**DDS LICENSURE AND CERTIFICATION**

**INTERPRETATIONS**

The fifth edition of the DDS Licensure and Certification Procedures Manual was promulgated in July 2010. Revisions to add new and revised indicators were made to the manual in 2016.

In order to increase consistency and transparency as well as to further foster a constructive and service enhancing process, the Office of Quality Enhancement has created this set of interpretations to frequently asked questions regarding indicators reviewed during the survey process.

These interpretations will be revised and updated periodically; current interpretations will be added and ones which are no longer relevant will be removed.

Interpretations are not intended to take the place of, but rather to supplement the Manual, Appendices, and Tools.

|  |
| --- |
| * **As of 12/19, all revisions and additions to the interpretations since the last publication 2/18, have an icon at the end denoting there is a change. New_icon[1]**
* **Additionally, the content text of any revisions and additions are in blue and reflect the date.**

**\*The table of contents includes hyperlinks: CTRl + click to follow the link\*** |

For your convenience, interpretations are presented in the following format:

1. **Interpretations to the Tool**

 Domain

* + Indicator (in order by number)
		1. Date
		2. Question: (when the interpretation is applicable to specific service types only, a notation will be made)
		3. Answer

 **II.** **Interpretations to the ratings**

 Topic (e.g. When to “not rate”)

* + Scope (e.g. all indicators; all licensure indicators)
		1. Date
		2. Question
		3. Answer

 **III.** **Interpretations to the Processes**

Sequence of survey activities (in order e.g. Pre-survey; Administrative Review; etc.)

* + Process (e.g. individual interview; training review)
		1. Date
		2. Question
		3. Answer

**Table of Contents**

I. INTERPRETATIONS TO THE TOOL

 **LICENSURE INDICATORS:**

**DOMAIN: PERSONAL SAFETY (L1 - L10; L91)**

 🏳 [L2 Allegations of abuse/neglect are reported as mandated by regulation](#TOOLL2)

 [L5 There is an approved Safety plan in home and work locations.](#TOOLL5)

 🏳 [L6 All individuals are able to evacuate](#TOOLL6)

 [L8 Emergency Fact Sheets](#TOOLL8)

 [L9 Individuals are able to utilize equipment and machinery safely.](#TOOLL9)

 [L91 Incidents are reported as mandated by regulations.](#L91Incidents)![New_icon[1]]()

**DOMAIN: ENVIRONMENTAL SAFETY (L11 – L30)**

 🏳 [L11 All required annual inspections have been conducted](#TOOLL11) ![New_icon[1]]()

🏳 [L12 Smoke detectors and carbon monoxide detectors, and other essential elements of the fire alarm system required for evacuation are located where required and are operational.](#L12SmokeDetectors)

 [L15 Hot water temperature tests between 110 and 120 degrees](#TOOLL15)

 [L18 All other floors above grade have one means of egress.](#TOOLL18)

 [L21 - Electrical equipment is safely maintained.](#L21ElectricalEquipment)

 [L27 - Swimming pools are safe and secure according to policy.](#L27SwimmingPools)

**DOMAIN: COMMUNICATION (C31-C32)**

**DOMAIN: HEALTH (L33 – L47)**

[L33 Individuals receive an annual physical exam.](#L33AnnualPhysical) ![New_icon[1]]()

[L34 Individuals receive an annual dental exam](#L33AnnualPhysical) ![New_icon[1]]()

[L36 Recommended tests and appointments with specialists are made and kept.](#L36RecommendedApptstest)

[L37 -Individuals receive prompt treatment for acute and episodic health care conditions.](#L37EpisodicCare)

🏳 [L38 Physicians’ orders and treatment protocols are followed.](#TOOLL38) ![New_icon[1]]()

[L39 Special dietary requirements are followed.](#l39Specialdiets)

[L41 Individuals are supported follow a healthy diet.](#L41Heathydiet)

🏳 [L46 All prescription medications are administered](#TOOLL46)

[L47 Individuals are supported to become self-medicating](#TOOLL47)

**DOMAIN: HUMAN RIGHTS (L48 – L77, L89, L 90)**

[L48 The agency has an effective Human Rights Committee](#L48HRCCommittee)  **![New_icon[1]]()**

[L49 Individuals and guardians have been informed of their human rights and know how to file a grievance or to whom they should talk if they have a concern.](#L49Humanrightsandgrievance)

[L55 Informed consent is obtained from individuals or their guardians.](#TOOLL55)

![New_icon[1]]()[L56 Restrictive practices intended for one individual that affect all individuals served at a location need to have a written rationale that is reviewed as required and have provisions so as not to unduly restrict the rights of others.](#L56RestrictivePractices)

[L60 Data are consistently maintained and used to determine the efficacy of behavioral interventions.](#L60Databehaviorplan)

[L61 Supports and health related protections are included in ISPs](#TOOLL61)

[L62 Supports and Health related protections are reviewed by the required groups.](#TOOLL62)

[L63 Medication Treatment Plans are in written format with required components.](#L63medicationtreatmentplan)

[L64 - Medication treatment Plans are reviewed by the required review groups.](#L64MTPreview)

[L65 Restraint reports are submitted within the required timelines.](#TOOLL65)

[L66 All restraints are reviewed by the Human Rights Committee](#TOOLL66)

[L67 There is a written plan in place accompanied by a training plan when the agency has shared or delegated money management responsibility.](#L67moneywrittenplan) ![New_icon[1]]()

[L68 Expenditures of individual’s funds are made only for purposes that directly benefit the individual.](#L68expendituresbenefitperson)

[L69 Individual expenditures are documented and tracked.](#L69indivexpendtracked)

[L70 Charges for care are calculated appropriately](#L70ChargesforCare)

Topic: [Review of supports to individuals to manage their monies](#ProcesssIndividualmanagemonies) ![New_icon[1]]() (moved; no major changes)

[L90 Individuals are able to have privacy in their own personal space.](#L90individualprivacy)

**DOMAIN: Competent Workforce (L74 – L88)**

[L76 The agency has and utilizes a system to track required trainings](#TOOLL76)

[L77 The agency assures that staff are familiar with the unique needs of individuals.](#TOOLL77)

[L78 Staff are trained to safely and consistently implement restrictive interventions](#TOOLL78)

[L80 Support staff are trained to recognize signs and symptoms of illness. ![New_icon[1]]()](#L80signsandsymptoms)

[L84 Staff / home care providers are trained in the correct utilization of health related protections per regulation.](#L84trainhealthprotections)

[L85 The agency provides on-going supervision and staff development](#TOOLL85).

**DOMAIN: GOAL DEVELOPMENT AND IMPLEMENTATION (L86 – L88)**

[L86 Assessments are submitted on time.](#TOOLL86)

[L87 Support Strategies necessary to assist an individual to meet their goals and objectives.](#TOOLL87)

[L88 Services and support strategies identified and agreed upon in the ISP for which the provider has designated responsibility are being implemented.](#L88SupportStrategies)

 **CERTIFICATION INDICATORS:**

**DOMAIN: PLANNING AND QUALITY MANAGEMENT (C1-C6)**

[C1-C6](#TOOLC123456) Certification indicators related to planning and quality management

**DOMAIN: COMMUNICATION (C7 – C8)**

[C7 Individuals have opportunities to provide feedback at the time of hire/ time of match and on an ongoing basis on the performance of staff/ actions of home care providers that support them.](#C7individualfeedbak) ![New_icon[1]]()

**DOMAIN: SUPPORTING AND ENHANCING RELATIONSHIPS (C9 – C12)**

[C12 Individuals are supported to explore, define, and express their need for intimacy and companionship.](#C12intimacyandsexuality)![New_icon[1]]()

**DOMAIN: CHOICE, CONTROL AND GROWTH (C13, C14, C15, C18 – C21, C51, C52, C53, C54)**

[C20 The provider has emergency back-up plans to assist the individual to plan for emergencies and/or disasters.](#C20emergencybackup)

[C51 Staff/ Home providers are knowledgeable about individual’s satisfactions with services and supports and support individuals to make changes as desired.](#C51indivdualsatisfaction)

[C53 Individuals are supported to have choice and control over what, when, where and with whom to eat**.**](#C53choiceeat)

**DOMAIN: CAREER PLANNING, DEVELOPMENT, AND EMPLOYMENT (C22 – C39)**

[C22-C37](#TOOLC2237)

**DOMAIN: MEANINGFUL AND SATISFYING DAY ACTIVITIES (C40 – C45)**

**DOMAIN: ACCESS AND INTEGRATION (C16, C17, C46 – C50)**

[C16 Staff (home providers) support individuals to explore, discover and connect with their interests for cultural, social, recreational, and spiritual activities.](#C16culturesocial)

