving services;

(f) in a clinic treatment facility (article 16 clinic), a clinic treatment coordinator, a medical director and an authorized party (see section 679.99 of this Title) providing services;

(g) a service coordinator and a supervisor of a service coordinator, including a Medicaid Service Coordinator (MSC) and a MSC supervisor; and

(h) a party whose work assignment location is at a certified site at least some of the time that persons are receiving services;

(ii) family care providers and all parties 18 years of age or older who are to reside in the family care home (except for individuals receiving family care services) as follows:

(a) prospective family care providers along with adult household members who are to reside in the prospective family care home;

- (b) prospective adult household members who are to reside in the home of a current family care provider (see OMRDD regulations for Family Care Homes, Part 687 of this Title, for additional requirements); and
- (c) current family care providers who are seeking recertification and adult household members who are to reside in the family care home when a criminal history record check has not previously been conducted concerning the subject party because of his or her status as a family care provider or household member;
- (iii) prospective volunteers who will have regular and substantial unsupervised or unrestricted physical contact with persons receiving services, as determined by the agency or provider of services according to criteria established by policies and procedures;
- (iv) employees, volunteers and operators who currently have a position or volunteer opportunity which does not involve regular and substantial unsupervised or unrestricted physical contact with persons receiving services, who will be assuming a position or volunteer opportunity which does involve such contact;
- (v) for an agency or other potential provider of services which applies to become certified, authorized, approved or funded through contract by OMRDD; all its current and potential operators, employees and volunteers who will have regular and substantial unsupervised or unrestricted physical contact with persons receiving services in the new program; and
- (vi) for an agency or other provider of services which has a change in ownership interest, any natural person that will become an operator due to such change, if he or she will have regular and substantial unsupervised or unrestricted physical contact with persons receiving service

*Applicability:

Note 1: Section 633.22 does not directly apply to state operated services, however, criminal background checks are required for staff in state operated services in accordance with NYS Civil Service Law and OPWDD policy. CBC standards in this protocol apply to state operated services and the content of 633.22 requirements associated with the standards is applicable for compliance determinations.

Note 2: Section 633.22 is otherwise directly applicable to all OPWDD certified, funded, and contract programs and services and to registered providers, unless an exception is noted in guidance.

Note 3: The initial CBC regulations in 633.22 were promulgated in April 2005 and applied only to parties hired on or after April 1, 2005. The Justice Center assumed OPWDD's role in managing the OPWDD CBC system with implementation of the Protection of People with Special Needs Act (PPSNA) on June 1, 2013. Any new CBC requirements associated with the PPSNA were effective on June 1, 2013.

Standard #	Standard Text	Decision
3	The agency maintains complete and up to date criminal background check records on each subject party, as required.	Met/Not Met

Guidance

Documentation Review:

- A list of all new employees, volunteers, contractors, and family care providers who were hired, taken on, contracted with, or certified since (respectively), for sampled time period described below.
- CBC information available on the Justice Center website
- Employee/volunteer roster
- Family Care provider roster
- Subject party consents and status updates

Interview:

- Personnel Manager/Administrator
- Agency Designated Authorized Party

Additional Guidance:

Review the list of new employees, volunteers, contractors, family care providers, etc.; compare the list with CBC information available on the Justice Center website; and compare information from those sources with rosters, consents, and other information required in paragraph 633.22(j)(2). The point of the comparison is to determine if the agency has a reliable system to maintain complete and up to date criminal background check records on each subject party, as required. Compare the names of sampled employees with the agency's records.

Choosing your sample:

- **New Employees:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- **Sample Sizes** are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if the agency maintains complete and up to date criminal background check records on each subject party, in accordance with 633.22(j)(2), as required.

Select Not Met if the agency does not maintain complete and up to date criminal background check records on each subject party, in accordance with 633.22(j)(2), as required.

Citations

633.22(d)(2)

Regulatory Reference: 633.22(d)(2). See applicability notes 1-3, below*.

(2) Criminal history record checks are required for the following parties:

- (i) prospective employees and operators who will have regular and substantial unsupervised or unrestricted physical contact with people receiving services, according to the criteria established by policies and procedures. Unless the agency or provider of services has documented the grounds for determining that the party does not have such contact, the following employees and operators are presumed to have regular and substantial unsupervised or unrestricted physical contact:
 - (a) a party providing direct care services to people in facilities and non-certified settings authorized, funded, or approved by OMRDD, including but not limited to:
 - (1) residential facilities (ICFs, CRs and IRAs);
 - (2) home and community-based waiver habilitation services (including residential habilitation, day habilitation, community habilitation, pathway to employment, supported employment, and pre-vocational services);
 - (3) day treatment facilities;
 - (4) day training facilities;
 - (5) sheltered workshops;
 - (6) respite services;
 - (7) recreational services;
 - (8) authorized demonstration programs (e.g., NYS-Options for People Through Services [NYS-OPTS]); and
 - (9) any service similar to those specified in sub-clauses (1) -(8) of this clause;
 - (b) a party providing line or onsite supervision of direct care staff;
 - (c) a party providing transportation services, whether driving or accompanying people while they are being transported;
 - (d) a job coach (or equivalent) providing supported employment services;
 - (e) a clinician providing clinical services to people receiving services;
 - (f) in a clinic treatment facility (article 16 clinic), a clinic treatment coordinator, a medical director and an authorized party (see section 679.99 of this Title) providing services;
 - (g) a service coordinator and a supervisor of a service coordinator, including a Medicaid Service Coordinator (MSC) and a MSC supervisor; and
 - (h) a party whose work assignment location is at a certified site at least some of the time that persons are receiving services;
- (ii) family care providers and all parties 18 years of age or older who are to reside in the family care home (except for individuals receiving family care services) as follows:
 - (a) prospective family care providers along with adult household members who are to reside in the prospective family care home;
 - (b) prospective adult household members who are to reside in the home of a current family care provider (see OMRDD regulations for Family Care Homes, Part 687 of this Title, for additional requirements); and
 - (c) current family care providers who are seeking recertification and adult household members who are to reside in the family care home when a criminal history record check has not previously been conducted concerning the subject party because of his or her status as a family care provider or household member;
- (iii) prospective volunteers who will have regular and substantial unsupervised or unrestricted physical contact with persons receiving services, as determined by the agency or provider of services according to criteria established by policies and procedures;
- (iv) employees, volunteers and operators who currently have a position or volunteer opportunity which does not involve regular and substantial unsupervised or unrestricted physical contact with persons receiving services, who will be assuming a position or volunteer opportunity which does involve such contact;
- (v) for an agency or other potential provider of services which applies to become certified, authorized, approved or funded through contract by OMRDD; all its current and potential operators, employees and volunteers who will have regular and substantial unsupervised or unrestricted physical contact with persons receiving services in the new program; and

(vi) for an agency or other provider of services which has a change in ownership interest, any natural person that will become an operator due to such change, if he or she will have regular and substantial unsupervised or unrestricted physical contact with persons receiving service

*Applicability:

Note 1: Section 633.22 does not directly apply to state operated services, however, criminal background checks are required for staff in state operated services in accordance with NYS Civil Service Law and OPWDD policy. CBC standards in this protocol apply to state operated services and the content of 633.22 requirements associated with the standards is applicable for compliance determinations.

Note 2: Section 633.22 is otherwise directly applicable to all OPWDD certified, funded, and contract programs and services and to registered providers, unless an exception is noted in guidance.

Note 3: The initial CBC regulations in 633.22 were promulgated in April 2005 and applied only to parties hired on or after April 1, 2005. The Justice Center assumed OPWDD's role in managing the OPWDD CBC system with implementation of the Protection of People with Special Needs Act (PPSNA) on June 1, 2013. Any new CBC requirements associated with the PPSNA were effective on June 1, 2013.

Standard #	Standard Text	Decision
4	The agency has developed and implements procedures that ensure required safeguards are provided to address situations in which staff may be temporarily approved to work pending results of submitted criminal background checks.	Met/Not Met

Guidance

Interview: as appropriate

- Personnel Manager/Administrator
- Agency Designated Authorized Party
- Program Manager/Administrator (esp. Residential)

Documentation Review:

- Agency policies and procedures
- A list of all new employees, volunteers, contractors, and family care providers who were hired, taken on, contracted with, or certified since (respectively), for sampled time period described below.
- Information about staff assignments and safeguards in place when needed.
- CBC information available on the Justice Center website
- Evidence that the agency implemented appropriate procedures for any temporarily approved staff or volunteer
- Application/Personnel records regarding crime question

Additional Guidance:

- Temporary approval pending CBC results is prohibited for family care providers and for registered providers.
- Review the CBC information available on the Justice Center website; and interview agency staff to determine if any parties on the list were temporarily approved to work on a provisional basis while the results of their criminal history record checks were pending.
- For those parties who were temporarily approved to work on a provisional basis pending the results of criminal history record checks, determine if the following safeguards are implemented and the agency's policies and procedures on that topic were met. Requirements during the provisional approval include:
 - o specific limitations on the subject party's responsibilities,
 - o an attestation from the subject party, and
 - o supervision of the subject party during the provisional approval.
- Survey staff must also ensure that temporary approval is denied for parties with pending charges or past convictions for certain crimes, in accordance with subparagraph 633.22(f)(1)(vi), when the agency is aware of such charges (e.g., the employment application shows evidence of a pending charge). The charges referred to are in NYS Executive Law section 845-b(5)(a), below

(a) Where the criminal history information concerning a subject individual reveals a felony conviction at any time for a sex offense, a felony conviction within the past ten years involving violence, or a conviction pursuant to section 260.00, 260.25, 260.32 or 260.34 of the penal law, and in the case of criminal history information obtained pursuant to section twenty-eight hundred ninety-nine-a of the public health law, where the criminal history information

concerning a subject individual reveals a conviction at any time of any class A felony; a conviction within the past ten years of any class B or C felony, any class D or E felony defined in article one hundred twenty, one hundred thirty, one hundred fifty-five, one hundred sixty, one hundred seventy-eight or two hundred twenty of the penal law; or any crime defined in section 260.32 or 260.34 of the penal law; or any comparable offense in any other jurisdiction, the authorized agency shall deny or disapprove the application for or renewal of the operating certificate, contract, approval, employment of the subject individual or other authorization to provide services, or direct the provider to deny employment, as applicable, unless the authorized agency determines, in its discretion, that approval of the application or renewal or employment will not in any way jeopardize the health, safety or welfare of the beneficiaries of such services.

Note: A failure to take timely and appropriate action on a Justice Center denial is addressed in another standard below.

Select Met when both of the following are evident:

- There is adequate oversight to ensure that all temporarily approved staff have been appropriately screened and supervised pending CBC results per regulation; and
- Policies and procedures must also be in compliance with 633.22(f)(1).

Select Not Met* when any of the following are evident:

- There is no oversight to ensure that any temporarily approved staff is assigned to an overnight shift; and/or
- There is no oversight to ensure that any temporarily approved staff or staff approved with pending charges is provided with required supervision; and/or
- The agency lacks the required policies and procedures to address this requirement, unless agency policy explicitly states that temporary approvals (for assignments with individuals) are prohibited pending CBC results are prohibited.

NOTE: *Survey staff must immediately contact a Bureau of Program Certification Area Director when the survey staff determine that any temporarily approved staff is assigned to an overnight shift; is not provided with required supervision in 633.22(f)(1)(i)-(ix); or is approved with pending charges noted above, at the time of the visit. A plan of correction will have to be taken during the visit to ensure that individuals receiving services are provided with appropriate protection, as required.

Citations

633.22(f)(1)(i)-(ix)

(f) Pending results/temporary approval of a subject party. Notwithstanding the provisions of subdivision 701.5(f) of this Title, the provisions of this subdivision govern the process for temporary approval of a subject party in the OPWDD system.

(1) The agency or provider of services may temporarily approve a subject party for employment or a volunteer opportunity on a provisional basis while the results of the criminal history record check are pending, so long as such party does not have unsupervised physical contact with persons receiving services. Temporary approval and the utilization of temporarily approved provisional employees and volunteers shall be in accordance with policies and procedures and the requirements of this section.

(i) Policies and procedures shall address the need for all temporarily approved provisional employees and volunteers to be monitored. Such policies and procedures shall:

(a) address the need for an employee to monitor the activities of all temporarily approved provisional employees and volunteers given the nature of the environment (e.g., layout of the site), staffing patterns, employee responsibilities, and characteristics of people receiving services; and

(b) include procedures for the agency or provider of services to ensure that the employee given responsibility to monitor the activities of temporarily approved provisional employees and volunteers:

- (1) was not subject to a criminal history record check or has had a criminal history record check determination issued from the Justice Center;
 - (2) has been trained in requirements concerning incidents and abuse (see section 633.8[a][1][iv]-[vi] of this Part and Part 624 of this Title);
 - (3) recognizes his or her obligations under Part 624 of this Title, including the obligation to report incidents and abuse allegations, and that ""the failure to exercise one's duty to intercede on behalf of a person receiving services also constitutes abuse"" (section 624.4[c] of this Title);
 - (4) is knowledgeable about the restrictions on the activities of temporarily approved provisional employees and volunteers established by this section; and
 - (5) knows whom to contact and in what manner, regarding concerns that may arise.
- ii) In order to be approved, temporarily approved provisional employees and volunteers shall provide an attestation that they understand basic elements of what is considered abuse according to the definition in Part 624 of this Title and that they know whom to contact, and in what manner, if they have questions about incidents/abuse; and that they affirm that they will not engage in abusive practices or knowingly endanger the physical or emotional well-being of people receiving services.
- (iii) If the temporarily approved provisional employee or volunteer is in the physical proximity of people receiving services, an employee meeting the standards specified in subparagraph (i) of this paragraph shall be in reasonable physical proximity of the temporarily approved provisional employee or volunteer at all times.
- (iv) The temporarily approved provisional employee or volunteer shall not be assigned personal care activities which require privacy for people receiving services (e.g., bathing, dressing and toileting), unless an employee meeting the standards of subparagraph (i) of this paragraph is present in the same room with the temporarily approved provisional employee or volunteer at all times while personal care activities are occurring.
- (v) A temporarily approved provisional employee or volunteer shall not be assigned to work at a residential facility during the typical nighttime shift (e.g., 11 p.m. to 7 a.m.).
- (vi) Temporary approval shall be denied if the agency or provider of services possesses written documentation, such as a statement provided by the subject party as part of the application process, that:
- (a) the subject party has a pending felony charge, or a conviction or pending charge for one or more of the crimes specified in section 845-b(5)(a) of the Executive Law; and/or
 - (b) the subject party has a pending misdemeanor charge or a conviction for any crime other than those specified in section 845-b(5)(a) of the Executive Law, unless the agency or provider of services documents that temporary approval will not pose a risk of harm to persons receiving services.
- (vii) At any time after the agency or provider of services receives a determination that the Justice Center is not issuing a denial or directing the agency or provider of services to issue a denial, the restrictions imposed during the period of temporary approval may be lifted. The agency or provider of services does not need to notify the OPWDD or the Justice Center regarding the end of temporary approval in this situation.
- (viii) When an agency or provider of services receives Justice Center notification of any result of the criminal history record check, except as specified in subparagraph (vii) of this paragraph any temporary approval of the subject party shall be revoked immediately, or as soon as reasonably possible. However, revocation of the temporary approval shall not be delayed if such delay may compromise the safety of people receiving services.
- (ix) Registered providers are not permitted to temporarily approve a subject party on a provisional basis.

Note: Section 633.22 does not directly apply to State operated services, however, criminal background checks are required for staff in state-operated services in accordance with NYS Civil Service Law and OPWDD policy.

Standard #	Standard Text	Decision
5	The agency has developed and implements policies and procedures to ensure prompt and appropriate action on criminal history determinations made by the Justice Center.	Met/Not Met

Guidance

Documentation Review:

- Agency policies and procedures
- A list of all new employees, volunteers, contractors, and family care providers who were hired, taken on, contracted with, or certified since (respectively), for sampled time period described below.
- CBC determination information available on the Justice Center website
- Evidence that the agency implemented appropriate procedures for any criminal history suitability decisions.
- Application/Personnel records regarding crime question.

Interview:

- Personnel Manager/Administrator
- Agency Designated Authorized Party
- Program Manager/Administrator (esp. Residential) as appropriate

Additional Guidance:

- When the Justice Center issues a denial or directs an agency to do so, the agency must deny the subject party any employment and/or volunteer opportunities involving any unsupervised or unrestricted physical contact with individuals receiving services. Any employee or volunteer who was temporarily approved pending CBC results in accordance with 633.22(f)(1)(i)-(ix) must be immediately removed from contact with individuals receiving services.
- For family care homes, any adult resident of the home other than an individual receiving services, must be subject to a criminal background check, including a child of the family care provider once the child is 18 years old. If the Justice Center issues a denial, the subject party must not reside in the family care home. The sponsoring agency must conduct a safety assessment of the service environment, and take all steps necessary to protect the health and safety of people receiving services. The safety assessment and steps must be documented; and people receiving services must be promptly relocated unless the family care provider and sponsoring agency document in writing that the relevant subject party is no longer residing in the family care home.

Select Met when both of the following are evident:

- The provider the agency takes prompt and appropriate action on criminal history suitability determinations made by the Justice Center; AND
- Pertinent policies and procedures to ensure the agency takes prompt and appropriate action in response to a denial by the Justice Center.

Select Not Met* when any of the following is evident:

- The agency does not take prompt and appropriate action on criminal history suitability determinations made by the Justice Center; and/or
- The agency lacks pertinent policies and procedures to ensure the agency takes prompt and appropriate action in response to a denial by the Justice Center.

NOTE: *Survey staff must immediately contact a Bureau of Program Certification Area Director when the survey staff determine that an agency did not remove a subject party from contact with individuals receiving services in response to a Justice Center denial based on the subject party's criminal history. A plan of correction must be taken during the visit to ensure that individuals receiving services are provided with appropriate protection, as required.

Citations

633.22(f)(viii)

Applicable to only JC determinations/denials for temporarily approved employees/volunteers:

633.22(f)

(viii) When an agency or provider of services receives Justice Center notification of any result of the criminal history record check, except as specified in subparagraph

(vii) of this paragraph [when "the Justice Center is not issuing a denial or directing the agency or provider of services to issue a denial"] any temporary approval of the subject party shall be revoked immediately, or as soon as reasonably possible. However, revocation of the temporary approval shall not be delayed if such delay may compromise the safety of people receiving services.

633.22(h)

Applicable to all CBCs:

633.22(h) Justice Center determinations. Justice Center determinations and the responses of the agencies and providers of services are made in accordance with section 701.5 of this Title.

633.22(h)(1)- (2)

Applicable to Family Care providers only:

633.22(h) Justice Center determinations. ... The following provisions concerning family care homes are in addition to the requirements of section 701.5 of this Title:

(1) OPWDD/sponsoring agencies shall deny an application to be a family care provider if the Justice Center issues a denial or directs the sponsoring agency to issue a denial concerning an applicant or an adult household member.

(2) If the Justice Center issues a denial or directs the sponsoring agency to issue a denial for a family care provider or adult household member, and a person is currently receiving family care services in the family care home:

(i) the family care provider shall be notified regarding the issuance of the denial;

(ii) the sponsoring agency shall conduct a safety assessment of the service environment, and shall take all steps necessary to protect the health and safety of people receiving services. The safety assessment and steps shall be documented; and

(iii) people receiving services shall be promptly relocated unless the family care provider and sponsoring agency document in writing that the relevant subject party is no longer residing in the family care home.

687.8(p)(7)- (8)



687.8(p)(7) If the Justice Center issues a denial or directs the sponsoring agency to issue a denial for a current family care provider or current adult household member, or if the potential household member begins to reside in the family care home, the sponsoring agency shall follow the requirements of section 633.22(h)(2) of this Title. If the Justice Center issues a denial or directs the sponsoring agency to issue a denial for a potential household member, family care provider shall not permit the subject party to reside in the family care home.

(8) If a criminal history record check was conducted concerning a party (other than the family care provider) and the party does not move into the family care home or permanently moves out of the family care home, the family care provider shall notify the sponsoring agency and the OPWDD in writing within 72 hours of the occurrence. The sponsoring agency shall notify the Justice Center within 14 days of the occurrence, in the form, format and manner required by the Justice Center.

Standard #	Standard Text	Decision
6	The agency has developed and implements procedures that ensure required safeguards to protect individuals receiving services if there is a conviction or impending charge subsequent to a subject party's initial criminal history background check.	Met/Not Met/NA

Guidance

Documentation Review:

- CBC information available on the Justice Center website
- Employee/volunteer roster
- Safety assessment documentation

Interview:

- Personnel Manager/Administrator
- Agency Designated Authorized Party
- Program Manager/Administrator (esp. Residential) as appropriate

Additional Guidance:

The Justice Center's CBC information is continually updated to document subsequent arrests and changes in a subject party's status after the subject party's initial CBC. The Justice Center will notify agencies and sponsoring agencies of subsequent arrests and convictions

- Review CBC Subsequent Arrest information for the agency on the Justice Center website for the time period since the time of the last agency review. This information should identify when the agency was notified of any subsequent arrests or convictions for agency employees, volunteers, contractors, and family care providers.
- Request from the agency authorized party records to show that the agency promptly conducted a safety assessment in response to a subsequent arrest of a subject employee, volunteer, family care provider, or adult resident of a family care home. This safety assessment must be clearly documented and identify potential risks to individuals receiving services. These might include consideration of the shift when the subject party works, the supervision of the subject party, and the capabilities and needs of the individuals receiving services.
- Review how the agency monitors the outcome of pending charges.

Select Met if the agency documents a safety assessment in response to subsequent arrests and convictions, as required, and implements recommendations that resulted from the assessment.

Select Not Met* if either of the following are evident:

- The agency did not document a safety assessment, as required; or
- The agency did not implement recommendations to protect the health and safety of individuals receiving services that resulted from the assessment.

*Survey staff must immediately contact a Bureau of Program Certification Area Director when the survey staff determine that an agency did not document a safety assessment, as required, though the subject party continued to have contact with individuals receiving services or when the agency did not implement recommendations from the assessment relevant to the immediate health and safety of individuals receiving services. A plan of correction may have to be taken during the visit to ensure that individuals receiving services are provided with appropriate protections, as required.

Select NA (Not Applicable) if there were no subsequent arrests or convictions since the last survey.

Citations

633.22(k)(2)

Upon receiving notification regarding the conviction or pending charge, or upon becoming aware of a conviction or pending charge subsequent to the initial criminal history record check, the agency, sponsoring agency or provider of services shall:

- (i) conduct a safety assessment of the service environment and take all appropriate steps to protect the health and safety of the persons receiving services. The safety assessment and steps shall be documented; and
- (ii) monitor the outcome of any pending charge, if the subject party continues to have regular and substantial unsupervised or unrestricted physical contact with people receiving services.

Standard #	Standard Text	Decision
7	The agency has developed and implements required safeguards applicable to background checks for registered providers.	Met/Not Met/NA

Guidance

Documentation Review:

- Policies and procedures
- Other records, as applicable

Interview:

- Personnel Manager/Contract Administrator
- Agency Designated Authorized Party
- Other Manager or Administrator

Additional Guidance:

- Determine if the agency contracted with or otherwise used the services of a registered providers during the last year.
 - o If yes, survey staff must review the agency's policies and procedures on registered provider responsibilities for compliance with OPWDD background check requirements in 633.22 and 633.24. (Section 633.24 details regarding SEL, SCR, and MHL 16.34 checks are reviewed in in other standards. This standard addresses policy and procedure requirements.)
- An agency providing OPWDD certified or funded services may contract with an OPWDD approved registered provider for services such as transportation or per diem staffing. The OPWDD certified or funded provider must have policies and procedures, at minimum, to require that:
 - o The agency has verified the contractor attained OPWDD registered provider status;
 - o The agency has a procedure to conduct a check, at least quarterly basis, to ensure the contractor maintains registered provider status;
 - o The agency has a procedure to ensure that the contractor maintains compliance with CBC, SEL, SCR, and MHL 16.34 background check requirements. A registered provider may subcontract with another registered provider – in these cases only one of the registered providers is required to complete the required background checks for employees. The agency procedure should address this arrangement.
- Survey staff must also ask agency staff if the agency had any problems with the registered provider's compliance with background check requirements, or compliance with any other term established by OPWDD for the approval of a registered provider, during the last year. If yes, determine if the agency notified OPWDD by the close of the fifth working day after it became aware of the non-compliance.

Select Met if the agency has policies and procedures to ensure that registered providers contracted to provide services for applicable programs and facilities, maintain their registered provider status and comply with OPWDD background check requirements in 633.22 and 633.24.

Select Not Met* if either of the following are evident:

- The agency does not have policies and procedures to ensure that registered providers contracted to provide services in applicable programs and facilities maintain their registered provider status and comply with OPWDD background check requirements in 633.22 and 633.24, and/or
- The agency was aware a registered provider was not in compliance with background check requirements, or compliance with any other term established by OPWDD, but did not report that non-compliance to OPWDD, as required.

*Survey staff must immediately contact a Bureau of Program Certification Area Director when the survey staff find the agency lacks policies and procedures to ensure registered providers contracted to provide services in its OPWDD operated, certified, and/or funded programs and facilities complete background checks (SEL, CBC, SCR, and MHL 16.34), as required. A plan of correction may have to be taken during the visit to ensure that individuals receiving services are provided with appropriate protection, as required.

Select NA (Not Applicable) if the agency does not contract with registered providers.

Citations

633.22(n)(4)- (5)

(4) Responsibilities of the agency or provider of services (including DDSOOs) concerning registered providers. The following requirements apply to an agency or provider of services that contracts with a registered provider (or when an entity contracts with the registered provider on behalf of the agency or DDSOO).

(i) The agency or provider of services shall develop and implement written policies and procedures to monitor whether the registered provider is in compliance with the requirements of this section, section 633.24 and terms established by OPWDD for the approval of a registered provider. At a minimum, the policies and procedures shall require that the agency or provider of services verify that the contractor has attained registered provider status initially and, on at least a quarterly basis, that the contractor maintains registered provider status. The requirement for policies and procedures applies regardless of whether the registered provider also contracts with OPWDD, or an entity on behalf of OPWDD. If an entity contracts with the registered provider on behalf of an agency or provider of services, the entity and agency (or provider of services) shall both develop and implement such written policies and procedures.

(ii) If the agency or provider of services becomes aware that the registered provider is out of compliance with the requirements of this section, section 633.24 or any term established by OPWDD for the approval of a registered provider, the agency or provider of services shall notify OPWDD by the close of the fifth working day after it becomes aware of the non-compliance.

(5) Notwithstanding any other requirement of this Part, when a registered provider meeting the criteria in clause (1)(ii)(b) of this subdivision subcontracts with another registered provider, only one of these registered providers shall assume responsibility for compliance with the requirements of this section and section 633.24 of this Part (e.g., submitting requests for background checks). This avoids duplicate requests concerning the same subject party and other duplicative compliance activities.

Standard #	Standard Text	Decision
8	The agency ensures that a check of the Staff Exclusion List (SEL) is completed for every subject party before hiring, or allowing that party any regular and substantial contact with an individual receiving services, until the agency has the results of the check.	Met/Not Met

Guidance

Documentation Review:

- A list of all new employees, volunteers, contractors, and family care providers who were hired, taken on, contracted with, or certified since (respectively), for sampled time period described below.
- Staff Exclusion List (SEL) check records

Interview:

- Personnel Manager/Administrator
- Agency Designated Authorized Party

Additional Guidance:

Note: SEL checks for registered providers are addressed in another standard.

- SEL requirements are applicable to applicants/employees hired on or after June 30, 2013.
- SEL checks are required for all applicants/employees/contractors/volunteers/family care providers (and adults other than individuals receiving services who reside in family care homes), in facilities and programs operated, certified, or funded by OPWDD, who are required to have CBCs; however, SEL checks results must be obtained before the applicant/employee/family care providers is hired or otherwise allowed any regular and substantial contact with an individual receiving services.
- Compare the names of the sampled employees, volunteers, contractors, and family care providers with SEL determinations issued by the Justice Center.
- The SEL determination notifications are sent to the agency designated authorized party and should be made available to survey staff by that authorized party.
- Discuss/resolve any missing/discrepant information with the designated authorized party.
- Ask about adults other than individuals receiving services who reside in family care homes to ensure all parties subject to SEL checks are checked, as required.

Choosing your sample:

- **New Employees:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- **Sample Sizes** are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if SEL checks were submitted for all new prospective employees, volunteers, and family care providers (and other adult residents in a family care home) who are subject to criminal background check.

Select Not Met* if SEL checks were not submitted for any new employee, volunteer, contractor, or family care provider (or other adult resident in a family care home).

*Survey staff must immediately contact a Bureau of Program Certification Area Director when the survey staff determine that a party who has regular and substantial unsupervised or unrestricted physical contact with persons receiving services has not been subject to a SEL check, as required. A plan of correction will have to be taken during the visit to ensure that individuals receiving services are provided with appropriate protection, as required.

Select NA (Not Applicable) if no new employees, volunteers, contractors, and family care providers (or new adult family care home residents) were hired, taken on, contracted with, or certified since the time of the last agency review.

Citations

633.24(b)

Check of the register of substantiated category one cases of abuse or neglect, also known as the Staff Exclusion List (SEL).

- (1) Agencies and sponsoring agencies shall request a check for all parties be subject to a criminal history record check in accordance with section 633.22 of this Part, to the extent permitted by section 495 of the Social Services Law. The term subject party has the same meaning in this section as the term is defined in section 633.22(b) of this Part.
- (2) Agencies (including agencies) shall comply with the requirements in section 495 of the Social Services Law and procedures established by the Justice Center for the Protection of People with Special Needs (Justice Center) for checking the SEL.
- (3) If the name of subject party has been submitted for a check of the SEL, the agency shall not allow the party to have regular and substantial contact with an individual receiving services until the agency has the results of the check.
- (4) If a party is listed on the SEL, the agency or sponsoring agency shall not hire or otherwise allow such party to have regular and substantial contact with an individual receiving services.
- (5) The agency or sponsoring agency shall comply with all requirements of the Justice Center regarding confidentiality and actions to be taken concerning the results of the SEL check.
- (6) Registered providers (see section 633.22[n] of this Part) shall request an SEL check for subject parties if the registered provider was required to request a criminal history record check for that party. Agencies with which the registered provider's contracts are not required to request an SEL check concerning subject parties of a registered provider with which it contracts.

687.8(p)

The following procedures and requirements apply when any party who is 18 years of age or older (except for an individual receiving family care services) begins to reside in the family care home, and when a current resident (except for an individual receiving family care services) reaches the age of 18 years:

- (1) The family care provider shall request that the sponsoring agency request background checks prior to or when such party begins to reside in the family care home or reaches the age of 18 years. The requested background checks include:
 - (i) a check of the staff exclusion list (SEL check) pursuant to section 633.24 of this Title;
 - (ii) a criminal history record check pursuant to section 633.22 of this Title; and
 - (iii) a check of the Statewide Central Register of Child Abuse and Maltreatment (SCR check) pursuant to section 633.24 of this Title.

Standard #	Standard Text	Decision
9	The agency ensures that a check of the Statewide Central Register of Child Abuse and Maltreatment is completed, where applicable, for every subject party before that party is allowed any unsupervised contact with an individual receiving services, and until the agency has and reviews the results of the check.	Met/Not Met/NA

Guidance

Documentation Review:

- A list of all new employees, volunteers, contractors, and family care providers who were hired, taken on, contracted with, or certified since (respectively), for sampled time period described below.
- SCR check records

Interview:

- Personnel Manager/Administrator
- Agency Designated Authorized Party

Additional Guidance:

- SCR requirements in 633.24(c) are applicable to applicants/employees hired on or after June 30, 2013. Before June 30, 2013 SCR checks were only required for applicants/employees who worked with children under the age of 18.
- SCR checks are required for all applicants/employees/contractors/volunteers/family care providers (and adults other than individuals receiving services who reside in family care homes), in facilities and programs operated or certified by OPWDD, who are required to have CBCs; however, SCR checks results must be obtained and reviewed by the agency/sponsoring agency before the applicant/employee/family care providers is allowed any unsupervised with an individual receiving services.
- Compare the names of sampled employees, volunteers, contractors, and family care providers with SCR determinations issued by the Office of Child and Family Services. The SCR determination notifications are sent to the agency designated authorized party and should be made available to survey staff by that authorized party.
- Discuss/resolve any missing/discrepant information with the designated authorized party.
- Survey staff will review written information on an agency's determination to hire, take on, or retain an applicant/employee/family care provider with an "indicated" report of child abuse and maltreatment report
- Note: SCR checks for registered providers are addressed elsewhere in this protocol.

Choosing your sample:

- New Employees: The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met when SCR checks were submitted for all new prospective employees, volunteers, and family care providers (and other adult residents in a family care home) who are subject to a criminal background check.

Select Not Met* when SCR checks were not submitted for any new employee, volunteer, contractor, or family care provider (or other adult resident in a family care home) who are subject to a criminal background check.

*Survey staff must immediately contact a Bureau of Program Certification Area Director when the survey staff determine that a subject party who has regular and substantial unsupervised or unrestricted physical contact with persons receiving services has not been subject to a SCR check, as required. A plan of correction will have to be taken during the visit to ensure that individuals receiving services are provided with appropriate protection, as required.

Select NA (Not Applicable) if no new employees, volunteers, contractors, and family care providers (or new adult family care home residents) were hired, taken on, contracted with, or certified since the time of the last agency review.

Citations

633.24(c)(1)- (5)

633.24(c) Statewide central register of child abuse and maltreatment (SCR).

(1) Agencies shall request a check of the Statewide Central Register of Child Abuse and Maltreatment (SCR) for all parties be subject to a criminal history record check in accordance with section 633.22 of this Part, to the extent permitted by section 424-a of the Social Services Law. SCR checks are required for all applicants (e.g., prospective employees, volunteers, and contractors) who are required or authorized to be checked pursuant to section 424-a of the Social Services Law. (Note that SCR checks are not required for current employees, volunteers, etc. but in some cases, are permitted by section 424-a of the Social Services Law.) SCR checks are also required for family care providers and adults who live in the home of the family care provider in accordance with requirements in Part 687 of this Title.

(2) Agencies shall comply with the provisions of section 424-a of the Social Services Law concerning checks which are required or authorized to be conducted.

(3) The SCR check shall be conducted after the agency obtains the results of the SEL check and shall only be requested if the agency does not deny the application based on the results of the SEL check.

(4) If the name of a subject party has been submitted for a check of the SCR, the agency shall not allow the party to have unsupervised contact with individuals receiving services until the agency has the results of the SCR check.

(5) The agency shall comply with the requirements of Article 6 of the Social Services Law and the Office for Children and Family Services (OCFS) concerning confidentiality and actions to be taken with regard to the results of the SCR check.

687.8(p)

Applicable to Family Care providers only:

687.8(p) The following procedures and requirements apply when any party who is 18 years of age or older (except for an individual receiving family care services) begins to reside in the family care home, and when a current resident (except for an individual receiving family care services) reaches the age of 18 years:

(1) The family care provider shall request that the sponsoring agency request background checks prior to or when such party begins to reside in the family care home or reaches the age of 18 years. The requested background checks include:

(i) a check of the staff exclusion list (SEL check) pursuant to section 633.24 of this Title;

(ii) a criminal history record check pursuant to section 633.22 of this Title; and

(iii) a check of the Statewide Central Register of Child Abuse and Maltreatment (SCR check) pursuant to section 633.24 of this Title.

Standard #	Standard Text	Decision
10	The agency ensures that a Mental Hygiene Law 16.34 check is completed for each subject party before that party has any unsupervised contact an individual receiving services.	Met/Not Met/NA

Guidance

Documentation Review

- A list of all new employees or volunteers, who were hired or taken on since the time of the last agency review.
- MHL 16.34 check records

Interview

- Personnel Manager/Administrator
- Agency Designated Authorized Party

Additional Guidance:

- MHL16.34 requirements in 633.24(d) are applicable to applicants for employment/volunteer opportunities hired on or after June 30, 2013.
- MHL 16-34 checks are required for all applicants/employees/volunteers in facilities and programs operated, certified, and/or funded by OPWDD, who are required to have CBCs; however, SCR checks results must be obtained and reviewed by the agency/sponsoring agency before the applicant/employee/contractor/volunteer is allowed any unsupervised with an individual receiving services. (MHL 16.34 checks are not required for family care providers or contractors.)
- Compare the names of the sampled employees and volunteers with MHL 16.34 information issued by the OPWDD. The MHL 16.34 information is sent to the agency designated authorized party and should be made available to survey staff by that authorized party.
- Discuss/resolve any missing/discrepant information with the designated authorized party
- Note: MHL 16.34 checks for registered providers are addressed
- Review of substantiated reports of abuse or neglect concerning a subject party are addressed elsewhere in this protocol.

Choosing your sample:

- New Employees: The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met when 16.34 checks were submitted for all prospective applicable employees and volunteers.

Select Not Met* when a 16.34 was NOT submitted for any prospective applicable employee and/or volunteer.

*Survey staff must immediately contact a Bureau of Program Certification Area Director when the survey staff determine that a subject party who has regular and substantial unsupervised or unrestricted physical contact with persons receiving services has

not been subject to a 16.34 check, as required. A plan of correction will have to be taken during the visit to ensure that individuals receiving services are provided with appropriate protection, as required.

Select NA (Not Applicable) if no new employees or volunteers were hired or taken on since the time of the last agency review.

Citations

633.24(d)

633.24(d) MHL 16.34 check.

- (1) Agencies shall submit a request for an MHL 16.34 check to OPWDD in accordance with section 16.34 of the Mental Hygiene Law, to the extent permitted by section 16.34 of the Mental Hygiene Law.
- (2) Agencies shall submit the request for an MHL 16.34 check in the form and format specified by OPWDD, including information from the applicant as specified by OPWDD.
- (3) The MHL 16.34 check shall be submitted to OPWDD after the agency obtains the results of the SEL check and shall only be requested if the agency does not deny the application based on the results of the SEL check.
- (4) If the name of a subject party has been submitted for an MHL 16.34 check, the agency shall not allow the party to have unsupervised contact with individuals receiving services until the agency has the results of the check.

Standard #	Standard Text	Decision
11	The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its decision to hire or allow the party to have regular and substantial contact with an individual receiving services.	Met/Not Met/NA

Guidance

Documentation Review:

- A list of all new employees, volunteers, contractors, and family care providers who were hired, taken on, contracted with, or certified since (respectively), for sampled time period described below.
- SEL check records
- MHL 16.34 check records

Interview:

- Personnel Manager/Administrator
- Agency Designated Authorized Party

Additional Guidance:

- SEL checks are required for all applicants/employees/contractors/volunteers/family care providers (and adults other than individuals receiving services who reside in family care homes), in facilities and programs operated, certified, or funded by OPWDD, who are required to have CBCs.
- SEL checks may identify category 2 conduct that does not place the subject party on the SEL.
- The MHL 16.34 check may also reveal a past incident of substantiated neglect or abuse. An agency may decide to hire or take on an employee//contractor/volunteer with such history, but must document a rationale for the decision. This requirement also applies to family care providers and adults who are not individuals receiving service who reside in a family care home.
- Where survey staff find that subject party was hired as an employee or contractor, taken on as a volunteer, certified as a family care provider or is an adult residing in a family care home with category 2 or MHL 16.34 conduct history, there must be written documentation of the agency's rationale for the decision to allow that party to have regular and substantial contact with an individual receiving services.
- Discuss/resolve any missing/discrepant information with the designated authorized party

Select Met when both of the following are evident:

- The agency reviews substantiated reports of abuse or neglect concerning a subject party that are received; AND
- The agency documents its decision to hire or allow the party to have regular and substantial contact with an individual receiving services.

Select Not Met when either of the following are evident:

- The agency has not reviewed substantiated reports of abuse or neglect concerning a subject party that are received; AND/OR

- The agency does not document its decision to hire or allow the party to have regular and substantial contact with an individual receiving services.

*Survey staff must immediately contact a Bureau of Program Certification Area Director when the survey staff find that 633.24(e) is not met - plan of correction may have to be taken during the visit to ensure that individuals receiving services are provided with appropriate protection, as required.

Select NA (Not Applicable) if no new employees, volunteers, contractors, and family care providers (or new adult family care home residents) were hired, taken on, contracted with, or certified since the time of the last agency review.

Citations

633.24(e)

633.24(e) Information about substantiated reports of abuse or neglect.

(1) The authorized party of an agency or registered provider may receive information about substantiated reports of abuse or neglect concerning a subject party as a result of a background check. This information may either:

(i) be provided by the Justice Center about category two conduct in accordance with section 562 of the Executive Law; or

(ii) be provided by OPWDD about substantiated reports of abuse or neglect occurring before June 30, 2013 in accordance with section 16.34 of the Mental Hygiene Law.

(2) In the event that such information is provided, the agency or registered provider is required to review the information provided and to make a decision about whether to hire or otherwise allow the party to have regular and substantial contact with an individual receiving services. Such decision and the rationale for the decision shall be documented.

Section 3: Initial Training

Qualifier	The agency has hired staff into a position(s) related to service planning, delivery and/or the management/oversight of service planning/delivery in the past year or since DQI's last review of initial training records.	Yes/No
Standard #	Standard Text	Decision
1	The agency ensures that employees receive training in principles of human growth and development within three months of initial employment.	Met/Not Met/NA

Guidance

Interview:

- Who you interview is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- A list of all new employees and volunteers who were hired or taken on for sampled time period described below.
- Training records, tracking system
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review/compare training records and a sample of personnel files of staff /volunteers/family care providers hired/engaged/certified less than 1 year to determine whether training occurred within the required timeframe (3 months / 90 days of initial employment).
- Initial date is the first calendar date employees reported to their work/volunteer assignment at the agency, or for family care providers, the effective date of the first certification as identified in the approved certification notice.
- As needed, review agency's Human Growth and Development training curriculum and/or policy and procedure related to this training.

Choosing your sample:

- **New Employees:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- **Sample Sizes** are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select MET if documentation verifies that sampled employees have received, or are scheduled to receive, the required training within the required timeframe.

Select Not Met if either of the following are evident:

- the required subject matter is not part of the agency training program; or
- it CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training within the required timeframe

Select NA (Not Applicable) if the agency has not hired new staff, engaged new volunteers, or certified new family care providers in the past year.

Citations

633.8(b)(1)(i)

(b) Standards of certification.