1. [**INTERPRETATIONS TO THE RATINGS**](#Interpetionstoratings)

Topic: [Rating indicators that relate to each other](#ratingsthatrelatetoeachother)

Topic: [When Licensure indicators are not applicable](#whenlicensureindicatorsarenotapplicable)

Topic: [Licensure administrative review indicators](#Licensureadministrativereveiwindicators)

Topic: [Follow-up on Licensure administrative review indicators](#followuponlicensureadministrativeindicto)

Topic: [Information about a provider’s non-licensed services](#informationaboutaprovidesnonlicensedseri)

1. **INTERPRETATIONS TO THE PROCESS**

Topic: [Selection of alternate individual to rate “specialty indicators”](#alternativespecialtyindictors)

Topic: [Critical indicators - Immediate Jeopardy; rating the standard not met](#Processcriticalindictorsimmediatejeapord)

Topic: [Issuing of Immediate Jeopardy / Action Required-Hot Water](#Processimmediatejeapordhotwater)

Topic: [Site feasibility; on site surveying](#Processsitefeasibility)

Topic: [Review of medication administration](#Processsmedicationadministration)

1. **INTERPRETATIONS TO THE TOOL**

**LICENSURE INDICATORS:**

**DOMAIN: PERSONAL SAFETY (L1 - L10; L91)**

**Indicator: L2 🏳 – Allegations of abuse/neglect are reported as mandated by regulation.**

**Date:** 10/11

**Question 1:**

How is this indicator assessed? What happens when something is revealed at the organizational level?

**Answer:**

This indicator is assessed at each location. Incident reports, communication logs, and other documentation are reviewed to assess whether any reference to reportable items were also filed as complaints. Staff are also interviewed to determine their knowledge of reportable allegations.

Information is also reviewed organizationally, through a review of various reports. In the event that incidents are identified organizationally that should have been reported to DPPC these are factored in. For example, 8 locations were found to report abuse and mistreatment allegations appropriately, and showed no evidence of unreported allegations. Each location would be rated as met. Two HCSIS incidents were revealed organizationally that met the reporting threshold, but had not been reported as allegations of abuse/ mistreatment. This would result in a score of 8 out of 10 standard met. If 80% have met the criteria for reporting as required, the Provider would receive a standard met for this indicator.

**Date:** 2015

**Question 2: Placement Services**

How is this reviewed in Placement services?

**Answer:**

There will typically be less written information available in Placement services to determine if allegations have been reported as required. Surveyors will need to base their rating on the information available, even though it is limited.

It is possible that during discussions with the home care provider or placement coordinator, the surveyor becomes aware of a situation that could potentially constitute abuse. If this was not reported, this would affect the rating of this indicator. The surveyor should ask the home care provider to describe any challenging situations which have occurred over the past year, and what actions she/he took to ameliorate these problems, as a first step in determining if relevant items have been reported as required. The surveyor will also review incident reports to determine whether an incident occurred that also met the expectation for reporting as there was reasonable cause to believe that potential abuse, neglect or mistreatment occurred.

The surveyor should question the placement coordinator on how they provide training and on-going monitoring of the home care provider so that allegations are reported as required.

**Indicator: L5     There is an approved Safety plan in home and work locations.**

**Date:** 3/12

**Question 1: Placement Services**

What happens when a placement service safety plan has caretaker patterns that are not reflective of expected practice in the home, inaccurate strategies, inaccurate description of safety features in the home? How does one rate when the safety plan is noted to be incomplete, but has been approved by the area office? What should be expected concerning strategies for second floor evacuation where there is no second means of egress from this floor?

**Answer:**

A safety plan needs to include “an evacuation plan that incorporates all information about the individual’s abilities, dynamics, responsibilities and egresses, into a clear plan”. If the safety plan is inaccurate or incomplete for instance, it does not include all individuals, does not list the correct caretakers or caretaker ratios, omits steps to be taken in an emergency and/or inaccurately describes the safety features of the home, the indicator should be rated as not met.

A second means of egress is not required for placement service locations (shared living) however the author of the safety plan is required to note both the primary and the secondary strategies to evacuate. The safety plan calls for completing a question on “identification of the secondary escape route”. Many safety plans describe the secondary strategy from the first floor for example, stating that the individual will go down the stairs and out the back door instead of down the stairs and out the front door. Therefore, assuming that the Safety Plan was current, complete and accurate, the standard would be met, as long as these questions were answered.

When designing a safety plan it is important for the author to consider the worst case scenario such as what strategies are in place for individuals living on the second floor when the only egress to grade is blocked. While not required, a more thorough answer to the question on secondary escape route is indicated. It is recommended that the safety plan detail what the secondary strategy would be from the second floor in the event that the stairs down to the first floor were blocked, such as using a large window to egress, or waiting for fire department rescue in a specific place.

**Date:** 3/12

**Question 2: Placement Services**

While not required, some Placement Service locations note that they will conduct fire drills throughout the year. How is this indicator rated if fire drills are not conducted as reflected in the approved safety plan?

**Answer:**

In this situation there is an appropriate approved safety plan in place and the indicator should be rated met. This situation does however, describe lack of follow-through and compliance with a well thought out and well-written safety plan. Evidence that fire drills are not being implemented as reflected in the safety plan, along with any other information on the individual’s ability to evacuate should be reviewed within the indicator below (L-6 Evacuation in 2.5 minutes).

**Date: 4/17**

**Question 3: When do Safety Plans need to be revised to include locks on bedroom doors?**

Safety Plans need to revised every two years, or if changes occur, they need to be refiled within 60 days of the change. The Safety Plans can be within the two year cycle for houses if the only change is that locks have been installed.  Regarding QE’s role to ensure that Safety Plans are accurate and current (L5), QE will not be marking down for not having a current and accurate Safety Plan if the only thing missing is the additional step(s) of opening locked doors.

Safety Plans need to be amended relative to the locks, in two places.  The Provider needs to revise the section on the sequence for evacuating all individuals and staff’s responsibilities, and the provider needs to include the kind and level of assistance needed for all individuals. When locks are being used, the Provider needs to outline any new/revised strategies used during awake and asleep hours.  In addition, the Safety Plan needs to be revised by marking “correct” relative to the question on whether there are any locks on bedroom doors that do not provide access to an egress:

The provider needs to state “correct” that all bedrooms are:

a. may be easily opened from the inside without a key and the individual is able to unlock the door from the inside;

b. staff carry a key to open the door in the event of an emergency.

\*\* Regarding b, although the Safety Plan form may still state “staff carry a key”, regulations do not require that all staff carry keys, rather they require that the staff have immediate/ ready access to the key to unlock doors.  The Provider should note how they access people’s locked bedrooms.  For example, the provider may state that the key is stored in the staff office or state that the Master key is in a coded lock box in the bedroom hallway or that the pin is above the doorway.

2.   Within Evacuation strategies during Awake and Asleep hours:  Strategies should include the sequence of steps that staff take to evacuate individuals including unlocking all locked bedroom doors.

Some providers are including the contraindication piece in the safety plan rather than the ISP.  If the individual does **not** have a lock on their bedroom door because it was felt to be contraindicated, the Safety Plan is **not** where this exception gets noted.   When a lock on a person’s bedroom door was felt to be contraindicated, this gets referred to in the ISP.

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**Date:** 9/17

**Question 4: Placement Services**

How should the need to support other people in the shared living home to evacuate be included in the safety plan?

**Answer:**

The Area Office is responsible for reviewing and approving the safety plan for DDS funded individuals. To do this, the Area Office must be provided, in the safety plan, with a clear knowledge of the needs of all individuals needing assistance at the site, whether or not they are supported by DDS, and the care taker actions/ responsibilities and those actions for any additional staff, for safe evacuation. With this knowledge, the Area Office can more accurately assess whether the plan meets the needs of those DDS funded individuals needing evacuation support at this site.

For example, in a shared living home, there may be individuals funded by another agency and/or family members living in the home that rely on the same home care provider for safe evacuation as the individual(s) funded by DDS. In this scenario, the needs of all of the individuals that would need the home care provider’s support for evacuation should be described in the evacuation plan component of the Safety Plan.

Individuals not funded by DDS but requiring supporter assistance to evacuate should be identified in the Safety Plan and the Safety Plan should detail how many people require assistance. In addition, how everyone will be evacuated safety should be clearly described in the evacuation plan narrative of the safety plan.

**Indicator: L6  🏳 - All individuals are able to evacuate homes in 2.5 minutes with or without assistance and workplaces within a reasonable amount of time.**

**Date:** 3/12

**Question 1: Placement Services**

How do you assess evacuation in 2.5 minutes in placement services where there is no requirement to conduct fire drills?

**Answer:**

Surveyors should verify that individuals can evacuate in 2.5 minutes through documentation review and interview. In homes where the regulation does not specify a minimum requirement for drills, the provider must have a means for initially and periodically assessing the individual’s ability to evacuate. Although not required, when the placement service conducts fire drills, fire drill documentation can be utilized to determine whether the individuals can evacuate within 2.5 minutes. In the event that fire drills were not conducted and/or documented, the surveyor should assess the presence of the indicator through the review of other documentation, for example, there should be a current assessment or evidence of practice evacuations, ”mock” fire drills, and/or training and reassessment documentation available for review. In addition, during the conduct of interview and observation, a determination is made on whether the individuals have been trained and know how to evacuate. This is a critical indicator that is rated “met” when there is clear evidence that the individuals can evacuate within 2.5 minutes.

**Date:** 9/17

**Question 2:**

Can you design a safety plan that calls for re-entering the home to evacuated people in stages?

**Answer:**

No. The new regulations were promulgated in July 2016 and the evacuation time remained at 2.5 minutes.  The new regulations continue to state that staffing patterns need to be sufficient to get folks out without having to re-enter.  In other words the safety plan needs to outline actions for the staff/ home care provider to get the individual (and other family members who need help) out the first time, rather than going back and forth in 2.5 minutes. If it is anticipated that the individual will be unable to evacuate in 2.5 minutes, the Area Office and the Provider would need to consider adding services/ supports to this location such that this was possible. Alternatively, the provider can submit a waiver petition requesting extended evacuation time and obtain approval for this extended evacuation time waiver. However, it is important to note that extended evacuation time waiver petitions are rare and then only granted after a full fire safety equivalency assessment, thorough review and approvals by a number of different parties. The home would need to be equipped with certain additional fire safety features such as sprinkler systems in order to meet the threshold for consideration of extended evacuation. Often, additional supports/ services or a different placement are more appropriate and safer alternatives.

**Indicator: L8 – Emergency Fact Sheets are current and accurate and available on site.**

**Date:** 10/11

**Question 1:**

This indicator seems to require that a lot of information be present and current in order to rate standard met. What should be in place?

**Answer:**

In answering the question, it is important to highlight the purpose of the emergency fact sheet. It is to provide information of use in finding an individual if missing or in an emergency. Information is used to aid in successfully locating the individual by police, to be used by medical personnel as a guide in providing initial treatment in a medical or health care emergency, etc. Therefore, detailed information is needed on a variety of items.

Key Components – must be present and filled in with current, accurate information for a rating of “standard met”

Emergency fact sheet is present on site and contains the following:

* Photograph – *current and accurate photograph (per regulations taken within the last 5 years and after any significant change in the appearance of the individual);*
* Name – *include any nicknames the individual might respond to;*
* Age – *could include the birth date, but if the age is included it needs to be accurate*;
* Language/Ability to Communicate – *Speaks English, Spanish, uses gestures, American sign language, etc.*
* General Physical Characteristics – *to include gender, weight, height, build, hair color, and any identifying marks or distinguishing items (for example, hearing aids, eye glasses);*
* General nature of abilities and physical handicaps – *travels independently, uses a wheelchair, easily confused, cannot travel safely independently, etc.*;
* Special medical problems – *should include all current medical and psychological diagnoses or conditions that could affect the immediate health or well being of the individual including known drug and food allergies, any significant past medical diagnoses or procedures that could potentially impact emergency care, such as spinal rods or organ transplants.*
* List of current medications – *need to include all medications listed on the current medication treatment chart or all medications that are currently prescribed/ordered/regularly taken. Does not need to include dosage;*
* Pattern of movement, if missing previously – *are there places the person would tend to frequent if missing*;
* Likely response to search efforts – *will the person tend to respond to the police, be frightened and hide, etc.;*
* Name and phone number for the designated contact person for each provider serving the individual;
* Guardian name and phone #
* Name and phone # for the friend or relative to be contacted in the event of an emergency *(if different from guardian referenced above)*;
* Name, phone # of primary physician;

Other Components – need not be present for a rating of “standard met” but should be filled in with current information

* Health Insurance Information – *health insurance status and the name of a person to be contacted about the individual’s medical status and needs.*
* Name, phone #, addresses of family, previous programs, etc.
* Name, phone # of service coordinator

**Indicator: L9 - Individuals are able to utilize equipment and machinery safely.**

**Date:** 10/11

**Question 1:** **All Services, except Placement Services**

This indicator is now rated for residential services as well as employment / day services. Should this indicator be rated for all individuals residentially? What should be in place?

**Answer:**

This indicator focuses on the provider’s ability to promote optimal independence while ensuring that individuals are safe in the process. To the extent possible this indicator should be rated in residential services. Equipment and appliances are defined in the broadest sense such as use of blenders, snow-blowers, etc. In general, providers need to have a written assessment for each individual on the individual’s home safety skills including use of equipment and their needs, if any. Evaluation of the individual’s skills and needs in relation to home safety, including operation of devices is the first step in working with the individual to gain greater independence safely.

Guidance, supervision, support, review of safety precautions, and training should then be provided to any individual assessed to need support to utilize equipment safely. While promoting optimal independence is desirable, the indicator measures the provider’s ability to support safe use of equipment rather than the quality of the provider’s training or the speed with which the individual gains independence.

When it is so clear from both the perspective of the provider and DDS surveyors that the individual is not now nor will likely ever be able to benefit from further training in home safety, elimination of unnecessary paperwork is supported. If individuals are not involved in, or participating in using equipment, and due to intensive medical or cognitive needs, this indicator is clearly not applicable to the particular individual, then a written assessment on the individual’s home safety skills may not be present, and this indicator does not need to be rated.

The indicator is rated once for the location based on a review of a sample of individual information. This is considered a “location indicator” as staff must ensure there is safe use of equipment for everyone living or working within the location.

**Indicator: L91 –Incidents are reported and reviewed as mandated by regulation. (new indicator in the Personal Safety Domain)**

**Date:** 11/18

**Question 1: All Services**

How is this new indicator evaluated, measured and rated?

**Answer:**

This is a site based indicator, meaning that it is rated for each site sampled. Please see tool for guidelines and criteria for rating. However, there are several sources of information and evidence that need to be collected to evaluate this indicator. There are several items that need to be assured to be successful in incident reporting:

1. Providers are responsible to meet the following required timelines regarding incident reporting:

|  |  |  |
| --- | --- | --- |
|  | Major incidents | Minor incidents |
| Initial  | 1 business day | 3 business days |
| Final | 7 business days  | 7 business days  |

**Instructions on how to determine:**

 **1. Generate Aging Incident Summary Report):** To review timelines for submission and finalization of incident reports for those locations selected as part of the survey sample. **\*\*\* Please note that effective in 10/18, this report will be enhanced to allow for the review of all incidents, both open and closed, to be assessed relative to timelines,** Review for the last 13 months.

* + \*\*This report only shows incidents that are out of compliance with the timelines\*\*.
	+ If the incident is listed but is noted to be 0 days late in the provider creation and provider finalization sections, then DDS was overdue in their review(s).
* Log into Virtual Gateway and Enter HCSIS
* Click on QM Tab
* Click on IM
* Click on Report
* Click on Incident Management
* Click on Aging Incident Summary Report
* Enter from date (Start) and To date (date range)
* Select Provider from Drop Down
* Select Report Format
* Click on View Report
* You can then preview or print report.





If an individual’s name appears without a site identified, determine the location that the incident occurred to determine if the incident occurred at any of the locations selected as part of the sample. If so, include as an incident for that location.



1. **Off – Site:**
	1. For each name that is not associated with a site on Aging Incident Summary report, review the incident to determine the type of service and location that the incident occurred.
	2. Review of submission of incident reports, for locations in sample, for compliance with required timelines. This report is produced once, and used to determine compliance with timelines for each location sampled. (Generate Aging Incident Summary Report)
	3. If the location/ individual “looks like” timelines are **not met per the Aging report, this is ONLY a starting point**.  The surveyor must drill down into each incident to determine whether there was an actual delay in reporting.
		1. If this was an unexpected hospitalization that remained un-finalized at the 7 day mark because the individual was in the hospital, then do not count this as late.
		2. Surveyors may have to recount by hand.  If upon recount, counting from the date of discovery as day 0 to the day of creation or finalization, you find that they are within timelines, do not count this as late.
2. All incidents need to be reported as mandated. Anything meeting the threshold of a reportable incident needs to have a corresponding incident report filed through HCSIS.