(1) OPWDD shall verify that employees, volunteers, and family care providers have received or will receive training within three months of initial employment, commencing volunteer activities, or initial certification as a family care provider. The training shall be on:

- (i) principles of human growth and development;

Standard #	Standard Text	Decision
2	The agency ensures that employees receive training in characteristics of the persons served within three months of initial employment.	Met/Not Met/NA

Guidance

Interview:

- Who you interview is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff to clarify procedures and documents that may be unclear.

Documentation Review:

- A list of all new employees and volunteers who were hired or taken on for sampled time period described below.
- Training records, tracking system
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review/compare training records and a sample of personnel files of staff /volunteers/family care providers hired/engaged/certified less than 1 year to determine whether training occurred within the required timeframe (3 months / 90 days of initial employment).
- Initial date is the first calendar date employees reported to their work/volunteer assignment at the agency, or for family care providers, the effective date of the first certification as identified in the approved certification notice.
- As needed, review agency's Characteristics of Persons Served training curriculum and/or policy and procedure related to this training.

Choosing your sample:

- New Employees: The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if documentation verifies that sampled employees have received, or are scheduled to receive, the required training within the required timeframe.

Select Not Met if either of the following are evident:

- the required subject matter is not part of the agency training program; or
- it CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training within the required timeframe

Select NA (Not Applicable) if the agency has not hired new staff, engaged new volunteers, or certified new family care providers in the past year

Citations

633.8(b)(1)(ii)

Regulatory Reference: 633.8(b)(1)(ii)

(b) Standards of certification.

(1) OPWDD shall verify that employees, volunteers, and family care providers have received or will receive training within three months of initial employment, commencing volunteer activities, or initial certification as a family care provider. The training shall be on:

(ii) characteristics of the persons served;

Standard #	Standard Text	Decision
3	The agency ensures that employees receive training in 'Promoting Positive Relationships and Safe Environments for People with Developmental Disabilities' within three months of initial employment.	Met/Not Met/NA

Guidance

Interview:

- Who you interview is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff to clarify procedures and documents that may be unclear.

Documentation Review:

- A list of all new employees and volunteers who were hired or taken on for sampled time period described below.
- Training records, tracking system
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review/compare training records and a sample of personnel files of staff /volunteers/family care providers hired/engaged/certified less than 1 year to determine whether training occurred within the required timeframe (3 months / 90 days of initial employment).
- Initial date is the first calendar date employees reported to their work/volunteer assignment at the agency, or for family care providers, the effective date of the first certification as identified in the approved certification notice.
- As needed, review agency's 'Promoting Positive Relationships and Safe Environments for People with Developmental Disabilities' training curriculum and/or policy and procedure related to this training.

Choosing your sample:

- New Employees: The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if documentation verifies that sampled employees have received, or are scheduled to receive, the required training within the required timeframe.

Select Not Met if either of the following are evident:

- the required subject matter is not part of the agency training program; or
- it CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training within the required timeframe

Select NA (Not Applicable) if the agency has not hired new staff, engaged new volunteers, or certified new family care providers in the past year.

Citations

633.8(b)(1)(iii)

(b) Standards of certification.

(1) OPWDD shall verify that employees, volunteers, and family care providers have received or will receive training within three months of initial employment, commencing volunteer activities, or initial certification as a family care provider. The training shall be on:

(iii) promoting positive relationships

Standard #	Standard Text	Decision
4	The agency ensures that employees receive training in abuse prevention, identification, reporting and processing of allegations of abuse within three months of initial employment.	Met/Not Met/NA

Guidance

Interview:

- Who you interview is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff to clarify procedures and documents that may be unclear.

Documentation Review:

- A list of all new employees and volunteers who were hired or taken on for sampled time period described below.
- Training records, tracking system
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review/compare training records and a sample of personnel files of staff /volunteers/family care providers hired/engaged/certified less than 1 year to determine whether training occurred within the required timeframe (3 months / 90 days of initial employment).
- Initial date is the first calendar date employees reported to their work/volunteer assignment at the agency, or for family care providers, the effective date of the first certification as identified in the approved certification notice.
- As needed, review agency's training curriculum on abuse prevention, identification, reporting and processing of allegations of abuse and/or policy and procedure related to this training.

Choosing your sample:

- **New Employees:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- **Sample Sizes** are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if documentation verifies that sampled employees have received, or are scheduled to receive, the required training within the required timeframe.

Select Not Met if either of the following are evident:

- the required subject matter is not part of the agency training program; or
- it CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training within the required timeframe

Select NA (Not Applicable) if the agency has not hired new staff, engaged new volunteers, or certified new family care providers in the past year.

Citations**633.8(b)(1)(iv)**

(b) Standards of certification.

(1) OPWDD shall verify that employees, volunteers, and family care providers have received or will receive training within three months of initial employment, commencing volunteer activities, or initial certification as a family care provider. The training shall be on:

(iv) abuse prevention, identification, reporting, and processing of allegations of abuse;

Standard #	Standard Text	Decision
5	The agency ensures that employees receive training in laws, regulations and policies and procedures governing protection from abuse within three months of initial employment.	Met/Not Met/NA

Guidance

Interview:

- Who you interview is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff to clarify procedures and documents that may be unclear.

Documentation Review:

- A list of all new employees and volunteers who were hired or taken on for sampled time period described below.
- Training records, tracking system
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review/compare training records and a sample of personnel files of staff /volunteers/family care providers hired/engaged/certified less than 1 year to determine whether training occurred within the required timeframe (3 months / 90 days of initial employment).
- Initial date is the first calendar date employees reported to their work/volunteer assignment at the agency, or for family care providers, the effective date of the first certification as identified in the approved certification notice.
- As needed, review agency's training curriculum on laws, regulations and policies and procedures governing protection from abuse and/or policy and procedure related to this training.

Choosing your sample:

- New Employees: The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if documentation verifies that sampled employees have received, or are scheduled to receive, the required training within the required timeframe.

Select Not Met if either of the following are evident:

- the required subject matter is not part of the agency training program; or
- it CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training within the required timeframe

Select NA (Not Applicable) if the agency has not hired new staff, engaged new volunteers, or certified new family care providers in the past year.

Citations

633.8(b)(1)(v)

Regulatory Reference: 633.8(b)(1)(v)

(b) Standards of certification.

(1) OPWDD shall verify that employees, volunteers, and family care providers have received or will receive training within three months of initial employment, commencing volunteer activities, or initial certification as a family care provider. The training shall be on:

(v) laws, regulations and policies/procedures governing protection from abuse;

Standard #	Standard Text	Decision
6	The agency ensures that employees receive training in incident reporting and processing within three months of initial employment.	Met/Not Met

Guidance

Interview:

- Who you interview is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff to clarify procedures and documents that may be unclear.

Documentation Review:

- A list of all new employees and volunteers who were hired or taken on for sampled time period described below.
- Training records, tracking system
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review/compare training records and a sample of personnel files of staff /volunteers/family care providers hired/engaged/certified less than 1 year to determine whether training occurred within the required timeframe (3 months / 90 days of initial employment).
- Initial date is the first calendar date employees reported to their work/volunteer assignment at the agency, or for family care providers, the effective date of the first certification as identified in the approved certification notice.
- As needed, review agency's training curriculum on incident reporting and processing and/or policy and procedure related to this training.

Choosing your sample:

- **New Employees:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- **Sample Sizes** are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if documentation verifies that sampled employees have received, or are scheduled to receive, the required training within the required timeframe.

Select Not Met if either of the following are evident:

- the required subject matter is not part of the agency training program; or
- it CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training within the required timeframe

Select NA (Not Applicable) if the agency has not hired new staff, engaged new volunteers, or certified new family care providers in the past year.

Citations

633.8(b)(1)(vi)

b) Standards of certification.

(1) OPWDD shall verify that employees, volunteers, and family care providers have received or will receive training within three months of initial employment, commencing volunteer activities, or initial certification as a family care provider. The training shall be on:

(vi) incident reporting and processing;

Standard #	Standard Text	Decision
7	The agency ensures that employees receive training in the agency's safety and security procedures including fire safety within three months of initial employment.	Met/Not Met

Guidance

Interview:

- Who you interview is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff to clarify procedures and documents that may be unclear.

Documentation Review:

- A list of all new employees and volunteers who were hired or taken on for sampled time period described below.
- Training records, tracking system
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review/compare training records and a sample of personnel files of staff /volunteers/family care providers hired/engaged/certified less than 1 year to determine whether training occurred within the required timeframe (3 months / 90 days of initial employment).
- Initial date is the first calendar date employees reported to their work/volunteer assignment at the agency, or for family care providers, the effective date of the first certification as identified in the approved certification notice.
- Review agency's training curriculum on the agency's safety and security procedures including fire safety and/or policy and procedure related to this training.
- The training must address fire safety, and any other topics of safety and security determined by agency policy.

Choosing your sample:

- New Employees: The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if documentation verifies that sampled employees have received, or are scheduled to receive, the required training within the required timeframe.

Select Not Met if either of the following are evident:

- the required subject matter is not part of the agency training program; or
- it CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training within the required timeframe

Select NA (Not Applicable) if the agency has not hired new staff, engaged new volunteers, or certified new family care providers in the past year.

Citations

633.8(b)(1)(vii)

(b) Standards of certification.

(1) OPWDD shall verify that employees, volunteers, and family care providers have received or will receive training within three months of initial employment, commencing volunteer activities, or initial certification as a family care provider. The training shall be on:

(vii) the agency's safety and security procedures including fire safety;

Standard #	Standard Text	Decision
8	The agency ensures that employees receive OPWDD Choking Prevention Initiative training as applicable to their position, within three months of initial employment.	Met/Not Met

Guidance

Interview:

- Who you interview is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff to clarify procedures and documents that may be unclear.

Documentation Review:

- A list of all new employees and volunteers who were hired or taken on for sampled time period described below.
- Training records, tracking system;
- Personnel records including job descriptions as needed.
- Agency policy/procedure and/or training curriculum as needed.
- It is mandated that the agency use the OPWDD Choking Prevention Initiative (CPI) training materials/curriculum (available on the OPWDD Internet website). The agency may supplement the training so long as it does not contradict.

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review/compare training records and a sample of personnel files of staff /volunteers/family care providers hired/engaged/certified less than 1 year to determine whether training occurred within the required timeframe (3 months / 90 days of initial employment).
- Initial date is the first calendar date employees reported to their work/volunteer assignment at the agency, or for family care providers, the effective date of the first certification as identified in the approved certification notice.
- It is mandated that the OPWDD Choking Prevention Initiative training materials/curriculum be used (available on the OPWDD Internet website). The agency may supplement the training so long as it does not contradict the OPWDD curriculum.
- Allowing for variances in agency job descriptions, following staff positions are applicable for training:
 - o Applicable Parties for Part 1 of OPWDD Choking Prevention Initiative training:

All staff working in Residential programs, Day programs, community based waiver service programs; Clerical staff; Direct Support Professionals; House Managers; Family Care Providers; Housekeepers/Cleaners; Investigators; LPNs; Managers/ Supervisors; Maintenance/Groundskeepers; MSC/PCSS; Human Resources; RN; Transportation; Psychologists; Dietitians, SLP; OT; PT; Habilitation Specialists; and Therapists.
 - o Applicable Parties for Part 2 of OPWDD Choking Prevention Initiative training: All staff responsible for preparing meals, serving meals, and/or providing oversight during eating / mealtimes and their direct supervisors including: Cooks, Direct Support Professionals; House Managers; Community Service Managers; LPNs, RNs; Dietitians; SLPs; and OTs.

Choosing your sample:

- **New Employees:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- **Sample Sizes** are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if documentation verifies that:

- sampled employees have received, or are scheduled to receive, the required OPWDD CPI training within the required timeframe; AND
- the sampled employees have received the required Parts of the CPI training (Part 1, or Parts 1 and 2) according to their position and job duties.

Select Not Met if any of the following are evident:

- the required OPWDD CPI training is not part of the agency training program; or
- it CANNOT be verified that sampled employees have received, or are scheduled to receive, the OPWDD CPI training within the required timeframe; and/or
- sampled employees received did not received the required parts of the training, including Part 2 when required according to the job duties of their position as described above.

Select NA (Not Applicable) if the agency has not hired new staff, engaged new volunteers, or certified new family care providers in the past year.

Citations

OPWDD ADM #2012-04

Regulatory Reference: OPWDD ADM #2012-04:

Applicability: This Administrative Memorandum (ADM) applies to:

All residential facilities certified or operated by Office for People with Developmental Disabilities (OPWDD) (including family care and supportive individual residential alternatives

[IRAs] and supportive Community Residences [CRs]); and

Free-standing respite centers certified as an IRA; and

All day services that are operated, certified and/or funded by OPWDD except supported employment services.

This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services.

Purpose: To promote the health and safety of the individuals receiving services, all applicable parties of OPWDD Developmental Disabilities State Operations Offices (DDSOO), Developmental Disabilities Regional Offices (DDROs) and provider agencies are required to complete the OPWDD Choking

Prevention Initiative (CPI) Part I and Part II training (if applicable) as detailed in this ADM. Beginning on the date that CPI training is required to be completed, DDSOOs, DDROs, and provider agencies must be in compliance with CPI's terminology, definitions, guidelines and food consistencies....

All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative.

Standard #	Standard Text	Decision
9	The agency ensures that Support Brokers have completed the OPWDD-approved Broker training prior to delivering brokerage services.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Broker Training

Interview:

As Needed: Support Broker, Training Department

Additional Guidance:

- Review training records to ensure Brokers received the required trainings prior to delivering brokerage services.
- The agency must ensure that employees hired to provide Support Brokerage services have the required training prior to implementation of their duties.
- Required trainings are:
 - o Broker Training Institute
 - o Introduction to Person-centered Planning
 - o Advanced Person-centered Planning
 - o Developing a Self-Directed Budget
 - o Self-Advocacy/Self Determination
- If the training has a test or evaluation component, the broker must pass the test for it to count as training.

Select Met if both of the following are evident:

- The agency has a mechanism to track the training that Support Brokers have completed, and can verify that the required initial training is completed prior to delivering services; AND
- Support Brokers have completed the required initial training modules prior to delivering brokerage services.

Select Not Met if:

- The agency does not have a mechanism to track the training that Support Brokers have completed, and therefore cannot verify that the required initial training is completed prior to delivering services; or
- Per review of training records, Support Brokers have not completed any of required trainings prior to delivering brokerage services; or
- Per review of training records, the Support Brokers training is incomplete. They completed some, but not all required trainings.

Citations

Administrative Memorandum 2015-06

Prior to delivering brokerage services, each Support Broker must complete Broker Training that is conducted using an OPWDD approved curriculum delivered by trainers approved by OPWDD. If the training has a test or evaluation component, the broker must pass the test for it to count as training. These trainings are Broker Training Institute, Person-centered Planning (Introduction to Person-centered Planning and Advanced Person-centered Planning), Developing a Self-Directed Budget, and Self-Advocacy/Self-Determination.

Section 4: Annual Training and Other Training Activities

Standard #	Standard Text	Decision
1	The agency has a mechanism to monitor/track that employees receive required training.	Met/Not Met

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for tracking and monitoring training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- Training tracking system, records, training logs, and/or training attendance sheets as appropriate;
- As needed: Documentation regarding content of sessions, training schedules

Additional Guidance:

- This standard reviews for agency mechanisms to ensure employees training records are maintained and monitored to ensure they receive the training they require, need, and want to complete their jobs competently.
- Interview staff responsible for maintaining and monitoring that staff participate in required and assigned training modules
- Request demonstration of the agency's mechanism used for tracking staff training and how it is used;
- Review whether the monitoring system addresses required training frequency and completion within time frames for completion.
- Review whether the monitoring system addresses required trainings for specific positions such as Support Brokers, RNs, etc.
- Review whether the monitoring system addresses training for skill development that may not be required by regulation, such as offered training for RNs, Clinicians, DSPs, Supervisory training, as offered or per agency policy, etc.
 - o E.g. First Aid, CPR, Training on specific medical, psychiatric or developmental diagnoses, advance directives, best practices in nursing, etc.
- Review whether the system not only tracks training, but also proactively ensures that required and needed training occurs within time frames, such as but not limited to advance scheduling, flexible scheduling, reminders to the person and supervisor, etc.
- Through your review of training records for this standard and others, verify that the agency's mechanism appears to be effective through evidence of:
 - o Verify that training records are maintained to ensure they accurately reflect training and show that training is generally up to date. The mechanism should be able to track training completed in different formats, e.g. on-line training, webinars, in person, etc.;
 - o Determine whether the agency mechanism addresses employee training that is overdue or omitted.
 - o If it appears that training is overdue or outdated, discuss with the agency how the mechanism was expected to address/prevent this.

o If possible, determine whether and how training that is evidenced through sign in sheets, or other formats, is incorporated into the agency's monitoring/tracking system.

Select Met if the following are evident regarding the agency's mechanism to track and monitor staff training:

- Mechanism is maintained and understood by employee(s) responsible to maintain; and
- The mechanism clearly identifies employee name, training topic, completion dates, and
- Tracking is maintained current/up to date; and
- The mechanism is effective in tracking due dates and ensuring that employees complete their training with the frequency and within time frames required.

Select Not Met if ANY of the following conditions exist:

- There is no formal mechanism to monitor staff training; or
- The mechanism does not clearly outline employee name, training topic, completion dates; or
- The mechanism is ineffective to ensure that staff complete training with frequency and within time frames required; or
- Tracking is not current; or
- Tracking is misleading, incoherent or otherwise illegible.

Citations

633.8(b)(3) (i-ii)

(b) Standards of certification.

(3) There is a mechanism for monitoring the type, frequency and amount of training employees, volunteers or family care providers need and received, and that:

(i) the records are current; and

(ii) employees, volunteers or family care providers, through interview, concur that they have received the specified training.

Standard #	Standard Text	Decision
2	The agency ensures that all employees receive mandatory annual training in Promoting Positive Relationships.	Met/Not Met

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- List of employees, volunteers, family care providers who have been associated with the agency two (2) or more years.
- Training records, tracking system
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review training records of veteran staff /volunteers/family care providers hired/engaged/certified 2 or more years to determine whether training has occurred annually (every 12 months or once each calendar year).
- As needed, review agency's 'Promoting Positive Relationships and Safe Environments for People with Developmental Disabilities' training curriculum and/or policy and procedure related to this training.

Choosing your sample:

- The sample must be a cross-section of employees and positions per agency services, organizational structure and positions.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if sampled employees have received, or are scheduled to receive, 'Promoting Positive Relationships and Safe Environments for People with Developmental Disabilities' training annually.

Select Not Met if any of the following is evident regarding 'Promoting Positive Relationships and Safe Environments for People with Developmental Disabilities':

- The training is not addressed in the agency training program; or
- Sampled employees have NOT received the required training; or
- It CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training within the required timeframe.

Citations

633.8(b)(2)(i)

b) Standards of certification.

(2) Employees, volunteers and family care providers shall receive training in the following areas on at least an annual basis:

(i) promoting positive relationships;

Standard #	Standard Text	Decision
3	The agency ensures that all employees receive mandatory annual training in abuse prevention, identification, reporting and processing of allegations of abuse.	Met/Not Met

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- List of employees, volunteers, family care providers who have been associated with the agency two (2) or more years.
- Training records, tracking system
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review training records of veteran staff /volunteers/family care providers hired/engaged/certified 2 or more years to determine whether training has occurred annually (every 12 months or once each calendar year).
- As needed, review agency's abuse prevention, identification, reporting and processing of allegations of abuse training curriculum and/or policy and procedure related to this training.

Choosing your sample:

- The sample must be a cross-section of employees and positions per agency services, organizational structure and positions.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if sampled employees have received, or are scheduled to receive, abuse prevention, identification, reporting and processing of allegations of abuse training annually.

Select Not Met if any of the following is evident regarding abuse prevention, identification, reporting and processing of allegations of abuse:

- The training is not addressed in the agency training program; or
- Sampled employees have NOT received the required training; or
- It CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training annually.



Citations

633.8(b)(2)(ii)

Employees, volunteers and family care providers shall receive training in the following areas on at least an annual basis:

- (ii) abuse prevention, identification, reporting, and processing of allegations of abuse;

Standard #	Standard Text	Decision
4	The agency ensures that all employees receive mandatory annual training in laws, regulations and policies/procedures governing protection from abuse.	Met/Not Met

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- List of employees, volunteers, family care providers who have been associated with the agency two (2) or more years.
- Training records, tracking system
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review training records of veteran staff /volunteers/family care providers hired/engaged/certified 2 or more years to determine whether training has occurred annually (every 12 months or once each calendar year).
- As needed, review agency's laws, regulations and policies and procedures governing protection from abuse training curriculum and/or policy and procedure related to this training.

Choosing your sample:

- The sample must be a cross-section of employees and positions per agency services, organizational structure and positions.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if sampled employees have received, or are scheduled to receive, laws, regulations and policies and procedures governing protection from abuse training annually.

Select Not Met if any of the following is evident regarding laws, regulations and policies and procedures governing protection from abuse:

- The training is not addressed in the agency training program; or
- Sampled employees have NOT received the required training; or
- It CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training annually.



Citations

633.8(b)(2)(iii)

(b) Standards of certification.

2) Employees, volunteers and family care providers shall receive training in the following areas on at least an annual basis:

(iii) laws, regulations and policies/procedures governing protection from abuse;

Standard #	Standard Text	Decision
5	The agency ensures that all employees receive mandatory annual training in incident reporting and processing.	Met/Not Met

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- List of employees, volunteers, family care providers who have been associated with the agency two (2) or more years.
- Training records, tracking system
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review training records of veteran staff /volunteers/family care providers hired/engaged/certified 2 or more years to determine whether training has occurred annually (every 12 months or once each calendar year).
- As needed, review agency's incident reporting and processing training curriculum and/or policy and procedure related to this training.

Choosing your sample:

- The sample must be a cross-section of employees and positions per agency services, organizational structure and positions.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if sampled employees have received, or are scheduled to receive, incident reporting and processing training annually.

Select Not Met if any of the following is evident regarding incident reporting and processing:

- The training is not addressed in the agency training program; or
- Sampled employees have NOT received the required training; or
- It CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training annually.

Citations

633.8(b)(2)(iv)

(b) Standards of certification.

(2) Employees, volunteers and family care providers shall receive training in the following areas on at least an annual basis:

(iv) incident reporting and processing;

Standard #	Standard Text	Decision
6	The agency ensures that all employees receive mandatory annual training in safety and security procedures including fire safety.	Met/Not Met

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- List of employees, volunteers, family care providers who have been associated with the agency two (2) or more years.
- Staff development records, tracking system
- Policy/Procedure regarding provision and staff completion training
- Personnel records as needed
- Training Curriculum as needed

Additional Guidance:

- Review training records to determine if the required subject matter has been addressed, and dates the specified training was, or is scheduled to be, delivered.
- Review training records of veteran staff /volunteers/family care providers hired/engaged/certified 2 or more years to determine whether training has occurred annually (every 12 months or once each calendar year).
- As needed, review the agency's safety and security procedures including fire safety training curriculum and/or policy and procedure related to this training.

Choosing your sample:

- The sample must be a cross-section of employees and positions per agency services, organizational structure and positions.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if sampled employees have received, or are scheduled to receive, the agency's safety and security procedures including fire safety training annually.

Select Not Met if any of the following is evident regarding the agency's safety and security procedures including fire safety:

- The training is not addressed in the agency training program; or
- Sampled employees have NOT received the required training; or
- It CANNOT be verified that sampled employees have received, or are scheduled to receive, the required training annually.

Citations

633.8(b)(2)(iv)

(b) Standards of certification.

(2) Employees, volunteers and family care providers shall receive training in the following areas on at least an annual basis:

(v) the agency's safety and security procedures (including fire safety).

Standard #	Standard Text	Decision
7	The agency staff participate in development activities for the NADSP Code of Ethics and the DSP Core Competencies per OPWDD requirements and agency policy/procedure.	Met/Not Met

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for design and provision DSP development to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- List of employees who are direct support professionals (DSPs). First year of review this may be all DSPs. Subsequent reviews should be newly hired DSPs.
- Development and training records for staff working as Direct Support Professionals (DSP) regarding Core Competencies, Code of Ethics and Performance Evaluation process
- Agency curriculum, regarding DSP Code of Ethics and Core Competencies, especially if customized
- Agency training policy/procedure, regarding same, as needed

Additional Guidance:

- Background:

- o The agency is required to ensure DSPs receive sufficient training and development to understand expectations related to the NADSP Code of Ethics, DSP Core Competencies and DSP Performance Evaluation process.
- o The core competencies and performance evaluations provide standardized expectations that focus on people-first services and advance the profession of direct support. Both present an opportunity for portability of skill transfer for DSPs, between DSP work settings within the same agency and across NYS OPWDD provider agencies.
- o Information provided to DSPs is standardized, and typically provided by the Regional Centers which ensures a more consistently trained workforce system wide. OPWDD recognized that this approach is necessary to be able to assure that a DSP working for one agency learns the same content that a DSP working at another agency. In this way Individuals and families/advocates can expect the same level of knowledge and service regardless of the OPWDD certified agency providing the services and supports.
- o Note: the agency DSPs must be informed with the standardized curriculum content. The agency may however, add customized core competency skills to the curriculum. (e.g. The agency serves a large urban population and customizes its training to include task examples of skills to support persons to explore their desire, aptitude and ability to use public transportation in support of a personal goal of greater independence in their community.)
- o Per OPWDD Informational Letter 16-INF-01 dated March 28, 2016:
- o In accordance with OPWDD Administrative Memorandum (ADM) #2014-03, providers are expected to utilize the Core Competencies and National Alliance for Direct Support Professionals (NADSP) Code of Ethics with all direct support professionals. This includes the completion of on-going training and development for staff on the Core Competencies and Code of Ethics and the use of the published Initial and Annual Evaluation tools as prescribed.
- Review Activities:
 - o Review personnel or staff development records for DSP staff to verify that received or are scheduled to participate in development programs. In the first year of review, any agency DSP may be included in the sample for this standard. Subsequent reviews should focus on staff newly hired or appointed to a direct support professional position.

o If staff, or a significant number of staff have not received training/participated, review agency policy and procedures for provision/completion/scheduling of DSPs new and current.

• If review of personnel records and policy is insufficient to evaluate the agency's commitment to ensure the DSPs receive training, or if any other clarification is needed, interview appropriate agency staff.

Sample:

- The sample must be staff in the role of direct support professional.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if both are present:

Ø Agency policy and procedure or Staff Development Program requires training/development activities for all DSP Staff on NADSP Code of Ethics, Core Competencies and Evaluation process

Ø sampled DSPs have received, or are scheduled to participate in training/development activities regarding the NADSP Code of Ethics, DSP Core Competencies and DSP Performance Evaluation process.

Select Not Met if any of the following are evident regarding the NADSP Code of Ethics, DSP Core Competencies and DSP Performance Evaluation process:

- The DSP Code of Ethics, Core Competencies and the evaluation process is not addressed in the agency staff development program; or
- Sampled DSPs have NOT participated in informative and development activities; or

Ø It CANNOT be verified that sampled DSPs have received, or are scheduled to participate in activities to understand NADSP Code of Ethics, DSP Core Competencies and DSP Performance Evaluation process.

Citations

ADM #2014-03

OPWDD ADM #2014-03: Service Provider Implementation of the National Alliance for Direct Support Professionals (NADSP) Code of Ethics, NYS DSP Core Competencies and NYS DSP Performance Evaluations Applicability: This communication pertains to all OPWDD state-operated and voluntary-operated services and supports that employ DSPs...

Purpose: ... The requirements of implementation are:

July 1, 2014: implement the practice of the NADSP Code of Ethics and the NYS DSP Core Competencies;

April 1, 2016: begin using the NYS DSP Performance Evaluations as the evaluation tools for DSPs;

Implementation of Code of Ethics, DSP Competencies and Performance Evaluations: Service Providers shall implement the NADSP Code of Ethics, the Core Competencies and Performance Evaluations for DSPs as outlined above under the heading entitled "Purpose." The requirements to implement the practice of the NADSP Code of Ethics, the NYS DSP Core Competencies and the NYS DSP Performance Evaluations shall pertain in years subsequent to April 1, 2017 according to DQI protocols.

The NADSP Code of Ethics

(<http://www.opwdd.ny.gov/code-of-ethics/home>) is incorporated in the DSP Core Competencies and the Initial and Annual Performance Evaluations, specifically in Goal 3, Competency Area N where all nine tenets are addressed.

Standard #	Standard Text	Decision
8	The agency staff providing direct services are provided training/learning experiences to develop/maintain the ability to identify, understand, and support the diverse personal outcomes of people they support.	Met/Not Met

Guidance

"This is a QUALITY INDICATOR."

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- If the agency has formalized agency processes for training to develop direct support staff skills regarding providing services in a person centered way, review the following as applicable:
 - o Agency policy and procedures related to training/skill development in recognizing and providing services and supports to individuals in person centered ways and communicating opportunities for individualization of supports.; and/or
 - o Training curriculum(s) used by the agency for service delivery staff regarding person centered service delivery and support and discovery.
 - o Management or Quality improvement plans that may explain the agency approaches to skill development on this topic.
- Training records/tracking system.

Additional Guidance:

- This Quality Indicator is based on the premise that the likelihood that individual's personal outcomes will be achieved is improved when those that can influence the success all understand the role they play. Inclusion of a curriculum related to achievement of personal outcomes in agency training requirements may demonstrate that this is considered a priority within the agency.
 - This QI standard reviews whether an agency systemically provides learning experiences to enhance staff's skills to work with individuals in a person-centered way both during formal service plan delivery and in daily activities and supports. For example, what are personal outcomes/desired outcomes/valued outcomes/dreams; employee role in supporting this achievement; this may be how to pay attention to the individuals' interests, wants, responses, encouraging experiences/interests/cultural/spiritual pursuits; etc.
- Staff providing direct services may include DSPs, habilitation, respite staff, recreation and education staff, and clinicians.
- Regarding DSPs, this standard applies to skill development activities provided or sponsored by the agency, in person centered services, in addition to the DSP Competencies training.
- Begin with interview staff described above as appropriate to agency operations and organization.
- Determine whether the agency has organized approaches in place to educate direct support staff on person centered service delivery.
- If the agency reports this is not addressed in any way, the review is complete and the decision is NOT MET.

- If the agency does provide education/training in this area, review any written/organizational plans, policy, procedures, mechanism, curriculums the agency uses.
- The agency may use or provide training from outside sources or their own curriculum.
- Review any tracking mechanisms the agency uses to ensure that applicable employees, per their own procedures, receive the training.
- If agency has not yet implemented strategies, but reports there are strategies in development, have further discussion with staff and review any documentation that evidences this.
- There is no expectation of training frequency for this standard, as this is an agency process.

Sample:

If the agency provides training in this area, to the best of your ability, decide who, per their policies is to receive the training, determine how best the agency can demonstrate that staff in those roles typically receive the training, through review documentation previously requested or some other information the agency can provide.

- The sample must be staff in the role of direct support professional and other staff providing direct services to individuals
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if the following are evident:

- The agency has a formal mechanism for skill development of staff who deliver services in person centered service delivery; AND
- There is evidence of implementation of the mechanism.

OR

- The agency demonstrates readiness to implement a formal mechanism for this skill development, and has a descriptive plan for its implementation within three (3) months.

Select Not Met if:

- The agency does not address skill development of staff who deliver services in person centered planning; and/or
- The agency is not developing a means to address the above; and/or
- The agency is developing a systemic means to address the above, but is not within 3 months of implementation; and/or
- The agency states that there is a systemic means to address skill development of aforementioned staff, but there is no evidence of implementation.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
9	The agency staff responsible for the design, development, and/or monitoring of services and supports, receive training regarding facilitation of person-centered planning and service delivery.	Met/Not Met

Guidance

This is a QUALITY INDICATOR.

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- If the agency has formalized agency processes for training to develop service planning staff skills regarding person centered practices, review the following as applicable:
 - o Agency policy and procedures related to training/skill development in person centered practices; and/or
 - o Training curriculum(s) used by the agency regarding person centered services; for example: facilitation of person centered planning, person centered service planning strategies, delivery of services and supports, operating programs and services in a manner that supports choice and individualization, how to determine what an individual values, etc. needed, and/or
 - o Management or Quality improvement plans that may explain the agency approaches to skill development on this topic.
- Training records, tracking system

Additional Guidance:

- This QUALITY INDICATOR reviews whether an agency systemically provides training to facilitate competency in person centered service planning and delivery, for staff responsible for service plan development, and/or oversight of development and delivery. This includes habilitation plans, service plans, program plans, support plans, clinical plans, etc. This facilitation may occur through skill development activities including training and education in person centeredness, person centered planning modalities, etc.
- Begin with interview of staff described above as appropriate to agency operations and organization.
- Determine whether the agency has organized approaches in place to educate staff responsible for oversight of service plans/planning to use person centered practices.
- If the agency reports this is not addressed in any way, the review is complete and the decision is NOT MET.
- If the agency does provide such education and training, review any written/organizational plans, policy, procedures, mechanism, curriculums the agency uses and can provide.
- The agency may use or provide training from outside sources on the facilitation and assurance of identifying an individual's priorities and assuring person-centered planning and service delivery.
- Review any tracking mechanisms the agency uses to ensure that employees determined to benefit from the training per policy, receive the training.

- If agency has not yet implemented strategies, but strategies are in development, have further discussion with staff and review any documentation that evidences this.
- There is no requirement for training frequency for this standard.

Sample:

If the agency provides training in this area, to the best of your ability, decide who, per their policies is to receive the training, determine how best the agency can demonstrate that staff in those roles typically receive the training, through review of documentation previously requested or some other information the agency can provide.

- The sample must be staff having a role in service plan (by whatever name) writing, developing, monitoring, or overseeing, or signing off.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if the following are evident:

- The agency has a formal mechanism for to provide training on person centered services to employees responsible for development or oversight of service plans and service delivery; AND
- There is evidence of implementation of the mechanism.

OR

- The agency has demonstrated readiness to implement a formal mechanism for this skill development, and has a descriptive plan for its implementation within three (3) months.

Select Not Met if:

- The agency does not address skill development in person centered planning to employees responsible for oversight or development of service planning and delivery; and/or
- The agency is not developing a means to address the above; and/or
- The agency is developing a systemic means to address the above, but is not within 3 months of implementation; and/or
- The agency states that there is a systemic means to address skill development of aforementioned staff, but there is no evidence of implementation.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
10	The workforce is trained to understand and implement their role in achieving the provider agency's mission.	Met/Not Met

Guidance

This is a Quality Indicator.

Interview:

Who you interview to gather or clarify information, is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- If the agency has formalized agency processes for training agency staff on the Agency Mission and what that means in practice, review the following as applicable:
 - o Agency policy and procedures related to training regarding Agency Mission; and/or
 - o Training curriculum(s) used by the agency for training on the Agency Mission.
 - o Management or Quality improvement plans that may explain the agency actions/approaches to skill development on this topic.
- Training records, tracking system

Additional Guidance:

- This is a Quality Indicator to determine if the agency take systemic action to train staff in their Agency Mission/Mission Statement and what this means in the completion of their day to day work duties.
- Begin with interview with the appropriate agency staff.
- Determine whether the agency has organized approaches in place to educate/train all agency staff in the Agency's Mission and achievement of same.
- If the agency reports this is not addressed in any way, the review is complete and the decision is NOT MET.
- If the agency does provide education and training regarding the Agency Mission and achievement of same, review any written/organizational plans, policy, procedures, mechanism, curriculums the agency uses and can provide.
 - o Review as possible the content of training. In addition to informing staff of the Mission, the training should address intent of the Mission and practical instruction to staff regarding the part they have in ensuring the mission is executed/achieved and strategies to use in their daily work.
 - o Determine whether the training is provided to all agency staff in all positions and levels or limited to certain positions.
 - o For purposes of this protocol, the training should be provided to employees with responsibility for service delivery including DSPs, Supervisors, Clinicians, Program Management and Administrators throughout agency divisions and departments.
- Review any tracking mechanisms the agency uses to ensure employees receive the training.
- If agency has not yet implemented strategies, but reports there are strategies in development, have further discussion with staff and review any documentation that evidences this.

- There is no requirement for training frequency for this standard. However, if the agency revised its Mission/Mission Statement, training to employees on the new Mission is expected should be provided in employees.

- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if the following are evident:

- The agency has a formal mechanism for training staff on the Agency Mission and employee support of the mission;
AND
- There is evidence of implementation of the mechanism, minimally for staff at all levels involved in direct service delivery and oversight of service delivery;

OR

- The agency has demonstrated readiness to implement a formal mechanism for training on the Agency's Mission, and has a descriptive plan for its implementation within three (3) months.

Select Not Met if:

- The agency does not train staff in the Agency Mission and employee support of the mission; and/or
- The agency is not developing a means to address the above; and/or
- The agency is developing a systemic means to address the above, but is not within 3 months of implementation; and/or
- The agency states that there is a systemic means to train staff on the Agency Mission, but there is no evidence of implementation.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
11	The agency ensures that clinicians who complete Functional Behavioral Assessments have training in functional behavior assessment techniques.	Met/Not Met/NA

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.
- This should include Supervisor/Administrator responsible for supervision of staff responsible for behavior supports/behavior support plans, such as Clinical Services Director, Chief Psychologist, Licensed Psychologist, Licensed Clinical Social Worker.

Documentation Review:

- List of employees or consultants hired and assigned as Behavior Intervention Specialists, Licensed Psychologists, Licensed Clinical Social Workers, Psychology Assistants (state position) responsible for Functional Behavior Assessments (FBA) as part of behavior support plan development.
- Training and certification records, tracking system, including information regarding the functional behavior assessment training received as appropriate.
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- The agency must ensure that the clinician was trained and maintain a record of the training in Functional Behavior Assessment (FBA) techniques.
- FBA training may be evidenced through educational transcript or certification from an approved training program, or other verifiable documentation.
- Review personnel files and training documentation for ALL applicable agency clinicians to verify they been trained in functional behavior assessment. Training may have occurred during the pursuit of a college degree or the agency may have obtained the training for the clinician.
- Sample: ALL applicable agency clinicians and Behavior Intervention Specialists.

Select Met if there is documentation verifying that all employees responsible for and completing Functional Behavior Assessments have been trained in FBA techniques.

Select Not Met if there is not documentation verifying that all employees responsible for and completing Functional Behavior Assessments have been trained in FBA techniques.

Select NA if the agency does not provide behavior supports nor develop or implement any behavior support plans.

Citations

633.16(d)(1)

- d) Functional behavioral assessment.
 - (1) Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning.

Standard #	Standard Text	Decision
12	The agency ensures that staff/supervisors responsible to implement behavior support plans that include use of physical intervention techniques completed and are annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques.	Met/Not Met/NA

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.
- This should include staff responsible for oversight of implementation of behavior supports/behavior support plans, such as Clinical Services Director, Chief Psychologist, Licensed Psychologist, Licensed Clinical Social Worker.

Documentation Review:

- Documentation related to agency monitoring that employees responsible to implement behavior support plans have completed the training annually.
- Documentation showing agency staff who require the training including direct support and their managers, habilitation staff, clinicians; per agency policy.
- Training and certification records, tracking system.
- Personnel records as needed
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- The agency must have a mechanism to verify that responsible* staff and supervisor have successfully completed training in an OPWDD-approved training course in positive behavioral approaches, strategies and/or supports and physical intervention techniques.
- Responsible* staff applies to staff who are responsible to implement BSPs that include physical intervention techniques and their supervisors.
- Through interview and documentation review, determine how the agency decides which staff members require the training and how they maintain records of this determination.
- Review the agency's training records to verify that applicable staff members have completed the required training and that they are certified annually (within the year).
- If necessary, review the curriculum used. Both SCIP-R and PROMOTE include these strategies and techniques.
- Training must be provided by certified instructors/trainers (instructor, instructor-trainer or master trainer). If necessary, review documentation of the trainer certification.
- Note: While it is OPWDD's expectation that all service providers transition to PROMOTE as the training curriculum for positive and physical behavioral strategies, this will take multiple years to complete.
- If the agency uses a curriculum you are not familiar with and you are unsure of OPWDD approval, contact your Area Director.

Select Met if the following is verified:

- applicable staff have completed OPWDD approved training behavior approaches/techniques as specified;
- AND
- training was delivered by an instructor, instructor-trainer or master trainer.

Select Not Met if:

- applicable staff have NOT completed OPWDD approved training behavior approaches/techniques as specified; OR
- instruction/training was NOT delivered by an instructor, instructor-trainer or master trainer; or
- training certification/recertification has NOT occurred annually (every 12 months since initial certification) for applicable staff.

Select NA if:

- The agency has a written policy that forbids the use of physical interventions; and/or
- Staff responsible for writing and oversight of Behavior Support Plans provide evidence that no plans include physical intervention techniques;

AND

- There has been no contradictory evidence to the above during reviews of services and/or certified sites.

Citations

633.16(i) (1- 4)

(i) Training.

- (1) Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
- (2) Staff, family care providers and respite substitute providers responsible for the support and supervision of a person whose behavior support plan includes the use of a restrictive/intrusive intervention shall be trained in the particular intervention(s) to be utilized with a specific person, prior to use.
- (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have:
 - (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and
 - (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required.
- (4) Supervisors of such staff shall receive comparable training.

Standard #	Standard Text	Decision
13	The voluntary provider agency ensures that members of its board of directors receive a one-time mandatory training in incident management within three months of becoming a board member.	Met/Not Met/NA

Guidance

Interview as needed

- Who you interview to gather or clarify information, is dependent on agency processes for design and provision of training to possibly include Training coordinators, Human Resources staff, Program Administrative or Executive Staff.
- Board member if necessary.

Documentation Review, as appropriate to agency mechanisms:

- Board membership; membership start dates;
- Documentation of completed training: e.g. Board minutes, training records, tracking system;
- Training Curriculum and/or policy/procedure as needed

Additional Guidance:

- Through the above activities verify status of all board members' training in incident management.
- This is a one-time training. There is no requirement for annual or ongoing training.
- Current members of the Board who were serving on or before November 01, 2011 should have received training by February 02/01/2012.
- Current members of the Board appointed after November 01, 2011 must receive the one-time training within three months of the date the party becomes a board member.