**1. On-Site:** Cross check

1. Interview staff for knowledge in incident definitions and reporting requirements
2. Review documentation (individual and location) to assess whether reportable items noted within communication log, individual record, or interview were also submitted as incident reports.
	* Examples of reportable incidents that may have occurred and would have required a corresponding incident report:
* Unexpected hospitalization noted through hospital discharge paperwork
* Injuries that meet the reportable threshold (communication logs, shift notes)
* Police involvement to manage a situation referenced in a communication log book
* Staff report/ describe an incident that occurred more than a week ago
1. Guardians need to be notified of all major incidents.

**Off- Site & During Survey:**

1. Confirm through guardian interview and
2. Check the box under notification on incident report (if major incident) that indicates that the guardian has been notified.



**DOMAIN: ENVIRONMENTAL SAFETY (L11 – L30)**

**I****ndicator: L11 🏳 – All required annual inspections have been conducted.**

**Date:** 10/11

**Question 1:** **Placement Services**

How is this indicator assessed for Placement services/care provider homes? What is the role of the Placement service in ensuring that necessary systems are inspected? How frequently should the Placement service review each home, and for what items?

**Answer - amended 3/12:**

This indicator assesses whether the necessary inspections have occurred. The Placement agency needs to monitor care provider homes to ensure that each complies with the environmental safety expectations referenced in 7.07 (5), oversees the environmental safety, maintenance and upkeep at each care provider home and ensures that the inspections noted above have occurred. The Placement agency needs to assure either through monthly visits or through some other process (e.g. an annual site inspection) that a mechanism is in place to monitor care provider homes and that the Placement agency is able to describe the system of oversight. The care provider homes must comply with all applicable laws, standards and regulations. For care provider homes, the following are specifically required:

* + Heating and plumbing systems installed and maintained (heating inspection)
	+ Fireplaces, wood burning stoves, pellet stoves when being utilized must be inspected
	+ Sprinklers when present must be inspected

**Date:** 9/17

**Question 2:**

What is the time range relative to annual inspections?

**Answer:**

The inspection must occur within the past 15 months (to allow reasonable time for any potential scheduling difficulties/ reporting).

**Date:** 9/17

**Question 3:**

What is expected relative to fire extinguishers?

**Answer:**

Fire extinguishers are now equipped with a dial that indicates in green that it is operational. As such there is no longer a need to annually inspect fire extinguishers. Fire extinguishers will need to remain in the green zone or to have some visual indication that they are operational.

**Date:** 3/19

**Question 3:**

What is expected relative to gas furnace inspections?

**Answer:**

The licensure tool has been revised in 3/1/2019 and no longer allows for possibility of having gas furnaces be visually inspected by a maintenance worker or potentially even the homeowner annually.  Implementation of a visual inspection by individuals who are not equipped to service the furnace is problematic because there is no standard for conducting this type of gas furnace inspection, and even when a problem is revealed, the person conducting the inspection may not be equipped to conduct the service or maintenance needed.

To assure that the proper safeguards are in place, DDS has made the following changes:

•             The gas furnace needs to have a service and maintenance inspection annually.

•             This inspection must be performed by a qualified service technician to confirm that it is functioning effectively and determine whether any service or maintenance is needed.

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**Indicator:** **L12 🏳 – Smoke detectors and carbon monoxide detectors, and other essential elements of the fire alarm system required for evacuation are located where required and are operational.**

**Date; 2012**

**Question 1:**

Briefly, what are the expectations to meet this indicator?

**Answer:**

Smoke detectors must be placed as required in the building code. Carbon monoxide detectors also need to be in place as required. If the home has interconnected smoke detectors, they need to work, and all detectors will be sounded during the review to ensure they are working properly. If the home has been built or upgraded since August 27, 1997, the smoke detection system would also need to be updated in accordance with the current building code, for example smoke detectors would also need to be in bedrooms.

**Date:** 9/17

**Question 2: Placement Services; also applies to Residential Services**

What do I need to keep in mind relative to the fire alarm system in a shared living home?

**Answer:**

Smoke detectors must be placed in the home care home as required in the building code. Carbon monoxide detectors also need to be in place as required. If the home has interconnected smoke detectors, they need to all work, and all detectors will be sounded during the review to ensure they are working properly and are fully interconnected. Battery operated detectors are acceptable. Homes built before 1975 must be equipped with smoke detectors with a ten year life span. All detectors should be periodically tested by the Provider or the home care provider to ensure they are working properly at all times.

If the home has been built or upgraded since August 27, 1997, the smoke detection system would also need to be updated in accordance with the current building code. For example, if a home has interconnected smoke detectors, and then is renovated to add a bedroom, the smoke detection system must also be upgraded such that the new system is interconnected inclusive of the new bedroom and meets current code requirements i.e. smoke detectors in all bedrooms.

**Indicator:   L15 – Hot water temperature tests between 110 and 120 degrees.**

**(Effective January 2014: Hot water temperature tests between 110 and 120 degrees.)**

**Date:**  1/14 (Revised 9/17)

**Question 1:**

What is the expectation for water temperature?

**Answer:**

As of January 2014 the standard which is based on the plumbing code, the State Sanitation code and the Consumer Product Safety Commission’s recommendations will be:

Deliverable water temperatures should be between 110 degrees and 120 degrees for residential faucets, 110 degrees for faucets in day program or employment training sites operated by DDS providers, and no more than112 degrees for shower temperatures.  The change in the guidelines regarding water temperature for both showers and sink faucets was made after review of the Plumbing Code (248 CMR 10.4 (3) (a) 2, 3, and after consultation with DDS Facilities Management staff. The objective in making this change was to best ensure individuals’ health and safety and to prevent scalding incidents.

While water heaters can be set slightly higher to ensure that bacteria is killed and dishwashers are accommodated, the delivered water temperature (temperature when it comes out of the faucet) should be at the temperatures referenced above.

The revised State Plumbing Code which has been in effect since 1988, does not require retro-fitting of existing homes, but does require appropriate deliverable water temperatures for new construction and/or renovation of existing homes (i.e. when a building permit needs to be pulled).  Some, but not all homes are already equipped with the appropriate “product -approved individual thermostatic / pressure balancing valve complying with ASSE 1016" which limits deliverable water temperature at the shower/ bath to 112 degrees, as they have been built or renovated since the plumbing standard went into effect and the device already installed by the licensed plumber.

While retro-fitting is not a requirement for existing homes, DDS is **strongly recommending** that providers move towards making the necessary modifications if they currently do not meet this standard. This is due to the obvious risks posed by temperatures that may result in scalding incidents.   Licensure and Certification staff will check water temperatures in both showers and sink faucets when conducting routine surveys, and will point out instances where shower/bath temperature is not consistent with the applicable Plumbing Code Standards.  Surveyors will **recommend** that temperatures be adjusted, but will not rate providers down if the temperature in showers does not comport with the Plumbing Code Standards.

The deliverable water temperature at the sink faucets, however, is tied to a combination of the existing State Sanitary Code (between 110 and 130 degrees) and guidelines published by the American Burn Association and the Consumer Product Safety Commission, which cap the upper limit to 120 degrees.  Surveyors therefore, will cite the location if deliverable water from any residential faucet or fixture exceeds 120 degrees.

In all locations, where individuals are utilizing water with staff assistance, all necessary precautions must be taken to regulate the water temperature, and to keep the temperatures at safe optimal levels.  For example, in locations where individuals are less mobile, water may pool/ collect on the individual and is more likely to scald at lower temperatures.  In these locations, use of scald protectors, adjustment of the water temperature to lower levels, and ongoing checks of the water temperature is advised.

The Burn Foundation and the American Burn Association outline general bathing precautions in their literature and on-line.  They instruct people to fill the tub to desired level and turn water off before getting in. Literature also suggests running cool water first, then adding hot. Then turn the hot water off first. This can prevent scalding in the event someone should fall in while the tub is filling. Mix the water thoroughly and check the temperature by moving your elbow, wrist or fingers with spread fingers for several seconds through the water before allowing someone to get in. The water should feel warm to touch.  Both groups recommend that the safest temperature for bathing is 100 degrees.

**Date:**  (9/17)

**Question 2:**

How are the expectations for water temperature as outlined below rated and when should an immediate jeopardy be issued?