Select Met if:

- All members of the agency's boards of directors have completed appropriate training within time frames; OR
- If the agency did not ensure timely training of board members previously but currently there is evidence of ALL of the following:
 - o All board members are now trained (except those on board less than 3 months); AND
 - o All new board members joining in the past 12 months have completed training within the required three months; AND
 - o The agency has and implements written procedures to provide the training within 3 months and monitoring that the training occurs with the time frame.

Select Not Met if:

- 1 or more current members of the board (except those on board less than 3 months) have not received incident management training;
- New members in the past 12 months did not receive the training within 3 months of membership

Select NA:

- If this is the agency's second Agency review protocol and there have been no new board members since the previous agency review.

Citations

633.8(b)(5)

(5) Effective November 1, 2011, members of boards of directors of certain not-for-profit corporations shall receive a one-time training within three months of the date the party becomes a board member.

(i) This requirement applies only to not-for-profit corporations which operate certified facilities and/or provide home and community based waiver services and/or provide Medicaid service coordination.

(ii) Training of board members is required in the following topics:

(a) abuse prevention, identification, reporting, and processing of allegations of abuse;

(b) laws, regulations and policies/procedures governing protection from abuse; and

(c) incident reporting and processing.

(iii) All parties serving on boards of directors on November 1, 2011 shall receive the specified training by February 1, 2012 (if the party remains on the board of directors on February 1, 2012).

Standard #	Standard Text	Decision
14	The agency ensures Support Brokers participate in 12 hours of ongoing professional development training annually.	Met/Not Met

Guidance

Interview:

As Needed: Support Broker, Training Department

Documentation Review:

Mandatory: Broker Training

Additional Guidance:

- Attendance at Broker Training required as part of initial training, cannot be counted towards the required annual professional development training hours.
- This professional development may include lectures, workshops, and other training sessions conducted by OPWDD, a Support Brokerage Learning Network, other agencies, or educational institutions. This may include online courses, webinars, or other electronic communication media, offered by OPWDD or other entities.
- The subject of the training must enhance the Support Broker’s ability to serve individuals with developmental disabilities.
- The Broker is responsible for ensuring that the subject matter is appropriate.
- The twelve-month period in which the Support Broker must participate in the required 12 hours of annual training is called the “training year.”
 - o For brokers who were providing brokerage services prior to 10/1/14, the training year is a calendar year.
 - o For brokers who began providing brokerage services on or after 10/1/14, the training year is the twelve-month period following the month the Broker first began providing Support Brokerage services.
- The broker is responsible for maintaining his/her training records that verify attendance. However, the agency must ensure/verify that 12 hours of training is completed so that the Support Broker maintains the requirements for the position.
- Proof of completion of Broker Training must be maintained indefinitely.

Select Met if both of the following are evident:

- The agency has a mechanism in place to track/verify the professional development training Support Brokers complete annually;

AND

- Support Brokers have completed the required 12 hours of professional development training annually.

Select Not Met if any of the following is evident:

- The agency does not have a mechanism in place to track/verify the training Support Brokers complete so cannot assure annual training has been completed by Brokers; OR
- Support Brokers have not completed required annual training or is below the required twelve (12) hours.

Citations

Administrative Memorandum 2015-06

Support Brokers must attend professional development training annually. The minimum number of training hours required is 12 hours annually.

Section 5: Evaluation and Competency

Standard #	Standard Text	Decision
1	Documentation indicates that Agency employees, volunteers and family care providers have been advised of conduct requirements, per Part 633.7(b)(2).	Met/Not Met

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes for provision of conduct requirement information to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- A list of all new employees, volunteers and family care providers who were hired/joined or taken on for sampled time period described below.
- Training records, tracking system
- Personnel records as needed
- Policy/Procedure as needed
- Training Curriculum as needed
- As needed, review agency policy and procedure for communicating conduct requirements to applicable parties, and/or agency training curriculum is that is the means of communication to employees.

Sample:

- The sample must be a cross-section of new employees, volunteers, and family care providers. As a general rule, choose the sample from new staff/parties in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Additional Guidance:

- Interview appropriate agency staff to learn the agency's process.
- Review training records and/or personnel records, or other agency mechanism demonstrating that the agency has advised the named parties of conduct requirements while functioning in a work-related capacity, per Part 633.7(b)(2).
- As needed, review agency policy and procedure for communicating conduct requirements to applicable parties, and/or agency training curriculum is that is the means of communication to employees.
- Conduct expectations advice to Family Care providers, must also be documented.
- Documentation may consist of a signed statement or notice that parties have been advised of the conduct expectations.

Select Met if:

- There is an effective mechanism to ensure and verify that parties are advised of conduct requirements; AND
- If the agency sponsors Family Care, family care providers have been advised of conduct expectations in writing; AND
- There is written acknowledgement by the sampled parties that they have been advised of conduct requirements/expectations.

Select Not Met if any of the conditions below exist:

- There is not an effective mechanism to ensure and verify that parties are advised of conduct requirements; and/or
- If the agency sponsors Family Care, family care providers have not been advised of conduct expectations in writing; and/or
- There is not written acknowledgement by the sampled parties that they have been advised of conduct requirements/expectations.

Citations**633.7(b)(2)**

(b) Standards of certification.

(2) OPWDD shall verify that employees and volunteers have been advised of conduct requirements while functioning in a work-related capacity.

(3) There is documentation that family care providers have been advised of conduct expectations in writing by the sponsoring agency.

ADM 2003-01

Applies to Certified Residences excluding Family Care Homes

Professional Nursing Availability

There shall be an RN available to unlicensed direct care staff 24 hours a day, 7 days a week. The RN must be either on site or immediately available by telephone. The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.

ADM 2015-03

Applies to providers of HCBS waiver services and services provided by registered professional nurses and direct support professionals to individuals with I/DD in their private homes and while accompanying the individuals in the community, in settings not certified by OPWDD.

Availability of RNs to DSPs

The approved provider shall ensure that one or more qualified RNs are available to provide adequate supervision of DSPs in the provision of nursing tasks when DSPs are performing such tasks on behalf of the individual, 24 hours a day, 7 days a week. The RN must be either on site or immediately available by telephone when necessary to ensure that the individual is safe and to prevent unnecessary emergency room visits....

Standard #	Standard Text	Decision
2	Agency custodians, employees, volunteers and family care providers have read and signed the code of conduct adopted by the Justice Center for People with Special Needs, upon employment and annually thereafter.	Met/Not Met

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes to ensure this is completed to possibly include Training coordinators, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- A list of all employees, volunteers and family care providers who were hired/joined or taken on for sampled time period described below.
- Training records, tracking system
- Personnel records as needed
- Policy/Procedure as needed
- Training Curriculum as needed
- As needed, review agency policy and procedure for this requirement.

Additional Guidance:

- Note: 633.7(c)(3) For the purposes of this section only, the definition of custodian is: A party that meets one of the following criteria:
 - (i) a director, operator, employee or volunteer of a facility or program which is certified or operated by OPWDD; or
 - (ii) a consultant or an employee or volunteer of a corporation, partnership, organization or governmental entity which provides goods or services to such facility or program pursuant to contract or other arrangement that permits such party to have regular and substantial contact with individuals receiving services from the facility or program; or
 - (iii) a family care provider; or
 - (iv) a family care respite/substitute provider.
- Review personnel files to determine that sampled custodians have read and sign the code of conduct at the time of employment or affiliation.
- Take note of hire / affiliation dates to determine that the required document has been signed at the time of hire / affiliation, for those onboarded since Justice Center implementation.
- The code of conduct must be signed annually (within twelve months of the previous signing) by all sampled applicable custodians employed or affiliated more than one year. Signature on the code of conduct must be accompanied by the date signed.

Sample:

- The sample must be a cross-section of new employees, volunteers, and family care providers. As a general rule, choose the sample from new staff/parties in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if sampled custodians have signed the Justice Center Code of Conduct:

- On the date of hire / affiliation for new custodians; AND
- Annually (within twelve months) for custodians that have been employed/affiliated for more than one year.

Select Not Met if sampled custodians have NOT signed the Justice Center Code of Conduct:

- On the date of hire / affiliation; and/or
- Annually (within twelve months) if employed/ affiliated for more than one year.

Citations**633.7(c) (4-5)**

- c) Requirements concerning the code of conduct adopted by the Justice Center for People with Special Needs (Justice Center).
 - (4) New custodians of the facility or program with regular and direct contact must read and sign the code of conduct at the time of employment or affiliation.
 - (5) All custodians with regular and direct contact must read and sign the code of conduct adopted by the Justice Center on at least an annual basis.

ADM 2003-01

Applies to Certified Residences excluding Family Care Homes

A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities. It is the responsibility of the employing agency to ensure that all staff is adequately trained regarding the elements of clinical nursing supervision, and the difference between clinical nursing supervision and administrative supervision.

Adequate nursing supervision is the provision of guidance by an RN for the accomplishment of a nursing procedure, including:

- initial training of the task or activity; and
- periodic inspection of the actual act of accomplishing the task or activity.
- The amount and type of nursing supervision required will be determined by the RN responsible for supervising the task or activity, and will depend upon:
 - the complexity of the task;
 - the skill, experience and training of the staff; and
 - the health conditions and health status of the consumer.

ADM 2015-03



Applies to providers of HCBS waiver services and services provided by registered professional nurses and direct support professionals to individuals with I/DD in their private homes and while accompanying the individuals in the community, in settings not certified by OPWDD.

RN Supervision of DSPs

An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities.

The approved provider shall ensure that each RN who supervises the performance of nursing tasks shall be:

- (1) thoroughly familiar with each individual's health status and nursing care plan and care needs;
- (2) informed of the approved provider's policy and procedures relating to the delegation of and supervision of nursing tasks performed by DSPs;
- (3) in receipt of required training relating to the supervision of nursing tasks provided by the DSPs;
- (4) authorized to oversee and direct care rendered by DSPs; and
- (5) capable of personally visiting the individual whenever necessary to protect the health and safety of the individual and prevent unnecessary emergency room visits.

Standard #	Standard Text	Decision
3	The agency has effective, and ongoing, policy and procedures for use of the National Alliance of Direct Support Professionals (NADSP) Code of Ethics, DSP Core Competencies and the NYS DSP Performance Evaluations.	Met/Not Met

Guidance

Interview:

- Agency management/administrative/Human Resources
- Who you interview to gather or clarify information, is dependent on agency processes to complete this requirement and may include, Human Resources staff, Program Administrative and Supervisory staff.

Documentation Review:

- Agency policy and procedures
- Agency training and/or personnel, human resources records

Additional Guidance:

- Implementation of the NADSP Code of Ethics, NYS DSP Core Competencies and the NYS DSP Performance evaluations have been required by OPWDD based on the following time line:
 - o July 1, 2014 agencies are required to implement the practice of the NADSP Code of Ethics and the NYS DSP Core Competencies.
 - o April 1, 2016 agencies are required to begin use of the NYS DSP Performance Evaluations as the evaluation tool for DSPs.
 - o March 31, 2017 complete NYS DSP Performance Evaluations for DSPs according to the provider's written policy.
- The goal of the Core Competencies and the Performance Evaluations is to provide standardized expectations that focus on people first services and to advance the profession of direct support. As service providers improve and change their organizational culture and focus on person-centered supports and outcomes across the service spectrum and provide more individualized, community based services, OPWDD has adopted and implemented use of the:
 - Ø NADSP Code of Ethics*,
 - Ø DSP Core Competencies, and
 - Ø DSP Performance Evaluations
- *The NADSP Code of Ethics has 9 nationally validated tenets which are incorporated into the DSP Core Competencies. While this document is similar to the Justice Center Code of Conduct (per Part 624), the two codes are separate and distinct.
- The NADSP established a set of DSP Core Competencies based on nationally validated community support skill standards and prepared DSP Performance Evaluations that parallel the DSP Core Competencies. The Core Competencies are comprised of 7 goals, 23 competencies and 60 skills. The Core Competencies contain examples of skills. The document contains task examples that illustrate each skill, however tasks are not skills but rather are representative of skills. Providers are allowed the flexibility to include example tasks that are relevant to their specific array of services (e.g. an agency which serves only children with a primary diagnosis of autism customizes skill example tasks to include staff knowledge of tablet technology to improve communication and learning skills.)
- Definition of a Direct Support Professional (DSP): A DSP is frontline staff whose primary job involves providing support to individuals. The term DSP includes many titles and functions, including: direct care, direct support worker/specialist/assistant/counselor, habilitation specialist, residential counselor, activities of daily living specialist,

relief staff, apartment worker, developmental disabilities specialist, job coach, employment specialist, community bridge builder, paid friend/neighbor, family care provider, family support services aide, community companion, personal assistant etc. A person who performs one of these or similar functions for a salary, stipend or payment for services rendered is considered a DSP.

- Not included as a DSP are: clinicians, administrators, frontline supervisors, managers, maintenance and clerical personnel. DSPs are also distinct from natural supports and volunteers.
- DQI Survey staff should have familiarity with the NADSP Code of Ethics, Core Competencies and Evaluations and/or be able to access these at the time of survey.
- Agency policies and procedures must effectively address the following:
 - o New employees are to receive an initial evaluation during the probationary period (as defined by agency policy and procedure; e.g. agencies may choose the DSP probation time span, such as 3 months, 6 months, etc.)
 - o After the initial evaluation, evaluations are completed yearly and are referred to as the 'ongoing' evaluation. Agencies may choose timing of the ongoing Performance Evaluation (e.g. a certain month every year for all DSPs or on the employee's anniversary.)
 - o Whether or not staff who mostly work in community settings will have the Performance Evaluation by individuals/family members/advocates** in conjunction, with supervisory input, in place of the ongoing Performance Evaluation
 - o Definition of provider staff considered to be DSP's (without deviation from OPWDD policy)
 - o Clear delineation of responsibility, of agency management and/or supervisory staff, for completion of the DSP Evaluation tools
 - o Agency storage and retention of the evaluations (evaluations must be kept for 6 years);
 - o Agency training requirements for staff on the NADSP Code of Ethics*, DSP Core Competencies, and DSP Performance Evaluations
- An agency policy, or practice, of no written evaluations or untimely written evaluations is unacceptable.

Select Met if all are present:

- Agency policies and procedures include information which substantially describes and directs the following actions necessary to effect DSP performance of the Core Competencies:
 - o the training, and
 - o implementation and
 - o evaluation processes

Select Not Met if:

- Agency policies and procedures lack information which would substantially describe and direct the following actions necessary to effect DSP performance of the Core Competencies:
 - o the training, and/or
 - o the implementation, and/or
 - o the evaluation processes

Citations

ADM #2014-03

"...The requirements of implementation are:

- July 1, 2014: implement the practice of the NADSP Code of Ethics and the NYS DSP Core Competencies;
- April 1, 2016: begin using the NYS DSP Performance Evaluations as the evaluation tools for DSPs;
*March 31, 2017: complete NYS DSP Performance Evaluations for DSPs according to the provider's written promulgated policy (e.g., some providers complete annual evaluations during a certain month of the year; other providers complete annual evaluations on each employee's anniversary date of hire; similarly, employee probation may be defined as three months or six months). A policy or practice of no written evaluations or untimely written evaluations is unacceptable.
- April 1, 2017: OPWDD's Division of Quality Improvement will begin verifying the implementation of the NADSP Code of Ethics, the NYS DSP Core Competencies and the NYS DSP Performance Evaluations according to protocols they will develop on or after October 2016....

Implementation of Code of Ethics, DSP Competencies and Performance Evaluations:

Service Providers shall implement the NADSP Code of Ethics, the Core Competencies and Performance Evaluations for DSPs as outlined above under the heading entitled "Purpose." The requirements to implement the practice of the NADSP Code of Ethics, the NYS DSP Core Competencies and the NYS DSP Performance Evaluations shall pertain in years subsequent to April 1, 2017 according to DQI protocols.

The NADSP Code of Ethics

(<http://www.opwdd.ny.gov/code-of-ethics/home>) is incorporated in the DSP Core Competencies and the Initial and Annual Performance Evaluations, specifically in Goal 3, Competency Area N where all nine tenets are addressed.

The NYS DSP Core Competencies

(http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies/dsp-competency-document) are arranged by goals, competencies, skills, and example tasks.

The NYS DSP Initial Performance Evaluation

(http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies/resources-tools) shall be completed at the end of a DSPs probationary period or traineeship as defined by the service provider's written policy as outlined above under the heading entitled "Purpose." DSPs, who have successfully completed their probationary period evaluation in a prior system of evaluation, will not be required to repeat that evaluation in the form of the NYS DSP Initial Performance Evaluation.

The NYS DSP Annual Performance Evaluation

(http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies/resources-tools). This evaluation shall be completed on an annual basis according to a provider's written promulgated policy as outlined above under the heading entitled "Purpose."

The NYS DSP Performance Evaluation by Individuals / Family Members / Advocates

(http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies/resources-tools) is designed to serve as an optional complement to the Initial and Annual Performance Evaluations. For DSPs who often function in settings where a supervisor is not present, this tool may serve as the principal evaluation tool complemented by supervisory input."

ADM 2003-01

Applies to Certified Residences excluding Family Care Homes

RNs who do not have previous experience in the field of mental retardation/developmental disabilities (MR/DD) nursing will be required to complete an orientation for registered nurses in MR/DD nursing within three months of being hired....

ADM 2015-03

Applies to providers of HCBS waiver services and services provided by registered professional nurses and direct support professionals to individuals with I/DD in their private homes and while accompanying the individuals in the community, in settings not certified by OPWDD.

The approved provider shall ensure that all RNs who do not have previous experience in the field of nursing for individuals with intellectual/developmental disabilities complete an orientation for registered nurses in developmental disabilities nursing within three months of being hired. The approved provider shall ensure that the new RN completes such orientation before being assigned to supervise or delegate the performance of nursing tasks to DSPs without clinical oversight by a qualified RN with experience in provision of nursing services to individuals with intellectual/developmental disabilities.

Standard #	Standard Text	Decision
4	The agency completes DSP Core Competency performance evaluations in accordance with OPWDD requirements.	Met/Not Met

Guidance

Interview:

- Agency management/administrative staff
- Who you interview to gather or clarify information, is dependent on agency processes to ensure this is completed to possibly include Human Resources staff, Program Administration, and Supervisors responsible for completion.

Documentation Review:

- Personnel records inclusive of performance evaluation documentation.
- Agency written policy/procedures: including definition of DSP specific to agency positions/responsibilities; probation periods; timing of evaluation completion; and evaluation process for staff whose primary assignments are in community settings.

Additional Guidance:

- Evaluate/verify that Direct Support Professional (DSP performance evaluations are completed per OPWDD and agency policy with the following considerations:
 - Agencies must ensure that evaluations of DSPs are completed per the probationary and annual/ongoing time frames; according to their own policy and OPWDD requirements.
 - Agency policy can dictate the initial probationary period for the DSP. New employees must receive the initial evaluation during the probationary period as defined by agency policy and procedure; e.g. probation time span, such as 3 months, 6 months, etc.
 - o Note: If a DSP accepts a position in another agency or seeks secondary employment at another NYS OPWDD provider agency, DSP's who have successfully completed their probationary period evaluation in a prior system of evaluation are not required to repeat that evaluation in the form of the NYS DSP initial performance evaluation. Annual evaluations will suffice.
 - After the initial evaluation, evaluations must be completed yearly and are referred to as the 'ongoing' evaluation. Agency policy determines the timing of the ongoing Performance Evaluation (e.g. a certain month every year for all DSPs or on the employee's anniversary.)
 - Agency policy will also dictate how DSP performance evaluations are completed for staff who work mostly in community settings, with the following options:
 - o Traditional DSP Performance Evaluation., in place of the ongoing Performance Evaluation;
 - o Performance Evaluation by individuals/family members/advocates in conjunction, with supervisory input;
 - § The Annual Performance Evaluation by Individuals/family members/advocates is an optional complement to the Initial and Annual Performance Evaluations. For DSPs who often work in settings where a supervisor is not present, making it difficult to answer questions thoroughly. This may serve as the principal evaluation tool complemented by supervisory input.
- Effective 4/1/17- Agency were expected to complete all DSP Performance Evaluations.
 - o DSP employees hired or appointed on or after 4/1/16 should have both an initial and ongoing evaluation;
 - o DSP employees hired prior to 4/1/16 will only have ongoing, annual Performance Evaluation(s).

- The DSP Performance evaluations must be kept for 6 years. The agency should be able to access past evaluations if needed.
- Surveyor should be able to access at least two evaluations for any veteran staff in sample to ensure the annual evaluation requirement is met.
- Per OPWDD Informational Letter 16-INF-01 dated March 28, 2016:

It is important to note that the evaluation tools should be used as is and are not intended be used as guidelines to create or modify agency-specific forms. To ensure consistency in the use and review of the tools, the only acceptable modifications to the forms are as follows:

1. Agencies may provide additional example tasks for goals 4 through 7; and
2. Agencies may, as long as the content of the evaluation form is not altered or changed, reformat the document.

Sample:

- The sample is only employees in DSP positions.
- The sample should include both new and veteran employees.
- For new DSPs: As a general rule, choose the sample from new DSP hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if ALL the following are evident:

- If hired after 4/1/16, Initial DSP Performance Evaluations have been completed per policy for sampled new DSPs; AND
- As of 4/1/17, ongoing Performance Evaluations have been completed annually per agency policy, for sampled DSPs working 2+ years; AND
- If the agency policy requires, inclusion of the Individual/Family evaluation in the evaluation process; AND
- Evaluations are performed per time frames in ADM 2014-03 requirements and agency policy; AND
- There is evidence that evaluations have been reviewed with the employees; AND
- No evidence of compliance with the above is discovered during other review activities.

Select Not Met if any of the following are present:

- If any of the bulleted requirements under 'Met' above are not evident; and/or
- Evaluations are incomplete; and/or
- Evaluations have not been reviewed with the employee;
- Evaluations are completed but there is compelling evidence gathered during other review activities that evaluations are not performed with or shared with employees.

Citations

ADM #2014-03

OPWDD ADM 2014-03 dated July 1, 2014

March 31, 2017: complete NYS DSP Performance Evaluations for DSPs according to the provider's written promulgated policy (e.g., some providers complete annual evaluations during a certain month of the year; other providers complete annual evaluations on each employee's anniversary date of hire; similarly, employee probation may be defined as three months or six months). A policy or practice of no written evaluations or untimely written evaluations is unacceptable...

The NYS DSP Initial Performance Evaluation

(http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies/resources-tools) shall be completed at the end of a DSPs probationary period or traineeship as defined by the service provider's written policy as outlined above under the heading entitled "Purpose." DSPs, who have successfully completed their probationary period evaluation in a prior system of evaluation, will not be required to repeat that evaluation in the form of the NYS DSP Initial Performance Evaluation.

The NYS DSP Annual Performance Evaluation

(http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies/resources-tools). This evaluation shall be completed on an annual basis according to a provider's written promulgated policy as outlined above under the heading entitled "Purpose."

Standard #	Standard Text	Decision
5	The agency has established performance expectations, in writing, for positions other than DSP and provided employees with the information appropriate to their position.	Met/Not Met

Guidance

This is a Quality Indicator.

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes to possibly include Human Resources staff, Program Administration, and Supervisors and other staff with knowledge of agency personnel activities/processes.

Documentation Review:

- Agency written policy/procedures: including written job standards and/or performance expectations.
- Personnel records demonstrating non-DSP employees have been informed for the job performance expectations for their position.

Additional Guidance:

- Written performance expectations/standards are a mechanism which enables agencies to inform staff of how they will be evaluated on job performance and monitor training and supervision needs.
- These performance expectations can take many forms, including job descriptions and/or performance evaluation standards.
- Discuss with agency staff and review policy and procedures to determine if a policy that requires identification of performance expectations exists for positions other than DSP.
- If there is policy/procedure regarding performance expectations for positions other than DSP, determine how performance expectations are communicated to the staff; e.g. verbally or in writing.
- Review for evidence of communication of the job performance expectations to the non-DSP employees. Best practice requires that staff acknowledge that they have received the information by signed acknowledgement.
- Review a sample of job performance expectation documents for sampled staff. To be effective, expectations should be clear and address tasks and quality specific to the position as well as general employee indicators such as adherence to person centered practices, personnel procedures, documentation, communication, and reporting requirements, etc.

Choosing your sample:

- First year of Agency review implementation, review sample of both new and veteran employees. Subsequent years of review may focus on new employees if the finding was met previously. However, if previous findings were NOT MET, subsequent years should continue to sample new and veteran employees.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if the ALL of the following are evident:

- The agency has established written performance standards/expectations for positions other than DSP; AND
- The written performance standards/expectation provide adequate description of performance expectations are sufficiently descriptive to guide the employee's completion of duties; AND
- Sampled employees have received the information appropriate to their position.

Select Not Met if either of the following are evident:

- The agency has NOT established written performance expectations for positions other than DSP; OR
- The agency has established written performance expectations for positions other than DSP but they lack the clarity or detail; AND/OR
- The agency has established written performance expectations but sampled employees HAVE NOT received the information appropriate to their position.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
6	The agency implements a formal mechanism(s) to evaluate the job performance of employees that are not DSPs, to verify they competently implement job tasks and/or provide the services they are responsible to deliver.	Met/Not Met

Guidance

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes to ensure this is completed to possibly include Human Resources staff, Program Administration, and Supervisors and other staff with knowledge of agency personnel activities/processes.

Documentation Review:

- Agency written policy/procedures: including job performance/competence evaluation processes.
- Personnel records demonstrating that formal performance evaluations for non-DSP employees have been completed.

Additional Guidance:

- Review policy and procedures to determine if a policy and /or procedure exists to complete some type of performance/competence evaluation for non-DSP employees.
- While the agency sets its own policy, good practices related to job performance/competence evaluations include:
 - o Identification of frequency of evaluation and parties responsible to complete and ensure completion;
 - o Evaluation of competence relates to pre-determined performance expectations/measures (see previous standard);
 - o A standardized written format to document evaluation findings;
 - o Clear identification of successes and areas of performance/competence needing improvement, if applicable;
 - o A plan to remediate areas needing improvement;
 - o Communication of evaluation findings with employee;
 - o Documentation of review of the evaluation with the employee and their written acknowledgement of same.
 - o While it is helpful to the employee to receive a written copy of the evaluation, it is acceptable for the supervisor to verbally review the evaluation with the employee, while retaining documentation only for the personnel record.
- The mechanisms for the completion of performance evaluation use various activities such as: standardized observations, discoveries of competency and quality of work as part of routine supervision, solicitation of input from service recipients and other stakeholders, testing, and written evaluation standards.

Choosing your sample:

- First year of Agency review implementation, review sample of both new and veteran employees. Subsequent years of review may focus on new employees if the finding was met previously. However, if previous findings were NOT MET, subsequent years should continue to sample new and veteran employees.

- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if ALL the following are verified for non-DSP employees:

- The agency has a mechanism(s) to assess/verify employee job performance/competence; AND
- Performance/competence evaluations are completed per agency policy for sampled employees.

Select Not Met if any condition below is evidenced regarding non-DSP employees:

- The agency does not have a mechanism to assess/verify employee job performance/competence; OR
- The agency has a mechanism but it is not implemented; OR
- Performance/competence evaluations are incomplete based on agency requirements or evaluations are not evidenced for sampled employees.

Citations**633.6(a)(1)(iii)**

Each agency/facility operated or certified by OPWDD shall establish written agency/facility policies/procedures relative to the supervision of employees and volunteers that, at a minimum:

- (iii) provide for periodic supervisory consultation with employees and volunteers;

633.6(a)(1)(v)

Each agency/facility operated or certified by OPWDD shall establish written agency/facility policies/procedures relative to the supervision of employees and volunteers that, at a minimum:

- (v) are available to employees and volunteers.

Standard #	Standard Text	Decision
7	The agency implements informal feedback systems to enhance and reinforce employee competence.	Met/Not Met

Guidance

This is a Quality Indicator.

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes to possibly include Human Resources staff, Program Administration, and Supervisors and other staff with knowledge of agency practices.
- DQI staff may have learned of or observed activities related to this standard during reviews of sites and services.

Documentation Review per agency practices/planning:

- Agency written policy/procedures, newsletters, employee communication, quality improvement activities or anything else provided by the agency that may evidence informal feedback activities used in the agency.
- DQI staff may have reviewed information related to this standard during reviews of sites and services.

Additional Guidance:

- In addition to formalized feedback to employees through performance evaluations, informal mechanisms are also effective to improve/enhance an employee's competence to provide person-centered services and complete their job duties.
- While the term "informal" is used to distinguish from formal performance evaluations; the informal process should be known actual "tools" in the agencies toolbox for development and/or reinforcement of staff performance/competence.
- This standard is not reviewing for evidence of a specific type for informal strategy. Agencies may implement activities that are uniquely their own as part of their employee development activities.
- Informal mechanism may serve different purposes: positive reinforcement, real time education, collective problem solving, etc. Following are examples of but not limited to ideas agencies may implement. For example:
 - o Mechanisms that recognize staff observed to do something well: Staff are recognized for actions like: supporting an individual to experience a new or meaningful activity; recognizing a need and coming up with a solution; setting a good example; helping a co-worker without complaint; etc. They may take the form of documented recognition in a newsletter or posting of "You've Been Caught", "You're a Star"; recognition during a staff meeting; etc.
 - o Mechanisms that take advantage of immediate identification of staff training needs: Some agencies require supervisors and clinicians to observe delivery of services. Reminders, refreshers and retraining are provided to staff in the moment when opportunities to improved are noted. For formal observation periods, these immediate actions may be documented on the observation form.
 - o Mechanisms that encourage staff to think through a different approach: When opportunities to improve are identified, staff are encouraged to think through "what could you have done differently?"
- As a best practice, it is helpful if supervisors keep record of these informal occurrences to inform formal performance evaluations.
- Implementation of the agency's informal mechanisms may be difficult to verify dependent on agency practices. Interview paired with your reviews of personnel records, incident review and observation of service delivery through the year(s) will contribute to your knowledge.



Select Met if it can be verified that the agency has created and implements informal feedback activities to support staff competency.

Select Not Met if it CANNOT be verified that the agency has created and implements informal feedback activities to support staff competency.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
8	The agency's performance evaluations/ feedback systems are designed to clearly promote motivation, commitment and career progression for all employees.	Met/Not Met

Guidance

This is a Quality Indicator.

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes to possibly include Human Resources staff, Program Administration, and Supervisors and other staff with knowledge of agency practices.

Documentation Review:

- Agency written policy/procedures,
- Performance evaluations and other personnel record documents;
- Performance improvement or enhancement documents;

Additional Guidance:

- Performance evaluation and feedback mechanisms that are not adequately designed, used or effective is equivalent to not having a mechanism to verify and communicate employee competency.
- Based on your review activities previously completed, determine whether the agency's formal performance evaluation systems and if applicable, informal feedback mechanisms, are designed to effectively promote employee motivation, commitment to the job and job performance, and career progression.
- Consider whether the evaluations and feedback mechanism are likely to provide input to the employee to reflect areas of growth and skill improvement, as well as need for growth and skill improvement. Needed growth and skill improvement should reflect not only address areas of underperformance that need improvement but should look to motivate employees to develop capacity by identifying potential and what to do to build skills and capacity to serve as mentors or leaders in their work environment and ready for promotional opportunities.

Select Met if agency's performance evaluations/ feedback system is designed to promote motivation, commitment and career progression for employees.

Select Not Met if the agency's performance evaluations/ feedback system does not appear to be designed to promote motivation, commitment and career progression for employees.

Citations

QI: This Standard is a Quality Indicator.

Section 6: Staff Management and Development

Standard #	Standard Text	Decision
1	The agency uses a mechanism to allocate staff in sufficient numbers to ensure that individuals' health and safety needs are met, planned individualized services/supports are delivered, and the diverse needs, interests, goals and abilities are accommodated.	Met/Not Met

Guidance

This is a Quality Indicator. The standard focuses on system to determine the number of staff to allocate to a service or setting.

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes to possibly include Human Resources staff, Program Administration, and Supervisors and other staff with knowledge of agency practices.

Documentation Review per agency practices/planning:

- Agency written policy/procedures regarding staff allocation.
- Management plans or quality improvement mechanisms used by the agency to decide the number of staff that need to be assigned to ensure that individuals are provided the services and supports they need, request and per their written plans.
- Staffing plans, documents showing staff allocations for various sites and services. Documents that support the allocation such as a needs assessment tool, Site plans, etc.
- Other agency specific documents if applicable, e.g. staffing committee meeting minutes, board or board sub-committee meeting minutes, reports on staffing needs and allocations, etc.

Additional Guidance:

- Interview agency staff to determine if the agency has a mechanism for assessing the number of staff necessary to provide the services and supports needed and wanted by individuals, for each of the agency's programs/sites; and allocating staff based on the assessment.
- Review available documentation describing the mechanism, if any (e.g. policy/procedure, management plan, etc.).
- Review documentation that shows implementation of the process and how the allocation of staff is decided. For example: Review a sample of staffing plans; agency tool or materials used to determine the individualized the needs/abilities and activities of people served by a site or program; consideration of varying needs dependent on shift; etc. Consider if the agency mechanism addresses the following:
 - o Additional determinants such as routine off-site activities, transportation needs, physical layout of settings, community-based versus site-based delivery of services; specialized needs of one (1) or more individual (e.g. 1:1 staff support), etc.;
 - o Individualized activities as well as assurance of health and safety;
 - o Uniqueness of the services, settings and individuals served, so that staff allocations are not universal across settings;
 - o Number of each type of staff needed: direct support, registered nurses and other clinicians, supervisors;
- The mechanism should include procedures to ensure the number of staff allocated still is appropriate:
 - o Periodic verification/validation that the staffing allocation is adequate and effective for delivery of individualized services and achievement of agency goals/mission;

- o There is a means to identify and recognize circumstances that require reassessment of the staff allocation; and
 - o This reassessment is completed. (e.g. when and individuals' needs for supervision, and/ health, behavior, habilitative, or adaptive supports change.
 - o Review evidence of who reviews staffing plans, how often reviews are conducted, and who ensures reviews are conducted.
- Knowledge gained and findings from DQI's reviews of site and services should put agency mechanism in context regarding effectiveness. If agencies have had deficiencies where insufficient staffing regarding inadequate delivery of services to individuals and/or compromised ability of individuals to take part in preferred and community activities; consider whether the agency mechanism for staff allocation was a contributing factor.

Select Met if all the following are present:

- The agency has a mechanism to assess number of staff needed and allocate staff;
- The mechanism results in assigning staff in sufficient numbers to ensure delivery of individualized safeguards, service delivery and desired activities;

AND

- The mechanism is implemented as designed;
- The mechanism appears effective.

Select Not Met if ANY of the following are present:

- The agency does NOT have a mechanism to assess number of staff needed and allocate staff; OR
- The agency has a mechanism to allocate staff but it does not adequately address assess the unique needs of the individuals, their activities, and the settings; OR
- The agency has an adequate written mechanism but it is not implemented;
- The agency has a mechanism but it is or not implemented effectively resulting in inadequate staffing.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The agency, with consideration of the individuals' viewpoint, assigns staff that have the skills/training to meet people's unique needs and accommodate their diverse individualized goals, interests, and abilities.	Met/Not Met

Guidance

This is a Quality Indicator. The standard focuses on agency systems to assign staff with skills, interests or other qualities likely to best accommodate the individual(s) achievement of goals/interests/met needs.

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes to possibly include Human Resources staff, Program Administration, and Supervisors and other staff with knowledge of agency practices.

Documentation Review per agency practices/planning:

- Agency written policy/procedures regarding staff assignment if present.
- Management plans or quality improvement mechanisms used by the agency regarding planned needs/skills/interest based, staff assignments.
- Staffing plans or other documents evidencing consideration of quality oriented individual specific information in assignment of staff; beyond number of staff and needs to maintain shift “minimums”.
- Other agency specific documents on staffing needs and allocations, if applicable; e.g. staffing/hiring committee meeting minutes, self-advocacy group recommendations/reports, board or board sub-committee meeting minutes, etc.

Additional Guidance:

- Interview agency staff to determine if the agency have a mechanism for thoughtful staff assignments as it relates/matches with the needs, interests, activities, culture of the individual, to maximize an individual's potential.
- If the agency reports there is no mechanism the review is complete and select NOT MET.
- Review available documentation describing the mechanism, if any (e.g. policy/procedure, management plan, etc.).
- Things to consider:
 - o Do individuals give input regarding any staff skills and qualities that would help them achieve their goals? How does this occur? How does the agency use this input? If individuals need assistance or a surrogate to provide this input, are family members, advocates, or staff who know them best asked for input on staff skills/interests needed.
 - o Are the manager of services and programs empowered to request specific skills/talents/interests for staff assigned or hired to best meet the needs of one or more individual?
 - o If a request for a staff with specific skill/interest is identified what actions does the agency take?
- In some cases, these special skills are absolutely necessary (e.g. language needs). In other cases, services can be provided without regard to staff variables, however if implemented the effectiveness and impact of service delivery may be maximized, (e.g. pairing a staff member interested in exercise and weight loss with an individual with the need/desire so they can take that journey together).
- Special skill/interest/talent can mean many things: e.g. a community habilitation staff with the ability to speak and/or write fluently in the foreign language or sign language of individual(s) they support; ability to play guitar for individual taking lessons and needing support practicing; shared hobbies/interests such as horseback riding, hiking, bird watching which may be identified in the person-centered plan. Pairing staff, even for limited parts of the scheduled

day/week/month, may enable an individual to participate more safely and knowledgably in the activities; perhaps widen the circle of acquaintances through introductions to others with the same interests, etc. etc. This may not only facilitate directed support to the individual but also aid in staff satisfaction and interest in their assignments.

- In addition to hiring and/or assigning staff matched with the individuals, determine whether the agency facilitates staff training in a specific area as needed to better support an individual (e.g. sign language);
- Note: An agency is very likely not able to accommodate specialization of staffing for each site/service/person. Sometimes a staff available do not have interests or skills to make that “match”. At other times, staff vacancies may make it difficult to do so. However, this reviews whether the agency, through an organized approach, makes good faith efforts to work in partnership with individuals and other stakeholders to recruit and assign the best suited staff per the individuals’ interests/characteristics, as appropriate and able.
- Review documentation that shows implementation of the process and how the assignment of staff is made.

Select Met if:

- The agency has a system/mechanism to identify situations where individuals will benefit from assignment of staff with special skills/interests in order to assign staff that can best provide services, supports and experiences; and
- The agency assigns staff per the above, when possible.

Select Not Met if:

- The agency does not have a system/mechanism to identify situations where individuals will benefit from assignment of staff with special skills/interests in order to assign staff that can best provide services, supports and experiences.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
3	The agency has a system in place to monitor staff vacancy rates and staff retention.	Met/Not Met

Guidance

This is a Quality Indicator.

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes to possibly include Human Resources staff, Program Administration, and Supervisors and other staff with knowledge of agency practices.

Documentation Review per agency practices/planning:

- Agency written policy/procedures as needed;
- Management plans to address staff vacancy and retention;
- Quality improvement tracking, data, analysis related to staff turnover, vacancy and/or retention;
- Board or board staffing sub-committee meeting minutes;
- Staffing plans

Additional Guidance:

- Interview agency staff to determine if the agency have a mechanism to track and monitor staff vacancy and retention rates.
- If the agency reports there is no mechanism the review is complete and select NOT MET.
- Review available documentation describing the mechanism, if any (e.g. policy/procedure, management plan, etc.). Mechanisms will vary from agency to agency from basic as described below to very sophisticated and multi-dimensional.
- The mechanism must include a written report summarizing the findings and identify the required frequency or time frames for the written summary.
- The mechanism should at minimum gather and track the following information:
 - o Tracking of the number of staff leaving agency or creating vacant position (i.e. vacancy created due to staff promotion);
 - o Tracking reason for vacancy (e.g. termination, resignation, promotion);
 - o Conversion of raw vacancy numbers to vacancy rates;
 - o Trending of vacancies/vacancy rates across variables determined by the agency: e.g. by position, shift, site, service type, location; and over a duration and/or per time periods.
 - o Analysis of the trends to pinpoint variables with highest retention, highest vacancy, etc. to facilitate quality improvement.
- Review the tracking and analysis information for the past year.
- The information should be current/up-to-date per agency procedures; e.g. according to whether the agency requires monthly, quarterly or annual vacancy/retention reporting. Allow variance if your review is around the time the current summary is due, so long as earlier reports are completed.

- The mechanism may do additional tracking of reasons for each employee's resignation, to enable a more detailed analysis e.g.: pay/salary, promotion, travel time/distance to work, didn't like the work, not enough staff to do the work, difficult coworkers, supervision problems, inadequate training, unsafe work environment, etc. This information is sometimes gathered through confidential personnel exit surveys or exit interviews. Additional information may aid an agency to act to improve staff retention (reviewed in next standard).

Select Met if both of the following are evident:

- The agency has a system / mechanism in place to monitor staff vacancy rates and staff retention that minimally includes the activities included in the 4th and 5th bullets under Additional Guidance above; AND
- The agency is implementing the tracking/monitoring system and it is relatively up to date.

Select Not Met if any of the following are determined:

- The agency DOES NOT have a system / mechanism in place to monitor staff vacancy rates and staff retention; OR
- The agency has a mechanism but does not include the 4th and 5th bullets under Additional Guidance above; OR
- The agency is not implementing the tracking/monitoring system, or the report is overdue.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
4	The agency implements strategies to address vacancy and retention to maximize retention and continuity of quality staff.	Met/Not Met

Guidance

This is a Quality Indicator.

Note: If the agency does not have a mechanism to monitor staff vacancy rates and retention, this standard is NOT MET; i.e. if standard 3.0 in this section is NOT MET; this standard is NOT MET. If the agency does not monitor vacancy/turnover/retention, they cannot make the judgement that any actions they are taking to address retention are effective.

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes to possibly include Human Resources staff, Program Administration, and Supervisors and other staff with knowledge of agency practices.

Documentation Review per agency practices/planning:

- Agency written policy/procedures as needed;
- Management plans to address staff turnover, vacancy and retention and strategies to address;
- Quality improvement information related to staff turnover, vacancy and/or retention; implementation of strategies and effectiveness;
- Human Resources or Business office initiatives related to improving retention;
- Board or board staffing sub-committee meeting minutes;
- Other agency mechanisms or activities, e.g. staff satisfaction surveys.

Additional Guidance:

- Discuss if and how the agency acts to address/improve staff retention.
 - Interview agency staff to determine how the agency “uses” it’s monitoring/analysis of staff turnover and vacancy (reviewed above), as a quality improvement tool. This analysis provides information about staff who have left their positions.
 - Inquire if the agency uses any other activities to find what current staff think about their jobs, the agency, etc.; for example, use of a Staff/Employee Satisfaction Survey?
- Complexity of the agency’s activities for analysis of staff turnover (as reviewed above) and/or current staff satisfaction will influence the conclusions made by the agency regarding why staff stay/leave; agency decisions on what contributing factors to address, and the activities to support retention. However simple or complex, the agency should learn from the information it gathers and take action to address factors that are within their ability to address.
- There is no one “right” factor to address and no required strategy. However, but the agency should be able to explain how they came to the decisions. Some considerations:
 - Agencies may focus on one or multiple issues/contributing factors.
 - Agencies may decide to address the main reason staff decide to leave (e.g. workplace injuries, too much overtime); and/or enhance the positive factor(s) the staff report as reasons they continue to work for the agency (e.g. job development, wellness programs).
 - Dependent on analyses, the agency may decide to focus on addressing vacancy factors related to a specific service (e.g. Community Habilitation); or shift; or position or sites, etc.

- The agency may also have strategies to anticipate retirements and promotions that assist in maintaining necessary staffing levels.
- Review documentation the agency provides regarding decision making and actions taken to address retention. The approach will likely be unique to each agency. Key elements of an agency strategy are:
 - The factor/factors affecting retention to be addressed are identified,
 - The activities to address the factor/factors are decided, and
 - The activities are implemented; and
 - The impact/effectiveness of the activities is reviewed through vacancy/retention analysis.

§ Note: this last element may not yet be implemented if the actions are recently implemented and/or the period for review of vacancy/retention has not yet occurred. Under these conditions the standard may still be met. However, if the agency has been implementing retention improvement strategies for more than one year, previous review of impact/effectiveness.

Select Met if the agency implements strategies to address employee vacancy and maximize retention and continuity of staff inclusive of the Key elements described above.

Select Not Met if:

- The agency DOES NOT implement strategies to address employee vacancy and maximize retention and continuity of staff;
- OR
- The agency has strategies to address employee vacancy and maximize retention but it is not clearly defined or utilized as it lacks one of more of the Key elements described above.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
5	The agency provides ongoing staff development opportunities to employees at all levels of the organization.	Met/Not Met

Guidance

This is a Quality Indicator.

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes to possibly include Human Resources staff, Program Administration, and Supervisors, Workforce representatives and other staff with knowledge of agency practices.

Documentation Review per agency practices/planning:

- Agency written policy/procedures as needed;
- Management plans to related to ongoing staff development;
- Quality improvement information staff development;
- Human Resources initiatives;
- Agency Newsletters focused on employees and employee needs;
- Training schedules and curriculums;
- Workforce representatives;
- Other agency mechanisms or activities.

Additional Guidance:

- Discuss with agency staff, actions taken by the agency to identify, enhance, encourage and develop employee potential and have progressive opportunities to contribute to the agency. This is not a review of training “classes” beyond what is required by regulation. This reviews that agencies are offer and engage staff at all levels in activities that develop their confidence, engagement and understanding of the agency; to increase their abilities and readiness for other opportunities within the agency.

- There is right or wrong way for an agency to address this and will be individualized per agency culture. Considerations:

- o What opportunities does the agency offer? E.g. receive mentoring by staff in positions the person aspires to have; membership on agency or program level committees; supervisions skills workshops; invitations to problem solving or quality improvement session with diverse agency membership; etc.

- o Are there opportunities for staff of all levels including direct support.

- o How does the agency communicate opportunities so that all staff are truly aware that they exist? E.g. posters, flyers, staff newsletters, email blasts and reminders; etc. Do the communication strategies clearly communicate how to sign up, volunteer, request to participate and to what job titles it is open to, including direct support staff.

- o Does the agency support staff participation in staff development opportunities through policies such as training leave, flexible work schedules, tuition assistance and CEU credits? Are these policies followed in practice? Is there evidence that staff at all levels are encouraged and approved to participate in external opportunities.

- Require the agency to demonstrate that their activities for staff development are implemented.



Select Met if it CAN be verified that agency provides ongoing staff development opportunities to employees at all levels of the organization.

Select Not Met if it CANNOT be verified that agency provides ongoing staff development opportunities to employees at all levels of the organization.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
6	The agency implements ongoing employee communication and engagement strategies to support workforce quality indicators.	Met/Not Met

Guidance

This is a Quality Indicator.

Interview:

- Who you interview to gather or clarify information, is dependent on agency processes to possibly include Human Resources staff, Program Administration, and Supervisors, Workforce representatives and other staff with knowledge of agency practices.

Documentation Review per agency practices/planning:

- Agency Newsletters whether online or hard copy
- Management plans or Quality Improvement plans describing communication strategies
- Quality improvement information staff development;
- Event schedules/Agency Calendars
- Agency written policy/procedures as needed;
- Other information agency provides evidencing efforts and activities for workforce communication and engagement.

Additional Guidance:

- Organized, consistent and clear communication regarding the agency is necessary to keep employees informed and engaged as a unified workforce. Engaged employees are likely to be more focused on agency priorities, initiatives, challenges, and successes, etc.
- This standard reviews whether the agency takes routine actions to keep employees at all levels of the organization informed of agency issues, priorities and developments; not just necessary business and personnel-oriented issues. It also reviews if the agency provides employees a means to engage with other employees and agency directors, so that communication flows both ways.
- Review agency communication strategies. Discuss how the agency/agency administration organizationally communicates with employees; e.g. newsletters, emails, posters, mailings in person meetings, agency “town halls” or forums with the executive or boards; etc. Determine whether the mechanisms are implemented routinely/regularly or only sporadically or ad hoc. How are staff made aware? Communication methods may vary according to information content and purpose. Review examples and evidence as provided by the agency. Discuss with multiple staff if needed.
- At the same time, review content of communications to employees. Determine if the agency engages in open communication with staff at all levels. While the specificity of information may vary from staff position to staff position; all staff should be informed of about agency issues, not just day to day issues. Organizational changes, new agency initiatives, new waiver service; what CCO means; and what this all means for staff and individuals, and the contributions staff can make, etc. Information affecting all or many should be provided to all staff and not compartmentalized in administration (within reason).
- Also review whether and how employees are able to request information and ask questions. Determine if the agency has one or more mechanism or platform to encourage employees to ask questions, give opinions, and engage in reciprocal communication with agency representatives whether they be the executive director or designee, the board representatives, agency administrators, or program management. Looking for opportunities for communication back

and forth, not just providing information to the workforce. Staff encouraged to engage will likely feel more participatory in the agency and agency mission and contribute to quality service delivery.

Select Met if information gathered shows:

- Organized, structured communication activities engaging all employees in agency information and issues; AND
- At least one strategy provides for reciprocal communication between and among administration and staff.
- The strategies are implemented/used.

Select Not Met if, based on information gathered:

- It cannot be verified that the agency has organized, structured communication activities to engage employees in agency information and issues; and /or.
- The agency has mechanisms/strategies that are not implemented; and/or
- There are no strategies for reciprocal communication. Employees only receive information.

Citations

QI: This Standard is a Quality Indicator.

Topic 7: Tuberculosis Control

Sample Guidance

- Section 1 - Use table on the right
- Section 2 - Per protocol (found in standard guidance)

OF New Employees, Contractors, Students, Volunteers

SAMPLE SIZE

≤10

All New Hires - maximum 3

11-50

15%, minimum 4, maximum 7

51+

10%, minimum 8, maximum
20

Section 1: TB Testing

Standard #	Standard Text	Decision
1	The agency implements effective procedures to ensure that employees, volunteers, and contractors, family care providers and approved substitute/respite providers have TB testing completed prior to their first day of employment or service provision. (If using the two-step PPD, individuals may begin work if the first test is negative.)	Met/Not Met

Guidance

Documentation Review:

Tracking of Tuberculosis (TB) testing completion

Interview: Agency staff knowledgeable of the agency's TB testing procedures.

Guidance:

- Ask responsible agency staff how TB testing is conducted (e.g. who does it, whether two-step PPD or IGRAs blood test is used, monitoring of results).
Review documentation verifying that TB testing occurred prior to first day of employment or contact with service recipients.
- Exception: If there is a previous documented positive test result, the party does not need to be TB tested. Review of compliance for exclusion from testing and screening/documentation
- Evidence of testing may be an agency tracking system/document that identifies the staff person, date of employment/service provision, and type of testing/evaluation and testing date(s). It is not necessary to review the specific test results.

Requirements for individuals with positive test results are found further in this protocol.

NOTE: The agency must demonstrate that they are completing and tracking TB testing for employees and other parties referenced in the standard. This is not a review of testing results, unless that documentation is the only means to evidence testing.

If the discussion regarding how testing is conducted, methods used, etc. raises concern about actual testing activities or if systemic problems in TB test tracking are noted, consult with the Area Director to determine whether to review Policies and Procedures and/or inquire further about testing activities.

Choosing your sample:

- New Employees: The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a general rule, choose the sample from

new hires in the past six (6) months. Increase the time frame beyond six months for sample selection or sample size if necessary to ensure review of personnel requirements for new hires since your last review of the standard.

- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if TB testing is evidenced for the sample as describe above, except when exclusions or contradictions are noted (to be reviewed below).

Select Not Met if TB testing cannot be verified for the sample, and exclusions or contraindications do not apply.

Citations

633.14(c)(1)(i)

Initial testing.

- All employees, volunteers, contractors, family care providers and approved substitute/respice providers shall have TB testing completed prior to their first day of employment or service provision. If using the two-step PPD, individuals may begin work if the first TST is negative.

Standard #	Standard Text	Decision
2	<p>Exclusions from Testing</p> <p>The Agency's implements effective procedures to ensure that persons are only excluded from pre-employment or pre-delivery of services testing, if the agency has documentation of one of the following reasons for the person's exclusion:</p> <ul style="list-style-type: none"> (i) prior documented significant reaction to TB testing; or (ii) adequate treatment for active pulmonary tuberculosis; or (iii) completion of adequate preventive therapy. 	Met/Not Met/NA

Guidance

Review only if sample included persons not tested due to stated exclusions

Documentation Review:

TB/PPD documentation evidencing that

- one of the 3 conditions allowing exclusion from TB testing, is present; and
- and if previous positive, evidence of adequate treatment; and/or resolution of illness described below.

Interview: As needed, agency staff responsible for policy, procedure, and tracking.

Guidance:

- Employees may not refuse testing.
- The exclusion to testing (and related requirements) relates to an employee's previous TB history.
- An agency may waive TB testing of an employee without consultation with the person's health care provider, if the agency has documented proof of one of the three conditions described below. Verify that the documentation is present for the sample selected if applicable.
 - (i) prior documented significant reaction to TB testing; or
 - (ii) adequate treatment for active pulmonary tuberculosis; or
 - (iii) completion of adequate preventive therapy.
- Employees who have had a past positive reaction to TB testing are not permitted to begin employment until they have been evaluated by a healthcare provider and found to be free of active TB or they meet the following criteria:
 - o Adequate treatment has been started,
 - o The cough has resolved; Sputum specimens are negative on 3 AFB smears.
- Regarding (iii) "preventative therapy" does not include BCG immunization. Acceptable preventative therapy would include INH treatment exclusive of symptoms.

Select Met if documentation evidences that:

- employees excluded from testing meet exclusion criteria; AND
- employees with past positives have been medically assessed and cleared as described above.

Select Not Met if:

- employees excluded from testing do not meet exclusion criteria; OR
- there is no documentation to evidence that employees excluded from testing, meet exclusion criteria; OR
- there is no documentation to evidence that employees with past positives have been medically assessed and cleared as described above.

Select NA only if no one in the sample was excluded from tuberculosis testing.

Citations**633.14(d)(1)(i)-(iii)**

In order for the service provider to permit a party's exclusion from either pre-employment/pre-receipt/pre-delivery of services or follow-up TST, the service provider shall have documentation of one of the following reasons for contraindication:

- (i) prior documented significant reaction to TB testing; or
- (ii) adequate treatment for active pulmonary tuberculosis; or
- (iii) completion of adequate preventive therapy.

Standard #	Standard Text	Decision
3	<p>Contraindication to Testing</p> <p>The Agency implements effective procedures to ensure that persons not tested for TB due to a contraindication are only excluded with a statement by a physician, nurse practitioner or physician's assistant that must include:</p> <ul style="list-style-type: none"> (i) a recommendation as to when and if testing would be appropriate at a designated point in the future; and (ii) how the party will be evaluated for active pulmonary tuberculosis in the interim. 	Met/Not Met/NA

Guidance

Review only if sample included persons not tested due to stated contraindications.

Documentation Review:

TB testing documentation as follows:

- Documentation justifying the contraindication;
- Evidence of adequate treatment; and/or resolution of illness described below.

Interview: As needed, agency staff responsible for policy, procedure, and tracking.

Guidance:

- This exception to testing applies to situations in which testing is contraindicated due to factors other than previous TB history.
- For this exclusion, the person's health care provider must provide written documentation that the person has a contraindication to testing, such as an extreme fear of needles (trypanophobia).
- The MD, PA or NP must write a letter/note:
 - o Stating the contraindication, and
 - o Describing how the person will be assessed for signs/symptoms of active pulmonary TB until testing can be completed; and
 - o Recommending when testing may be appropriate in the future.
- For sample employees excluded from testing due to contraindication, verify that documentation is present from an MD, PA or NP describing the above information.

Select Met if there is documentation from medical practitioners of employees with contraindications that includes all the elements below:

- o Describes the contraindication, and

- o Describes how the person will be assessed for signs/symptoms of active pulmonary TB until testing can be completed; and
- o Recommends when testing may appropriate in the future.

Select Not Met if there is NOT documentation from medical practitioners of employees with contraindications inclusive of all the elements below:

- o Describes the contraindication, and
- o Describes how the person will be assessed for signs/symptoms of active pulmonary TB until testing can be completed; and
- o Recommends when testing may appropriate in the future.

Select NA only if no one in the sample was excluded from testing due to a contraindication.

Citations

633.14(d)(2)(i)-(ii)

A statement by a physician, nurse practitioner or physician's assistant of contraindication shall be acceptable as long as the statement includes:

- (i) a recommendation as to when and if testing would be appropriate at a designated point in the future; and
- (ii) how the party will be evaluated for active pulmonary tuberculosis in the interim.

Section 2: TB Evaluation for Excluded Persons

Qualifier	Were any employees excluded or contraindicated for TB testing? (i.e. were 2.0 or 3.0 above answered with a met or not met?)	Yes/No
Standard #	Standard Text	Decision
1	The Agency implements effective procedures to ensure that persons excluded from TB testing, are evaluated by a registered nurse taking into account any symptomology and history since the person's previous TB test or evaluation.	Met/Not Met

Guidance

Applies to people excluded from TB testing.

Documentation Review: TB testing/tracking information and the documents for evaluation of symptomology.

Interview: agency staff as needed for clarification.

Guidance:

- Individuals for whom TB testing met exclusion or contraindication criteria (2.0 and 3.0 above), must be evaluated using a questionnaire that screens for the presence of any signs or symptoms of active pulmonary TB. (e.g. malaises, fever, weakness, weight loss, cough, and night sweats.)
- The screen must be done by an RN, NP, PA, or MD.
- The screening is to occur with the same frequency as TB testing would be done if the individuals were to be tested.
- NOTE: Persons with a history of a positive PPD can be screened with a whole blood interferon-gamma release assays (IGRAs) if the agency so desires and the test is available in the person's geographic area.
- NOTE: If warranted by results of an RN evaluation, the nurse may refer the person to a physician, nurse practitioner or physician's assistant for a formal diagnostic evaluation to exclude active pulmonary tuberculosis.
- NOTE: OPWDD does not require nor encourage, the use of chest x-rays for routine screening of persons for TB.

Select Met if there is documentation for employees excluded or contraindicated for tuberculosis testing which shows:

- completed screening of TB symptomology by an RN, NP, PA, or MD, OR
- testing through IGRAS.

Select Not Met if:

- there is no documented evidence of screening or IGRAS; OR
- when screening is used, it is not done by an RN, NP, PA, or MD

Citations

633.14(d)(3)

Evaluation of parties excluded from TB testing. A registered nurse shall conduct a general evaluation of the party taking into account any present symptomatology and history since the party's previous TB test or evaluation. Based on such evaluation the nurse may refer the party to a physician, nurse practitioner or physician's assistant for a formal diagnostic evaluation to exclude active pulmonary tuberculosis. Routine chest x-ray examinations are not required.

Topic 8: Personal Allowance

Sample Guidance

	# OF INDIVIDUALS (for whom the agency manages funds)	SAMPLE SIZE
		≤50
	51-100	20% - maximum 15
	101+	15% - maximum 20

Section 1: Personal Allowance Oversight

Standard #	Standard Text	Decision
1	The Agency has an effective procedure to ensure the proper amount of personal allowance is provided to individuals monthly.	Met/Not Met

Guidance

Interview:

Agency staff assigned to administer allocation of personal allowance (PA) to individuals for whom the agency is responsible for PA receipt and distribution/representative payee.

Documentation:

Records of agency and individuals' accounts to evidence provision of personal allowance; agency written procedures as needed.

Guidance:

- Ask agency staff responsible at agency level to explain and demonstrate for a sample, that the correct amount was credited/given to the individual through distribution to the individual's account at the residence, or deposit to an individual's bank account.
- Minimum Statutory Allowance
 - + \$20.00 Disregard for Income other than SSI
 - + \$65.00 Of Gross Wages
 - + ½ Earnings Above \$65 =

MONTHLY PERSONAL ALLOWANCE
- For minimum allowance, refer to most current SSI benefits chart.
- Review agency written procedures addressing the allocation of personal allowance to individuals monthly, including appropriate amount, as needed if questions/concerns about the agency process.
- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if : The agency records for the sample demonstrate that individuals are receiving the proper amount of personal allowance monthly.

Select Not Met if any of the following are evident:

- There are no agency records to demonstrate crediting of PA funds to individuals; OR
- Agency records show that at least one sampled individual does not get the proper amount of personal allowance monthly;

Citations**633.15(e)(1)(i) (a-d)**

Monies accrued from the monthly portion of income made directly available to an individual that is intended for his/her personal expenditure. The monthly personal allowance is that portion of income which is made available on a monthly basis to every person residing in a facility operated or certified by OPWDD.

(1) For persons residing in family care homes, community residences, Individualized Residential Alternatives (IRAs) and private schools, the amount will be determined, regardless of the source of income, using the current amount stated in section 131-o of the Social Services Law, and any and all income exemptions provided for in current regulations governing SSI and Medicaid eligibility and payment.

(i) Personal allowance may have several components, depending on individual circumstances. On a monthly basis, these include, but are not limited to:

(a) The minimum statutory allowance - for all persons.

(b) A \$20 income disregard - for all persons with any income other than SSI.

(c) A work-related exemption of up to the first \$65 of gross wages plus one half of earnings above \$65 - for all employed persons. The work-related exemption of \$65 is intended to be used to pay for costs incurred because a person works. Examples are: union dues, health insurance, uniforms, lunches purchased while at work, and transportation costs incurred because the person works.

(d) Incidental income - for all persons, whenever it exists. Incidental income is irregular or infrequent income which is not received on a scheduled basis; or is received no more than quarterly, even if scheduled, and does not exceed \$30 in a given quarter if earned, or \$60 if unearned.

Standard #	Standard Text	Decision
2	The Agency has an effective procedure to ensure that personal allowance funds are credited to an individual's account within three (3) business days of receipt of the person's income.	Met/Not Met

Guidance

Interview:

Agency staff assigned to administer allocation of personal allowance (PA) to individuals for whom the agency is responsible for PA receipt and attribution.

Documentation:

Records of agency and individuals' accounts to evidence provision of personal allowance; agency written procedures as needed.

Guidance:

- Interview agency staff and ask them to demonstrate that the personal allowance funds have been transferred to the individual or their account within 3 business days. This may be evidenced by:

- o A general ledger transfer: Moving the dollar amount to an account that belongs to the individual.

- o A check cut to the individual.

- Review agency written procedures addressing the allocation of personal allowance to individuals monthly, including time frames; as needed if questions/concerns about the agency process.

Note: Inadequate agency systems may or may not result in individuals not receiving PA funds at the residence. If inadequate systems are discovered, discuss with the Area Director to determine if and what survey actions need to be taken at residences.

- Sample Sizes are identified on the Agency Review Sample Size document in the Agency Review Protocol Manual and Help Section of DQIA.

Select Met if: The agency records for the sample demonstrate that PA funds are typically credited to individuals within three (3) business days of receipt.

Select Not Met if any of the following is evident:

- There are no agency records to demonstrate crediting of PA funds to individuals; OR

- Agency records show that funds are credited to individuals but the time frame is routinely greater than three (3) days

Citations

633.15(i) (11)

When the chief executive officer is the payee, the appropriate amount of personal allowance shall be credited to the personal allowance account within three business days of receipt of income which includes personal allowance monies.

633.15(i) (12)

When the payee is other than the chief executive officer, the personal allowance received from that payee shall be credited to the personal allowance account within three business days of receipt of the agency or sponsoring agency

Standard #	Standard Text	Decision
3	The Agency conducts audits of 25% of personal allowance accounts yearly.	Met/Not Met

Guidance

Interview:

Agency staff responsible for personal allowance (PA) audits, who are often, but not limited to agency business office staff.

Documentation:

Audit report; agency written procedures as needed.

Guidance:

- Agencies must conduct annual audits of at least 25% of personal allowance accounts for which they are responsible.
- Verify also that the audits for the past year have been completed. This can be evidenced by the agency through their audit reports or tracking mechanisms. Request that agency staff show/demonstrate that the audits were done and the sample size was met.
 - o Verify only that the audits have been completed. Do not review the accuracy or quality of the audit. OPWDD Office of Audit Services (OAS) is responsible for review of the audits.
- NOTE:
 - o The Agency is responsible for the personal allowance account if:
 - § It is representative payee, i.e. the party receiving the person's funds from entities on behalf of the individual;
 - OR
 - § Someone else is rep payee, but designates the agency to manage the PA funds.
- AGENCY is NOT responsible for the personal allowance account if:
 - § It is not rep payee, AND
 - § The funds are send directly to the individual or an external party as rep payee (not the agency); AND
 - § The funds are managed by the individual or external party.
- Review agency written procedure for conducting the audits, as needed if questions/concerns about the agency process; inclusive of: staff responsible, by titles; frequency; and sample size and method.

Select Met if: The agency demonstrates completion of audits for 25% of personal accounts for which the agency is responsible.

Select Not Met if any of the following is evident:

- There are no agency records to demonstrate yearly audits of PA accounts; OR
- Agency audits are conducted but frequency is less than annually, and/or sample is less than 25%

Citations

633.15(i) (10)

In order to assure the proper management of personal allowance accounts, the agency or sponsoring agency shall conduct annual internal agency audits, on a random basis, of at least 25 percent of the personal allowance accounts for which they are responsible in all residential types of facilities except family care. The agency or sponsoring agency shall conduct annual internal agency audits on at least 10 percent of the personal allowance accounts in family care programs. These audits shall demonstrate compliance with the requirements of this section.

Standard #	Standard Text	Decision
4	The Agency has effective written procedures for the security and safeguarding of Personal Allowance Funds.	Met/Not Met

Guidance

Interview:

As needed: Agency staff knowledgeable of personal allowance policy and procedure.

Documentation:

- Agency written policy and procedures;
- IRMA review to identify financial theft or exploitation incidents or occurrences;
- Summary of Site Protocol performance related to security of funds on site;
- if necessary, evidence of oversight of the implementation of agency policy and procedure.

Guidance:

- Written procedures should provide specificity sufficient to ensure continuity of actions, regardless of personnel changes.
- Through review of policy and procedure documentation verify that agency has policy and procedure related to security of funds. Procedure should minimally include:
 - o Methods to secure cash, checks, gift cards,
 - o Security of Debit Cards including PIN codes,
 - o Assignment of personnel who have access to funds and accounts,
 - o Review of agency procedures for adequacy, when incidences of theft have been reported or identified.

Select Met if the following are evident:

- The Agency has written procedures to address and ensure the security and safeguarding of personal allowance funds per guidance above; AND
- Procedures appear effective and/or are reviewed for effectiveness as evidenced by:
 - o No incidents of theft/financial exploitation in the past year, or
 - o Procedures for the security and safeguarding for personal allowance funds were promptly reviewed and revised as needed, based on lessons learned from a theft/financial exploitation event or DQI/BPC cited deficiencies regarding security/safeguarding occurring in the past year.

Select Not Met if any of the following is evident:

- The Agency does not have written procedures to address and ensure the security and safeguarding of personal allowance funds per guidance above; OR
- Procedures appear ineffective and are not reviewed for needed revision as evidenced by:
 - o Incidents of theft/financial exploitation occurred in the past year and the agency took no action to improve agency security and safeguarding processes, or

Procedures for the security and safeguarding for personal allowance funds were not promptly reviewed and revised as needed, following DQI/BPC cited deficiencies regarding security/safeguarding occurring in the past year.

Citations

633.15(d)(1)

Each agency or sponsoring agency operating a residential facility (see section 633.99 of this Part) shall develop and implement policies and procedures which reflect compliance with this section. (1) Each agency which operates a residential facility or sponsors a family care home and manages personal allowance; or operates a non-residential facility or service and accepts responsibility for handling the personal allowance of residents of residential facilities; shall develop and implement policies and procedures to ensure safeguarding and accurate accounting of such personal allowance.

633.15(d)(3)

Each agency or sponsoring agency operating a residential facility (see section 633.99 of this Part) shall develop and implement policies and procedures which reflect compliance with this section. (3) Policies and procedures shall address, at a minimum: security; accountability of staff, volunteers, and/or family care providers; recordkeeping both on paper and electronically; usage; and monitoring of all personal allowance monies and other income of residences received by the agency. Policies and procedures shall include specific measures that will be taken to safeguard cash, including location maintained and restrictions on access.

Section 2: Personal Allowance Policy/Procedure

Qualifier	In consultation with the Area Director, has it been determined that agency level practices related to Personal Allowance must be reviewed. (Note: This determination may be due to findings of other survey activities, complaints, or other known concerns regarding the use, handling and accounting for personal allowance and/or personal needs allowance funds.)	Yes/No
Standard #	Standard Text	Decision
1	The Agency has written established policies and procedures regarding management of personal allowance, in accordance with OPWDD regulations and guidelines.	Met/Not Met

Guidance

Interview:

Agency staff responsible for assurance personal allowance (PA) management and oversight processes; e.g. business office and/or quality assurance staff;

Documentation:

Agency written policy and procedures.

Guidance:

- Interview staff and review policies and procedures. Policies and procedures should minimally address the following PA topics and regulatory requirements:
 - o Security of funds (location and restrictions on access) and maximum funds on site
 - o Accountability of staff
 - o Record keeping (electronic and paper)
 - o Usage of funds
 - o Appropriate Expenditures
 - o Monitoring PA monies and other income
 - o Personal Expenditures Planning and Money Management Assessment
 - o Replacement or Reimbursement of Funds
 - o Record Retention
 - o In addressing the above, the following need to be addressed in policy/procedure:
 - § Agency, Payee, and Person-owned bank accounts, as applicable
 - § Debit Accounts and ATM usage, as applicable
 - § Assurance of day program processes, if applicable

- • Written procedures should provide specificity sufficient to ensure continuity of actions, regardless of personnel changes. Policies and procedures must be sufficiently describe:
 - o Actions and activities;
 - o Staff responsible to complete actions, by title(s);
 - o Staff responsible to monitor completion of actions, by title(s);
 - o Frequency or timing or sequence of activities;
 - o Documentation, forms, and formats:
 - o Communication and notification.,

Select Met if the following are evident:

- The Agency has written procedures to comprehensively address personal allowance topics identified in above guidance; AND
- Written procedures appear aligned with regulatory requirements

Select Not Met if any of the following is evident:

- The Agency does not have written procedures to comprehensively address personal allowance topics identified in above guidance; OR
- Written procedures do not align with regulatory requirements

Citations

633.15(d)

Each agency or sponsoring agency operating a residential facility (see section 633.99 of this Part) shall develop and implement policies and procedures which reflect compliance with this section.

(1) Each agency which operates a residential facility or sponsors a family care home and manages personal allowance; or operates a non-residential facility or service and accepts responsibility for handling the personal allowance of residents of residential facilities; shall develop and implement policies and procedures to ensure safeguarding and accurate accounting of such personal allowance.

(2) Policies and procedures shall reflect and implement the responsibility of the agency to maintain resident's funds in a fiduciary capacity in accordance with section 33.07(e) of the Mental Hygiene Law, when the agency assumes management responsibility over the funds of a resident pursuant to this section.

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

(4) Policies and procedures shall indicate that the use of personal allowance is to benefit the person only and shall reflect the person's personal spending choices in expenditures made. Policies and procedures shall include a process for individual personal expenditure planning and the implementation of a personal expenditure plan (PEP).

Standard #	Standard Text	Decision
2	The Agency has written policies and procedures regarding the responsibilities of the representative payee, in accordance with OPWDD regulations and guidelines.	Met/Not Met

Guidance

Interview:

As needed to clarify written procedures: Agency staff responsible for assurance representative payee processes and activities; e.g. residential services director, business office, and/or quality assurance staff;

Documentation:

Agency written policy and procedures.

Guidance:

- Review policies and procedures. Interview agency staff as needed to clarify, etc.
- If the agency director serves or may serve as representative payee, then the residential services agency must establish policies and procedures for the management and use of funds paid to the agency director as representative payee. Policies and procedures should minimally address the following:
 - o establishment and maintenance of beneficiary (hereafter referred to as individual, individuals, or individuals') accounts in interest bearing accounts;
 - o individual accounting to segregate balances and to enable the application of interest earned, if any, on a pro-rated basis to individuals, for collective accounts;
 - o internal controls to keep the individuals' accounts and funds secure, prevent identity theft, provide specific authorization for banking transactions, and document receipts and disbursements;
 - o response to a request to review the representative payee account;
 - o designation of an appropriate staff member to act as a liaison between the agency director and the individual;
 - o management of the personal allowance derived from the benefit referenced in section 633.15 (reviewed in the standard above); and
 - o consideration of the use of a Medicaid exception trust, supplemental needs trust, or similar device to protect a lump sum retroactive benefit, inheritance or any other funds which would affect eligibility for benefits.
 - o The following must be addressed and provided, if the agency director serves as the representative payee:
 - § managing the benefits and the personal allowance portion of the benefits without charging a fee;
 - § maintaining a record of all funds received, including earned income, and report to the benefit paying organization(s) on these funds as required; and
 - § maintaining a record of all resources, with current values, to meet all benefit paying organization(s) reporting requirements and to ensure that the entitlements are not jeopardized by an individual's resources exceeding regulatory limits.
 - o The following must be addressed when/if an individual does not have a representative payee:
 - § The agency or sponsoring agency must offer to assist with:
 - Ø reporting both earned and unearned income to benefit paying organization(s), as required;
 - Ø reporting resource amounts to benefit paying organization(s), as required;

Ø monitoring resource amounts to ensure that the beneficiary's entitlements are not jeopardized by having excess resources; and

Ø reporting any changes that may affect a beneficiary's entitlements to benefit paying organizations, as required.

Ø In addition, the agency or sponsoring agency must offer to manage the individual's personal allowance. The offer must be in writing and made within 10 business days of the beneficiary's move or change of representative payee.

Select Met if the following are evident:

- The Agency has written procedures to address representative payee responsibilities and issues identified in above guidance; AND
- The written procedures appear aligned with regulatory requirements

Select Not Met if any of the following is evident:

- The Agency does not have written procedures to address representative payee responsibilities and issues identified in above guidance; OR
- The agency has written procedures regarding the representative payee, but they do not align with regulatory requirements.

Citations

633.9(e)(1)- (4)

(1) If a facility director serves or may serve as representative payee, then the residential services agency must establish policies and procedures for the management and use of funds paid to the facility director as representative payee.

These policies and procedures must be in compliance with all applicable Federal and State laws and regulations. At a minimum, such policies and procedures must include provisions for:

- (i) establishment and maintenance of beneficiary accounts in interest bearing accounts;
- (ii) individual accounting to segregate balances and permit the application of interest earned, if any, on a pro-rated basis, for collective accounts;
- (iii) internal controls to keep the beneficiary accounts and funds secure, prevent identity theft, provide specific authorization for banking transactions, and document receipts and disbursements;
- (iv) response to a request to review the representative payee account;
- (v) designation of an appropriate staff member to act as a liaison between the facility director and the beneficiary;
- (vi) management of the personal allowance derived from the benefit referenced in section 633.15 of this Part; and
- (vii) consideration of the use of a Medicaid exception trust, supplemental needs trust, or similar device to protect a lump sum retroactive benefit, inheritance or any other funds which would affect eligibility for benefits.

(2) If the representative payee is the facility director, then the representative payee must:

- (i) manage the benefits without charging a fee;
- (ii) manage the personal allowance portion of the income without charging a fee;
- (iii) maintain a record of all funds received, including earned income, and report to the benefit paying organization(s) on these funds as required; and
- (iv) maintain a record of all resources, with current values, to meet all benefit paying organization(s) reporting requirements and to ensure that the entitlements are not jeopardized by a beneficiary's resources exceeding regulatory limits.

(3) When a beneficiary does not have a representative payee, the agency or sponsoring agency must offer to assist with:

- (i) reporting both earned and unearned income to benefit paying organization(s), as required;



- (ii) reporting resource amounts to benefit paying organization(s), as required;
 - (iii) monitoring resource amounts to ensure that the beneficiary's entitlements are not jeopardized by having excess resources; and (iv) reporting any changes that may affect a beneficiary's entitlements to benefit paying organizations, as required.
- (4) When the facility director is not the representative payee, the agency or sponsoring agency must offer to manage the beneficiary's personal allowance. The offer must be in writing and made within 10 business days of the beneficiary's move or change of representative payee.

Standard #	Standard Text	Decision
3	The agency has written procedures regarding determination of an individual's need for a representative payee, in accordance with applicable OPWDD regulations.	Met/Not Met

Guidance

Interview:

As needed to clarify written procedures: Agency staff responsible for assurance representative payee processes and activities; e.g. residential services director, business office, and/or quality assurance staff;

Documentation:

Agency written policy and procedures.

Guidance:

- Part 633.9(c)(1)-(3) address Determination of need for representative payee.
- Review policies and procedures. Interview agency staff as needed to clarify processes and activities related to review of an individual's need for representative payee.
- Agency written procedures should ensure compliance with the following requirements:
- If the individual does not have a representative payee:
 - o Within 10 business days of an individual's move into a residence/facility, the director, in consultation with the individual's planning team, must conduct a review to determine whether the appointment of a representative payee to manage the individual's benefits is advisable.
 - o If the director and the planning team question whether an individual is able to manage his or her benefits, then the individual must be evaluated by a health care professional. If, in the health care professional's opinion, the individual cannot manage his or her benefits, then the facility director may apply to become the individual's representative payee. If, in the health care professional's opinion, the individual is capable of managing his or her own benefits, then the facility director may not apply to become the individual's representative payee.
- If the individual has a representative payee:
 - o Within 10 business days of a beneficiary's move into a residence/facility, the director, in consultation with the individual's planning team, must conduct a review to determine whether there is a continuing need for the appointment of a representative payee for the individual.
 - o If the director and the planning team determine that the individual continues to require a representative payee, then the director may apply to become the individual's representative payee.
 - o If the agency director and/or the planning team determine that an individual may no longer require a representative payee, or are unsure, then the individual must be evaluated by a health care professional. If the health care professional's opinion is that the individual cannot manage his or her benefits, then the facility director may apply to become the beneficiary's representative payee. If the health care professional's opinion is that the individual can manage his or her benefits, then the director may not apply to become the individual's representative payee.
 - o The director must notify the benefit paying agency of any change.

- The basis for the determination of the individual's need or continuing need for a representative payee, must be documented in the individual's record.
- Residential moves/transfers requiring review of need for a representative payee include:
 - o Moves from non-certified into certified residence.
 - o When a person moves from one residence into another within the same agency, and the person needs different supports;
 - o Every time a person moves from a residence into one operated by a different agency.
- A determination of an individual's need for a representative payee must also be made:
 - o when there is a significant change in the individual's physical or mental condition;
 - o in response to a circumstance that affects the individual's ability to manage his or her benefits;
 - o upon request of the individual or a party making a request on behalf of the individual;
 - o moves from one certified residence to another as described above
- While the need for policies and procedures is not explicitly described in 633.9, regulatory intent for Part 633 describes: Intent 633.2 (b) To provide the basis to agencies whereby they shall develop and implement written agency/facility (see glossary) specific policies/procedures (see glossary), which reflect compliance with this Part. Such policies/procedures shall become part of the agency/facility policy and/ or procedure manual(s). Upon development, such policies/procedures shall be implemented and the agency/facility shall be responsible for ensuring ongoing compliance with said policies/ procedures.

Select Met if the following are evident:

- The Agency has written procedures to address determination of need for representative payee identified in above guidance; AND
- The written procedures appear aligned with regulatory requirements

Select Not Met if any of the following is evident:

- The Agency does not have written procedures to address determination of need for representative payee identified in above guidance; OR
- The agency has written procedures for this topic but they do not align with regulatory requirements.

Citations

633.9(c)(1)- (3)

(c) Determination of need for representative payee.

(1) The beneficiary does not have a representative payee. If an individual does not have a representative payee, then within 10 business days of a beneficiary's move into a facility, the facility director, in consultation with the beneficiary's planning team, must conduct a review to determine whether the appointment of a representative payee to manage the individual's benefits is advisable. The basis for the determination must be documented in the beneficiary's record. If the facility director and the planning team question whether an individual is able to manage his or her benefits, then the individual must be evaluated by a health care professional. If, in the health care professional's opinion, the beneficiary cannot manage his or her benefits, then the facility director may apply to become the beneficiary's representative payee. If, in the health care professional's opinion, the beneficiary is capable of managing his or her own benefits, then the facility director may not apply to become the beneficiary's representative payee.

(2) The beneficiary has a representative payee. If an individual has a representative payee, then within 10 business days of a beneficiary's move into a facility, the facility director, in consultation with the beneficiary's

planning team, must conduct a review to determine whether there is a continuing need for the appointment of a representative payee for the beneficiary.

(i) If the facility director and the planning team determine that the beneficiary continues to require a representative payee, then the facility director may apply to become the beneficiary's representative payee.

(ii) If the facility director and/or the planning team determine that a beneficiary may no longer require a representative payee, or are unsure, then the individual must be evaluated by a health care professional. If the health care professional's opinion is that the beneficiary cannot manage his or her benefits, then the facility director may apply to become the beneficiary's representative payee. If the health care professional's opinion is that the beneficiary can manage his or her benefits, then the facility director may not apply to become the beneficiary's representative payee. The facility director must notify the benefit paying agency of any change.

(iii) The basis for the determination of the beneficiary's need or continuing need for a representative payee, as set forth in subparagraphs (i) and (ii) of this paragraph, must be documented in the beneficiary's record.

(3) A determination of a beneficiary's need for a representative payee must also be made under the following circumstances and must be documented in the beneficiary's record:

- (i) when there is a significant change in the beneficiary's physical or mental condition;
- (ii) in response to a circumstance that affects the beneficiary's ability to manage his or her benefits;
- (iii) upon request of the beneficiary or a party making a request on behalf of the beneficiary;
- (iv) when a beneficiary transfers from one certified residence to another and both residences are operated by the same agency, and the person needs different supports, then the facility director must follow the requirements of paragraphs (1) and (2) of this subdivision; and
- (v) when a beneficiary transfers from one certified residence to another, and the residences are operated by different agencies, then the facility director must follow the requirements of paragraphs (1) and (2) of this subdivision.

Standard #	Standard Text	Decision
4	The agency has written procedures to provide required notice to qualified parties when the agency director applies to serve as an individual’s representative payee, in accordance with applicable OPWDD regulations.	Met/Not Met

Guidance

Interview:

As needed to clarify written procedures: Agency staff responsible for assurance representative payee processes and activities; e.g. residential services director, business office, and/or quality assurance staff;

Documentation:

Agency written policy and procedures.

Guidance:

- Parts 633.9(c)(4) and 633.9(d) address Notice to qualified persons of intent and application for representative payee status
- Review policies and procedures. Interview agency staff as needed to clarify processes and activities related to communication/notification of the agency director’s application to serve as an individual’s rep payee.
- The agency must ensure there are procedures to follow the following:
 - o Whenever the agency director applies/intends to apply to be the representative payee for an individual receiving services in an OPWDD certified facility, the director must give notice to proper parties. If notice is not provided, then the reason must be documented in the individual’s record.
 - o The director must give concurrent written notice of the intent to apply to be representative payee, to qualified parties [MHL 33.16(a)(6): individual, guardian, parent, spouse, adult child] and any other party designated by the individual.
 - o A director is not required to provide notice if the individual is a capable adult as defined in 633.99(bp), and the individual objects to such notice; if notice is prohibited by court order; or, if the director, in consultation with the planning team, determine that it would cause substantial and identifiable harm to the beneficiary. This determination must be documented in the beneficiary’s record.
 - o The agency’s procedures should ensure and evidence that the notice of the intent to apply for representative payee status has occurred by one of the following methods: hand delivered, mailed by first class mail to the last known address of the recipient(s) of the notice, or mailed electronically to the last known email address of the recipient(s).
 - o The notice to individuals must include information that the Mental Hygiene Legal Service is available to advise them regarding the application process.
 - o The residence or agency facility must ensure that the individual is apprised of his or her right at any time to request to receive benefits directly, or to request a change in representative payee, and how to do so. (Request must be directed to the Social Security Administration or the Federal or State entity that made the appointment.)
- While the need for policies and procedures is not explicitly described in 633.9, regulatory intent for Part 633 describes: Intent 633.2 (b) To provide the basis to agencies whereby they shall develop and implement written agency/facility (see glossary) specific policies/procedures (see glossary), which reflect compliance with this Part. Such policies/procedures shall become part of the agency/facility policy and/ or procedure manual(s). Upon development, such

policies/procedures shall be implemented and the agency/facility shall be responsible for ensuring ongoing compliance with said policies/ procedures.