**Answer:**

Licensure and Certification staff have been checking water temperatures in both showers and sink faucets since 2014, and pointing out instances where shower/bath temperature is not consistent with the applicable Plumbing Code Standards. Although the indicator requires that the water temperature at sinks be between 110 and 120 degrees, and at the showers be between 110 and 112, if the water temperature at sinks or showers is between 100 and 120 degrees the indicator will be rated met.  A temperature tested at the faucet and shower that lies below 100 or above 120 degrees, will be rated as a not met.

Immediate Jeopardy should be issued and the Provider given 1 day to correct the situation when the residential water temperature exceeds 120 degrees at either the sink or shower and the individuals are not independent. While the Provider has up to a day to correct the deliverable water temperature, they need to take immediate preventative actions to ensure that all individuals are safe in the interim and that the water temperature is regulated and adjusted to safe and comfortable levels prior to utilization/showering/ bathing.  An action required notice is given if the individuals can independently adjust water temperature.

**Indicator: L18 - All other floors above grade have one means of egress and one escape route on each floor leading to grade**.

**Date:** 3/12; revised 12/17

**Question 1: Placement Services**

Do you rate this indicator in placement services?

**Answer:**

Placement service locations are not required to have two means of egress (or one means and one escape route) from any floor other than grade level. The presence of egresses on other floors for placement service locations is not rated, unless this is a Provider owned / leased property.

**Date:** 3/12

**Question 2:**

The indicator states that floors above grade need one means of egress and one escape route. Is this also true for floors below grade, such as basements?

**Answer:**

Yes. Any floor above/ below grade utilized by individuals need to have one means of egress and one escape route and be referenced in the Safety Plan.  In addition, floor plans need to be included with the Safety Plan. This indicator is rated for all 24 hour, placement service, and employment locations, which are owned or leased by the Provider. It is also rated for community based day.

**Indicator: L21 - Electrical equipment is safely maintained.**

**Date:** 9/17

**Question 1: Placement Services**

What is the expectation regarding reviewing this indicator as it pertains to placement services?

**Answer:**

The surveyors will conduct a brief walk- through of the basement to ensure that as on other floors, there are no overloaded outlets, electrical wires passing across frequently traveled floor areas, etc. As circuit breakers are in the family home, the home care provider needs to ensure that they are familiar with which circuit breaker goes to which part of the home, however, the requirement that circuit breakers are labeled does not apply to placement services.

**Indicator: L27 - Swimming pools are safe and secure according to policy.**

**Date:** 9/17

**Question 1: Placement Services**

What is expected relative to swimming pools in placement services?

**Answer:**

Having a pool in/at the home can be a positive addition to individuals’ quality of life. If used safely, it can increase a person’s physical fitness and overall sense of well-being. There need, however, to be procedures in place that support safety when there is a pool. Please refer to the document: **DDS Water safety - safeguards at home and within the community- 5/2013.** In summary, the expectations for use of a pool are:

* Environmental safeguards (e.g. locked access when not in use) must be in place.
* An assessment of each individual's water safety skills must be made.
* The home care provider supervising individuals must be trained in water safety and CPR, with documentation present in the home. (An on-line Basic Water Safety course which covers basic water safety can suffice).
* Policies and procedures outlining supervision and use of pool need to be in place, and the home care provider needs to be knowledgeable in these.

The Provider has a key role in ensuring success in this indicator. The Provider can develop a systemic approach, providing guidance, training and support to all individual home care providers with pools to facilitate each home care provider’s understanding of water safety, the particular individual’s water safety skills and to assist in the development of safe practices for use of the pool.

**DOMAIN: COMMUNICATION (L31 – L32)**

**DOMAIN: HEALTH (L33 – L47)**

**Indicator: L33- Individuals receive an annual physical exam.**

**Date:** 9/17

**Question 1:**

Does an appointment for an acute illness/ routine healthy follow-up visits suffice as an annual physical exam?

**Answer:**

No, it does not. Certainly, appointments with primary care providers are important and should occur whenever needed. However, an annual physical includes a more thorough review and preventive and routine health screenings that are not necessarily included in “sick visits” or in routine update visits.

The Provider has a key role in ensuring success in this indicator. The Provider should work closely with the staff/ home care providers to make sure that the annual physical occurs and is complete and that documentation reflects full information on the annual physical visit.

**Date:** 1/20

**Question 2:** How is this indicator assessed?

**Answer:** Current annual physical examinations should be within 15 months of the previous physical examination. Although physical examinations are required to be annual, surveyors will consider the physical exam current if it falls within 15 months of the previous one to account for scheduling difficulties. Surveyors will be reviewing the past two physical examinations to ensure that they have occurred within a 15 month interval.

**Indicator: L34** - Individuals receive an annual dental exam

**Date: 9/17**

**Question 1:**

Does Mass Health still pay for dental exams?

**Answer:**

Yes, for individuals who are covered by MassHealth. The Provider has a key role in ensuring success in this indicator. The Provider can assist staff/ home care providers with the documentation and information they need to make sure that the annual dental exams occur.

**Date:** 1/20

**Question 2:** How is this indicator assessed?

**Answer:** Current annual dental examinations should be within 15 months of the previous dental examination. Although dental examinations are required to be annual, surveyors will consider the dental exam current if it falls within 15 months of the previous one to account for scheduling difficulties. Surveyors will be reviewing the past two dental examinations to ensure that they have occurred within a 15 month interval.

**Indicator: L36 - Recommended tests and appointments with specialists are made and kept.**

**Date: 9/17**

**Question 1:**

Does this indicator refer to tests and appointments requested by family members/guardians?

**Answer:**

No. This indicator relates specifically and only to recommendations made by health care providers (HCPs). Tests and specialists only requested by guardians/family members are not the focus of this indicator. The Provider has a key role in reviewing health care information routinely and ensuring that all tests, appointments, and follow-up visits occur as recommended by the HCPs.

**Indicator: L37 - Individuals receive prompt treatment for acute and episodic health care conditions.**

**Date: 9/17**

**Question 1: Placement services; also applies to all services**

What is the expectation within a placement service home to determine whether individuals receive prompt treatment for health care conditions?

**Answer:**

Home care providers/staff need to receive training to ensure that there is awareness of the individual’s condition, and those observable symptoms that might warrant medical attention. Training and review of facts sheets and reference guides located on the web are a first step to ensure that the home care provider/staff is familiar with common ailments and when to call the doctor, and to access medical treatment.

In addition to review of documentation, such as logs etc. which are often less prevalent in a placement service home, surveyors will interview the Provider, the home care provider and the individual to assess whether the individual is receiving prompt treatments for acute and episodic events.

**Indicator: L38 🏳- Physicians’ orders and treatment protocols are followed. (When agreement for treatment has been reached by the individual/ guardian/ team).**

**Date:** 1/20

The following set of Interpretations incorporates all relevant information from past 2011-2018 into one modernized section. This section replaces previous interpretations which have now been deleted from this Interpretations guide.

**WHEN IS A MEDICAL TREATMENT PROTOCOL**

**(HEALTH CARE MANAGEMENT PLAN) NEEDED?**

If a person has a medical condition that requires staff to perform specific actions steps to manage/treat and/or prevent a more serious health issue, the need for a protocol/management plan should be discussed with the Health Care Practitioner (HCP)\*. Part of this discussion with the HCP should include when the HCP or 911need to be contacted if specific symptoms are observed.

* If the HCP did not write a treatment protocol initially, when a known significant medical condition exists, it is important for the staff/provider to follow-up with the HCP, and inquire about whether a written treatment protocol/management plan should be put into place to specify actions for staff to follow.

There is no exact list of “significant medical conditions” that automatically warrant a medical treatment protocol/ home health management plan. In large part, the determination of the need for a health care management plan is based on whether staff intervention to monitor, prevent, treat, and/or seek medical assistance for the condition is needed.

|  |
| --- |
| **Examples of significant medical conditions may include but are not limited to:** |
| Dysphagia | Diabetes | Epilepsy/Seizure Disorder | Severe Allergies/Asthma | Sleep Apnea |

**Health Care Practitioner (HCP)** means an individual who is licensed or otherwise authorized by a state to provide health care services. (45 CFR § 60.3)

**WHAT SHOULD BE IN PLACE?**

\*\*Verification can consist of using an original health care practitioner encounter form if it gives instructions regarding action steps and when to access a healthcare practitioner and/or 911.

The frequency of review of should be determined by the monitoring HCP

**The Protocol/Health management plan can vary in complexity based on the person’s support needs. It is important that health care management plans be written in a manner that direct support staff can easily understand and are able to follow the guidance/ instructions necessary to address the significant health condition.**

**\*\*\*The following examples are for illustration only, not meant for reproduction \*\*\***

***Dysphagia - A Medical Treatment Protocol/ health management plan that outlines action steps for staff to implement******in order to assist the person with managing dysphagia and prevent choking and/or aspiration. It must include information about how to recognize choking and/or aspiration and when to access medical assistance.***

**Name: John Jones**

**Action Steps:**

1. **Diet: Encourage small bites and sips**
* Honey consistency liquids
* Pureed foods
1. John should sit up at a 90 degree angle for 30 minutes after eating
2. John’s bed should be elevated 45 degrees when sleeping.

**Aspiration** is defined as when something enters the airway or lungs by accident.

**\*\*\* If any of these symptoms are note, contact the HCP.**

Aspiration from dysphagia can cause signs and symptoms such as:

* Feeling that food is sticking in your throat or coming back into your mouth.
* Pain when swallowing.
* Coughing or wheezing after eating.
* Coughing while drinking liquids or eating solids.
* Chest discomfort or heartburn.
* Elevated temperature/Fever minutes to an hour after eating

 **What are symptoms of aspiration pneumonia?**

* chest pain.
* shortness of breath.
* wheezing.
* fatigue.
* blue discoloration of the skin.
* cough, possibly with green sputum, blood, or a foul odor.
* difficulty swallowing.

**\*\*\*\*If the person is having difficulty breathing call 911.\*\*\***

Joan Happy SLP 3/11/19

Valid until reevaluated which is recommended every 3 years or if instances of choking/ aspiration or pneumonia continue.

***Congestive Heart Failure (CHF) - A Medical Treatment Protocol/ health management plan that outlines action steps for staff implement******to assist the person with managing CHF how to recognize when to access medical assistance.***

****

***Severe Asthma - A Medical Treatment Protocol/ health management plan that outline action steps for staff implement******to assist the person with managing Asthma and how to recognize when to access medical assistance.***

**Verification that the CHF protocol/home management plan is recommended to be followed per practictioner.**



**Name: Tim Strong DOB: 10/15/1980**

Action Steps

1. Tim is highly allergic to dust, mold and tree pollen – These can trigger a severe allergic attack.
* Staff have to dust daily at a time the John is not present in the area.
* During the months of Sept. Oct. Nov (Fall) the pollen counts are high
	+ Windows should remain closed. Hepa Air filter kept on at all time.
1. Tim also has exercise induced asthma attacks. It is important for him to warm up slowly and adequately prior to rigorous exercise.
2. Tim is prescribed daily medications to treat his asthma.
* He is also prescribed Pro- Air a quick-acting (rescue inhaler) to be used when he is having a flare up.

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Directions for Use** |
| Pro Air Inhaler | 90 mcg | 2 puffs by mouth for asthma flare up symptoms* + Wheezing
	+ Coughing
	+ Difficulty breathing

Diff | Repeat in 20 minutes if no improvement.Repeat up to 3 times |

**Call 911** any of these symptoms are observed.

* Severe [wheezing](https://www.webmd.com/asthma/video/prevent-wheezing-in-children-with-asthma) when breathing both in and out
* [Coughing](https://www.webmd.com/cold-and-flu/cough-relief-12/slideshow-cough-treatments) that won't stop
* Very rapid breathing
* Chest tightness or pressure
* Difficulty talking
* Feelings of [anxiety](https://www.webmd.com/anxiety-panic/default.htm) or [panic](https://www.webmd.com/balance/stress-management/rm-quiz-stress-anxiety)
* Pale, sweaty face
* Blue lips or [fingernails](https://www.webmd.com/webmd/consumer_assets/controlled_content/healthwise/symptom/nail_problems_and_injuries-topic_overview_symptom_hw257352.xml)
* No improvement after using a quick-acting (rescue) inhale

John Smith John Smith MD – 3/14/19

**HOW IS THIS INDICATOR EVALUATED?**

Surveyors must assess that treatment protocols/ health management plans are implemented consistently. In summary the following items must be in place to render a rating of met:

* Written protocol
* Staff are knowledgeable (*Based on interview and training documentation*)
* Correct implementation of protocol/health management plan

Staff must be trained, **knowledgeable, and consistently following** the **medical treatment protocols** to rate this indicator met. Thus, evidence is needed that all staff have been trained in this protocol, **and** that this protocol is being consistently implemented. If treatment protocols have not been implemented consistently, the standard is not met, regardless of the presence of training documentation.

**Person has Significant Medical condition**

**There are no action steps for staff**

**or**

**Individual**

 **self -manages**

**Staff need to monitor and implement actions steps**

**Not Rated**

**(L 38)**

Yes

Yes

Yes

Yes

Yes

**Met**

Yes

Yes

Staff implement accurately

No

**Not Met**

Staff demonstrate knowledge of action steps

(interview and training)

No

**Not Met**

Written Protocol

(2 elements listed in flow chart above)

No

**Not Met**

**WHAT IS THE THRESHOLD FOR STAFF KNOWLEDGE AS DETERMINED THROUGH INTERVIEW?**

Staff must be both trained and knowledgeable. Surveyors will review training documentation and interview direct support staff about whether the sampled individual(s) has a health care protocol, and ask them to describe the protocol and what actions steps they take.

To be rated **met**, staff must be aware that a protocol is in place, and staff must be knowledgeable in the specific actions they are expected to implement.

There may be circumstances when staff are required to be familiar with every action step in the protocol; there may be other circumstances when staff need to be knowledgeable in when to seek medical assistance but could reference to the protocol for guidance regarding specific action steps. For example:

**Allergy to Bee Stings** – Staff must know exactly all the actions steps to respond immediately including the administration of medication and contacting emergency personnel.

**Dysphagia** – Staff need to know that a person has a protocol in place, but could reference the protocol for specificity around diet texture, the angle the person needs to sit at when eating. Staff however, have to be knowledgeable of how to immediately respond to signs of choking or aspiration.

\*\* All staff must be knowledgeable concerning when to call 911.\*\*

**CAN A MEDICAL CONDITION EXIST WITHOUT A HEALTH MANAGEMENT PLAN, AND WHEN WOULD A PROTOCOL BE INDICATED?**

Yes. A health care protocol is not necessary for an individual with a medical condition who receives on-going monitoring from a healthcare practitioner (HCP) who does not recommend any staff actions other than the administration of medication sand there is no requirement for contacting medical professionals and/or emergency medical services if specific symptoms occur between appointments.

Over time, this may change and the health care practitioner encounter forms should be reviewed for instructions regarding action steps and when to access a healthcare practitioner and/or 911. When HCP notes reflect needed staff actions to treat/manage the condition and instructions to contact medical professionals and/or emergency medical services if specific symptoms occur, then a protocol would be necessary.

**HOW DOES AGREEMENT WITH A HEALTH MANAGEMENT PLAN WORK?**

During the appointment with the HCP, the individual will learn about their significant medical condition and of the recommendations for staff actions. Once developed and verified with the HCP, the proposed treatment / health management plan needs to be discussed with the person and/or their guardian to ensure that he/she is willing to accept/participate in the proposed action steps. Health care management plans are required to be incorporated into the ISP.

**QUESTIONS:**

**Date: 12/19 version**

**Question 5:** When someone has a significant medical condition resulting in the need for a special diet, does the person also need a medical treatment protocol/health management plan?

**Answer:**

No, a medical treatment protocol is not always required. A Medical Treatment Protocol should be developed and implemented only when the significant medical condition requires staff intervention to monitor, prevent, treat, and seek medical assistance for the condition. For example, the HCP may recommend that someone with blood pressure concerns go on a low salt diet, with ongoing monitoring during regular follow-up appointments with no other health care management strategies. Special diets such as low salt diets, diabetic diets, gluten free diets, and should be evaluated within indicator L-39.

Also special diets may be in place for reasons other than a significant medical condition. These would be evaluated in L39. For example someone who is on a ground diet because they are edentulous does not meet the threshold for having a significant medical condition, and would therefore not automatically need a corresponding Medical Treatment Protocol.

**DATE: 2/15; revised 1/20**

**Question 6: Day Supports**

How is this indicator reviewed in a day service?

**Answer:**

The considerations are essentially the same across service types. It is essential that staff supporting the person, including day service support staff, be aware of significant medical conditions affecting a person’s health. Further, staff should be knowledgeable of their role and action(s) to take in supporting the person should the condition become active during the day service.