Select Met if the following are evident:

- The Agency has written procedures to address notice to qualified persons of intent and application for representative payee status identified in above guidance; AND
- The written procedures appear aligned with regulatory requirements

Select Not Met if any of the following is evident:

- The Agency does not have written procedures to address notice to qualified persons of intent and application for representative payee status identified in above guidance; OR
- The agency has written procedures for this topic but they do not align with regulatory requirements

Citations

633.9(c)(4)

If the facility director applies to be representative payee, the director must provide notification in accordance with subdivision (d) of this section. If notice is not provided, then the reason must be documented in the beneficiary's record.

633.9(d)

Notice to qualified persons of intent and application for representative payee status.

(1) Whenever a facility director intends to apply to be representative payee of a beneficiary who is receiving services from an OPWDD operated or certified residential facility, the facility director must give concurrent written notice to the qualified parties as set forth in Mental Hygiene Law section 33.16(a)(6) and any other party designated by the beneficiary, of the facility director's intent to make such application.

(i) A facility director is not required to provide notice pursuant to this section if the beneficiary is a person, capable adult as defined in section 633.99(bp) of this Part, and the beneficiary objects to such notice; if such notice is prohibited by court order; or, if the facility director, in consultation with the planning team, determine that it would cause substantial and identifiable harm to the beneficiary. This determination must be documented in the beneficiary's record.

(ii) The notice will be deemed to have been provided if hand delivered, mailed by first class mail to the last known address of the recipient(s) of the notice, or mailed electronically to the last known email address of the recipient(s).

(iii) The notice to beneficiaries must include information that the Mental Hygiene Legal Service is available to advise beneficiaries regarding the application process.

(2) During the application process or following the appointment of a facility director as a beneficiary's representative payee, the facility must ensure that the beneficiary is apprised of his or her right at any time to request to receive benefits directly, or to request a change in representative payee. Such request must be directed to the Social Security Administration or the Federal or State entity that made the appointment.

Standard #	Standard Text	Decision
5	The agency has written procedures for the expenditure of and accounting for the Personal Needs Allowance/Clothing Allowance funds, in accordance with OPWDD regulations. Voluntary Agencies Only	Met/Not Met

Guidance

Interview:

As needed to clarify written procedures: Agency staff responsible e.g. residential services director, business office, and/or quality assurance staff;

Documentation:

Agency written policy and procedures.

Guidance:

- Interview agency staff and review written procedures related to the bi-annual Clothing Allowance (aka Personal Needs Allowance).
- The procedures should minimally include:
 - o That Personal Needs/Clothing Allowance funds, are ledgered separately from personal allowance funds and PA fund activity; and
 - o Receipt and expenditure of the funds are recorded on the ledger; and
 - o Expenditures are appropriate to intended purpose of the funds:
 - § replacement of necessary clothing;
 - § personal requirements and incidental needs; and
 - § recreational and cultural activities.

Select Met if the following are evident:

- The Agency has written procedures to address expenditure of and accounting for the Personal Needs Allowance/Clothing Allowance funds identified in above guidance; AND
- Written procedures appear aligned with regulatory requirements

Select Not Met if any of the following is evident:

- The Agency does not have written procedures to address expenditure of and accounting for the Personal Needs Allowance/Clothing Allowance funds identified in above guidance; OR
- The agency has written procedures for this topic but they do not align with regulatory requirements

Citations

635-9.1(a)(1)(xvi)(b)(1)

Community residences assume the cost of basic clothing, except where the following funds are available: (1) section 41.36(n) funds (see glossary);

635-99.1(au)

(au) Funds, section 41.36(n) (sic*)

A payment (as of December 23, 1992) of up to \$250 per year, per person residing in a voluntary-operated community residence which may be available to the operator of the facility for one or more of the following needs of the people residing there:

- (1) replacement of necessary clothing;
- (2) personal requirements and incidental needs; and
- (3) recreational and cultural activities.

The funds are made available in accordance with section 41.36(n) (sic*) of the Mental Hygiene Law and payment is made on a semi-annual basis to the agency operating the community residence.

DQI NOTE *: Current MHL reference is 41.36 (a)-(c), not (n); however, Part 633 Glossary has not been updated to reflect "

Topic 9: Safety and Maintenance

Section 1: Safety and Maintenance

Standard #	Standard Text	Decision
1	The agency has written procedures in place to ensure that OPWDD is notified immediately of anticipated or actual termination of any service vital to the continued safe operation of the facility or the health of persons receiving services and personnel.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Agency policy and procedure

Interview:

Mandatory: Agency Management Staff, Quality Assurance Staff

Guidance:

- Interview agency management staff and review the agency’s written procedures for OPWDD notification of disruption of vital services. • Written procedures should provide specificity sufficient to ensure continuity of actions, regardless of personnel changes. The procedures should minimally include:
 - o Description of service interruption or termination situations that require OPWDD notification.
 - o OPWDD departments/divisions to be contacted; e.g. local DDRO and BPC; and how to contact.
 - o Time frame for notification.
 - o Person(s) responsible for notification by staff title.
- Per the regulation, such services include, but are not limited to the following: telephone, electric, gas, fuel, water, septic tank, heat, air conditioning, contract food services, contract laundry services, smoke detection equipment or heat detection equipment or sprinkler systems.
- Immediate notification will be reviewed as within 24 hours to DDRO and next working day for DQI.
- “Minor”, “inconvenient”, “inconsequential” situations that can be remediated “short term” or “timely” may be considered maintenance issues that do not significantly affect the comfort and safety of the individuals and/or can be repaired/corrected within the same day of discovery and may not require notification. Surveyor discretion is expected in making the determination.

Select Met if both of the following are evident:

- Agency has a written procedure for notification to OPWDD when vital services are disrupted;
- AND
- Agency written procedure minimally includes information outlined above.

Select Not Met if either of the following are evident:

- Agency does not have a written procedure for notification to OPWDD when vital services are disrupted;
- AND/OR
- Agency written procedure does not include the minimal information outlined above.

Citations

635.7.4(b)(3)(iv)

FOR IRAs and FAMILY CARE PROVIDERS ONLY:

The family care provider or the operator of the IRA shall notify OPWDD immediately of the anticipated or actual termination of any service vital to the continued safe operation of the home or IRA or the health of persons receiving services. This shall include but not be limited to the following services: telephone, electric, gas, fuel, water, septic tank, heat, air conditioning, smoke or heat detection equipment or sprinkler systems. All situations which, in the reasonable opinion of the family care provider or the operator of the IRA, are of minor or merely inconvenient, inconsequential nature to persons receiving services, and which can be remedied in a short-term, timely fashion, need not be reported. The family care provider or the operator of the IRA is to promptly apply remedial measures to correct the circumstances described above.

635-7.3(c)(7)

FOR OTHER CERTIFIED SITES:

The facility shall notify OPWDD immediately of anticipated or actual termination of any service vital to the continued safe operation of the facility or the health of persons receiving services and personnel, including, but not limited to the following services: telephone, electric, gas, fuel, water, septic tank, heat, air conditioning, contract food services, contract laundry services, smoke detection equipment or heat detection equipment or sprinkler systems. All situations which, in the reasonable opinion of the agency, are of a minor or merely inconvenient inconsequential nature to persons receiving services in the facility, and which can be remedied in a short term, timely fashion, need not be reported. The facility is to promptly apply remedial measures to correct the circumstances described above.

Standard #	Standard Text	Decision
2	The agency has written procedures to ensure that safety plans are approved by OPWDD/DQI prior to facility renovations affecting normal operations at the site, and implemented.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Agency policy and procedure

Interview:

Mandatory: Agency Program Management Staff, Quality Assurance Staff, Agency Facilities staff as applicable to agency organization

Guidance:

- Interview knowledgeable staff and review the agency's written procedures to determine agency procedures regarding assurance of safety plans, and the process for getting approval from OPWDD.
- Written procedures should provide specificity sufficient to ensure continuity of actions, regardless of personnel changes. Written procedures should minimally include:
 - o Description of situations that require submittal of a Safety Plan to DQI;
 - o Safety Plan content;
 - o When the Safety Plan must be given/sent to DQI, (i.e. time frame in advance of renovation start date);
 - o DQI Contact information for OPWDD;
 - o Person(s) by staff title responsible for Safety Plan development and submittal to DQI; and actions to ensure approval by OPWDD prior to work beginning;
 - o Actions to be taken at the site where renovations are occurring to ensure/monitor that the Safety Plan is implemented.
- Facility Renovations affecting normal operations of the house include but are not limited to the following renovation situations:
 - o creates potential hazards such as exposed walls or floors, exposed wires, access to tools/power tools, construction debris, etc.;
 - o impacts operation of fire safety equipment such as detection, alarms, and access to pull stations;
 - o impacts normal flow of the house necessitating changes in evacuation paths and/or exit points;
 - o requires relocation of individuals to spaces not previously used as bedroom space;
 - o requires accommodation for individuals due to limited access to home facilities, such as closure of 1 bathroom, limited access to kitchen.
 - o Safety Plans are not necessary for minor renovations that have no impact on access to the home or its safety features. "Minor", "inconvenient", "inconsequential" situations that can be remediated "short term" or "timely" may be considered maintenance issues that do not significantly affect the comfort and safety of the individuals and/or can be repaired/corrected within the same day of discovery and may not require notification. Surveyor discretion is expected in making the determination.

Select Met if both of the following are evident:

- Agency has a written procedure for Safety Plan development, approval by OPWDD and implementation;

AND

- Agency written procedure minimally includes information outlined above.

Select Not Met if either of the following are evident:

- Agency does not have a written procedure for Safety Plan development, approval by OPWDD and implementation;

OR

- Agency written procedure does not include the minimal requirements outlined above.

Citations

635-7.1(g)

If any physical plant modifications are initiated that are subject to the building codes in effect at the time of receipt of the permit for such modification or any requirements of this section, the provider shall notify the local Developmental Disabilities services Office (DDSO) and the appropriate designee in the OPWDD Division of Quality Assurance in writing of the proposed changes. Once the project is complete, the facility shall maintain documentation that such changes are in compliance with all applicable building codes and related guides. Subsequent to such modifications, recertification shall be subject to compliance with the applicable building code, unless an exemption is requested and granted in conformance with the Uniform Code or the Building Code of the City of New York and applicable Department of State rules and regulations.

635-7.3(c)(7)

FOR SITES THAT ARE NOT IRA or FAMILY CARE HOMES:

The facility shall notify OPWDD immediately of anticipated or actual termination of any service vital to the continued safe operation of the facility or the health of persons receiving services and personnel, including, but not limited to the following services: telephone, electric, gas, fuel, water, septic tank, heat, air conditioning, contract food services, contract laundry services, smoke detection equipment or heat detection equipment or sprinkler systems. All situations which, in the reasonable opinion of the agency, are of a minor or merely inconvenient inconsequential nature to persons receiving services in the facility, and which can be remedied in a short term, timely fashion, need not be reported. The facility is to promptly apply remedial measures to correct the circumstances described above.

635.7.4(b)(3)(iv)

The family care provider or the operator of the IRA shall notify OPWDD immediately of the anticipated or actual termination of any service vital to the continued safe operation of the home or IRA or the health of persons receiving services. This shall include but not be limited to the following services: telephone, electric, gas, fuel, water, septic tank, heat, air conditioning, smoke or heat detection equipment or sprinkler systems. All situations which, in the reasonable opinion of the family care provider or the operator of the IRA, are of minor or merely inconvenient, inconsequential nature to persons receiving services, and which can be remedied in a short-term, timely fashion, need not be reported. The family care provider or the operator of the IRA is to promptly apply remedial measures to correct the circumstances described above.

Standard #	Standard Text	Decision
3	The agency has procedures to assess smoke detectors every 10 years and determine if replacement is necessary.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Agency policy and procedures, Equipment Tracking per agency processes

Interview:

Mandatory: Facilities Manager/Maintenance Administrator and/or Quality Assurance; Maintenance personnel as needed

Guidance:

- Through routine activities, discover if the agency has a mechanism to track and access smoke detector age and needed replacement.
- The assessment for smoke detector replacement may be done by qualified agency staff or the agency may choose to have the assessment conducted by a qualified vendor agency that gives written recommendations to the agency.
- If conducted by the vendor agency, this assessment should be included in the written vendor contract/agreement.
- In cases where the agency staff conduct the assessment, the agency should have written procedures that minimally include the following
 - o Tracking of smoke detector purchase/installation dates, reviews, and decisions;
 - o Retention of manufacturer's instructions for care and maintenance;
 - o Assessment of smoke detectors every 10 years and decision making for whether replacement is called for per their condition or manufacturer's recommendation.
- Ask agency staff to show implementation of the procedures per tracking documents or other means. Verify that replacement needs are reviewed and decisions documented and smoke detectors replaced when determined necessary.

Select Met if both the following is evident:

- The agency has a written procedure in place to track assess smoke detectors every 10 years and determine if replacement is necessary to be completed by qualified agency staff or a qualified vendor as described above; AND
- There is documentation of the smoke detector assessments, decisions, and completion of needed replacement.

Select Not Met if any of the following is evident:

- The agency does not have any procedures to track and assess smoke detectors every 10 years and determine if replacement is necessary, by qualified agency staff or vendor.
- The agency does not complete smoke detectors assessment every 10 years and determination if replacement is necessary.
- The agency cannot show that smoke detector assessment, determinations and needed replacement occurs.

Citations

635-7.3(h)(5)

All facilities, except family care home and IRAs for eight or fewer persons, shall comply with the following requirements: The maintenance and/or cleaning of any heating, air conditioning and/or air filtrations equipment, and fire protection equipment, shall be performed on a regular basis and in accordance with the recommendations of the manufacturer.

635-7.4(b)(3)(xviii)

For IRAs eight beds or fewer and family care homes: Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.

Standard #	Standard Text	Decision
4	The agency has procedures to assess Carbon Monoxide detectors every five years and determine if replacement is necessary or occurs per manufacturer's instruction.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Agency policy and procedures, Equipment Tracking per agency processes

Interview:

Mandatory: Facilities Manager/Maintenance Administrator and/or Quality Assurance; Maintenance personnel as needed

Guidance:

- Through routine activities, determine if the agency has a mechanism to track carbon monoxide detector age and needed replacement.
- The agency should have written procedures that minimally include the following:
 - o Tracking of CO detector purchase/installation and replacement dates
 - o Retention of manufacturer's instructions for care and maintenance
 - o Replacement of CO detectors every 5 years or per manufacturer instructions or per their condition if early replacement is warranted.
- Ask agency staff to show implementation of the procedures per tracking documents or other means. Verify that replacement needs are reviewed and decisions documented and CO detectors replaced when determined necessary.

Select Met If both of the following are evident:

- The agency has written procedure for the replacement of all carbon monoxide detectors every 5 years or per the manufacturer's instruction or condition inclusive of minimal elements noted above; AND
- There is documentation of the carbon monoxide detector assessments, decisions, and completion of needed replacement.

Select Not Met if any of the following is evident:

- The agency does not have a written procedure for the replacement of carbon monoxide detectors; OR
- The agency does not complete carbon monoxide detectors replacement every 5 years or per manufacturer's instruction; OR
- The agency cannot show that carbon monoxide detectors are replaced every 5 years or per manufacturer's instruction.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
5	The agency has procedures to ensure that Smoke Detection and Fire Alarm Systems are properly tested and maintained.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Agency Procedures; As Appropriate: Contracts for testing and maintenance, Staff Qualifications

Interview:

Mandatory: Facilities Manager/Maintenance Administrator and/or Quality Assurance; Maintenance personnel as needed

Guidance:

- Review the agency's written procedures/systems for testing and maintenance and related documentation.
- If a provider Agency's own personnel conduct the testing of Fire Alarm and Smoke Detection Systems, the agency must have procedures that:
 - o Include completion of a full written record of all testing actions completed, the findings, and maintenance actions taken by the person(s); and
 - o Ensure that staff completing tasks are qualified to conduct testing/maintenance including documentation of qualification.
- Agencies contracting with outside entities for testing and maintenance must:
 - o has procedures that ensure the receipt of a full written record of all testing actions and findings, and the maintenance actions taken during testing and maintenance activities; and
 - o use the OPWDD provided templates for new or renewed contracts for the services, that follow NFPA 72 Guidelines for Alarm and Detection Systems and the expected routine testing and maintenance, to ensure that the contracts clearly and comprehensively describe the responsibilities of the vendor to ensure appropriate testing and maintenance of the systems.

Select Met if both of the following are evident:

- The agency has written procedures related to testing and maintenance of fire alarm and smoke detection systems in agency sites;
- AND
- The written procedure requires testing, maintenance and documentation as outlined above whether the agency or an outside vendor is performing the testing and maintenance.

Select Not Met if one of the following is evident:

- The agency does not have a written procedure related to testing and maintenance of their fire alarm and smoke detection systems in agency sites;
- OR
- The agency has a written procedure; however, it does not ensure testing, maintenance and documentation as outlined above whether the agency or an outside vendor is performing the testing and maintenance.

Citations

635-7.3(i)(1)

FOR CRs, IRAs (9 beds or more), ICFs: In addition to the requirements of subdivision

(h) of this section, all supervised community residences, IRAs housing nine or more persons and all intermediate care facilities for persons with developmental disabilities shall also comply with the following requirements:

(1) There is documentation that all heat and smoke detecting alarm devices have been tested quarterly.

635-7.4(b)(3)(xviii)

FOR IRAs and FCHs: Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.

ADM 2012-02

To ensure consistency and code compliance across the state, contract templates for sprinkler system testing and maintenance and fire alarm and smoke detection system testing and maintenance, that include information related to fire alarm system central station monitoring requirements, are available.

Agencies that are negotiating or renewing contracts for these services must utilize these templates to ensure that contracts are sufficiently clear and comprehensive with regard to the responsibilities of the vendor.

The sprinkler system contract meets NFPA requirements (NFPA 25), and is designed to hold companies performing testing and maintenance to the industry-accepted standard.

The fire alarm systems contract template follows NFPA requirements for fire alarm systems (NFPA 72) and exceeds testing frequency for that standard. The fire alarm systems contract template also contains clear language related to the central station-monitoring vendor's responsibility to immediately contact emergency responders and specifically prohibits vendors from calling the home or day setting first to verify the validity of the alarm.

Standard #	Standard Text	Decision
6	The agency has procedures to ensure that Sprinkler Systems are properly tested and maintained.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: Agency Procedures; As Appropriate: Contracts for testing and maintenance, Staff Qualifications

Interview:

Mandatory: Facilities Manager/Maintenance Administrator and/or Quality Assurance; Maintenance personnel as needed

Guidance:

- Review the agency's systems for testing and maintenance and related documentation.
- If a provider Agency's own personnel conduct the testing of Sprinkler systems, the agency must have procedures that:
 - o Include completion of a full written record of all testing actions completed, the findings, and maintenance actions taken by the person(s); and
 - o Ensure that staff completing tasks are qualified to conduct testing/maintenance including documentation of qualification.
- Agencies contracting with outside entities for testing and maintenance must:
 - o has procedures that ensure the receipt of a full written record of all testing actions and findings, and the maintenance actions taken during testing and maintenance activities;
 - o use the OPWDD provided templates for new or renewed contracts for the services, that follow NFPA 25 Guidelines for Sprinkler Systems and the expected routine testing and maintenance, to ensure that the contracts clearly and comprehensively describe the responsibilities of the vendor to ensure appropriate testing and maintenance of the systems.

Select Met if both of the following are evident:

- The agency has written procedures related to testing and maintenance of sprinkler systems in agency sites;
- AND
- The written procedure requires testing, maintenance and documentation as outlined above whether the agency or an outside vendor is performing the testing and maintenance.

Select Not Met if one of the following is evident:

- The agency does not have a written procedure related to testing and maintenance of their sprinkler systems in agency sites;
- OR
- The agency has a written procedure; however, it does not ensure testing, maintenance and documentation as outlined above whether the agency or an outside vendor is performing the testing and maintenance.

Select NA if none of the sites under the auspices of the agency have a sprinkler system.

Citations

ADM 2012-02

To ensure consistency and code compliance across the state, contract templates for sprinkler system testing and maintenance and fire alarm and smoke detection system testing and maintenance, that include information related to fire alarm system central station monitoring requirements, are available.

Agencies that are negotiating or renewing contracts for these services must utilize these templates to ensure that contracts are sufficiently clear and comprehensive with regard to the responsibilities of the vendor.

The sprinkler system contract meets NFPA requirements (NFPA 25), and is designed to hold companies performing testing and maintenance to the industry-accepted standard.

The fire alarm systems contract template follows NFPA requirements for fire alarm systems (NFPA 72) and exceeds testing frequency for that standard. The fire alarm systems contract template also contains clear language related to the central station-monitoring vendor's responsibility to immediately contact emergency responders and specifically prohibits vendors from calling the home or day setting first to verify the validity of the alarm.

Standard #	Standard Text	Decision
7	The agency has a mechanism to ensure that vehicles used in the transportation of service recipients are safe and properly maintained.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: Agency policy and procedures, Maintenance Tracking per agency processes

Interview:

Mandatory: Transportation or Maintenance Administrator and/or Quality Assurance; Maintenance personnel as needed

Guidance:

- Interview management staff and review written vehicle maintenance procedures if any.
- The agency procedures may include:
 - o Procedures to ensure vehicles receive routine maintenance (oil changes, tune ups, inspections, etc.) when it is needed/due per vehicle specifications;
 - o A mechanism for reporting problems with vehicles and scheduling for needed evaluation or service;
 - o Review that vehicles' adaptive equipment is operable and safe, e.g. lifts, wheelchair securing equipment;
 - o Identification of staff (by title) responsible for these tasks;
 - o Communication of problems noted with vehicles provided by a transportation vendor, and a mechanism to have these issues resolved promptly.
- If agencies expect or allow use of staff's personal vehicles, verify that the agency has procedures to verify that staff licenses are current and that staff have liability insurance.

Select Met if the following is evident:

- The agency has a mechanism in place to ensure that vehicles used in the transportation of service recipients are safe and properly maintained.

Select Not Met if the following is evident:

- The agency does not have a formal mechanism in place to ensure that vehicles used in the transportation of service recipients are safe and properly maintained.

Select NA if the agency does not use agency vehicles or staff personal vehicles to transport individuals.

Citations

633.4(a)(4)(i)

No person shall be denied: a safe and sanitary environment;

Standard #	Standard Text	Decision
8	All agency staff receive training in the agency procedures to report site maintenance problems affecting individuals' safety and well-being.	Met/Not Met

Guidance

Documentation Review:

Mandatory:

- Staff Training Curriculum, Staff Orientation information, or
- Any other related agency procedures related to identifying and reporting maintenance issues

Interview:

As needed: Training Coordinator, QA Staff, Program and Department Administrators

Guidance:

- This standard is a quality indicator.
- The standard reviews for an agency system that train/informs staff members of the role and responsibility to report known environmental hazards and maintenance issues. Entitling all staff to report known maintenance needs increases likelihood of prompt correction.
- Review staff orientation topics, training curriculum and procedures to evaluate whether the agency has some way to teach/train/inform agency staff of their responsibility to report maintenance needs and how to do so.
- Staff training/orientation should include recognizing issues that need immediate attention and how to report vs. notification/processes for more routine maintenance concerns.

Select Met if both of the following are evident:

- The agency has a mechanism to inform staff through training or orientation, how to identify and report maintenance issues.
- The agency has a procedure in place for staff to report site maintenance problems that pose a risk to safety of individuals.

Select Not Met if any of the following are evident:

- The agency does not have a mechanism to inform staff through training or orientation, how to identify and report maintenance issues.
- The agency does not have a procedure in place for staff to report site maintenance problems that pose a risk to safety of individuals.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
9	The agency has and implements procedures for direct observational review of sites to ensure the environment is clean, appropriately maintained, and safe.	Met/Not Met

Guidance

Documentation Review:

Mandatory:

- Agency written procedures related to physical plant checks/monitoring; and
- Documentation of the environmental reviews completed.

Interview:

Mandatory: QA Staff, Program Management, and Facilities Management staff as appropriate to the agency organization.

Guidance:

- This standard is a quality indicator.
- The standard reviews for an agency system that mandates physical plant “walk throughs” intended to verify that agency programs/sites are well maintained, clean, and have no safety hazards (fire safety and general safety); and to identify problems related to maintenance, cleanliness, and safety so that correction occurs promptly.
- Through interview and documentation review, verify that the agency has a written procedure for review of the physical condition of facility sites.

The procedure should include:

- o A designated person(s) by staff title, responsible to conduct the review/observation;
- o Description of how reviews must be conducted;
- o Frequency of the reviews and/or when reviews will be conducted
- o Documentation of reviews/review findings.

- Review documentation of completed environmental reviews for the past six (6) months for a sample of agency sites. Verify that the reviews are occurring per agency policy

Select Met if both of the following are evident:

- The agency has a written procedure for the completion of observational review of sites to ensure they are clean, safe and maintained, inclusive of the elements of the procedure noted above (who, how, when and how documented; AND
- There is documentation of the completed site environmental reviews, showing completion per agency procedure.

Select Not Met if any of the following are evident:

- The agency does not have a written procedure for the completion of observational review of sites to ensure they are clean, safe and maintained;
- The agency has a procedure but it does not include the elements of the procedure noted above (who, how, when and how documented;
- There is no documentation of the completed site environmental reviews;
- Documentation shows that environmental reviews are completed inconsistently or incompletely per agency procedure.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
10	The agency acts to remediate and/or prioritize remediation for any maintenance and cleaning needs identified during environmental review of agency sites.	Met/Not Met

Guidance

"Documentation Review: Mandatory:

- Agency written procedures related to physical plant checks/monitoring; documentation of the environmental reviews completed;
- Documentation related to follow-up and correction of cleaning and maintenance needs identified through internal reviews and external reviews.

Interview: Mandatory: QA Staff, Program Management and Facilities Management staff as appropriate to the agency organization.

Guidance:

- Determine through interview and documentation review how the agency decides corrective actions to be taken regarding cleaning, maintenance, and environment safety.
- Agency process should include review of reported issues identified by:
 - o External reviews (e.g. DQI-BPC); and
 - o Internal reviews, e.g.:
 - § Site staff reports of issues through agency mechanism, and
 - § Routine environmental reviews conducted by e.g. agency maintenance, agency management or board members.
- The agency should be able to show that it:
 - o identifies reported issues that require immediate action due to the impact to health and/or safety; and
 - o prioritizes other reported issues related to the impact on individual well-being and quality of life;
 - o and has a plan, including timeline for other reported corrections or repairs identified. corrective actions that need to be taken from and verifies their implementation.
- Written evidence of remediation or planned remediation may take any format per agency procedures. However, the plan for correction of the environmental issues should include:
 - o documentation of actions taken or to be taken
 - o party responsible, and
 - o date completed or planned completion date.

- The agency may have justifiable reasons for prioritizing some corrections over others, some sites over others, and delaying some corrections that affect appearance but not structure and safety. However, verify that the agency system appears effective to prioritize and promptly address physical plant issues most impactful to safety, health, and well-being.

Select Met if ALL of the following are evident:

- The agency has a clear process to remediate and/or prioritize remediation for any maintenance and cleaning needs identified during review of physical plant; AND
- The agency has documentation showing that issues are corrected and/or plans made for the correction of identified cleaning and maintenance issues; AND
- The agency ensures that correction of environmental concerns related to safety and health are given priority and promptly corrected.

Select Not Met if any of the following are evident:

- The agency does not have a clear process to remediate and/or prioritize remediation for any maintenance and cleaning needs identified during review of physical plant; AND
- The agency does not have documentation showing that issues are corrected and/or plans made for the correction of identified cleaning and maintenance issues; AND
- The agency does not ensure that correction of environmental concerns related to safety and health are given priority and promptly corrected.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
11	The facility has preventative maintenance schedule or review schedule to aid in the routine maintenance of the physical plant on a regular basis.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Written Maintenance Schedules; agency policy/procedure if any

Interview:

Mandatory: Quality Assurance Staff, Facilities/Maintenance Director, or Agency Management staff per agency responsibilities and organization

Guidance:

- Inquire if the agency has written maintenance or review schedules for larger maintenance items that are routinely necessary, some which may be costly or time intensive.
- Interview agency staff to determine whether and how planning for the replacement and/or renovation of physical plant items for which this is would be necessary. Examples include but are not limited to: roof replacement, carpet cleaning and replacement, exterior/interior painting, driveway blacktopping/tarring, checks of HVAC systems, etc.
- The plan may also include a schedule for the review of the condition of the above items, to aid in long term planning.
- Planning for these types of maintenance activities may aid an agency to plan annual expenses over time and the ability to address issues before they become more costly or problematic.

Select Met if the following is evident:

- The agency has a preventative maintenance and/or maintenance review schedule to aid in the upkeep of agency sites.

Select Not Met if the following is evident:

- The agency DOES NOT have a preventative maintenance and/or maintenance review schedule to aid in the upkeep of agency sites.

Citations

QI: This Standard is a Quality Indicator.

Topic 10: Incident Management

Sample Guidance

CLASSIFICATION	SAMPLE SIZE
Reportable Incidents	20% Minimal all or 5, whichever is smaller Maximum 25
Serious Notable Occurrences	20% Minimal all or 5, whichever is smaller Maximum 25
Minor Notable Occurrences	10% Minimal all or 5, whichever is smaller Maximum 15
Part 625 Events	10% Minimal all or 5, whichever is smaller Maximum 15
Agency Events/Minor events <i>(events by agency policy required to be reported and documented that do not require reporting per 624 and 625)</i>	5% Minimal all or 5, whichever is smaller Maximum 20

Section 1: Notification of Policy and Procedures

Standard #	Standard Text	Decision
1	The agency has procedures to ensure that individuals are offered written information regarding incident reporting policies and procedures when beginning services and annually thereafter.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Agency Policies related to Incident Management, Agency forms related to notification.

Discussion:

With agency personnel regarding process to notify individuals and families of their right to information regarding incident reporting. As Needed: Discussion with Individual and Parents/Advocates about their receipt of information.

Guidance:

- An incident management process cannot be effective unless all parties involved are aware of the agency's policies and/or procedures to be followed. Agencies must offer to make information available annually. Agency policy should clearly explain how the agency will communicate the right to individuals and/or their family, advocates, and representatives. Surveyors should interview Quality Assurance staff and/or Agency Management to determine how the agency verifies that rights information has been shared.
- When services are provided to persons in either certified or non-certified settings, to avoid conflict or problems at a later date, individuals receiving services, family, advocates and representatives should be advised of the policies and procedures of the agency relative to reporting situations that meet the definition of a reportable incident or notable occurrence. The agency must outline in their policies and procedures how it will ensure that written copies of the "Learning about Incidents" brochure and a copy of the agency's policies and procedures will be available to individuals and family members. This

satisfies the requirement that the agency must provide instruction on how to access such information in electronic format and upon written request, provide paper copies of such information.

Select Met if both of the following are evident:

- The agency policy and procedure describe a process to ensure Individuals are offered written information regarding policies and procedures related to incident management when beginning services and annually thereafter; and
- The agency has a mechanism in place to ensure individuals are offered information regarding policies and procedures.

Select Not Met if either of the following are evident:

- The agency policy and procedure does not adequately address offering individuals written information regarding policies and procedure; or
- The agency does not have a mechanism in place to ensure individuals are given information upon enrollment and annually thereafter.

Citations

624.5(a)(3)(i)

Upon commencement of service provision, and annually thereafter, an agency must offer to make available written information, developed by OPWDD in collaboration with the Justice Center, and a copy of the agency's policies and procedures, to persons receiving services who have the capacity to understand the information and to their parents, guardians, correspondents (see glossary, section 624.20) or advocates (see glossary, section 624.20), unless a person is a capable adult who objects to their notification. The agency must also offer to make available a copy of OPWDD's Part 624 regulations. In order to satisfy this requirement, the agency shall:

- (a) provide instructions on how to access such information in electronic format and;
- (b) upon written request, provide paper copies of such information.

Standard #	Standard Text	Decision
2	The agency has written procedures for providing all staff and applicable associates the policies and procedures on incident reporting when beginning employment and annually thereafter.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Agency procedures related to the VPCR reporting and monitoring/verification of reporting to VPCR; Documentation (if any) of implementation of policy to ensure required staff have reported or are named in the report.

Interview:

As Needed: Incident Management Coordinators Quality Assurance Staff, Agency Management

Guidance:

- While all parties who reported to the VPCR can be found through IRMA, the agency's ability to verify that all applicable staff have reported may be difficult. However, an adequate review of the initial information should allow an agency to identify staff who witnessed or discovered a reportable incident.
- As the agency is responsible for the competency of the staff members to understand their reporting responsibilities, the agency should have a means to ensure that all staff required to report to the VPCR complete the reporting immediately upon their witnessing or discovery of the reportable incident.
- All custodians in programs or facilities operated or certified by OPWDD are "mandated reporters" and are required to report reportable incidents to the VPCR immediately upon discovery of the reportable incident unless: 1. The custodian knows that the report has already been made by another mandated reporter; AND 2. The custodian knows that they have been named in that report as a person with knowledge of the incident.

•"Discovery" occurs when the mandated reporter witnesses a suspected reportable incident or when another party, including an individual receiving services, comes before the mandated reporter in the mandated reporter's professional or official capacity and provides the mandated reporter with reasonable cause to suspect that the individual has been subjected to a reportable incident.

Note: Custodians of voluntary agencies providing waiver services in the community which are not part of a certified facility's program are not required to report to the Justice Center.

Select Met if the following is evident:

- Through documentation review and discussion with Agency personnel you verify that the agency has an effective mechanism in place to ensure staff required to contact the VPCR have done so.

Select Not Met if either of the following is evident:

- The agency does not have a mechanism in place to ensure that staff required to contact the VPCR have done so; or
- The mechanism is ineffective.

Citations

624.5(a)(3)(ii)

Upon employment or initial volunteer, contract, or sponsorship arrangements, and annually thereafter, an agency must make the agency's policies and procedures on incident management known to agency employees, interns, volunteers, consultants, contractors, and family care providers. For parties who are required to be trained, this information must be provided in conjunction with training conducted in accordance with section 633.8 of this Title.

Section 2: VPCR Reporting

Standard #	Standard Text	Decision
1	The agency has a mechanism to ensure that staff required to contact the VPCR for a particular incident, have done so.	Met/Not Met

Guidance

Documentation Review:

Mandatory: IRMA Review.

Interview:

As Needed: Quality Assurance Staff, Agency Management

Guidance:

While all parties who reported to the VPCR can be found through IRMA, the ability to verify that all applicable staff have reported is difficult. However, an adequate review of the initial information should allow an agency to identify staff who witnessed or discovered a reportable incident. As the agency is responsible for the competency of the staff members to understand their reporting responsibilities, the agency should have a means to ensure that all staff required to report to the VPCR complete the reporting immediately upon their witnessing or discovery of the reportable incident. All custodians in programs or facilities operated or certified by OPWDD are "mandated reporters" and are required to report reportable incidents to the VPCR immediately upon discovery of the reportable incident unless:

1. The custodian knows that the report has already been made by another mandated reporter; AND
2. The custodian knows that they have been named in that report as a person with knowledge of the incident. For purposes of this Part, "discovery" occurs when the mandated reporter witnesses a suspected reportable incident or when another party, including an individual receiving services, comes before the mandated reporter in the mandated reporter's professional or official capacity and provides the mandated reporter with reasonable cause to suspect that the individual has been subjected to a reportable incident.

Custodians of voluntary agencies providing waiver services in the community which are not part of a certified facility's program are not required to report to the Justice Center.

Select Met if the following is evident:

- Through documentation review and discussion with Agency personnel you verify that the agency has an effective mechanism in place to ensure staff required to contact the VPCR have done so.

Select Not Met if either of the following is evident:

- The agency does not have a mechanism in place to ensure that staff required to contact the VPCR have done so; or
- The mechanism is ineffective.

Citations

624.5(d)(2)- (3)

(2) All custodians (see glossary, section 624.20) in facilities or programs operated or certified by OPWDD are "mandated reporters" and are required to report reportable incidents to the VPCR.

(3) All custodians in facilities or programs operated or certified by OPWDD must submit reports of reportable incidents to the VPCR immediately upon discovery of the reportable incident.

Section 3: IRC – General Requirements

Standard #	Standard Text	Decision
1	The agency's IRC membership meets regulatory and agency requirements.	Met/Not Met

Guidance

Documentation Review:

Mandatory: Agency Policy and Procedure Manual, minutes of IRC meetings

Interview:

As Needed: IRC Chair, QA staff

Guidance:

During the agency review, the surveyor should check the minutes of IRC meetings for the past year to verify that required members were present at meetings. The Incident Review Committee is required to include members that meet the following criteria: a member of the governing body; (except for State-operated services), for State-operated services, a high level administrator (note: this cannot be the director); at least two professional staff, including but not limited to, licensed clinicians, such as occupation, physical and speech therapists, social workers psychologists, and nurses; a behavioral intervention specialist (BIS, see subdivision 633.16(b)); and others with primary responsibility for developing and/or monitoring individuals' plans of care, such as developmental and habilitation specialists or a QIDP.

At least one of the professional staff must be a licensed health care practitioner (e.g. physician, physician's assistant, nurse practitioner, or registered nurse).

- (iv) other staff, including administrative staff, as deemed necessary by the agency to achieve the purposes of the committee pursuant to this section;
- (v) at least one direct support professional (except for agencies that do not have direct support professionals);
- (vi) at least one individual receiving services;
- (vii) at least one representative of advocacy organizations (e.g. self-advocacy, family, or other advocacy organizations); and
- (viii) the participation of a psychologist on the committee is recommended. Agency policy can place additional requirements for membership on the IRC that are not contained in regulation.

Select Met if the composition of the IRC generally meets the regulatory and agency requirements.

Select Not Met if the composition of the IRC is not compliant with the regulatory requirements and there are no intentions to change the makeup of the committee.

Citations

624.7(f)(4) (i-viii)

(4) Membership of an IRC must include:

- (i) except for state-operated services, a member of the governing body;
- (ii) for state-operated services, a high-level administrator (note: this cannot be the Director);
- (iii) at least two professional staff, including but not limited to, licensed clinicians, such as occupational, physical, and speech therapists, social workers, psychologists, and nurses; a behavioral intervention specialist (BIS, see subdivision 633.16(b)); and others with primary responsibility for developing and/or monitoring individuals' plans of care, such as developmental and habilitation specialists or a QIDP. At least one of the professional staff must be a licensed health care practitioner (e.g. physician, physician's assistant, nurse practitioner, or registered nurse).
- (iv) other staff, including administrative staff, as deemed necessary by the agency to achieve the purposes of the committee pursuant to this section;
- (v) at least one direct support professional (except for agencies that do not have direct support professionals);
- (vi) at least one individual receiving services;
- (vii) at least one representative of advocacy organizations (e.g. self-advocacy, family, or other advocacy organizations); and
- (viii) the participation of a psychologist on the committee is recommended.

Standard #	Standard Text	Decision
2	The IRC guards against conflicts of interest.	Met/Not Met

Guidance

Documentation Review:

Mandatory: IRC Minutes

Interview:

Mandatory: IRC Chairperson, AS needed: IRC Members, Quality Assurance Staff

Guidance:

Discuss with the IRC chair and other members if possible regarding how this is guarded. During review of IRC minutes, be cognizant of the issues that may point to a potential conflict.

Any committee member who recognizes a potential conflict of interest in his or her assignment, initially or while the investigation is underway, must report this information to the committee and recuse him or herself from participating in committee review of the incident or occurrence in question.

No committee member may participate in the review of any reportable incident or notable occurrence in which he or she was directly involved, in which his or her testimony is incorporated, in which his or her spouse, domestic partner, or other immediate family member was directly involved, or which he or she investigated or participated in the investigation. Such members may, however, participate in committee deliberation regarding appropriate corrective, preventive, or remedial action.

For reportable incidents and serious notable occurrences, no committee member may participate in the review of an investigation in which his or her spouse, domestic partner, or immediate family member provides supervision to the program where the incident took place or supervised directly involved parties.

No committee member may participate in the review of a reportable incident or serious notable occurrence, if such committee member is the immediate supervisor of staff directly involved in the event or situation.

Such member may, however, participate in committee deliberation regarding appropriate corrective, preventive or remedial action.

It is understood that there may be case specific occurrences, when someone from or with knowledge of the agency's own organizational entity where the event which is under discussion occurred; or by someone who is familiar with the person(s) involved organizational entity where the event which is under discussion occurred; or by someone who is familiar with the person(s) involved needs to be present to provide information. However, if there is conflict, they should not be present for discussion or deliberation.

Select Met if: through review of IRC minutes and discussion with IRC Chair the agency is reporting potential conflicts and members are recused as indicated above.

Select Not Met if: through review of IRC minutes and discussion with the IRC Chair the agency does not report potential conflicts to the IRC and members are not recusing themselves when potential conflicts occur.

Citations

624.7(f)(7) (a-d)

(ii) Restrictions on review of specific incidents or allegations of abuse.

- (a) Any committee member who recognizes a potential conflict of interest in his or her assignment must report this information to the committee and recuse him or herself from participating in committee review of the incident or occurrence in question.
- (b) No committee member may participate in the review of any reportable incident or notable occurrence in which he or she was directly involved, in which his or her testimony is incorporated, in which his or her spouse, domestic partner, or other immediate family member was directly involved, or which he or she investigated or participated in the investigation. Such members may, however, participate in committee deliberation regarding appropriate corrective, preventive, or remedial action.
- (c) For reportable incidents and serious notable occurrences, no committee member may participate in the review of an investigation in which his or her spouse, domestic partner, or immediate family member provides supervision to the program where the incident took place or supervised directly involved parties.
- (d) No committee member may participate in the review of a reportable incident or serious notable occurrence, if such committee member is the immediate supervisor of staff directly involved in the event or situation. Such member may, however, participate in.

Standard #	Standard Text	Decision
3	Members of the committee are trained in confidentiality laws and regulations, and comply with section 74 of the Public Officers Law.	Met/Not Met

Guidance

Documentation Review:

Mandatory: IRC Minutes, Training Records

Interview:

Mandatory: IRC Chairperson, As Needed: IRC Members, Quality Assurance Staff, Agency Management Staff

Guidance:

Verify that the IRC members have been trained on confidentiality laws. This training can be documented in IRC meeting minutes or on a training roster/sign-in Training should have occurred annually beginning June 30, 2013.

Select Met if: It is verified that Committee members are trained in confidentiality laws and regulations and comply with Section 74 of the Public Officers Law.

Select Not Met if: You are unable to verify training for 2 or more of the committee members.

Citations

624.7(f)(8)

(8) Members of the committee must be trained in confidentiality laws and regulations, and shall comply with section 74 of the public officer's law.

Standard #	Standard Text	Decision
4	The IRC monitors trends of other events or situations which may be potentially harmful, but do not meet the definition of a reportable incident or notable occurrence	Met/Not Met

Guidance

Documentation Review:

Mandatory: IRMA, IRC minutes
As Needed: Incident Trend Report.

Interview:

As Needed: IRC Chairperson, Quality Assurance Staff, Agency Management.

Guidance:

The full committee may take on this responsibility or it may be done by a subcommittee, with a member of the subcommittee reporting to the full committee. Review meeting minutes to ensure that the committee is monitoring for general trends and/or patterns of events that may be potentially harmful to individuals. The committee should evaluate information provided about minor notable occurrences and agency reported events that do not meet the definitions of notable events for trends and/or patterns. If a pattern or trend is identified, the committee minutes should document that the committee recommended corrective actions to protect individuals and prevent recurrence. If the surveyor identified any patterns or trends during his/her sample review of minor notable occurrences, verify that the committee also identified the trend/pattern. For state agencies and voluntary agencies that use IRMA to report minor notable occurrences, the surveyor should generate a report from IRMA to gather information about whether any patterns/trends should have been identified.

Select Met if the IRC generally monitors and identifies trends.

Select Not Met if the agency failed to identify a trend that may be potentially harmful to individuals served.

Citations

624.7(c) (10)

(c) An IRC must:

(10) monitor trends of other events or situations attributable to a person receiving services which may be potentially harmful, but do not meet the definition of being a reportable incident or notable occurrence (see subdivision 624.2(e)). This may be done by the full committee or a member of a subcommittee reporting to the full committee;

Standard #	Standard Text	Decision
5	The IRC reported at least annually to the chief executive officer, chief agency executives, the governing body, and OPWDD concerning its monitoring functions, including trend analysis and response.	Met/Not Met

Guidance

Documentation Review:

Mandatory: IRC Minutes, Trend Report, Board Minutes

Interview:

As Needed: IRC Chairperson, CEO, Board President, Quality Assurance Staff

Guidance:

- The committee may prepare a single report summarizing the activities over the course of the past year which may serve all parties identified in the regulation; they may report monthly or quarterly; or they may report to any frequency as long as it is no less than annually.
- Trend reporting to OPWDD: Copies of trend reports should be submitted to the Incident Management Unit (IMU) as best practice, but minimally must be provided to OPWDD-DQI upon request.

The emphasis of the report is to be on the general activities/functioning of the committee. Hence, information included in the report should include aggregated data and/or information and not individual case specifics.

- The report should include, at a minimum, the general identified trends in reportable incidents and notable occurrences for the time period which the report covers; an analysis of the trends identified; and a summary of the types of corrective action(s) which have been developed, taken by the agency, in an effort to avoid circumstances known to have resulted in reportable incidents and notable occurrences. The IRC must report on identified trends in reportable incidents and notable occurrences, as well as corrective, preventative, remedial and/or disciplinary action pertaining to these trends.

An IRC should ensure that the trend report is inclusive of all incident categories, including internal and that the analysis can result in effectiveness of initiatives implemented and recommendations for future agency actions.

Consider the following when reviewing annual incident trend report, a quality report may include:

- Provide a comparison of incident types and number over a period of time as identified by the agency
- Identify trends within the agency and by site. This may include trends in date, time of day, location, person receiving services, involved staff, circumstances (e.g. staffing level, type of activity, individual behavior, etc.)
- Identify reasons for the trends and increases/decreases in incidents
- Identify corrective actions and systemic changes implemented over the year based on incidents reported and reviewed throughout the year
- Provide analysis of whether the changes/actions implemented were effective
- Provide recommendations for future actions based on current trend analysis
- Provide a trend analysis of Internal Events/Notable Events/Minor Events/Agency Reportables
- Provide a trend analysis of Medication Errors if managed through the agency's incident management process or "agency reportable" process

Select Met if both of the following are evident:

- The agency generally submits at least an annual report to the required parties named in the standard; and
- The report contains at a minimum the general identified trends in reportable incidents and notable occurrences for the time period which the report covers; an analysis of the trends identified; and a summary of the types of corrective action(s) which have been developed, taken by the agency, in an effort to avoid circumstances known to have resulted in reportable incidents and notable occurrences.

Select Not Met if any of the following are evident:

- The agency failed to submit at least an annual report to the required parties named in the standard; or
- The report does not contain the general identified trends in reportable incidents and notable occurrences for the time period which the report covers; an analysis of the trends identified; and a summary of the types of corrective action(s) which have been developed, taken by the agency, in an effort to avoid circumstances known to have resulted in reportable incidents and notable occurrences.

Citations**624.7(c) (11)**

(c) An IRC must:

(11) in accordance with agency policy, report periodically, but at least annually, to the chief executive officer, chief agency executives, the governing body, and OPWDD concerning the committee's general monitoring functions; general identified trends in reportable incidents and notable occurrences; and corrective, preventive, remedial and/or disciplinary action pertaining to identified trends;

Section 4: IRC – Incident Review Requirements

Standard #	Standard Text	Decision
1	The IRC meets within one month of a report of a reportable incident or serious notable occurrence or (minimally) on a quarterly basis.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRC Minutes, IRMA review

Interview:

Mandatory: IRC Chairperson, AS Needed: Quality Assurance Staff, Agency Management Staff

Guidance:

Depending on the size of the agency, the number of its facilities, the services provided, and the characteristics of its population, monthly meetings may be excessive. Therefore, the regulations allow an agency to determine how frequently the committee must meet, but this can be no less than quarterly. However, the committee is mandated to meet within one month of the date that a reportable incident or serious notable occurrence is discovered and reported. An IRC must meet as determined by agency policy, but no less frequently than on a quarterly basis and always within one month of the report of a reportable incident or serious notable occurrence or sooner should the circumstances so warrant. The IRC must meet as necessary to meet the timeframes established for submission of a final report to the Justice Center for reportable incidents.

Through review of IRMA information of dates of reported events and classifications and review of meeting minutes, ensure that the committee is meeting initial and subsequent review timeframes and are meeting with the required frequency. There should be minutes that document date, time, participants, and deliberations of meetings. Dates/times should provide evidence that the IRC met with the required frequency.

Select Met if: Per review of IRMA and IRC minutes the committee generally is meeting within one month of a report of a reportable incident or serious notable occurrence or minimally on a quarterly basis.

Select Not Met if: Per review of IRMA and IRC minutes the committee does not consistently meet within one month of a report of a reportable incident or serious notable occurrence or minimally on a quarterly basis.

Select NA if there are no incidents reported.

Citations

624.7(c)(1)

(c) An IRC must:

(1) meet as determined by agency policy, but no less frequently than on a quarterly basis and always within one month of the report of a reportable incident or serious notable occurrence, or sooner should the circumstances so warrant. The IRC shall meet as necessary to meet the timeframes established for submission of a final report to the Justice Center for reportable incidents, if required;

Standard #	Standard Text	Decision
2	The IRC reviews and monitors the minor notable occurrence, serious notable occurrence, or reportable incident.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRC minutes

Interview:

As needed: IRC Chairperson, Quality Assurance Staff, Agency Management staff

Guidance:

- It is the responsibility of the committee to oversee the process for minor notable occurrences. This can be done in the manner deemed most appropriate by the agency. It is acceptable for various members of the committee to be assigned to review minor notable occurrences as a small group (sub-committee of the incident review committee) or even as individuals; there is nothing, however, to preclude the review being done by the entire committee.
- Regardless of the way the review is accomplished, there should be a record of the review, any recommendations made or the actions taken.
- The full committee is to be made aware of the activities/findings of those who handle minor notable occurrences if the review and monitoring is not done by the full committee.
- Statistics should be maintained on all minor notable occurrences, which can then be used to develop trend information.

Select Met if: there is verification that the IRC reviews and monitors the minor notable occurrence, serious notable occurrence or reportable incident.

Select Not Met if Per review of IRC minutes and discussion with the IRC Chair the committee does not consistently review and monitor the minor notable occurrence, serious notable occurrence, or reportable incident.

Select NA if there are no incidents reported.

Citations

624.7(c)(2)

(c) An IRC must:

- (2) review and monitor all minor notable occurrences that are reported, which may be done by a sub-committee of the IRC or by individual assignment to members of the IRC, and maintain a record of such incident/occurrence review, recommendations, and/or actions taken in such a manner as to provide for tracking and trending;

Standard #	Standard Text	Decision
3	The IRC reviews and monitors investigatory procedures for the reportable incident or serious notable occurrences.	Met/Not Met

Guidance

Documentation Review:

Mandatory: IRMA Review, IRC Minutes

Interview:

As Needed: Quality Assurance Staff, IRC Chairperson, IRC Committee Members

Guidance:

- The committee is to critically assess whether or not appropriate investigatory procedures are followed when the investigation is completed by the agency.
- The committee is to make recommendations to the chief executive officer, or designee, when necessary (see paragraph 624.7(c)(6)).
- Members or a member of the committee should not routinely (regularly) conduct or participate in investigations at the agency.
- If a member conducts an investigation, he or she should not be involved in the committee's review and evaluation of the incident and its investigation and is responsible for voluntarily withdrawing from deliberations. That person could, however, participate in making recommendations and other functions of the committee.
- When the investigation is completed by the agency the committee must ensure that the investigator has reviewed all appropriate documentation, interviewed all pertinent witnesses, and thoroughly examined all evidence.
- When the investigation is completed by the agency the committee must make sure the investigation identified contributing factors and the cause(s) of the incident so that they can make appropriate recommendations to address the current incident and to help prevent similar incidents from occurring in the future. If the committee finds that the investigation is inadequate the committee should request that the investigation be re-opened. The incident should remain open until an acceptable investigation is completed.
- It is recommended that committee members receive investigation training.

Select Met if both of the following are evident:

- Per documentation review and discussion with the IRC Chair, IRC members are not routinely conducting investigations; and
- Review of the IRC meeting minutes verify that the Committee is generally reviewing Investigations thoroughly.

Select Not Met if either of the following is evident:

- Review of IRC minutes reveals that the committee is not thoroughly reviewing investigations and is not identifying and/or questioning the thoroughness of the investigator consistently; or
- Per review of records and discussion IRC members are consistently investigating reportable incidents or notable occurrences.

Citations

624.7(c)(4)

(c) An IRC must:

(4) review and monitor investigatory procedures, but shall not perform the routine investigation of reportable incidents or notable occurrences;

Standard #	Standard Text	Decision
4	The IRC makes written recommendations to appropriate staff to improve processes and minimize the prevalence of a reportable incident or notable occurrence.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRC Minutes, IRMA Review

Interview:

As Needed: IRC Chairperson, Quality Assurance Staff, Agency Management

Guidance:

- It is the related responsibility of the agency’s administration and governing body to create an environment whereby committee recommendations are positively received and considered in the interest of minimizing future occurrences of incidents and responded to, by the designated administrator in writing.
- It is the responsibility of the agency’s administration and the governing body to ensure and enforce an agency procedure which provides for a written response to the committee, by staff receiving recommendations.

Select Met if: It is verified that the IRC makes written recommendations to appropriate agency staff to minimize the occurrence of future incidents, for incidents and allegations sampled.

Select Not Met if: It cannot be verified that the IRC makes written recommendations to appropriate agency staff to minimize the occurrence of future incidents, for incidents and allegations sampled.

Select NA if either of the following are concluded:

- There are no incidents reported.
- For incidents sampled, there are no reasonable recommendations to be made.

Citations

624.7(c)(5)

(c) An IRC must:

(5) make written recommendations to appropriate staff to eliminate or minimize similar reportable incidents and/or notable occurrences in the future, and/or to improve investigatory or other procedures;

Standard #	Standard Text	Decision
5	The IRC forwards findings and recommendations to the CEO within two weeks of meeting.	Met/Not Met/NA

Guidance

Documentation Review: IRC Minutes

Interview:

As Needed: IRC Chairperson, CEO, Quality Assurance Staff

Guidance:

- The manner in which such information is forwarded to the chief executive officer, or designee, and other staff is to be determined by the agency but must be documented and available for review. These recommendations could include changes to agency policy or procedures and improvements to conditions contributing to incidents.

Select Met if it is verified that the IRC forwards findings and recommendations consistently to the CEO within two weeks of meeting.

Select Not Met if per documentation review the agency does not consistently forward findings and recommendations to the CEO within two weeks of meeting.

Select NA if there are no incidents reported.

Citations

624.7(c)(7)

(c) An IRC must:

(7) forward findings and recommendations to the chief executive officer within two weeks of meeting;

Standard #	Standard Text	Decision
6	The IRC documents their reviews and recommendations and tracks the conveyance of results and recommendations to appropriate parties within the Agency.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRC minutes

Interview:

As needed: IRC Chairperson, Quality Assurance Staff

Guidance:

- The agency determines how such documentation will be made. Inclusion in the committee minutes would be sufficient to document that such recommendations have been forwarded.
- The confidentiality of those whose names appear in the minutes need to be considered.
- The agency must establish a standardized procedure and written format for the regular transmittal of the standing committee findings and recommendations to the appropriate agency executives. The IRC through its chair must communicate the committee's findings and recommendations to agency management responsible to address, and track the distribution of same.
- Verify the IRC's implementation of its mechanism to ensure recommendations are sent to parties responsible and that responses are provided to the IRC.

Select Met if: Per review of minutes and discussion with the IRC chair the agency consistently tracks the conveyance of findings and recommendations to appropriate agency management.

Select Not Met if it cannot be verified that the IRC conveys and/or tracks the conveyance of findings and recommendations to appropriate agency management.

Select NA if either of the following are concluded:

- There are no incidents reported.
- For incidents sampled, there are no reasonable recommendations to be made.

Citations

624.7(c)(8)

(c) An IRC must:

(8) provide documentation that all reports of reportable incidents and serious notable occurrences have been reviewed by the committee and that results and recommendations have been conveyed to appropriate agency executives and others with a need to know;

Standard #	Standard Text	Decision
7	The IRC monitors implementation of actions taken on recommendations made, including those made by OPWDD or the Justice Center.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRC Minutes, IRMA Review

Interview:

As Needed: IRC Chairperson, Quality Assurance Staff, Agency Management Staff

Guidance:

- The IRC must monitor actions taken as a result of on their own recommendations as well as those made by the investigator. This also includes Corrective Actions plans developed as a result of their investigation of reports of abuse and neglect.
- Note:
 - At State Operated facilities this excludes disciplinary actions
 - At VOs, this includes disciplinary actions

Similarly, to monitoring implementation of agency/internal recommendations, the IRC should be requesting and receiving information regarding actions taken in response to the recommendations made to the agency by OPWDD and the Justice Center, including Corrective Action Plans (CAPs). This requires reviewing/monitoring that the actions were appropriate. Evidence of the monitoring should be documented in the meeting minutes.

- The IRC must request and receive confirmation that actions on the recommendations has occurred. Evidence of the IRC's monitoring should be documented in the meeting minutes.
- NOTE: The IRC must advise the Chief Executive Officer if they perceive any problems with the implementation of recommendations. If there is a lack of action taken, without justification, the chief executive officer, or designee, needs to be made aware of the situation. It is ultimately the responsibility of the chief executive officer and the governing body to ensure that committee recommendations are positively received and considered in the interest of preventing future occurrences of incidents and abuse.

Select Met if: IRC meeting minutes reflect the IRC's consistent monitoring of actions taken on recommendations made, including those made by OPWDD or the Justice Center.

Select Not Met if: IRC meeting minutes do not reflect the IRC's monitoring that action is taken on recommendations made, including those made by OPWDD or the Justice Center.

Select NA if either of the following are concluded:

- There are no incidents reported.
- For incidents sampled, there are no reasonable recommendations to be made.

Citations

624.7(c)(9)

(c) An IRC must:

(9) monitor actions taken on any and all recommendations made and advise the chief executive officer when there is a problem;

624.7(e)(3)

(e) Role of the IRC when investigations are conducted by the Central Office of OPWDD or the Justice Center. Notwithstanding any other provision of this Part, when an investigation of an incident or occurrence is conducted by the Central Office of OPWDD or the Justice Center:

(3) Concerning services operated by OPWDD:

(i) The IRC must monitor all actions taken to implement recommendations made by the Central Office of OPWDD or the Justice Center, except recommendations for disciplinary action.

(ii) The IRC for state-operated services must not review or monitor disciplinary action recommendations made by the Central Office of OPWDD or the Justice Center.

Standard #	Standard Text	Decision
8	Within three weeks of the IRC meeting, the portion of the minutes addressing Reportable Incidents and Serious Notable Occurrences are entered into IRMA.	Met/Not Met

Guidance

Documentation Review:

Mandatory: IRMA, IRC Minutes

Interview:

As Needed: IRC Chairperson, Quality Assurance Staff

Guidance:

Entry of IRC meeting minutes can be verified through IRMA review. Verify in IRMA that minutes are entered within three weeks of the date of the meeting.

Select Met if: Per review of IRMA the IRC meeting minutes addressing Reportable Incidents and Serious Notable Occurrences are routinely entered within three weeks of the date of the meeting.

Select Not Met if: Per review of IRMA the IRC meeting minutes addressing Reportable Incidents and Serious Notable Occurrences are not routinely entered within three weeks of the date of the meeting.

Citations

624.7(g)(1)

- (g) Minutes. The chairperson of an incident review committee must ensure that minutes are kept for all meetings.
 - (1) For reportable incidents and serious notable occurrences, the portion of the minutes that discuss matters concerning the specific event or situation must be entered into IRMA within three weeks of the meeting.

Standard #	Standard Text	Decision
9	IRC minutes include all of the required information regarding Reportable Incidents and Serious Notable Occurrences.	Met/Not Met

Guidance

Documentation Review:

Mandatory: IRC Minutes, IRMA Review

Interview:

As Needed: IRC Chairperson, Quality Assurance Staff, Agency Management staff

Guidance:

- The minutes must clearly state: the filing number of the report, the person's full name, a brief summary of the situation (including date, location and type) that caused the report• committee findings (including reclassification of event, if applicable), and
- recommendations and actions taken on the part of the agency as a result of such recommendations.
- Full names of all parties involved are to be recorded (not initials).
- NOTE: IRC minutes included in the IRMA record for an incident, should be only for that specific incident. (i.e. there should not be information relevant to other incident reviewed at that same IRC meeting.

Select Met if: the minutes routinely contain all of the required information identified above. Select

Select Not Met if: the minutes do not routinely contain all of the required information identified above.

Citations

624.7(g)(2)

(2) Minutes addressing the review of specific reportable incidents and/or serious notable occurrences must clearly state the filing number or identification code of the report (if used), the person's full name and identification number (if used), and provide a brief summary of the situation (including date, location, and type) that caused the report to be generated, committee findings (including reclassification of event, if applicable), and recommendations and actions taken on the part of the agency as a result of such recommendations. Full names of all parties involved must be recorded (not initials).

Section 5: IRC – Part 624 Reporting and Notification Requirements

Standard #	Standard Text	Decision
1	Minor Notable Occurrences are reported to the CEO within 48 hours of occurrence or discovery.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRMA Review, As Needed: Agency notification sheet

Interview:

As Needed: Quality Assurance Staff, Agency Management Staff

Guidance:

- The CEO may designate a designee who must be a senior staff person.
- This notification should be documented to indicate at least date, time, and who was notified.
- If agency uses IRMA for Minor NOs it will be entered in IRMA.

Select Met if: Per review of IRMA Minor Notable Occurrences are routinely reported to the CEO or designee within 48 hours of occurrence or discovery.

Select Not Met if: Per review of IRMA Minor Notable occurrences there are multiple occurrences of late or omitted notification to the CEO or designee within 48 hours of occurrence or discovery, which have been unidentified and/or unaddressed by the agency and/or the IRC.

Select NA if there are no incidents reported.

Citations

624.5(b)(2)(i)

(i) All minor notable occurrences, as defined in section 624.4 of this Part, must be reported to the agency's chief executive officer (or designee) within 48 hours upon occurrence or discovery.

Standard #	Standard Text	Decision
2	Minor Notable Occurrences are either detailed in a written initial incident/occurrence report or entered into IRMA within 48 hours or by close of the next working day, whichever is later.	Met/Not Met/NA

Guidance

Documentation Review:

IRMA Review; As Needed: Initial Incident/occurrence report (147)

Interview:

As Needed: Quality Assurance Staff, Agency Management Staff, IMU Regional Compliance Officer

Guidance:

It is NOT REQUIRED that Minor notable occurrences are entered into IRMA, but agencies may enter information about minor notable occurrences into IRMA in lieu of completing a written initial incident/occurrence report. Therefore: the agency must either:

- (a) complete a written initial incident/occurrence report in the form and format specified by OPWDD; or
- (b) enter initial information into IRMA.

Select Met if: Per review of IRMA or agency filed 147 reports minor notable occurrences are consistently entered into IRMA or detailed in a written 147 report within 48 hours or by close of the next working day, whichever is later.

Select Not Met if per review of IRMA and/or agency filed 147 reports minor notable occurrences are not consistently entered into IRMA or detailed in a written 147 report within 48 hours or by close of the next working day, whichever is later.

Select NA if there are no incidents reported.

Citations

624.5(f)(2)(i)

(ii) Reporting initial information in IRMA.

(i) Minor notable occurrences. Agencies may enter information about minor notable occurrences into IRMA in lieu of completing a written initial incident/occurrence report. Within 48 hours of occurrence or discovery or by close of the next working day, whichever is later, the agency shall either:

- (a) complete a written initial incident/occurrence report in the form and format specified by OPWDD; or
- (b) enter initial information into IRMA.

Standard #	Standard Text	Decision
3	Reportable Incidents and Serious Notable Occurrences are reported to the CEO immediately upon occurrence or discovery.	Met/Not Met

Guidance

Documentation Review:

Mandatory: IRMA Review, As Needed: Agency notification sheet

Interview:

As Needed: Quality Assurance Staff, Agency Management Staff

Guidance:

- The CEO may include a designee who must be a senior staff person.
- Immediately means without delay but within 24 hours.
- Notification should be entered into IRMA and should indicate at least date, time, and who was notified.
- Verify through review of IRMA that notification was completed timely.

Select Met if: Per review of IRMA the CEO or designee was consistently notified of reportable incidents and Serious Notable Occurrences immediately upon occurrence or discovery.

Select Not Met if: Per review of IRMA the CEO or designee was not consistently notified of reportable incidents and Serious Notable Occurrences immediately upon occurrence or discovery.

Citations

624.5(b)(2)(ii)

(ii) All reportable incidents, as defined in section 624.3 of this Part, and serious notable occurrences, as defined in section 624.4 of this Part, must be reported to the agency's chief executive officer (or designee) immediately upon occurrence or discovery.

Standard #	Standard Text	Decision
4	Reporting updates requested by IMU, are entered into IRMA.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRMA Review

Interview:

As Needed: Quality Assurance Staff, Agency Management staff, Regional Compliance Officer (IMU)

Guidance:

Look at Information requested in IRMA by IMU. To locate this information, enter the Master Incident Number in the search box and click go. Click on the blue bubble on the right side of the screen under Action. This is where you will find any requests by IMU to the agency.

Information to be updated into IRMA should occur as follows for all Reportable Incidents and Serious Notable Occurrences:

(m)(2) The Updates should occur through completion of required field in IRMA for the reporting update. The reporting update should include:

- o a brief review of additions to the evidence summary and specific investigatory actions taken since the last update was entered into IRMA, if any;
- o if there have been no additions to the evidence summary or investigatory actions taken since the last report, an explanation of why no progress has been made.
- o This would be where the agency would report that they are awaiting Justice Center's acceptance of the results of the agency's investigation of abuse/neglect.

(m)(3) If the agency is not responsible for conducting the investigation, the agency should complete the required fields to the extent possible given information provided to the agency.

(m)(4) If the agency is responsible for conducting the investigation and it has not been completed within 30 days, the agency must inform OPWDD of the reason for extending the timeframe of the investigation and should continue to keep OPWDD informed on at least a monthly basis of the progress of the investigation and other actions taken. (Effective July 29, 2013)

(m)(5) If closure of an incident is exclusively pending written notice from the Justice Center (Letter of Determination), monthly updates are not required if the agency enters an initial update to note that closure is pending written notice for the Justice Center and an update on the fifth working day after the agency receives the written notice.;

Updates may need to occur more frequently if requested by OPWDD. This is information that IMU RCO would provide if applicable.

Select Met if: Per review of IRMA and discussion with the RCO reporting updates are consistently entered into IRMA when requested by IMU.

Select Not Met if: Per review of IRMA and discussion with the RCO reporting updates are not consistently entered into IRMA when requested by IMU.

Select NA if there are no incidents reported that require IRMA entry.

Citations

624.5(M) (1-5)

(m) Reporting updates.

- (1) For reportable incidents and serious notable occurrences, an agency must enter reporting updates into IRMA on at least a monthly basis, or more frequently as requested by OPWDD, until closure of the incident or occurrence, except as noted in paragraph (5) of this subdivision.
- (2) The agency must complete required fields in IRMA for the reporting update. Among other required information, the reporting update must include:
 - (i) a brief review of additions to the summary of evidence and specific investigatory actions taken since the last update was entered into IRMA, if any; and
 - (ii) if there have been no additions to the summary of evidence or investigatory actions taken since the last report, an explanation of why no progress has been made.
- (3) If the agency is not responsible for conducting the investigation, the agency must complete the required fields to the extent possible given information provided to the agency.
- (4) If the agency is responsible for conducting the investigation and if the investigation has not been completed within the timeframe specified in subdivision (n) of this section, the agency must inform OPWDD of the reason for extending the timeframe of the investigation and continue to keep OPWDD informed on at least a monthly basis of the progress of the investigation and other actions taken.
- (5) For reportable incidents of abuse and neglect in facilities and programs that are certified or operated by OPWDD, an agency may enter reporting updates into IRMA less frequently than on a monthly basis, if closure of the incident is exclusively pending receipt of written notice from the Justice Center in accordance with subdivision (o) of this section, and:
 - (i) an initial update is entered into IRMA to document that closure of the incident is pending receipt of such written notice from the Justice Center;
 - (ii) an update is entered into IRMA by the close of the fifth working day after the agency receives the written notice; and
 - (iii) no additional updates are requested by OPWDD.

Standard #	Standard Text	Decision
5	For an individual residing in a facility certified or operated by OPWDD, MHLS is notified within three working days of all reportable incidents of abuse or neglect.	Met/Not Met

Guidance

Documentation Review:

Mandatory: IRMA Review

Interview:

As Needed: Quality Assurance Staff, Agency Management staff, Regional Compliance Officer (IMU)

Guidance:

- This is applicable for an allegation of abuse or neglect involving a person who resides in a facility certified or operated by OPWDD.
- Responsibility for submittal of the initial report to MHLS falls to the agency under whose auspices the event occurred and/or that is responsible for the person.
- This notification to MHLS should be evidenced in IRMA documentation

Select Met if: Per IRMA review for an individual residing in a facility certified or operated by OPWDD, MHLS is routinely notified within three working days of all reportable incidents of abuse or neglect.

Select Not Met if: Per IRMA review for an individual residing in a facility certified or operated by OPWDD, MHLS is not routinely notified within three working days of all reportable incidents of abuse or neglect.

Citations

624.6(a)

(a) For a report of abuse or neglect involving a person who resides in a facility certified or operated by OPWDD, the agency under whose auspices the event occurred and/or that is responsible for the person must send the written initial incident/occurrence report to the Mental Hygiene Legal Service (MHLS; see glossary, section 624.20) within three working days of occurrence or discovery. The responsible agency or program must also inform MHLS of the results of the investigation.

Standard #	Standard Text	Decision
6	For an individual in a State Operated or Sponsored site, the Board of Visitors is notified within three working days of all reportable incidents of abuse or neglect.	Met/Not Met

Guidance

Documentation Review: IRMA Review

Interview: Quality Assurance Staff, Agency Management staff, Regional Compliance Officer (IMU)

Guidance:

- The DDSOO must send a written initial incident report (form 147) to the appropriate board of visitors within three working days of occurrence or discovery.
- Applicable for a report of abuse or neglect that occurs when a person receiving services is under the auspices of:
 - o a residential facility operated by OPWDD
 - o a certified day program operated by OPWDD
 - o a family care home sponsored by OPWDD
- Verify through review of IRMA information and agency used notification sheet.

Note: DDSOO must also inform the board of visitors of the results of the investigation.

Select Met if: Per review of IRMA the Board of Visitors is routinely notified within three working days of all reportable incidents of abuse or neglect.

Select Not Met if: Per review of IRMA the Board of Visitors is not routinely notified within three working days of all reportable incidents of abuse or neglect.

Citations

- 624.6(b)**
- (b) For reports of abuse or neglect that occur when a person receiving services is under the auspices of a residential facility operated by OPWDD, a family care home sponsored by OPWDD, or a certified day program operated by OPWDD, OPWDD must send the written initial incident report to the appropriate board of visitors within three working days of occurrence or discovery. OPWDD must also inform the board of visitors of the results of the investigation.

Standard #	Standard Text	Decision
7	Telephone notification of required information is made to appropriate involved parties for the reportable incident and notable occurrence.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRMA review

As Needed: Agency Notification sheet for minor notable occurrences

Interview:

As Needed: Quality Assurance Staff, Agency Management staff, MSC, Family Members, Regional Compliance Officer (IMU)

Guidance:

- The agency must provide telephone notice to one of the following: a person’s guardian, a parent, spouse or adult child.
- If the person does not have a guardian, parent, spouse or adult child, or if those parties are not reasonably available, or if there is written advice that such parties do not want to be notified; the agency must provide notice to the person receiving services, if the person is a capable adult; and the person's advocate or correspondent (if one exists).
- The telephone notice should be provided as soon as reasonably possible, but no later than 24 hours after completion of the written initial incident/occurrence report (for minor notable occurrences) or entry of initial information in IRMA by the agency.
- However, the agency should not provide such notice to a party in the following situations:
 - o there is written advice from the guardian, parent, spouse or adult child that he or she objects to such notification to himself or herself (notice should then be provided to another party who is a guardian, parent, spouse or adult child, if one exists); or
 - o if the person receiving services is a capable adult who objects to such notification being made. If the capable adult objects to notification of all parties who are a guardian, parent, spouse or adult child, the capable adult should be provided the notice described in this subdivision; or
 - o if the guardian, parent, spouse or adult child is the alleged abuser.
- Most agencies have a "script" which they use to document that this telephone notification has occurred, the information conveyed, and response/request by the parties notified.

Select Met if: Per IRMA review telephone notification is made to appropriate parties for the reportable incident and notable occurrence.

Select Not Met if: Per IRMA review telephone notification is not made to appropriate parties for the reportable incident and notable occurrence.

Select NA if: there are no incidents reported.

Citations

624.6(f) (1-4 & 6)

(f) For all reportable incidents and notable occurrences:

(1) The agency must provide telephone notice to one of the following: a person's guardian, parent, spouse, or adult child.

(2) However, the agency must not provide such notice to a party in the following situations:

(i) if the guardian, parent, spouse, or adult child is the alleged abuser;

(ii) if there is written advice from the guardian, parent, spouse, or adult child that he or she objects to receiving such notification. The notice must then be provided to another party who is a guardian, parent, spouse or adult child, if one exists; or

(iii) if the person receiving services is a capable adult who objects to such notification being made. If the capable adult objects to notification of all parties (guardian, parent, spouse or adult child), the capable adult must be provided the notice described in this subdivision.

(4) The telephone notice must include:

(i) a description of the event or situation and a description of initial actions taken to address the incident or occurrence, if any;

(ii) an offer to meet with the chief executive officer (or designee) to further discuss the incident or occurrence; and

(iii) for reports of abuse and neglect, an offer to provide information on the status and/or finding of the report. Requested information shall be provided verbally or in writing, unless the person is a capable adult and objects to the provision of this information. In providing such information, the agency must protect the privacy rights of other parties.

(6) If the person does not have a guardian, parent, spouse or adult child, or if such parties are not reasonably available, or if there is written advice that such parties do not want to be notified; the agency must provide notice to the following parties in the manner (and subject to the same limitations) specified in this subdivision:

(i) the person receiving services, if the person is a capable adult; and

(ii) the person's advocate or correspondent (if one exists).

Standard #	Standard Text	Decision
8	The Agency provides a written report (OPWDD 148) to any party who received the telephone notification on initial actions taken to address the incident/notable occurrence, within 10 days of completion of the incident report (MNO) or entry into IRMA.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRMA Review, As Needed: Agency Notification Sheet

Interview:

As Needed: Quality Assurance Staff, Agency Management staff, MSC, Family Members

Guidance:

The report on initial actions taken must be documented on the OPWDD 148 – Report on Actions Taken and should include:

- any immediate steps taken in response to the incident or occurrence to safeguard the health or safety of the person receiving services
- A general description of any initial medical or dental treatment or counseling provided to the person in response to the incident or occurrence
- The report must be provided within 10 days of initial entry into IRMA or for minor notable occurrences, completion of the 147.

In providing such information, the agency must protect the privacy rights of other parties.

Select Met if: Per review of IRMA there is verification that the agency provided a written report (OPWDD 148) to any party who received the telephone notification on initial actions taken to address the incident/notable occurrence, within 10 days.

Select Not Met if: Per review of IRMA you are unable to verify that the agency provided a written report to any party who received telephone notification on initial actions taken to address the incident/notable occurrence, within 10 days.

Select NA if: There are no incidents reported.

Citations

624.6(f)(7)(iii)

(iii) The copy of the initial incident/occurrence report must be provided to an eligible requestor as soon as reasonable, but in no event, more than 10 days after the request is made.

Standard #	Standard Text	Decision
9	The Agency provides the written incident/occurrence report (OPWDD 147) to eligible requestor(s) within 10 days of the request.	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRMA Review, As Needed: Agency Notification Sheet

Interview:

As Needed: Quality Assurance Staff, Agency Management staff

Guidance:

Review agency tracking logging of all requests made for the form 147 for incidents and occurrences reported, and evidence that the report was provided to requestors and when. Tracking should identify date the request was received and date provided and or sent to the requestor

The copy of the written initial incident/occurrence report (147) must be provided to an eligible requestor as soon as reasonable, but in no event more than 10 days after the request is made.

The agency should be able to provide documentation that demonstrates whether the request was made and when/how the report was provided to the requestor.

In providing such information, the agency must protect the privacy rights of other parties.

Select Met if: Per review of IRMA there is verification that the agency provided the written incident/occurrence report (OPWDD 147) to eligible requestors within 10 days.

Select Not Met if: Per review of IRMA the agency cannot show that the agency provided the written incident/occurrence report (OPWDD 147) to eligible requestors within 10 days.

Select NA if:

- There are no incidents reported
- There have been no known requests for the report

Citations

624.6 (f)(8)(i)-(iii)

(i) The agency must provide a report on initial actions taken to address the incident or notable occurrence. Such report must include:

- any immediate steps taken in response to the incident or occurrence to safeguard the health or safety of the person receiving services; and
- a general description of any initial medical or dental treatment or counseling provided to the person in response to the incident or occurrence.

(ii) The agency must provide the report on actions taken to any party specified in paragraph (1) or (6) of this subdivision who received the notification.

- The report must be provided within 10 days of the completion of the initial incident/occurrence report (for minor notable occurrences) or entry of initial information in IRMA by the agency.

Standard #	Standard Text	Decision
10	The Agency releases records and documents pertaining to reportable incidents to eligible requestors in accordance with 624.8 (Jonathan's Law requirements).	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRMA Review, Agency Policy and Procedure, Jonathan's Law documents, Agency tracking of Jonathan's Law requests, decisions made, responses and distributions of materials

Interview:

Mandatory: Incident Management and/or Quality Assurance Staff

Guidance:

- Ask the agency for information about any/all Jonathan's Law requests for information, rather than focusing only on the sampled incidents. Request that the agency provide details of all requests for release of records since DQI's last review, and for the documented evidence of their decision making and provision of materials.
- Agencies Release of Records and documents:
 - Agencies are required to release all records and documents pertaining to allegations and investigations into abuse which occurred under the auspices of the agency that occurred prior to June 30, 2013.
 - Agencies are required to release records and documents pertaining to allegations of abuse which occurred or were discovered on or after May 5, 2007, regardless of the date of the submission of the written request.
 - Agencies are required to release all records and documents pertaining to reportable incidents to eligible requestors who make a request. Eligible requestors must submit a written request to staff designated by agency policy/procedures. ----- If the request is made prior to the closure of the incident, the parties specified by the agency policy/procedures must provide the requested records no later than 21 days after the closure of the incident.
 - If the request is made subsequent to the closure of the incident, the agency must provide the requested records no later than 21 days after the request is made.
- Prior to the release of records, agencies must redact the names of employees who are involved in the incident or the investigation or who are interviewed as a part of the investigation, persons receiving services, and any information tending to identify such employees or persons.
- The written request for the release of records must be maintained and the time the request was received must be documented. A copy of the redacted records that were released must be maintained and the time the records were provided must be documented.
- Persons receiving services or who formerly received services, and guardians, parents, spouses, and adult children of such persons are eligible to request the release of records.

Select Met if both of the following are evident:

- The agency has a policy and procedure concerning the process for requesting the release of records; and
- The agency maintains documentation to verify all requests that met the requirements were released within the timeframe listed above.

Select Not Met if either of the following are evident:

- The agency does not have a policy and procedure concerning the process for requesting the release of records; or
- The agency does not have documentation to verify that all requests that met the requirements were released within the required timeframe outlined above.

Select NA if:

- There are no incidents reported
- There have been no known requests for the information required by Jonathan's Law

Citations**624.8(a)**

Policies and procedures. Agencies must have policies and procedures concerning the process for requesting the release of records, including but not limited to identifying appropriate staff who are authorized to receive requests and those who are authorized to release records.

624.8(c)

Records subject to release concerning reports of abuse that occurred prior to June 30, 2013.

(1) Agencies are required to release all records and documents pertaining to allegations and investigations into abuse as defined in applicable OPWDD regulations in effect at the time the allegation occurred under the auspices of the agency or sponsoring agency to eligible requestors who make a request in accordance with the provisions of this section.

(2) Agencies are required to release records and documents pertaining to allegations of abuse which occurred or were discovered on or after May 5, 2007, regardless of the date of the submission of the written request.

624.8(d)

Records subject to release concerning reportable incidents that occurred on or after June 30, 2013. Agencies are required to release all records and documents pertaining to reportable incidents to eligible requestors who make a request in accordance with the provisions of this section.

Standard #	Standard Text	Decision
11	Deaths are reported to the Justice Center as required.	Met/Not Met

Guidance

Documentation Review: IRMA Review, Report of Death Form

Interview: As Needed: Quality Assurance Staff, Agency Management Staff

Guidance:

- Applies to: State Operated – All Sites and Services: Voluntary Operated - All Certified Sites
- The agency must immediately report the death of any individual who received applicable services upon discovery (witnessing or learning). For purposes of this requirement, notification must occur no later than 24 hours after discovery.
- The notification should occur via telephone using the Justice Center Death Reporting Line (Note: The Justice Center Death Reporting Line is separate from the VPCR.)
- This is applicable to any individual receiving services at the time of death or within 30 days preceding her/his death.
- This reporting must occur regardless of whether the death did or did not occur under the auspices of an agency.
- Notification should be entered into IRMA and should indicate at least date, time, and who was notified.
- Surveyor should verify through review of IRMA information.
- Note: A death is to be reported as a serious notable occurrence.

Select Met if: Based on IRMA review deaths are consistently reported to the Justice Center no later than 24 hours after discovery.

Select Not Met if: Based on IRMA review deaths are not consistently reported to the Justice Center within 24 hours of discovery.

Citations

624.5(e)(1)

(1) In accordance with New York State Law and guidance issued by the Justice Center, the death of any individual who had received services operated or certified by OPWDD, within thirty days preceding his or her death, must be reported to the Justice Center. Specifics of the reporting requirement are as follows:

- (i) The initial report must be submitted by the agency's chief executive officer or designee to the Justice Center death reporting line, in a manner specified by the Justice Center.
- (ii) The death must be reported immediately upon discovery and in no case more than twenty-four hours after discovery.
- (iii) Subsequent information must be submitted to the Justice Center, by submission of the Report of Death in IRMA within five working days of discovery of the death.
 - The results of an autopsy, if performed and if available to the agency, must be submitted to the Justice Center and OPWDD, in a manner specified by the Justice Center, within sixty working days of discovery of the death. (The Justice Center may extend the timeframe for good cause.)

Standard #	Standard Text	Decision
12	Deaths are reported to OPWDD.	Met/Not Met

Guidance

Documentation Review: IRMA Review

Interview:

As Needed: Quality Assurance Staff, Agency Management Staff

Guidance:

- All deaths that are reported to the Justice Center must also be reported to OPWDD.
- A death that occurred under the auspices of an agency must be reported as a serious notable occurrence
- A death that did not occur under the auspices of an agency (e.g., the death of a person who received certified day habilitation services, but died at his or her private home of causes not associated with the day services) must be reported in accordance with Part 625.
- Both Voluntary Providers and State Operations Offices must notify OPWDD immediately through the Incident Management Unit (IMU) of Reportable Incidents and Serious Notable Occurrences. Immediate IRMA entry and/or reporting to the Justice Center (VPCR) by the agency does not qualify as notification to OPWDD.
- Notification should be entered into IRMA and should indicate at least date, time, and who was notified.
- Surveyor should verify through review of IRMA.

Select Met if: per review of IRMA, deaths are consistently reported to OPWDD.

Select Not Met if per review of IRMA, deaths are not consistently reported to OPWDD.

Citations

624.5(e)(2)

(2) All deaths that are reported to the Justice Center must also be reported to OPWDD.

- (i) A death that occurred under the auspices of an agency (see paragraph (4) of this subdivision) must be reported as a serious notable occurrence in accordance with this Part (see also paragraph (3) of this subdivision).
- (ii) A death that did not occur under the auspices of an agency (e.g., the death of a person who received certified day habilitation services, but died at his or her private home of causes not associated with the day services) must be reported in accordance with Part 625 of this Title.