As a day service provider does not typically coordinate an individual’s health care, obtaining timely and accurate information can present a challenge. The surveyor begins with reviewing what information is documented about an individual; Emergency Fact Sheet, Health Care Record (if available), and the Individual Support Plan as examples. Along with the information present in the individual’s record, a surveyor would want to know how the provider ascertains health information and what the mechanism is for seeking this information from the person’s service coordinator, residential service provider, and/or family.

Once the surveyor has a sense of what the person’s medical conditions are, the surveyor can research the situation to determine as noted above whether there is a necessity for a medical treatment protocol. The criteria are basically the same:

* There is a diagnosed significant medical condition affecting the person’s health;
* The condition is active and/or being actively treated;
* This condition is present and staff are providing ongoing support and /or actions /emergency response is potentially needed during the **day** service hours.

When the above is true, the day service provider must obtain or develop a protocol / health management plan guiding its staff. If a person is supported residentially, the residential home may have obtained/developed a specific treatment protocol/ health care plan, a copy of which should be made available to the day service.  In situations where the individual does not receive another service, the day service must rely on its own mechanisms for obtaining relevant health information. In any event, if a person has a significant medical condition, , it is essential that there be a consistent approach to treatment, and a written protocol/ health care management plan is required as noted above. Depending on the severity of the condition and the information available to the day service, this can be a generalized protocol outlining staff actions, for example in the event of seizures, staff contact 911.  However, when the significant medical condition has specific action steps for implementation these should be clearly outlined in addition to noting when to contact medical professional and/or call 911 if necessary when medical emergency. .

Based on the need for a protocol that would need to be present during the day service, the rating of the indicator will be focused on the following:

* There is a mechanism for ascertaining what awareness/support might be needed during the day service;
* There is a protocol outlining the condition that has sufficiently specificity\* to the person and the steps staff should be prepared to take if needed;
* Staff are knowledgeable of the condition and the steps they should take;
* There is evidence of the protocol being implemented correctly when /if it has been needed.

\* “Sufficiently specificity” means commensurate with the severity of the condition and the level of intervention needed by staff. For example, a person with epilepsy that is infrequent may have a more generalized health care protocol with contains only generalized actions and emergency contact steps. But a more severe, active form of epilepsy may require a more individualized health care management plan with defined steps based on identified criteria. As mentioned above, both components need to be addressed within a medical treatment protocol:

|  |  |
| --- | --- |
| A series of actions that staff/providers need to implement to treat/manage or prevent a more serious condition | How to recognize issues related to the condition to determine when to contact medical professional and/or call 911 if necessary. |

In assessing the above, the surveyor conducts the following activities:

Offsite

* The surveyor reviews ISPs, HCRs, and Site information via the Meditech and/or HCSIS systems to learn about the individual’s needs and the setting(s) where he or she is supported. This helps the surveyor understand what services and supports they should be expected to see and hear about when they visit.

Onsite

* The surveyor reviews the individual’s record, such as the Emergency Fact Sheet, progress notes, or communication logs. When a protocol should be present, the surveyor will also review documentation to identify if there were any instances of the protocol needing to be implemented. The surveyor reviews any documentation related to the protocol, including training documentation.
* The surveyor interviews staff about the individual’s supports to verify that staff are knowledgeable of the protocol.
* The surveyor will ask if the protocol has been implemented and request evidence of that, whether in an incident report, progress note, or communication log.

The following examples are intended to help illustrate this applicability and rating process.

**Medical condition: Seizure Disorder/Epilepsy – Day Services**

|  |
| --- |
| **Scenario 1*** Emergency Fact Sheet documents “history of seizures.” (e.g., family reported there had been a seizure when person was a child);
* The person is not prescribed a neuroleptic;
* There is not an actual diagnosis documented;
* There has been no known seizure activity;
* The agency has evidence of its request for medical information from the residential services provider and/or family and there were no instructions related to this condition.

Protocol Needed: NoRated: NoProvider asked to seek verification/correction to this notation on the EFS. |
| **Scenario 2*** Emergency Fact Sheet documents “Epilepsy”;
* The person is prescribed a neuroleptic;
* There has been no seizure activity in last 5 years;
* There is no physician ordered instructions or recommendations available at the day service;
* The agency has evidence of its request for medical information from the residential services provider and/or family and there were no instructions related to this condition.

Protocol Needed: Yes – can be general in accordance with DDS Seizure guidelines; andStaff knowledgeable of protocol: If Yes, Rating: Met If No Rating: Not Met; andIf Protocol has been implemented, was protocol followed: If Yes, Met If No, Not Met  |
| **Scenario 3*** Emergency Fact Sheet documents “Epilepsy”;
* The person is prescribed a neuroleptic, including PRN Diastat for seizure lasting greater than 1 minute;
* There has been seizure activity in last 5 years;
* There is no physician ordered instructions/ recommendations available at the day service; or There are physician ordered instructions or the provider has requested medical information from residential services provider and/or family and there were specific instructions related to this condition.
* The agency has evidence of its request for medical information from the residential services provider and/or family and there were no instructions related to this condition.

Protocol Needed: Yes and must be individual specific for rating of Met; the day service protocol should agree with / correspond with the physician instructions and the residential services provider planStaff Knowledgeable of protocol: If Yes, – Met If No – Not Met; andIf Protocol has been implemented, was protocol followed: If Yes, Met If No, Not Met |
| **Medical Condition: Diabetes Scenario 1*** Emergency Fact Sheet documents “Diabetes”
* Dietary recommendations include low calorie and avoiding sugary foods
* The person is not prescribed a medication related to this condition
* There are no “triggers” as to when to contact medical professionals
* The agency has evidence of its request for medical information from the residential services provider and/or family and there were no instructions related to this condition.

Protocol Needed: NoStaff knowledgeable of person’s condition: Yes but not rated in L38. |
| **Scenario 2*** Emergency Fact Sheet documents “Diabetes”
* The person is on a strict diet for this condition
* Medical professionals need to be contact when the person’s condition reaches a certain point
* The person has a treatment order to test blood sugar during day program hours.
* The person can independently test blood sugar level but needs support to interpret and respond appropriately to those results.
* The provider holds a supply of glucose tabs to be administered if needed.
* The provider has requested medical information from residential services provider and/or family and there were special instructions related to this condition.

Protocol Needed: Yes - must include parameters for glucose tabs and agree with special instructions from HCP.Staff Knowledgeable of protocol: Yes – Met No – Not Met; andIf Protocol has been implemented, was protocol followed: If Yes, Met If No, Not Met |

**Date: 9/17; revised 1/20**

**Question 7: Placement Services**

What is the role of the Provider and the home care provider in meeting this indicator?

**Answer:**

It is the responsibility of the Provider in collaboration with and under the direction of the health care provider, to ensure that there is a health care management plan when indicated. The Provider supports the home care provider to implement the medical treatment protocols/ health care management plans. The home care provider is also responsible for tracking health related data per recommendation of the HCP, and for keeping the health care provider and the Provider up to date on the individual’s current status.

The surveyors will start with the Provider and inquire as to which individuals have a significant medical condition which warrants the need for a treatment protocol/ health management plan. While the treatment protocol may be available at the corporate site and/or at the home, it is important that the home care provider is accurately implementing all action steps outlined. The Provider needs to ensure that the home care provider is trained, knowledgeable and familiar with the treatment protocol/ health management plan. When the surveyor meets with the home care provider, the surveyor will review the treatment protocol, and interview the care provider about the protocol and about what is occurring and how these actions are being documented and shared with the doctor.

**Indi****cator: L39- Special dietary requirements are followed.**

**Date:** 9/17

**Question 1: Placement Services**

What is the home care provider’s role in meeting this indicator?

**Answer:**

This indicator relates to any situations in which a special diet is present. Individuals are supported to have a healthy diets is rated in L41. It is the responsibility of the Provider to determine and then develop, in collaboration with and under health care provider guidance, any special diet necessary. The individual home care provider should be knowledgeable and fully implementing any special dietary requirements of the individual, as evidenced through documentation and interview with the home care provider. For example, the HCP may advise the individual to go on a low-salt diet. The Provider needs to outline in writing, with the assistance of the HCP, specific instructions/ specific written guidance on expectations for maintaining a low-salt diet.

As less documentation such as menus are available within the shared living home, surveyors will be collecting evidence in support of this indicator through interviews with the home care provider, and Provider, as well as documentation. No review of the actual food in the home is necessary. Interviews will concentrate on validating that the special diet and guidance put together above is being followed. For example, someone on a low sugar diet has a list of foods to avoid, is advised to stay away from cookies and cakes, and desserts no longer include these items as options.