Standard #	Standard Text	Decision
13	The Coroner/Medical Examiner is notified if the death was a suicide, homicide, accidental death, or death due to suspicious, unusual, or unnatural circumstances. In NYC, the NYC police are also notified.	Met/Not Met/NA

Guidance

Documentation Review: IRMA, As Needed: Report of Death-IRMA

Interview: As Needed: Quality Assurance Staff, Agency Management Staff

Guidance:

- All suicides, homicides, accidental deaths due to suspicious, unusual, or unnatural circumstances must be reported immediately by telephone, and later in writing, to the coroner/ medical examiner. In New York City, the police must also be notified.
- Verify that this has been done, if needed, through review of IRMA.

Select Met if: per IRMA review all deaths outlined above were consistently reported to the Coroner/Medical Examiner and the police if in NYC.

Select Not Met if: Per IRMA review all deaths outlined above were not consistently reported to the Coroner/Medical Examiner and the police, if in NYC.

Select NA if the deaths reported and sampled did not meet the standard for notification to these parties.

Citations

- 624.6(c)**
 (c) All suicides, homicides, accidental deaths, or deaths due to suspicious, unusual, or unnatural circumstances must be reported immediately by telephone, and later in writing, to the coroner/ medical examiner. In New York City, the police must also be notified.

Section 6: IRC – Part 625 Requirements

Standard #	Standard Text	Decision
1	All events and situations as defined in Part 625 are reported to OPWDD through IRMA entry.	Met/Not Met

Guidance

Documentation Review: Mandatory: IRMA Review

Interview: As Needed: Agency incident management coordinator

Guidance:

During review of the sample of agency minor events/non-reportable, determine if any events meet the requirement for reporting per 625. Events and situations to be reported include those that meet the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation. Follow up on any information provided to determine if it should have been reported. Applicable events should be entered into IRMA.

Select Met if: Per documentation review all events and situations defined in Part 625 are routinely reported to OPWDD through IRMA entry.

Select Not Met if: Per review of documentation multiple events and situations as defined in Part 625 were not consistently reported to OPWDD through IRMA entry, and the issue has been unaddressed by the agency.

Citations

625.4(a)(1)

(1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA).

625.5 (c)(2)

(2) The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.

Standard #	Standard Text	Decision
2	The Agency takes action to protect the individual when the event or situation meets Part 625 reporting definitions (non-death).	Met/Not Met/NA

Guidance

Documentation Review:

Mandatory: IRMA Review.

Interview:

Agency Incident Management and/or Program Management Staff as needed.

Guidance:

The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following. The agency is expected to act diligently in the best interest of protecting the person. Agency actions as stated in the requirement below must be entered into IRMA.

- (1) notifying an appropriate party that may be in a position to address the event or situation (e.g. Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline);
- (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties;
- (3) interviewing the involved individual and/or witnesses;
- (4) assessing and monitoring the individual;
- (5) reviewing records and other relevant documentation; and
- (6) educating the individual about his or her choices and options regarding the matter.

Please Note:

Per 625.3(d) The agency must notify Adult Protective Services (APS) of any of the described events that involve an adult receiving services who: only receives FSS, ISS or Article 16 services; is not available the agency staff, or is in need of protective services the agency cannot provide.

Per 625.3(e) Statewide Central register of Child Abuse and Maltreatment must be contacted by mandated reporters for incidents of child abuse or maltreatment.

Select Met if there is documentation that demonstrates that the agency consistently takes action as needed to protect individuals impacted by Part 625 events.

Select Not Met if any of the following are evident:

- The agency does not take needed action to protect individuals impacted by the 625 events.
- There is no documentation to demonstrate that the agency consistently takes action as needed to protect individuals impacted by the Part 625 event.

Select NA if: There were no reasonable actions to take regarding the events/situations reported.

Citations

625.3(b)(1)- (6)

(b) The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:

- (1) notifying an appropriate party that may be in a position to address the event or situation (e.g. Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline);
- (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties;
- (3) interviewing the involved individual and/or witnesses;
- (4) assessing and monitoring the individual;
- (5) reviewing records and other relevant documentation; and
- (6) educating the individual about his or her choices and options regarding the matter.

Standard #	Standard Text	Decision
3	Subsequent information is provided to OPWDD via IRMA entry.	Met/Not Met/NA

Guidance

Documentation Review: Mandatory: IRMA

Interview: As Needed: Quality Assurance Staff, Agency Management staff

Guidance:

- Subsequent information should be provided as known within 24 hours or within close of the next working day. This information should include initial actions taken by the agency to protect the individual.
- Updates should be entered into IRMA on a monthly basis until the event/situation is resolved and/or as requested by IMU

Select Met if: Per review of IRMA the agency is entering subsequent information and reporting updates at least monthly or as requested, until the event or situation is resolved.

Select Not Met if: Per review of IRMA the agency is not entering subsequent information and reporting updates at least monthly or as requested until the event is resolved.

Select NA if information entered into IRMA initially, appears to include all needed information.

Citations

625.4(a) (2-3)

(2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual.

(3) The agency must report updates on the event or situation in IRMA on a monthly basis or more frequently upon the request of OPWDD until the event or situation is resolved. Such updates must include information about subsequent interventions (see subdivision 625.3(b)) and include information about the resolution of the event or situation.

Standard #	Standard Text	Decision
4	Information regarding the death is submitted to the Justice Center as required.	Met/Not Met

Guidance

Documentation Review: Mandatory: IRMA review; As Needed: Death Report

Interview: As Needed: Quality Assurance Staff, Agency Management staff

Guidance:

- The mechanism for this is the Report of Death in IRMA
- Information known timely re: the death must be provided within five working days of discovery of the death.
- The results of an autopsy, if performed and if available to the provider agency, should be submitted to the Justice Center within 60 working days of discovery of the death. (The Justice Center may extend the timeframe for good cause.)

Select Met if: There is verification that reasonably known information regarding deaths are consistently submitted to the Justice Center as required.

Select Not Met if: it cannot be verified that reasonably known information regarding deaths is being submitted consistently to the Justice Center as required.

Citations

625.5(a) (3-4)

- (3) Subsequent information must be submitted to the Justice Center, by submission of the Report of Death in IRMA within five working days of discovery of the death.
- (4) The results of an autopsy, if performed and if available to the provider agency, must be submitted to the Justice Center within sixty working days of discovery of the death. (The Justice Center may extend the timeframe for good cause.)

Section 7: IMU Measures

Standard #	Standard Text	Decision
1	The Reportable Incident or Serious Notable Occurrence is reported immediately to OPWDD.	Met/Not Met

Guidance

THIS STANDARD WILL BE ROUTINELY BE COMPLETED THROUGH COMMUNICATION WITHIN DQI AND COMPLIANCE DECISION BASED ON IRMA DATA.

Select Met if: IMU reports indicate that the agency met compliance threshold for reporting to OPWDD.

Select Not Met if: IMU report indicate that the agency has not met compliance threshold for reporting to OPWDD.

FOR BPC Only if: Directed to review independently of IMU reporting: Both Voluntary Providers and State Operations Offices must notify OPWDD immediately through the Incident Management Unit (IMU) of Reportable Incidents and Serious Notable Occurrences. Immediate IRMA entry and/or reporting to the Justice Center (VPCR) by the agency does not qualify as notification to OPWDD.

- Notification should be entered into IRMA and should indicate at least date, time, and who was notified. The agency will likely also use a document to capture notifications prior to IRMA entry.
- Surveyor should verify through review of IRMA information.

Appropriate notifications to IMU can be made in the following ways:

ON HOURS:

Reportable Incidents and other incidents which are egregious or are sensitive in nature must be reported to OPWDD/IMU via telephone or email to the local incident compliance office/regional compliance officer.

OFF HOURS:

(i) Telephone Notification

Reportable Incidents and other incidents which are egregious or are sensitive in nature must be reported to OPWDD/IMU via telephone during off hours.

(ii) Email Notification

Notifications of incidents which do not rise to the level of a Reportable Incident but for which immediate notification to OPWDD is required or for which technical assistance is not needed may be made by sending the following information to OPWDD.Incident.Notifications@opwdd.ny.gov

Select Met if: Review of IRMA verifies that OPWDD is notified immediately of Reportable Incidents or Serious Notable Occurrences.

Select Not Met if: Per review of IRMA the agency does not consistently ensure Reportable Incidents or Serious Notable Occurrences are reported immediately to OPWDD.

Citations

624.5(c) (1-3)

(c) Immediate reporting to OPWDD.

- (1) All reportable incidents and serious notable occurrences must be reported immediately to OPWDD in the manner specified by OPWDD.
- (2) Immediate entry of initial information into the OPWDD Incident Report and Management Application (IRMA) does not satisfy the reporting requirement in paragraph (1) of this subdivision.
- (3) Immediate reporting of reportable incidents to the VPCR (where applicable) does not satisfy the requirement to immediately notify OPWDD of these incidents in accordance with paragraph (1) of this subdivision.

Standard #	Standard Text	Decision
2	Law Enforcement was notified as required.	Met/Not Met/NA

Guidance

THIS STANDARD WILL BE ROUTINELY BE COMPLETED THROUGH COMMUNICATION WITHIN DQI AND COMPLIANCE DECISION BASED ON IRMA DATA.

Select Met if: IMU reports indicate that the agency met compliance threshold for reporting to OPWDD.

Select Not Met if: IMU report indicate that the agency has not met compliance threshold for reporting to OPWDD.

Select NA if there were no incidents or occurrences that required notification to law enforcement.

FOR BPC Only if directed to review independently of IMU reporting:

Documentation Review: Mandatory: IRMA Review.

Interview: As needed: Quality Assurance Staff, Agency Management.

Guidance:

- An appropriate law enforcement official must be contacted immediately in the event that an emergency response by law enforcement is needed.
- Agencies shall report to an appropriate law enforcement official anytime a crime may have been committed against an individual by a custodian. This is in addition to reporting to the Justice Center when the event or situation is a reportable incident (if the services are certified or operated by OPWDD).
- The report to the appropriate law enforcement official shall be made as soon as practicable, but in no event later than 24 hours after occurrence or discovery.
- Information about the report to the appropriate law enforcement official shall be entered into IRMA within 24 hours of the report being made. Surveyor should verify through review of IRMA information.
- OPWDD requires providers of services to notify local law enforcement of all reports of physical and sexual abuse (OPWDD Memorandum-Incident Management Updates, January 12, 2015) and all abuse/neglect related to death. Local law enforcement must also be notified of all other possible crimes against an individual by a custodian.

Select Met if: Through review of IRMA there is evidence that Law Enforcement was notified timely as required.

Select Not Met if: Through review of IRMA the agency does not consistently notify Law Enforcement or the notification is consistently late.

Select NA if there were no incidents or occurrences that required notification to law enforcement.

Citations

624.6(d) (1-2)

(d) Reporting to law enforcement.

(1) An appropriate law enforcement official must be contacted immediately in the event that an emergency response by law enforcement is needed.

(2) Agencies must report to an appropriate law enforcement official anytime a crime may have been committed against an individual by a custodian. This is in addition to reporting to the Justice Center when the event or situation is a reportable incident (if the services are certified or operated by OPWDD).

Standard #	Standard Text	Decision
3	The Incident or occurrence is closed in IRMA within acceptable time frames.	Met/Not Met

Guidance

THIS STANDARD WILL BE ROUTINELY BE COMPLETED THROUGH COMMUNICATION WITHIN DQI AND COMPLIANCE DECISION BASED ON IRMA DATA.

Select Met if: IMU reports indicate that the agency met compliance threshold for reporting to OPWDD.

Select Not Met if: IMU report indicate that the agency has not met compliance threshold for reporting to OPWDD.

FOR BPC Only if directed to review independently of IMU reporting:

Documentation Review: Mandatory: IRMA, IRC minutes

Interview: As Needed: IRC Chairperson, Quality Assurance staff

Guidance:

- For all incidents of reportable abuse and neglect under the jurisdiction of the Justice Center, regardless of the delegation of the investigation, the Justice Center’s findings in the Letter of Determination are considered the final findings. If the Justice Center amends the agency’s findings the agency must update information in IRMA to reflect the final findings by the Justice Center. § Surveyor should verify through review of IRMA information and determine if based on information available the incident should be closed.

§ An incident or occurrence is considered closed:

- o For incidents and occurrences that are not subject to Justice Center (VPCR) oversight (i.e. notable occurrences or incidents/occurrences in programs that are not certified or operated by OPWDD)

§ If the agency conducts the investigation, when the IRC has ascertained that no further investigation is necessary; or

§ if the investigation is conducted by the Central Office of OPWDD, when the Central Office of OPWDD notifies the agency of the results of the investigation; or

- o For incidents that are subject to Justice Center (VPCR) oversight (i.e. reportable incidents in programs certified or operated by OPWDD):

§ If the agency conducts the investigation, when the Justice Center provides written notice to the agency of the JC’s review of the investigation

§ if the Central Office of OPWDD conducts the investigation, when the Justice Center provides the agency written notice of JC’s review of the investigation; or

§ if the Justice Center conducts the investigation, when the Justice Center provides written notice to the agency that the investigation is completed.

Select Met if: The Incident or occurrence is closed in IRMA within acceptable time frames identified above.

Select Not Met if: The Incident or occurrence is not closed in IRMA within acceptable time frames identified above.

Citations

624.5(o) (1-2)

(o) Closure of an incident or occurrence. An incident or occurrence is considered closed:

(1) for reportable incidents of abuse and neglect in programs that are not certified or operated by OPWDD, or are certified under paragraph 16.03(a)(4) of the Mental Hygiene Law and not operated by OPWDD, and for reportable significant incidents and notable occurrences in all facilities and programs certified, operated, or funded by OPWDD:

(i) if the agency conducts the investigation, when the IRC has ascertained that no further investigation is necessary; or

(ii) if the investigation is conducted by the Central Office of OPWDD, when the Central Office of OPWDD notifies the agency of the results of the investigation; or

(2) for reportable incidents of abuse and neglect in facilities and programs that are certified or operated by OPWDD:

(i) if the agency conducts the investigation, when the Justice Center provides written notice to the agency of the Justice Center's review of the investigation; or

(ii) if the Central Office of OPWDD conducts the investigation, when the Justice Center provides written notice to the agency of the Justice Center's review of the investigation; or (iii) if the Justice Center conducts the investigation, when the Justice Center provides written notice to the agency that the investigation is completed.

Standard #	Standard Text	Decision
4	The agency completed timely submission of an acceptable Reportable Abuse/Neglect investigation record via the WSIR.	Met/Not Met

Guidance

THIS STANDARD WILL BE ROUTINELY BE COMPLETED THROUGH COMMUNICATION WITHIN DQI AND COMPLIANCE DECISION BASED ON IRMA DATA.

Select Met if: IMU reports indicate that the agency met compliance threshold for reporting to OPWDD.

Select Not Met if: IMU report indicate that the agency has not met compliance threshold for reporting to OPWDD.

FOR BPC Only if directed to review independently of IMU reporting:

Documentation Review: Mandatory: IRMA Review.

Interview: As needed: IRC Chairperson, Quality Assurance Staff

§ Final reports for reportable incidents of abuse/neglect must be submitted within 50 days of the Justice Center (VPCR) accepting a report of abuse or neglect. Final reports include the full investigative record.

§ Surveyor will review agency mechanism to ensure that these submissions are occurring within time frames and review their documentation and IRMA information to verify timeframes.

§ For allegations of abuse/neglect occurring after January 01, 2015, the final report/investigative record must be uploaded by the provider agency. If the document/information is viewable in the IRMA folder, it has been provided to the Justice Center via the WSIR.

Select Met if: Per review of IRMA there is evidence that final reports are uploaded via the WSIR within 50 days of the Justice Center accepting a report of abuse or neglect.

Select Not Met if: Per review of IRMA there is evidence that final reports are not uploaded via the WSIR consistently within 50 days of the Justice Center accepting a report of abuse or neglect.

Citations

624.5(p)(1)- (4)

(p) Submission of investigative records. If an agency conducts the investigation of a report of abuse or neglect or the death of an individual that occurred under the auspices of an agency, the agency must submit the entirety of the investigative record to the Justice Center and/or OPWDD, within 50 days of the VPCR and/or OPWDD accepting such report, as follows:

(1) For reports of abuse or neglect that were reported to the Justice Center, the agency must enter the entirety of the investigative record in the Justice Center's Web Submission of Investigation Report (WSIR) application; or

(2) Effective January 1, 2016, for reports of abuse and neglect that are not required to be reported to the Justice Center and for the death of any individual that occurs under the auspices of an agency, the agency must enter/upload the entirety of the investigative record in IRMA.

(3) Notwithstanding the timeframe specified in this subdivision, the agency may take additional time to submit the investigative record provided, however, that the reasons for any delay must be for good cause and must be documented. The record must be submitted as soon thereafter as practicably possible.

(4) Notwithstanding the requirements in paragraphs (1) – (3) of this subdivision, in the event that the Justice Center or OPWDD conducts the investigation instead of the agency, the agency is not required to submit the investigative record to the Justice Center and/or OPWDD. In the event that OPWDD conducts the investigation, OPWDD will submit the investigative record to the Justice Center. However, agencies must provide information as requested by the Justice Center and/or OPWDD that may be deemed necessary to complete the record.

Topic 11: Facilitating Connections

Section 1: Natural Supports and Relationships

Standard #	Standard Text	Decision
1	The agency implements specific strategies to facilitate the creation, development, and continuation of natural support networks for individuals.	Met/Not Met

Guidance

Quality Indicator

Documentation Review:

Written policy/procedure, strategies, management planning, etc. the agency may offer to demonstrate the strategies. If the agency has and has implemented organizational strategies to facilitate natural supports, ask them to provide the evidence.

Interview:

Agency staff/management knowledgeable of and/or coordinating the efforts.

Guidance:

- This quality indicator reviews whether that agency has developed and implemented specific organizational mechanisms aimed to actively facilitate natural supports for individuals receiving services.
- Natural Supports are people with whom the individual builds a relationship that are based on mutual interests and compatibility as part of community living. Typical examples of Natural Supports include co-workers, community members and family members. These natural and supportive relationships, assist individuals to develop and pursue their goals and interests. Natural Supports are NOT paid supports.
- When looking for agency strategy(ies), look beyond the maintenance of a familial relationship or friendship. Looks for agency approaches to foster relationships and make connections to activities, experiences and learning through natural supports vs. paid supports.
- An agency level approach demonstrates that the agency considers this an important area to address. A specific type of strategy is not required. However, the agency must be able to show that they have equipped their staff with tools to try to build natural supports and that there is monitoring at the agency level of the activities implemented. There should be something in writing.
- Examples include but are not limited to:
 - o Curriculum guided training staff on natural supports and how to identify potential natural supports opportunities through routine services and activities;
 - o Providing a “script” to help staff talk to people in way that facilitates developing the natural support;
 - o Providing suggestions or opportunities to express appreciation to natural supports and natural support networks events
 - o Setting agency goals and related strategies for the increase in meaningful natural support relationships.
- This does not mean to supplant individualized situations where natural supports are formed or fostered.

Select Met if the agency can demonstrate the routine implementation of any strategies designed or organized by the agency to facilitation natural support development.



Select Not Met if the agency cannot demonstrate the routine implementation of any strategy designed or organized by the agency to facilitate natural support development.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The agency has policies and procedures for regular and timely communication regarding individuals, with the individuals' family/advocates and/or natural supports, per the individual's preferences.	Met/Not Met

Guidance

Quality Indicator

Documentation Review:

Written policy/procedure regarding contacts/communications with family/advocates/natural supports.

Interview:

As needed, staff/management knowledgeable of policy; if concerns and absolutely necessary, family/advocates/individuals.

Guidance:

- This quality indicator reviews whether the agency expects good flow of information about the individual they support to advocates, family, etc.
- This addresses communication of issues separate from regulation required notifications, e.g. incident notification.
- Determine whether the agency has written policy/procedures (p/p) addressing the communication of status, updates, information to family/advocates/natural supports. These communications serve to supplement direct communication with the individuals and their family, advocates, supports.
- Communications may include positive news as well as concerns. (E.g. “thought you’d like to know...”, or “here’s an update on how your sister is doing this week...”; or “your son is going to have a busy May, here is what he has planned...”). Communications mechanisms (e.g. phone call, email) and topics may vary by agency and agency policy/procedure.
- This standard expects that this communication practice is implemented organizationally or widely within the parameters of agency p/p, not just a best practice implemented by a particular site or service.
- Written expectations/procedures in this area should minimally address:
 - o The types of information regarding an individual that should be communicated to their family/advocates/supports;
 - o How the communication should occur and within what time frame or regularity;
 - o Input of individuals regarding whether their family/advocate/natural supports should be contacted, who to contact, types of information to include and the ability to take part in the communication.
 - o Variances or exceptions to the communication, if any, e.g. request by family not to receive communications, to receive them in a certain way, or with a specific frequency, or only on a certain topic.
 - o Availability of contact list (who should be contacted) for each individual.

Select Met if the agency has written procedures guiding communication to/with individuals' family/advocates/natural supports (in addition to communication required by regulation).



Select Not Met if the agency DOES NOT have written procedures guiding communication to/with individuals' family/advocates/natural supports, (in addition to communication required by regulation).

Citations

QI: This Standard is a Quality Indicator.

Section 2: Community Engagement

Standard #	Standard Text	Decision
1	The agency works collaboratively with other community organizations, to develop the role of the agency in the community, to foster opportunities for individuals.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency staff/management knowledgeable of and/or coordinating the efforts with other organizations; as needed agency board member.

Documentation:

- o If the agency engages in such activities, their management is best suited to direct you to/provide you with documentation evidencing their sustained efforts.
 - o There may be information in an agency management plan regarding goals and strategies in this area.
- o Less likely, but possible, there may Policy/Procedure if there is a formalized strategy to engage and seek engagement,
- o Agency documentation to identify and evidence collaboration with community may include but is not limited to agency newsletters, board or board sub-committee meeting minutes, department reports, agency website news, etc.

Guidance:

- This quality indicator standard reviews whether the agency/organization actively promotes and demonstrate actions as a community member rather than just being located in that community. It assesses whether the agency/organization actively promotes the agency in order to partner with other local organizations to meet community needs. This is an organization to organization collaboration. It expands the role and perception of the agency in the community. Such collaborations have been shown to support the goals of the provider agency and create expanded opportunities for the people it supports.
- This means that the agency and its representatives are working toward or have achieved meaningful cooperative engagement with local community businesses and/or civic, cultural, and/or social organizations; community grass roots efforts, etc. A specific type of strategy is not required. Collaboration can take many forms dependent on the community itself. Examples include:
 - o Working with a community organization to create and sustain a community garden facility; Actively engaging in community fundraisers that are not for the agency itself (e.g. collaborating with a local bank to initiate, promote and work a local charity run with agency participation, including individuals); Membership, participation and volunteering with in cultural organizations and community arts programs (theaters, museums, historical societies); neighborhood organizations where the agency headquarters is located, etc.
- Collaboration should seize upon opportunities to involve the individuals receiving services as much as possible.
- Speak with agency representatives about their collaborations and review any information provided that will help you in evaluating this standard.
- Information may be in the agency management plan, board minutes, p/p, and any documented account of agencies efforts in this area. See documentation suggestions above. Agencies are proud to promote their involvement, and the individuals' involvement in community efforts, so if it is occurring there may be documentation.
- Best practice of agency commitment is inclusion of collaboration strategies in the agency management or strategic plan.



Select Met if the agency demonstrates organization level effort and activities to engage collaboratively with other community organizations and entities in a manner described in guidance.

Select Not Met if the agency cannot demonstrate organization level effort and activities to engage collaboratively with other community organizations and entities in a manner described in guidance.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The agency implements community outreach intended to increase opportunities and meaningful relationships for the individuals supported (e.g. work, education, associational).	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency staff/management knowledgeable of and/or coordinating the efforts; as needed agency board member.

Documentation: per agency processes

- o There may be information in an agency management plan regarding goals and strategies in this area.
- o There may Policy/Procedure if there is a formalized strategy regarding outreach and outreach priorities.
- o Agency documentation to identify and evidence community outreach in support of the opportunities for individuals.

Guidance:

- The standard above reviews for organization to organization collaboration in the local community as a contributing community member. This standard reviews for organized agency strategic approaches to seek and create opportunities for the individuals they support in line with their interests, needs and goals. It may be separate from or the next step to the types activities expected for the standard above. This looks for an organizational effort, not a person by person approach.
- Organizational engagement community outreach enables the agency to provide services and supports aligned with what the individuals need and want, and in settings that they provides greater integration. A focused and assigned effort to broaden agency exposure to local businesses, employers, organizations, clubs, churches, schools/colleges/adult education, sports teams, gyms, charities, etc. can open doors to the creation or discovery of meaningful opportunities, activities, and service environments for individuals.
- Speak with agency representatives to determine if the agency has designed and implements activities to reach out and find opportunities for individuals in areas where the agency has programs and delivers services. The outreach must be intended to broaden and keep the network of partners that may offer settings or occasions that generally fit the interests, goals, and needs of individuals; and opportunities to meet people and develop relationships, learn, develop cultural or spiritual connections, practice skills, have fun, get healthy, find meaningful employment or volunteer work, etc.
- A best practice is hiring or designating staff whose responsibilities include outreach and expansion of networks and opportunities. Outreach and relationships built may be as diverse as the individuals the agency supports. Examples include but are not limited to:
 - o If the agency serves many individuals interested in learning more about their heritage, connections to cultural or heritage organization;
 - o For individuals interested in music reach out to establish connections related to the interest, e.g. create a event that recruit local music majors to connect with individuals;
 - o Create an ongoing relationship with a local community theater for participation of individuals to perform, create props or take tickets, or see performances;

- o Outreach to casual kickball leagues, bowling leagues, etc. to integrate individuals as a team or to join integrated teams vs. starting a disabilities only league;
 - o Integrated college experiences.
- A quality practice would be for the agency to ensure outreach based on collection of information from and about the individuals they support. This may be aggregation and analysis of findings from POMs, requests from self-advocates and self-advocacy groups, surveys, etc.
 - This does not replace individualized efforts to create individualized activities and opportunities for individuals' work, leisure, and social life. However, this broad outreach is prudent as it may create ways for individuals to have new experiences and discover new interests and people in a way they had not thought of before. It can also create more sustained opportunities that may reduce wait time or gaps in linkage to services or activities.
 - Review documentation the agency provides to help you evaluate this standard. Best practice of agency commitment to such outreach is inclusion in the agency management or strategic plan. Information may be in management plans, board minutes, p/p, and documentation of outreach and linkage successes. Ask the agency to direct you to documentation if any.

Select Met if the agency demonstrates management directed purposeful outreach to create opportunities for individuals to develop relationships and meaningful participation in the community.

Select Not Met if the agency cannot demonstrate management directed purposeful outreach to create opportunities for individuals to develop relationships and meaningful participation in the community.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
3	The agency supports their employees to develop social networks and community connections for individuals and/or to enable individuals to build their own social networks and community connections.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency staff/management knowledgeable of agency actions to support agency employees and volunteers (if applicable) assist individuals to establish social networks and community connections.

*Note: from this point forward, guidance will refer only to staff or employees but should be interpreted to include volunteers if the agency uses volunteers, and if the agency chooses to include them in this supported activity.

Documentation: per agency processes

- There may be information in an agency management plan regarding goals and strategies in this area.
- There may Policy/Procedure if there is a formalized strategy for staff* actions related to social networks/community connections.
- Agency documentation to identify and evidence activities in this area.

Guidance:

- This QI standard reviews whether the agency/organization has organized strategic approaches to support and encourage agency employees* to seek and create opportunities for the individuals they support in line with their interests, needs and goals as well as provide the support individuals need to make/maintain the connections.
- Agency support and encouragement of staff* to also have a role in creating connections (as described in standard above), broadens even further, the ability to provide services and supports aligned with what the individuals need and want and in settings that they offer greater integration. Employees*, especially those working directly with individuals, know their interests and desires best, and have the best ideas of the connections to pursue or assist the individuals to pursue. If appropriate to individuals' interests, employees* also already have their own community associations and connections, that may bridge the connection between the organization, club, sport, venue, church, etc. and make introduction and acceptance of an individual(s) easier.
- Agency support and encouragement may take many forms, but for this standard, must be an organization level practice. A specific type of strategy is not required.
- Examples of support and encouragement of staff* to develop networks/connections meaningful to an individual/individuals:
 - o Implementing agency "challenges" or "contests" challenging individual staff* or a group of employees/department/service to create one new opportunity for an individual;
 - o Asking staff to develop to a performance goal related to discovering or creating a meaning new connection for one person whom they support;
 - o Incentives and rewards to staff* when meaningful connections are made and implemented for a person

o Providing a list of possible community or relational connections to staff as a starting point to assist them to engage in any of the above efforts.

- Speak with agency representatives to determine if and how the agency supports and encouraged staff to take initiative to create connections.
- Review documentation the agency offers to help you in evaluate this standard. Best practice of agency commitment to such outreach is inclusion in the agency management or strategic plan. Ask about Management Plans, board minutes, p/p, personnel practices, and other documentation that evidences support of staff's role in creating community connections.

Select Met if the agency demonstrates organizational support and encouragement of staff to create and support opportunities for individuals to develop relationships and meaningful participation in the community.

Select Not Met if the agency cannot demonstrate organizational support and encouragement of staff to create and support opportunities for individuals to develop relationships and meaningful participation in the community.

Citations

QI: This Standard is a Quality Indicator.

Topic 12: Agency Management

Section 1: Agency Mission

Standard #	Standard Text	Decision
1	The agency has a clearly written mission statement, and related goals/objectives.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff to determine how this information is documented and can explain content; as needed agency board member.

Documentation:

Agency Mission statement, Agency written goals/objectives however AND wherever documented, e.g. Stand-Alone document, in the Agency Management Plan, in an Agency Strategic Plan.

Guidance:

- Review documentation provided by the agency that identifies the agency's mission, goals/objectives.
- An agency best practice is to detail the information in a management plan or strategic plan, outlining the actions to be taken to achieve the mission, goals and objectives.

Select Met if the agency has determined and documented its mission and goals/objectives.

Select Not Met if the agency has NOT determined and/or documented its mission and goals/objectives.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The Agency's, written goals, and objectives align its services and supports with achievement of individuals' valued outcomes.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff to determine how this information is documented and can explain content; as needed agency board member.

Documentation:

Agency Mission statement, Agency written goal and objectives however documented, e.g. Agency Management Plan, Strategic Plan.

Guidance:

- Review information provided by the agency.
- While the content of agency mission, goals/objectives (by whatever name used by the agency) may address many areas, determine if it demonstrates that the agency values the achievement of individual's desired outcomes by including goals/objectives related to person-centered services and delivery of supports that result in individuals living the life they want. This means that the agency's goals and objectives include the means to support individuals to achieve the life they want.

Select Met if the agency's written mission, goals/objectives align with individuals' achievement of their desired outcomes.

Select Not Met if either of the following are evident:

- The agency does not have written mission and goals; or
- the agency's written mission, goals/objectives do not align with individuals' achievement of their desired outcomes.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
3	The Agency's mission, goals, and objectives support the vision/outcome priorities of OPWDD.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff to determine how this information is documented and can explain content; as needed agency board member.

Documentation:

Agency Mission statement, Agency written goal and objectives however documented, e.g. Agency Management Plan, Strategic Plan.

Guidance:

- Review information provided by the agency.
- Content of agency mission, goals/objectives (by whatever name used by the agency) should demonstrate support of OPWDD's vision for the people supported through OPWDD services. OPWDD's Vision is that "People with developmental disabilities enjoy meaningful relationships with friends, family and others in their lives, experience personal health and growth and live in the home of their choice and fully participate in their communities."
- The provider agency's mission, goals/objectives should be individualized. Therefore, they do not need to be worded to include the specific words in OPWDD's vision. Review instead that the provider agency's mission, goals/objectives can be reasonably expected to support the outcomes related to health, meaningful relationships, meaningful employment/ day activities, and active participation in the community.

Select Met if the agency's mission, goals/objectives support the outcomes of OPWDD's Vision as described above.

Select Not Met if any of the following are evident.

- The agency does not have a mission and/or goals/objectives;
OR
- The agency's mission and/or goals/objectives do not support the outcomes of OPWDD's Vision as described above.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
4	The Agency's mission and goals are communicated to all people receiving supports and services, their families/advocates; all level of staff; and the governing body.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff and/or a board member to determine how agency's mission and goals are communicated.

Documentation:

Based on agency's response in interview, review documentation that describes communication strategies to the varied parties, and evidence of communication.

Guidance:

- The agency should have a mechanism to communicate the agency mission and goal to everyone involved with the agency, to foster an agency culture and multiply the participation of everyone to achieve the goals. A shared vision to achieve goals and agency excellence fosters agency wide quality actions and an organizational drive to succeed.
- Verify that the agency communicates the decided upon agency mission and goals.
- There is no specific required mechanism. The agency must show that communication has/is occurring, to the various stake holders. Communication strategies may be different for different stakeholders.
- How the mission and goals are communicated may include but are not limited to town halls, meetings, newsletters, email blasts, or other means.
- While it is acceptable that the communication occurs once at the time that that mission and goals are determined, and again when revised; best practice includes strategies for sustained communication to keep stakeholders aware, as well as weaving the mission and goals into agency policies, procedures, and planned activities, and job performance to ensure that stakeholders not only know, but also support the vision and goals.
- Stakeholders include the individuals receiving services; family, advocates/guardians; and agency staff in all agency roles and departments.

Select Met if the agency demonstrates all the following:

- How communication is completed when mission and goals are confirmed or revised, and that it has occurred as needed;
- AND
- That communication includes all stakeholders named above.

Select Not Met if any of the following are evident:

- The agency does not communicate its mission and goals; OR
- The agency does not communicate to all stakeholders named above; OR
- The agency has not communicated mission and goals when changes occur, if applicable.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
5	Agency leadership engages all agency members in the implementation of the mission and goals of the agency.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff and/or a board member to determine how agency members (employees, board members) are engaged in the achievement of agency mission and goals.

Documentation:

Review documentation that demonstrates agency member participation in the implementation and achievement of the agency mission and goals. This will be based on agency practices and may include, written agency policy/procedure, job performance expectation, expected practices in agency departments, divisions, location, etc.

Guidance:

- Agencies that engage their organization members to work together to implement and achieve the agency mission and goals facilitate an agency culture to promote the valued outcomes of the people supported by the agency.
- Based on the information gathered, consider whether the agency incorporates the mission and goals into agency policies and procedures; required mechanisms of service delivery, and/or job performance expectations, for example (but not limited to):
 - o Expect agency departments/divisions establish division goals related to agency goals and implement strategies to succeed;
 - o Include activities and duties related to the mission and goals in employee job performance requirements;
 - o Require that Service planning activities address specific outcomes included in agency mission/goals;
 - o Engage agency board members in encouragement, oversight and verification that programs are operated in a manner supportive of agency mission and goals.

Select Met if the agency can demonstrate specific written strategies and implementation of activities that engage agency staff and board members in the facilitation and implementation of activities in support of agency mission and goals.

Select Not Met if the agency cannot demonstrate specific written strategies and implementation of activities that engage agency staff and board members in the facilitation and implementation of activities in support of agency mission and goals.

Citations

QI: This Standard is a Quality Indicator.

Section 2: Agency Leadership

Standard #	Standard Text	Decision
1	The Agency monitors its processes to facilitate compliance with applicable NYS and Federal requirements.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff knowledgeable of management oversight of agency systems to facilitate compliance with applicable regulations and requirements.

Documentation:

Review documentation demonstrating agency process meant to facilitate compliance and administrative oversight that the agency systems are adequate to achieve success. This may include policy/procedure, a management plan, or management meeting structure, or any other viable means.

Guidance:

- Agency leadership must ensure that its organizational practices will result in ongoing agency compliance in its operations and delivery of services to individuals.
- Agency leadership should implement practices to review the compliance status of programs and services. This review should include:
 - o review of agency policies/procedures as needed to ensure that they support rather than obstruct compliance;
 - o review of summaries of non-compliance identified through external or self-assessment, including possible root causes; and
 - o input from agency stakeholders, as needed.
- This is separate from a quality improvement process. This is an agency management/leadership level review and management of its systems and operations implemented to facilitate compliance. "Review" requires that the agency leadership/management is aware/informed of compliance successes and concerns and well as agency practices or lack of procedures that may influence this. "Management" requires that the agency management/leadership takes action at a management level, as needed, based on their "review". This may include revising procedures, new training curriculums, revised hiring practices accordingly, addressing low performers by learning from high performers, etc. It may impact decisions made by the agency which may include updates to the management/strategic plan.

Select Met if the agency leadership implements mechanisms to ensure that agency systems support compliance of agency programs and services with NYS and Federal requirements, similar to those described above or other mechanisms likely to foster the same outcome.

Select Not Met if the agency leadership does not implement mechanisms to ensure that agency systems support compliance of agency programs and services with NYS and Federal requirements.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The Agency monitors its processes to facilitate quality services that support individuals' desired outcomes.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff knowledgeable of management oversight of agency systems to facilitate services that support the individuals' desired outcomes.

Documentation:

Review documentation showing the agency process meant to facilitate compliance and administrative oversight that the agency systems are appropriate to achieve success. This may include policy/procedure, a management plan, or management meeting structure, or any other viable means.

Guidance:

- Agency leadership must demonstrate its commitment to person centered services and ensure that its organizational practices facilitate the delivery of quality services to individuals in order to support their desired/valued outcomes.
- Agency leadership should implement practices to review the efficacy of agency systems for service planning and delivery that will facilitate the desired outcomes of individuals. This review should include:
 - o review of agency policies/procedures as needed to ensure that they support rather than obstruct person centered services and encouragement of autonomy, choice, independence, and desired quality of life;
 - o receipt and review of the agency's successes and barriers to help individuals in the pursuit of their outcomes;
 - o review of summaries of failures to meet HCBS person centered and HCBS requirements, and quality indicators identified through external or self-assessment, including possible root causes; and
 - o input from agency stakeholders, as needed.
- The agency leadership level monitoring and understanding of status in this area should impact decisions made by the agency which may include updates to the management/strategic plan.
- This is separate for a quality improvement process. This is an agency level review and management of systems and operations related to person centered desired outcomes. This activity may be informed through some quality improvement measures. However this is agency/organization management of activities/practices/procedures that impact the delivery of quality individualized services.

Select Met if the agency leadership implements mechanisms to ensure that agency systems are effective to support the individuals' desired outcomes, similar to those described above or other mechanisms likely to foster the same outcome.

Select Not Met if the agency leadership does not implement mechanisms to ensure that agency systems are effective to support the individuals' desired outcomes.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
3	The Agency has written conflict of interest policies and procedures.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff and/or board members knowledgeable of agency conflict of interest policies and procedures.

Documentation:

Review agency policies and procedures, and/or agency practices, if any, related to addressing and preventing conflict of interest.

Guidance:

- A conflict of interest is a situation in which:
 - o the concerns or aims of two different parties are incompatible or
 - o a person is in a position to derive personal benefit from actions or decisions made in their official capacity.
- The agency should have policies and procedures to prevent and address conflict of interest.
- Conflict of interest can apply to many different aspects of agency activities and service planning. Conflict of interest should be defined by the agency in writing. Conflict of interest concerns may apply to many agency practices including hiring and other personnel practices, purchasing practices, incident review committee activities (reviewed via another standard), and person-centered planning.
- While the agency should have systemic policies for all potential conflict of interest, this standard reviews that the agency has policies and procedures to address conflict related to person-centered planning and services addressed in Part 636-1.2. Agencies must develop guidelines that ensure conflicts of interest do not interfere in the person-centered planning process.
- Regarding person-centered planning and service delivery, a conflict of interest means that a member of the person-centered planning team has a competing interest with the interests of the person with ID/DD which a reasonable person would regard as making it difficult to properly perform their responsibilities to the person with disability. Conflicts of interest may include, but are not limited to: competing priorities among planning team members, financial interests in the provision of services, and any personal or familial relationships of staff with the circle of support or individual.
- Agency processes should address conflicts or disagreements in the person-centered planning process, including clear conflict of interest guidelines for the agency, agency personnel, and individuals, and communicating to involved parties as needed.
 - o There should be clear and accessible dispute resolution process when there are disagreements within the person-centered planning process;
 - o There should also be strategies to handle conflicts and disagreements between person-centered planning team members;
 - o The preferences and values of the person with ID/DD must be at the center of all strategies to handle conflict of interests and conflicts in the planning process.

Select Met if both the following are evident:

- The agency has written policy and procedures regarding conflict-of-interest within person-centered planning, AND
- A clearly identified dispute resolution process pertaining to disagreements between person-centered planning team members.

Select Not Met if any of the following are evident:

- The agency does not have written policy and procedures regarding conflict-of-interest within person-centered planning,
AND/OR
- The agency does not have a clearly identified dispute resolution process pertaining to disagreements between person-centered planning team members.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
4	The agency actively supports a leadership culturally competent in the diversity of individuals served.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff and/or board members.

Documentation:

Agency organizational chart.

Guidance:

- Discuss with agency leadership, agency approaches to diversity and cultural competence.
- The standard is not a measurement that every individual served is represented in kind by someone in agency management. However, it does ask that an agency is sensitive to diversity and capable to understand and assist individuals with strong cultural competence and organizationally aware how cultural background, religious background, or gender identity affects competent service delivery.
- Consider whether any members of agency leadership/management are able to communicate/speak the language of individuals (families) served, if a significant number of people served are more proficient in languages other than English, and actions taken by the agency to facilitate clear communication among parties when management lacks the skills.
- Consider how the agency ensures that members of agency leadership/management are knowledgeable in the diverse cultural and/or religious norms of the individuals supported, so they may assist other agency and staff to be culturally competent. An agency may find it difficult to ensure management diversity and/or competence related to the individuals served (e.g. person speaks Spanish). The agency however, should be able to demonstrate:
 - o efforts to recruit representative diverse management when determined necessary by the agency or stakeholders;
 - o efforts to educate and advance leadership/management's understanding of the diverse cultural, language religious, and gender interests of the individuals supported, as needed;
 - o efficient access to resources to assist in language interpretation for meetings and engagement with individuals and/or their families.
- Some agencies may be organized to serve individuals with a specific religious or cultural background. In such cases the agency leadership/management team may not include a range of cultural background or experience. However, as described above, should be competent to represent and understand the perspective of other individuals served, as needed.

Select Met if: The agency demonstrates active efforts to facilitate cultural competency in the agency leadership/management through training and responsiveness to the language and cultural interests of individuals receiving services.

Select Not Met if: The agency cannot demonstrate active efforts to facilitate cultural competency in the agency leadership/management through training and responsiveness to the language and cultural interests of individuals receiving service.

Citations

QI: This Standard is a Quality Indicator.

Section 3: Governing Body

Standard #	Standard Text	Decision
1	The Agency's governing board (Board of Directors) provides active oversight to ensure effectiveness the agency in carrying out its mission and goals.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency board of director's member(s).

Documentation:

Board meeting minutes, board sub-committee meeting minutes.

Guidance:

- Review board meeting minutes and subcommittee meeting minutes and supplements/attachments that would have been provided to board members as part of the meeting discussions.
- The minutes and documents should be sufficiently descriptive and demonstrate the content of information shared and discussed in board meetings and sub-committee activities; reactions or feedback from the Board; recommendations from the Board, and proposed or actual involvement of the board.
- The board must receive regular reports regarding agency operations and services to oversee and provide governance regarding agency goals and services delivered.
- Board meeting minutes should regularly reflect comprehensive reporting by management and active discussion by the Board of issues related to quality programming/services. This means the full board and/or through activities of its subcommittees, is actively involved in oversight of agency operations impacting the agency mission and goals including but not limited to: staffing status and issues; program activities and service delivery; regulatory issues, changes and impacts; survey and certification issues; priorities of individuals the agency supports; agency effectiveness in supporting valued outcomes, quality improvement, agency development, review of status of the agency's management/strategic plan, quality improvement plan, etc.
- Best practices include board member participation in discussions with individuals receiving services, site visits (if applicable), including guided/focused purpose during such activities.

Select Met if: The agency governing body (board) is actively involved in the effectiveness of the agency to fulfill its mission and goals, as evidenced by:

- The board receiving information to be well informed;

AND

- Board active engagement, discussion and decision making regarding issues impacting the agency and its delivery of quality services.

Select Not Met if: It there is not sufficient evidence that the agency governing body (board) is actively involved in the effectiveness of the agency to fulfill its mission and goals, as described above.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The agency Board of Directors has a framework to exercise active governance.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency board of director’s member(s).

Documentation:

Board of director’s by-laws.

Guidance:

- There should be written by-laws guiding the Agency’s Board of Director activities and practices.
- By-laws should address board organization, composition of membership, officers, terms, conflict of interest, participation expectations, board committees and subcommittees, board activities, and documentation of board activities.

Select Met if:

- The agency governing body/board of directors has written by-law which address most of the elements described in guidance.

Select Not Met if the agency governing body/board of directors:

- Does not have written by-laws;
- OR
- Written by-laws largely omit elements described in guidance.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
3	The Board has a mechanism for active representation of individuals receiving services in agency governance and decision making.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency board of director's member(s); individuals with I/DD representing the individuals' priorities and interest with the board of directors.

Documentation:

Board of directors meeting minutes, agency management plan, by-laws.

Guidance:

- There should be a mechanism for participation in Agency Governance by individuals served.
- Determine how the agency board of directors asks for the perspective of the individuals it supports to guide and inform agency governance.
- The agency mechanism may be unique to each agency and may include, but not limited to the following:
 - o inclusion of individual(s) with I/DD in board membership;
 - o board sub-committee of individuals with I/DD or whose purpose is to integrate the priorities and input of the service participants;
 - o a mechanism to regularly and in an organized manner, solicit input from individuals assigned/elected/chosen to represent service participants and their interests and priorities;
 - o Support recipient input into the organization and the assessment of support recipient satisfaction regarding policy/program changes within the organization.
 - o establishment of a self-advocate serving as a board liaison to take part in discussions as needed based on proposal or issue set before the board;
 - o any other reasonable approach that engages the perspective of individuals supported in board discussion, deliberation and decision making.
- There must be documentation that clearly shows the participation and/or organized input of the individuals with I/DD with and/or before the governing body.
- The persons' involvement in all aspects of the agency assists the agency to achieve its goals as contained in its management and strategic plans.

Select Met if the following is evident:

- The board of directors has a mechanism(s) for active involvement of individuals in agency decision making;
OR
- The board has a mechanism to receive receipt of the input of individuals with I/DD supported by the agency to inform their decision making;
AND
- There is documentation demonstrating that the mechanism is implemented.

Select Not Met if any of the following is evident:



- The board of directors does not have a mechanism(s) for active involvement of individuals in agency decision or to receive the input of individuals with I/DD supported by the agency;

AND/OR

- There is no documentation demonstrating the mechanism is implemented.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
4	The Board demonstrates oversight of the Executive Director including adherence to executive compensation requirements.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency board of director’s officer(s) or knowledgeable member.

Documentation:

Agency by-laws, minutes, board agreements with the Executive Director/CEO, board oversight expectations.

Guidance:

- The governing body should be able to demonstrate that they:
 - o Established performance expectations of the agency executive director/CEO;
 - o Review and maintain executive compensation in-line with NYS requirements related to compensation.
- Governing body oversight processes and implementation should be documented.

Select Met if both the following are evident:

- The board has a written process for the oversight of the executive director/CEO performance and adherence to compensation requirements; and
- The board can evidence oversight of the executive director/CEO.

Select Not Met if either of the following are evident:

- The board does not have a written process for the oversight of the executive director/CEO performance and adherence to compensation requirements; and/or
- The board cannot evidence oversight of the executive director/CEO.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
5	The Board's membership has diversity of the appropriate skills and cultural competency to make decisions in alignment with the organization's mission.	Met/Not Met

Guidance

Quality Indicator

Interview:

Board of directors officer or member knowledgeable of board membership efforts.

Documentation:

If necessary, board membership committee documentation.

Guidance:

- Discuss with board representative(s) the board membership, and the representative skills/assets of board members that ensures the governing body collectively has the skills necessary to oversee the agency and understand the priorities of the individuals the agency supports (e.g. Background in I/DD, Financial acumen, healthcare professional, etc.). This standard is not a checklist of skills and background to be represented on a board, but rather an assessment of whether the board has a reasoned approach to considering diverse membership for an effective board. Include in the discussion, the board's assessment of the demographic of individuals served, especially in regards to cultural, ethnic, religious and language diversity. Discuss considerations made by the governing body to ensure board members are familiar with the diverse cultural priorities of the individuals supported by the agency and culturally competent.
- Discuss how the board members are educated to best serve the individuals as needed, so they may assist the agency in effectiveness and support of individuals of diverse backgrounds.
- Consider whether any members of the board can communicate/speak the language of individuals (families) served, if a significant number of people served are more proficient in languages other than English; and how the board addresses communication in these situations.
- A board may find it difficult to recruit board members to facilitate skill diversity and/or cultural competence. Consider whether the board has:
 - o Implemented efforts to recruit representative diverse skill as needed by the board or requested by stakeholders;
 - o Implemented efforts to educate and advance board members' skill as determined necessary;
 - o Implemented efficient access to resources to assist in language interpretation for meetings and engagement with individuals and/or their families, as needed;
 - o Initiated education and offered resources to aid board members to understand the cultural, language religious, and gender interests of the individuals supported, as needed.

Select Met if the agency's governing body actively facilitates a board membership with appropriate skills and cultural competence to govern the agency.

Select Not Met if the agency's governing body does not actively facilitate a board membership with appropriate skills and cultural competence to govern the agency.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
6	The Board provides fiscal direction and oversight.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency board of directors' member(s).

Documentation:

Board meeting minutes, board sub-committee meeting minutes for the past six meetings.

Guidance:

- Review board meeting minutes and subcommittee meeting minutes and supplements/attachments that would have been provided to board members as part of the meeting discussions.
- The minutes and documents should be sufficiently descriptive and show the content of information shared and discussed in board meetings and sub-committee activities; reactions or feedback from the Board; recommendations from the Board, and proposed or actual involvement of the board.
- The board must receive regular and transparent reports regarding agency fiscal status and stability; expenditures and payments routine and non-routine; and possible or expected fiscal issues, concerns or vulnerabilities.
- Board meeting minutes should regularly reflect comprehensive reporting by agency management and active discussion and decision making by the Board of issues related to agency fiscal health. This means the full board and/or through activities of its subcommittees, is actively involved in agency operations regarding agency finances and fiscal issues and concerns, and the impact fiscal issues may have on agency programs and services.

Select Met if the agency governing body (board) is actively involved in the agency fiscal direction and oversight, as evidenced by:

- The board receiving information to be well informed of the agency's fiscal health and vulnerabilities; AND
- Board active engagement, discussion and decision making regarding issues impacting the agency fiscal stability.

Select Not Met if it there is not sufficient evidence that the agency governing body (board) is actively involved in agency fiscal direction and oversight.

Citations

QI: This Standard is a Quality Indicator.

Topic 13: Agency Quality Improvement

Section 1: QI Plan Components

Qualifier The agency has a quality improvement plan/strategy.

(Applies to all Sections)

Yes/No

Standard #	Standard Text	Decision
1	The quality improvement plan includes measurement, aggregation, and analysis of factors related to the outcomes and quality of life desired by individuals.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff with understanding and responsibility regarding the agency Quality Improvement Plan (QIP)

Documentation:

The Quality Improvement Plan and documentation related to its measures, analysis, implementation, and review.

Guidance:

- There is no prescriptive format or methodology for agency Quality Improvement Plans and strategies.
- This standard looks for demonstration of ongoing outcome measurement of valued outcomes, quality of life.
- Verify that the quality improvement plan includes a means to assess whether the individuals are experiencing/achieving the outcomes and quality of life they want, compile the findings, and analyze the results to determine strategies to address/improve.
- Measurement/Assessment: How this occurs may be decided by the agency, so long as the intent of the measurement/assessment is to determine outcomes related to quality of a person's desired life, from the perspective of the individuals with I/DD and with the support of people who know them best if necessary. There are different mechanisms to include determine individuals' outcomes and if they are being achieved, e.g. CQL Personal Outcome Measures, University of Toronto Quality of Life Instrument, agency designed assessment/measurement tools, etc.
- Aggregation: This expects that the agency collects the results of the outcome measurements and sums up the response results.
- Analysis: The agency reviews the aggregated outcome measurements to examine what the results reveal regarding outcomes achieved, outcomes not achieved, trends noted, etc. per the agency's Quality Improvement Plan focus. For example, the analysis may identify outcomes with high achievement, low achievement, differences among different service types, etc. The analysis should be used to inform next steps in the agency systemic strategies to improve peoples' outcomes.

Select Met if Quality Improvement strategies include measurement and analysis of individuals' quality of life outcomes.

Select Not Met if Quality Improvement strategies do not include measurement and analysis of individuals' quality of life outcomes.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The quality improvement plan addresses person-centered planning and service delivery.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff with understanding and responsibility regarding the agency Quality Improvement Plan

Documentation:

The Quality Improvement Plan and documentation related to its measures, analysis, implementation, and review.

Guidance:

- There is no prescriptive format or methodology for agency Quality Improvement Plans and strategies.
- Verify that the written quality improvement plan addresses quality person centered planning and service delivery.
- This means that the quality improvement plan includes attention to:
 - o Assessment/measure of agency effectiveness to plan and deliver services that are truly person centered;
 - o Setting goals and agency strategies related to improving person centered planning and service delivery or factors that contribute to person centered planning and service delivery;
 - o A best practice would be to set QI goals or strategies to address person centered planning based at least partly on the analysis of valued outcome measures, DQI survey results, and input from self-advocates.

Select Met if the agency's Quality Improvement Plan includes activities to address agency effectiveness in person centered planning and service delivery.

Select Not Met if the agency's Quality Improvement Plan does not include activities to address agency effectiveness in person centered planning and service delivery.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
3	The written quality improvement plan addresses assurance of individuals' health, safety, rights, and freedom from abuse/neglect and exploitation.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff with understanding and responsibility regarding the agency Quality Improvement Plan

Documentation:

The Quality Improvement Plan and documentation related to its measures, analysis, implementation, and review.

Guidance:

- There is no prescriptive format or methodology for agency Quality Improvement Plans and strategies.
- Verify that the written quality improvement plan includes activities related to the physiological, safety, and security of individuals.
- This means that the quality improvement plan includes strategies to:
 - o Assess and/or measure factors influencing the individuals' outcomes related to health, protections, and well-being of the individuals, and/or assess agency service delivery impact/relation to the health, protections, and well-being of individuals;
 - o Setting goal and strategies related to agency systems to improve outcomes of individuals' health, protections, and well-being; and/or assess agency service delivery impact to ensure the health, protections and safety needs of individuals are consistently met at a high degree of quality.
- Agency measures may be self-determined but may include use of the DQI survey results, agency self-assessment activities, information from incident trending and analysis, input from individuals, etc.

Select Met if the agency's Quality Improvement Plan includes activities to address individuals' health, safety, rights, and freedom from abuse/neglect and exploitation.

Select Not Met if the agency's Quality Improvement Plan does not include activities to address individuals' health, safety, rights, and freedom from abuse/neglect and exploitation.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
4	The quality improvement plan includes goal, objectives, and processes to address compliance with OPWDD, state and federal requirements.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff with understanding and responsibility regarding the agency Quality Improvement Plan

Documentation:

The Quality Improvement Plan and documentation related to its measures, analysis, implementation, and review.

Guidance:

- There is no prescriptive format or methodology for agency Quality Improvement Plans and strategies.
- Verify that the written quality improvement plan addresses agency compliance with OPWDD, state and federal requirements.
- This means that the quality improvement plan includes strategies to:
 - o Assess and/or measure rates of compliance and/or factors influencing the compliance/non-compliance;
 - o Setting goal and systemic strategies related to maintaining or improving the level of agency compliance.

Select Met if the agency's Quality Improvement Plan includes activities to address compliance with OPWDD, state and federal requirements.

Select Not Met if the agency's Quality Improvement Plan does not include activities to address compliance with OPWDD, state and federal requirements.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
5	The agency quality improvement plan addresses areas important to stakeholders based on their solicited input.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff with understanding and responsibility regarding the agency Quality Improvement Plan and solicitation of input.

Documentation:

The Quality Improvement Plan and documentation related to its measures, analysis, implementation, and review.

Guidance:

- The agency should have mechanisms to proactively solicit input from staff, individuals, and families. A mechanism may specifically be implemented to gather input/opinions for quality improvement plan goals and strategies; or the agency may choose to use input received through the year via advocacy groups, family forums, staff forums, strategic planning exercises, complaints, etc.
- The agency should review input identifying areas for improvement and make decision whether they should be addressed systemically through inclusion in agency quality improvement goals and strategies.
- Determine how the agency solicits information from stakeholders for inclusion in the quality improvement plan, how the information is reviewed to make decision regarding what reported input/concerns should be addressed through the quality improvement plan.
- There is no prescriptive format or methodology for agency Quality Improvement Plans and strategies.

Select Met if the agency’s quality improvement process and planning includes input from agency stakeholders.

Select Not Met if the agency’s quality improvement process and planning does not include input from agency stakeholders.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
6	The quality improvement plan addresses findings from satisfaction surveys.	Met/Not Met/NA

Guidance

Quality Indicator

Interview:

Agency management staff with understanding and responsibility regarding the agency Quality Improvement Plan and how information gathered through satisfaction surveys is used/incorporated.

Documentation:

The Quality Improvement Plan and documentation related to its measures, analysis, implementation, and review.

Guidance:

- If the agency does not implement satisfaction surveys, select NA.
- If the agency implements a satisfaction survey, determine whether the agency uses the satisfaction survey findings in their quality improvement planning. If the agency does not use satisfaction survey findings for systemic QI practices, select NOT MET.
- If the agency uses satisfaction survey findings for quality improvement activities, determine how the agency reviews, aggregates and analyzes information, and decides the findings to be addressed through the QI Plan, related goals, and quality improvement strategies.
- There is no prescriptive format or methodology for agency Quality Improvement Plans and strategies.

Select Met if the agency’s quality improvement process and plan formally addresses findings from satisfaction surveys.

Select Not Met if the agency’s quality improvement process and plan do not formally address findings from satisfaction surveys.

Select NA if the agency does not distribute and solicit response to satisfaction surveys.

Citations

QI: This Standard is a Quality Indicator.

Section 2: QI Plan Communication

Standard #	Standard Text	Decision
1	The quality improvement plan is reviewed and approved by the board of directors on at least an annual basis.	Met/Not Met

Guidance

Quality Indicator

Interview:

Board of director's officer or member knowledgeable of board membership efforts; Agency management staff with understanding and responsibility regarding board of directors' review and approval of the agency Quality Improvement Plan

Documentation:

If necessary, board membership committee documentation.

Guidance:

- Through survey activities, verify that the agency implements processes to present the agency's Quality Improvement Plan to the board of directors for review and approval annually. The review and approval may occur per agency processes.
- Documentation of the board's review, discussion of and approval should be apparent minimally in board meeting minutes.

Select Met if the agency can show that review and approval of the Quality Improvement Plan by the board of directors has occurred within the past year.

Select Not Met if the agency cannot evidence review and approval of the Quality Improvement Plan by the board of directors within the past year.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	There is a mechanism for making the Quality Improvement Plan known to persons supported, staff, agency stakeholders and other interested parties.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff with understanding and responsibility regarding the agency Quality Improvement Plan and how information gathered through satisfaction surveys is used/incorporated.

Documentation:

The Quality Improvement Plan and documentation related to its measures, analysis, implementation, and review.

Guidance:

- A shared vision of quality improvement fosters excellence throughout the agency.
- The agency should have a strategy to communicate the agency Quality Improvement Plan to agency stakeholders (staff, individual, family). Determine how this occurs. It may occur differently for different stakeholders; e.g. writing, verbally, during organized meeting, etc.
- Involving everyone in the quality improvement goals and activities benefits an agency's quality culture. Participation by individuals, staff, families, and the board encourage all parties to take part in the achievement of the quality improvement goals.
- Verify that the stakeholders mentioned have been informed of the Quality Improvement Plan, its goals, and strategies.

Select Met if the agency can evidence the stakeholder have been informed of the agency Quality Improvement Plan.

Select Not Met if the agency cannot evidence that stakeholders have been informed of the agency Quality Improvement Plan.

Citations

QI: This Standard is a Quality Indicator.

Section 3: Quality Improvement Actions

Standard #	Standard Text	Decision
1	The agency's QI plan identifies quality improvement actions to be taken during the year.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff with understanding and responsibility regarding the agency Quality Improvement Plan

Documentation:

The Quality Improvement Plan and documentation related to its measures, analysis, implementation, and review.

Guidance:

- Quality improvement planning requires that the agency select the specific areas to be focused on and evaluated, and the QI actions to be taken.
- Verify that the written QI Plan describes for each area being targeted, the specific actions that will be taken to influence the improvement desired and measure the impact of the actions.
- There is no prescriptive format for how this is documented in the Quality Improvement Plan.
- Some of the agency's action items may be written as completion of a specific action or series of acts. Others may be written as the implementation of an ongoing process (e.g. survey all families / advocates within the next 12 months regarding satisfaction with services delivered, analyze and review results with senior Management).
- The QI plan is typically a component of an agency's overall systems to deliver quality services, paired with the agency management plan.
- Best practice requires that continuous effort is given to identifying and correcting problems as part of an agency's quality improvement process. QI plans should be dynamic and responsive.
- Quality Improvement planning typically informs and at times overlaps the agency's strategic goals and/or activities identified in the management plan. However, they are not the same. The Quality Improvement Plan reflects the area of interest/improvement and the actions to be taken related to the QI plan; e.g. measures, sources, analyzing options, and even the actions to be taken to impact areas identified. However, it is at the agency management/strategic level that the QI actions are operationalized, i.e. how the actions will be implemented in the agency, necessary policy and/or procedure changes, necessary training, timing of the roll out, etc.

Select Met if the Quality Improvement Plan describes the quality improvement actions to be taken during the period of the plan.

Select Not Met if the Quality Improvement Plan does not describe the quality improvement actions to be taken during the period of the plan.

Citations

QI: This Standard is a Quality Indicator.

Standard #	Standard Text	Decision
2	The agency's quality improvement activities include an annual progress summary that identifies the quality improvement actions taken and the results/effectiveness.	Met/Not Met

Guidance

Quality Indicator

Interview:

Agency management staff with understanding and responsibility regarding the agency Quality Improvement Plan

Documentation:

The Quality Improvement Plan and documentation related to its measures, analysis, implementation, and review.

Guidance:

- Verify the implementation of the agency's quality improvement plan focusing on the agency's annual summary of the QI actions and the effectiveness of the strategies.
- Minimally the agency should provide a summary describing the implementation of quality improvement actions and the summary analysis of the effects of the actions to bring about the desired and intended change/improvement. The summary aids the agency in deciding next steps and provides a format for review by leadership and the governing body.
- The progress summary should reflect the significant and minor improvements/changes in quality, as well as actions that appear to have had no impact, if any.
- The QI Summary gives the agency one point of information to look ahead to actions for the next year.
- The QI summary should be completed timely.

Select Met if the agency completes an annual summary of the Quality Improvement Plan describing actions taken and the results of those actions.

Select Not Met if any of the following are evident:

- The agency has does not completes an annual summary of the Quality Improvement Plan describing actions taken the results of those actions.

Citations

QI: This Standard is a Quality Indicator.



**Office for People with
Developmental Disabilities**

Appendix

Access Guides

How to Access the Compliance Report in Business Intelligence

- Go to OPWDD Intranet homepage.
- Click on Applications

[Division of Administration](#)

Quick Links

- [2018 SEFA Campaign](#)
- [Applications](#)
- [Commissioner's Dashboard](#)
- [Computer Support](#)
- [Community Transitions and MFP](#)
- [Electronic Bulletin Board – Workplace Notices](#)
- [Electronic Health Record Project \(EHR\)](#)
- [Email](#)
- [Employee Resource Page](#)
- [Reasonable Accommodation Request Forms](#)
- [Fit It In](#)
- [Flash Messages](#)



Electronic Bulletin Board – Workplace Notices
More...



LATS-NY/BSC
LATS-NY/BSC
More...



Enter a Helpdesk Ticket
More...



Information Line
TEL: 1-866-946-9733
Those with hearing impairment dial 7-1-1
opwdd.ny.gov/InfoLine



Language Access Employee Tools
Language Access Employee Tools
More...



SFS
This site houses information and resources for the Statewide Financial System (SFS) implementation for New York State government.
More...



Clinical Pharmacology Web-based Professional Reference Tool
More...



- Under OPWDD Statewide Applications, select Business Intelligence Reporting.

Applications

- Inter-Agency Applications
 - CIRIS
 - [Application Login](#)
 - [Access Request Form](#)
 - [Training Guide](#)
 - NYBEAS
 - NYSTEP
 - OSC e-Government (PayServ, Control-D, Web CAS)
 - Statewide Learning Management System (SLMS)
 - [Application Login](#)
 - [Information and Instructions](#)
- OPWDD Statewide Applications
 - [Internet Secured Applications](#)
 - [Acumatica – Individual Cash \(AQ\)](#)
 - [Acumatica – Petty Cash \(AQ\)](#)
 - [Aging Out \(AO\)](#)
 - [Business Intelligence Reporting](#)
 - [Central Data Management System \(CM\)](#)
 - CHOICES
 - [Application Login](#)
 - [Training Materials](#)
 - Consolidated Fiscal Reporting (CF)
 - [Application Login](#)

- Sign in using your OPWDD username and password.

Sign In

Enter your user id and password.

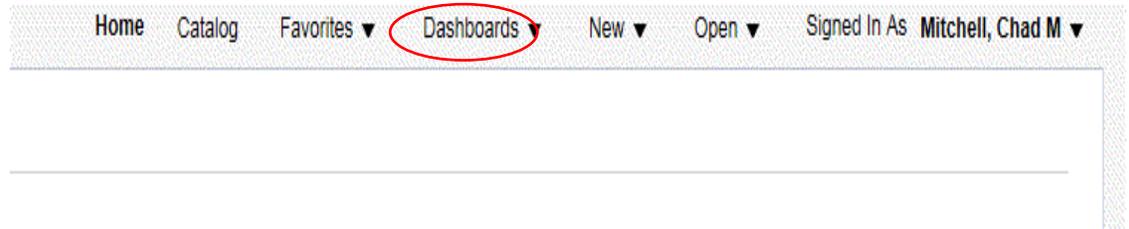
User ID

Password

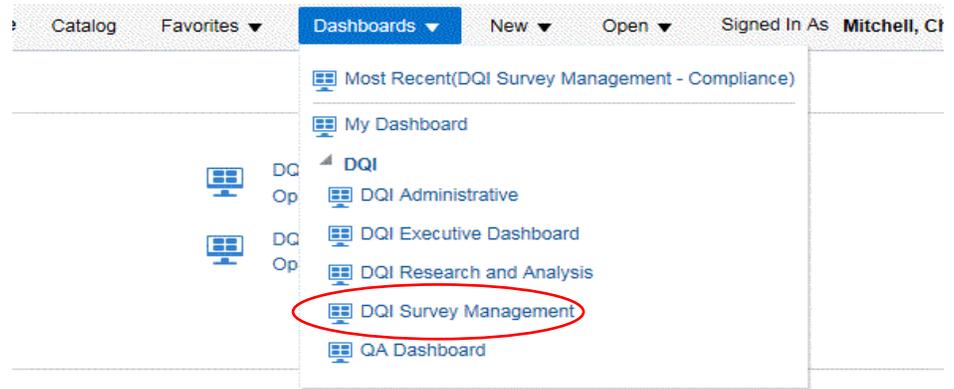
Accessibility Mode

English ▼

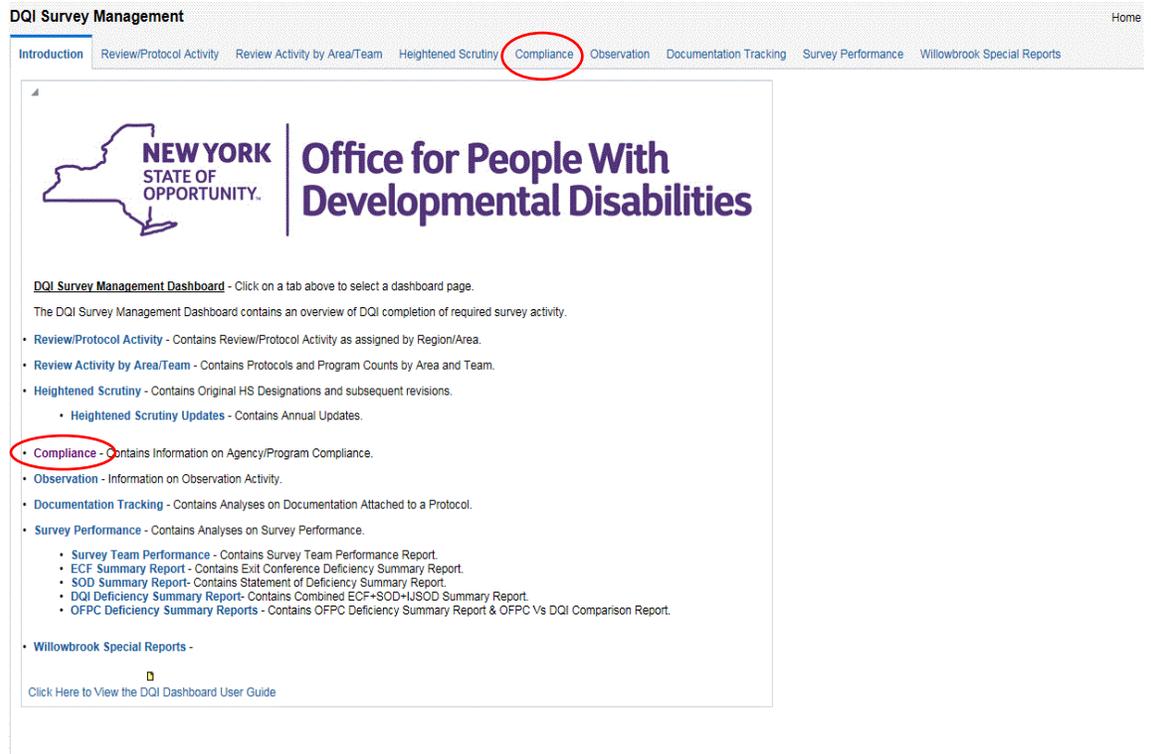
5. Once in the system, click on dashboards.



6. This will bring up a drop-down list of dashboards available. Select DQI Survey Management.



7. Once on the Survey Management dashboard, select the Compliance Tab. That can be done by clicking on the Compliance Tab across the top or in the list.



8. The report will be set to the current survey year; unless you change the filter.

Remember to hit the apply button after making any changes to the filters.

Currently this is only available for the Site Review; however, the report will be available for the PCR in the near future.

Selections

Review Cycle Start Date	10/01/2018	Partial Review Reason	--Select Value--	Completed by Team	--Select Value--	Program Type	--Select Value--
Protocol Type	Site Protocol	Agency Legal Name	--Select Value--	Surveyor Name	--Select Value--	Life Safety Code	--Select Value--
Is Partial Review	No	DQI Region	(All Column Value)	Program Sector	--Select Value--	DDSO	--Select Value--
		DQI Area	--Select Value--				

How to Search for an Authorized Person Report

1. Go to OPWDD Intranet Home page.

2. Click on NY.GOV login.

3. Log in using your ny.gov ID username and password.

The screenshot shows a navigation menu with the following items: Flash Messages, Governor's Medicaid Redesign Website, IMS Implementation Unit, Language Access Employee Tools, Medicaid Compliance, **NY.Gov Login** (circled in red), NY - Alert, NYS Agencies, OPWDD Organizational Chart, OPWDD Internet Home Page, Sharepoint, and Synchronize Enterprise. To the right, there are three featured sections: WTM Administrative Directives, Employee Resource Page, and Travel Guidelines.

Please login after reading the Acceptable Use Policy below

The login form features the NY.gov ID logo at the top. Below it are two input fields labeled 'Username:' and 'Password:'. A large grey button labeled 'Sign In' is positioned below the fields. At the bottom, there is a link for 'Forgot your Username or Password' and a smaller link for 'NY.gov ID - Terms of Service'.

[Agency Assistance & Contact Information](#)

4. The landing page will list the applications you have access to. Choose Justice Center CBC.

Welcome *Chad*, to the My NY User Management site at [NY.gov](#)
 Your NY.gov ID is - *mitchcm*
 Last login - *Thu Nov 01 14:11:16 EDT 2018* [Log Out](#)

You have access to the following applications

Justice Center CBC	NYS IT Service Management System
NYS IT Service Management System 2.0	NYS Payroll Online
Statewide Learning Management	

5. Hover mouse over Reports, and Click on "Authorized Person Update Report"

IMPORTANT NOTICE UPDATE: Records in Applied status for over 3 months will not automatically receive a subsequent arrest notice. You are responsible for ensuring that you receive a result on an applicant that you did not recently send for fingerprinting, please let the CBC Unit know via email ASAP. Please ensure that you are using the correct provider number for your program when scheduling fingerprint appointments. Failure to do so will result in the determination and it will delay your hiring process ***

Use one or any combination of search criteria. Multiple search criteria will be AND'ed. Searches on just the first part of a name are allowed. This Search will return only applicant records entered by your agency.

Agency Group:

Search (Last, First, Middle):

Applicant Number:

6. For a State Agency Group, select "OPWDD-Providers"

Authorized Person Update Report

State Agency Group:

File Format:

AP Status:

[View report](#) [Clear Criteria](#)

For File Format select format you prefer to use.

For AP Status, most routinely you will select "Active".

Select pending separately as needed if the agency reports they have submitted new/additional staff members to be authorized for information.

Click on View Report.

- The pdf and Excel reports provided include all providers so it is recommended that you use the "Find" tool to search for agency's name. E.g. if the county name is in the name of the agency, searching the word "Onondaga" will find the agencies with that in the title, and when you hit next, bring you to each agency with the word in it in succession. Simply, right click on your mouse and select Find. Type in the word and click next.

Criminal Background Check Guide

1. Go to OPWDD Intranet Home page.

2. Click on NY.GOV login.

Flash Messages
[Governor's Medicaid Redesign Website](#)
[IMS Implementation Unit](#)
[Language Access Employee Tools](#)
[Medicaid Compliance](#)
[NY.Gov Login](#)
[NY - Alert](#)
[NYS Agencies](#)
[OPWDD Organizational Chart](#)
[OPWDD Internet Home Page](#)
[Sharepoint](#)
[Synchronize Enterprise](#)

WTH Administrative Directives
More...

Employee Resource Page
Career Development, Orientation, Health and Employee Benefits, Payroll, Resources, Safety, Time and Attendance, and Training.
More...

Travel Guidelines
This Traveler's Guide will help OPWDD employees understand OPWDD-specific travel requirements not contained in the NYS Travel Manual.
More...

STOP MEDICAID FRAUD

False Claims Recoveries (Deficit Reduction)

Statewide Learning Management

Sharepoint...
SharePoint O365
More...

3. Log in using your ny.gov ID username and password.

Qs About NY.gov ID Help Desk Information Privacy Policy Terms of Service

Please login after reading the Acceptable Use Policy below

NY.gov ID

Username:

Password:

Sign In

Forgot your [Username](#) or [Password](#)

[NY.gov ID - Terms of Service](#)

[Agency Assistance & Contact Information](#)

4. The landing page will list the applications you have access to. Choose Justice Center CBC.

Welcome *Chad*, to the My NY User Management site at [NY.gov](#)
 Your NY.gov ID is - *mitchcm*
 Last login - *Thu Nov 01 14:11:16 EDT 2018*

[Log Out](#)

You have access to the following applications

Justice Center CBC	NYS IT Service Management System
NYS IT Service Management System 2.0	NYS Payroll Online
Statewide Learning Management	

5. In the State Agency Group drop down you can select State Agency Group-Choose for OPWDD Employees (DSO Staff) or choose OPWDD-Providers for Voluntary Staff.

Enter one or any combination of search criteria. Multiple search criteria will be AND'ed. Searches on just the first part of a name are allowed.
 Note: This Search will return only applicant records entered by your agency.

State Agency Group:

Name (Last, First, Middle):

CBC Applicant Number:

SSN:

NYSID:

Fingerprint Status:

Employment Status:

Date Application Submitted: From: To:

Date Fingerprinted: From: To:

Search

Clear Criteria

6. Select State Agency Group. For this example I selected OPWDD-Employees.

Then Enter Name (Last, First, Middle) of the staff in the sample and then click search.

Enter one or any combination of search criteria. Multiple search criteria will be AND'ed. Searches on just the first part of a name are allowed.
Note: This Search will return only applicant records entered by your agency.

State Agency Group: OPWDD-Employees

Name (Last, First, Middle): Mitchell Chad M

CBC Applicant Number: []

SSN: []

NYSID: []

Fingerprint Status: All

Employment Status: All

Date Application Submitted: From: [] To: []

Date Fingerprinted: From: [] To: []

Search Clear Criteria

7. The following appears when you click search. If a staff has had multiple checks; you will receive multiple results. Click on the Application Number of the results.

Application Number	Last Name	First Name	Current FP Status	Current Employment Status	App Submit Date	FP Date
2014030216-1	MITCHELL	Chad	DC/IS responded	Applied	12/23/2010	12/23/2010

8. Results will appear.

You will see one of the following:

Denied,
Pending,
Held in Abeyance,
Non-denied-No criminal history,
Not denied-non ident.

APPLICANT DETAILS

Provider Name: Central New York DDSO

* Employment Status: Applied

Effective Date: 12/23/2010

* Applicant Type: NYS Employee (SOA)

* Hiring Category: New Hire

OPWDD program type: []

* Position Category: Not applicable

* Enter a brief description of job duties. (Please limit descriptions to 400 words.)
OPWDD Record - pre July 1, 2013. No documents attached.

DETERMINATION

JC Final Determination: Not Denied - No criminal history

Sample Guidance

Topic 5: Oversight of Healthcare Services

Applicable sections:

- Section 2 – Medication Administration

Agency Reportables

Medication Errors: 10%

Topic 6: Workforce

New Employees and/or Employees Hired for New Positions

Applicable sections:

- Section 1 – Hiring Practices
- Section 2 – Background Checks
- Section 3 – Initial Training)

OF New Employees, Contractors, Students, Volunteers

SAMPLE SIZE

# OF New Employees, Contractors, Students, Volunteers	SAMPLE SIZE
≤10	All New Hires - maximum 3
11-50	15%, minimum 4, maximum 7
51+	10%, minimum 8, maximum 20

- New Employees or Employees in New Positions:** The sample must be a cross-section of employees and positions per agency services and organization: e.g. DSPs, DSP supervisors, nursing staff and other clinicians, transportation drivers or aides if the agency provides the service, other supervisory and management positions. As a rule, choose the sample from new hires and agency staff appointed to new positions in in the past one to two (1-2) years or since last review of hiring practices. Increase the time frame beyond 2 years for sample selection or sample size if necessary to ensure review of personnel requirements.

Veteran Employee Sample

Applicable sections:

- Section 1 - Hiring Practices (related to licenses and credentials)
- Section 4-Annual Training and Other Training Activities

of on-going Employees, Contractors, Students, Volunteers

SAMPLE SIZE

# of on-going Employees, Contractors, Students, Volunteers	SAMPLE SIZE
≤10	All – maximum 3
11-50	15%, minimum 4, maximum 7
51+	10%, minimum 8, maximum 20

Other Notes

- Clinical Staff:** Many clinical positions require licensure through the New York State Education Department (NYSED). Select a sample of licensed clinical staff not included in the “new” sample and verify that licensure necessary for their position is current. Discuss with personnel, the agency process for ensuring and verifying that licensure/certification is up to date.

Topic 7: Tuberculosis Control

- Section 1 - Use table on the right
- Section 2 - Per protocol (found in standard guidance)

OF New Employees, Contractors, Students, Volunteers

SAMPLE SIZE

≤10

All New Hires - maximum 3

11-50

15%, minimum 4, maximum 7

51+

10%, minimum 8, maximum 20

Topic 8: Personal Allowance

OF INDIVIDUALS (for whom the agency manages funds)

SAMPLE SIZE

≤50

25% - minimum 2, maximum 10

51-100

20% - maximum 15

101+

15% - maximum 20

Topic 10: Incident Management

CLASSIFICATION

SAMPLE SIZE

Reportable Incidents

20%

Minimal all or 5, whichever is smaller
Maximum 25

Serious Notable Occurrences

20%

Minimal all or 5, whichever is smaller
Maximum 25

Minor Notable Occurrences

10%

Minimal all or 5, whichever is smaller
Maximum 15

Part 625 Events

10%

Minimal all or 5, whichever is smaller
Maximum 15

Agency Events/Minor events

5%

(events by agency policy required to be reported and documented that do not require reporting per 624 and 625)

Minimal all or 5, whichever is smaller
Maximum 20

Agency Review-Section 6.1: Workforce-hiring practices

Under each new staff person’s initials, note all items found in his/her personnel records (hired since the last survey):

	STAFF Names & Title												
6.1.1 Verification and documentation that met qualifications for position hired													
6.1.2 Employees who are developing/monitoring Behavior Support services meeting educational and experiential qualifications													
6.1.3 Certified clinic is assigned a qualified Medical Director who is a licensed physician or dentist.													
6.1.4 Confirmation of last place of employment													
6.1.5 Statement regarding ever having been convicted of a misdemeanor or felony or any pending criminal charge													
6.1.6 Statement indicating any convictions of moving violations in the last 3 years; any suspension, revocation, alcohol and drug related offenses, driving while intoxicated convictions.													
6.1.7 Provides written/signed acknowledgement that information provided on the application is true													

Agency Review-Section 6:2 Workforce: Background checks

Under each new staff person’s initials, note all items found in his/her personnel records (hired since the last survey):

Last Survey Date: _____

	STAFF INITIALS												
6.2.2 Criminal background checks are submitted													
6.2.3 Maintains complete and up to date cbc records													
6.2.4 If staff was temporarily approved to work pending results of CBC safeguards were in place.													
6.2.5 Prompt and appropriate action on criminal history determinations made by the Justice Center.													
6.2.6 If there is a conviction or impending charge following the initial CBC required safeguards were put in place.													
6.2.7 Required safeguards are implemented applicable to background checks for registered providers.													
6.2.8 Staff Exclusion List is completed before hiring or prior to regular and substantial contact													
6.2.9 SCR check is completed before any unsupervised contact													
6.2.10 MHL 16.34 check is complete before any unsupervised contact.													
6.2.11 Information received about substantiated reports of abuse or neglect is reviewed and a decision to hire is documented.													

Agency Review-Section 6:3 Workforce: New Employee Training

Under each new staff person’s initials, note all items found in his/her personnel records (hired since the last survey):

Last Survey Date: _____

	STAFF INITIALS												
6.3.1 Training in principles of human growth and development received within 3 months of initial employment.													
6.3.2 Training in characteristics of the person served received within 3 months of initial employment.													
6.3.3 Training in Promoting PROMOTE received within 3 months of initial employment.													
6.3.4 Training in abuse prevention, identification, reporting and processing of allegations of abuse received within 3 months of initial employment.													
6.3.5 Training in laws, regulations and policies and procedures governing protection from abuse received within 3 months of initial employment.													
6.3.6 Training in incident reporting and processing received within 3 months													
6.3.7 Training in the agency’s safety and security procedures including fire safety received within 3 months of initial employment.													
6.3.8 Training in OPWDD Choking Prevention Initiative as applicable to their position was received within 3 months of initial employment.													
6.3.9 Support Brokers have completed the OPWDD approved Broker training prior to delivering brokerage services.													

Agency Review-Section 6:5 Workforce: Code of Ethics/DSP Performance Evals

Under each new staff, volunteer or family care providers initials, note all items found in his/her personnel records (hired since the last survey):

Last Survey Date: _____

	STAFF INITIALS												
6.5.1 Employees, volunteers and family care providers have been advised of the conduct requirements.													
6.5.2 Agency custodians, employees, volunteers and family care providers have read and signed the code of conduct adopted by the Justice Center, upon employment and annually thereafter.													
6.5.4 DSP Core Competency performance evaluations are completed in accordance with OPWDD requirements.													
6.5.5 Employees have received written performance expectations for positions other than DSP.													
6.5.6 Non DSP's job performance is evaluated to verify they competently implement job tasks													