**Indicator: L41 – Individuals are supported follow a healthy diet.**

**Date:** 9/17

**Question 1: Placement Services**

How does the survey team evaluate whether the home care provider is supporting the individual to follow a healthy diet?

**Answer:**

This is an area that can be more challenging to evaluate because surveyors may not see the same documentation they will see in 24 hour staffed homes. However, the home care providers should be interviewed to determine whether the indicator is met. Home care providers should first be interviewed to determine whether they are knowledgeable concerning what constitutes a healthy diet, including familiarity with Executive Order 509, the USDA MyPlate model or other nutritional models.

Secondly, the home care provider should be able to describe how they use their knowledge and framework for a healthy diet, within the home. The home care provider should be able to describe how they determine meals/ menus, and what typical meals are generally provided. For example the surveyors may ask what meals were provided last week. The surveyor will also inquire about what types of items and what portions are typically served and what options are available as snacks. They will ask whether the individual has specific eating preferences and dislikes and how the home care provider works with these preferences to support options in line with a healthy diet. The surveyor will inquire about whether these preferences affect the ability to have a healthy diet and what the home care provider has done to mitigate these issues.

**Indicator: 🏳 L46 - All prescription medications are administered according to the written order of a practitioner and are properly documented on a Medication Treatment Chart.**

**Date:** 10/11

**Question 1: Placement Services**

While Placement agencies do not need to comply with MAP, what are the expectations for medication administration in care provider locations?

**Answer:**

Each care provider is free to establish his/her own mechanism for administration of medication. However, there needs to be some sort of overall system to ensure that medications are administered properly. The following components are needed:

1. Current Health Care Provider orders
2. Medication (side effect) information
3. Labeled pharmacy containers
4. Assurance by the care providers that medications are given consistent with

 Physician’s orders, and therefore should have a system to reflect/ document

 that medications have been administered in that manner e.g. check mark on a

 calendar; medication sheets, etc.

1. The Placement agency must have a mechanism to monitor and oversee medication administration at each care provider home and the ability to describe the system. For example, the placement coordinator could review medication information such as the physician’s orders, the pharmacy containers, and proof of administration of medications during the monthly visits.

**Date:** 2/15; revised 9/17

**Question 2**:

How does one determine a rating in L46 when the individual is on multiple medications and there may be a great deal of information?

**Answer:**

A Medication Issue is defined as missing one of the five “rights” under MAP (person, med, dose, time, route), and the presence/administration of expired medication.

A Documentation Issue includes missing signatures/initials for administration, use of whiteout, discrepancies between physician orders, labels, and/or MARs, missing orders, failure to note the issue identified by a circled administration sign-off, failure to note the effects of an administered PRN.

Placement Services: For homes where MAP does not apply, documentation issue includes missing signatures/initials/notation for administration; use of whiteout; discrepancies between physician orders, labels, and/or daily charting records or daily system; missing orders; or missing information to determine whether the medication has been given.

Medication prescribed for specific medical diagnosis includes both regularly administered medications and those administered PRN, even if OTC. In considering degree of severity, these should be distinguished from standing PRN orders for OTC medication intended to treat commonly occurring, temporary conditions such as fever, cough, dry skin, and upset stomach.

**Decision Considerations**

When identifying issues within the medication administration system, the following considerations should be made in determining the relative severity of the concern and whether the rating should be impacted. The information presented is intended to offer a structure for thinking through what is found. As there are a myriad of possible scenarios, it is not possible to provide guidance at a truly granular level.

**Medication Issues**

1. Was the issue noted already identified by the provider or the QES?
	1. If Provider:
		1. Were the proper steps implemented?
		2. Did these steps seem to address and resolve the issue, or are similar issues present in the current MAR?
		3. Is there any information indicating that the person was impacted? For examples:
			1. Seizure medication was missed and you noted an increase in seizures during the same period.
			2. Missing psychotropic medication that’s accompanied by significant incident or physical restraint.
		4. Are there other issues also noted, such as use of white out, missing sign-offs, or a transcription Issue?
	2. If QES:
		1. Is this medication specifically prescribed for a diagnosed condition or an over-the-counter medication for common conditions such as fever, cold or flu?
		2. Is this an isolated instance (e.g., 1 or 2 instances across the 3 months reviewed, among many meds/passes)?
		3. Is there any information indicating that the person was impacted? For examples:
			1. Seizure medication was missed and you noted an increase in seizures during the same period.
			2. Missing psychotropic medication that’s accompanied by significant incident or physical restraint.
		4. Are there other issues also noted, such as use of white out, missing sign-offs, or transcription issues?
2. **Documentation Issues**

In determining a rating on the basis of documentation issues, the criteria for rating “not met” is that the documentation issue be “significant”. To help determine this threshold, the following thought process is outlined.

* 1. Is there a discrepancy in the administration instructions that has, or likely would result in missing one of the 5 Rights of MAP? For examples:
		1. Example of discrepancy that has little potential for misadministration:
			1. Order reads: “Apply small amount to rash on buttocks morning and night.” and Label/MAR reads: “Apply to affected area twice daily.”
		2. Example of discrepancy that has potential for misadministration: Discrepancies that have the potential for misadministration include items which lack specificity or are inconsistent.
			1. Order reads: “325 mgs every 6 hours prn for physical aggression towards others not to exceed two doses within 24 hours”. MAR reads: “1 Tab two times daily for physical aggression towards others.”
			2. Order reads: Depakote 500 mg twice a day and MAR reads: Depakote 500 mg. three times a day
	2. Are there numerous discrepancies that appear ongoing and unresolved or is it just a couple instances in the past that are not currently present in the active MARs? Or in the active system, if SL/Placement Services?
	3. If the discrepancy is missing sign-offs/missing notation in SL, can it be determined that the medication was actually administered?
1. **Determining the Rating**

The following flow chart illustrates the rating determination after following the above thought processes. Additionally, a rating decision may likely be based on an overlap between a documentation issue and whether that issue is also indicative of a medication error. If so, then, both sets of considerations should be followed for determining the rating.

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|  |  |  |  |  |  |  |  |  |  |  | Medication IssueIdentified |  | Medication Issue is defined as missing one of the “5 Rights” or the presence/administration of expired medications. |
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| Proper steps takenANDNo evidence of adverse impact AND Appears resolved |  |  | Proper steps not taken OR Evidence of adverse impact OR Appears ongoing |  | Standing OTC PRN such as Tylenol, Cough syrup, Metamucil,Pepto Bismal, or Bacitracin ointment |  |  |  |  |  |  | Prescribed Oral orTopical Medication for specific medical condition |
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|  |  |  |  |  |  |  |  |  |  | 1-3 instancesLow potential of adverse impactNo other issues |  | 1-2 instances (out of many meds)ANDNo evidence of adverse impact ANDNo other issues |  | 3 + Med Issues OREvidence of adverse impact OROther issues present |
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| SIGNIFICANTUncorrected discrepancy resulted in or has clear potential for missing one of the 5 Rights under MAPORNumerous (3 or more) discrepancies that appear recurrent and/or unresolvedOR3 or more instances of missing sign-offs and it cannot be verified that the medication was given as ordered. |  |  | NOT SIGNIFICANTDiscrepancy would not likely result in the misadministration of the medicationORIt can be verified that the meds missing sign-offs were administered and the issue is being addressedORExisting physician’s order is missing but is obtained and there is no evidence that the medication was missed or given incorrectly or given without medication having been prescribed.OROccasional use of white-out on the MAR and no evidence of errors or omissions |
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**Date:** 9/17

**Question 3: Placement Services**

While shared living homes do not have to comply with MAP, what is expected for the Provider in terms of oversight?

**Answer:**

The Provider must have a mechanism to monitor and oversee medication administration at each home care provider home and the ability to describe the system. For example, the placement coordinator needs to review medication information such as the physician’s orders, the pharmacy containers, and proof of administration of medications during the monthly visits.

**Indicator**: **L47 Individuals are supported to become self-medicating when appropriate.**

**Date:** 10/11; changed 1/20

**Question 1**:

Who needs a self-medication assessment and who needs to be rated here?

**Answer:**

This indicator focuses on the provider’s ability to ensure that individuals are safe in the process of self-administering their medications. This indicator should be rated for individuals who are self-medicating, and to the extent possible this indicator should be rated. Therefore if the person selected in the sample is not self-administering their medications, select someone in the location who is.

If someone is noted to be self-administering their medications, and is being served in a MAP site, the following items are required:

* The individual is storing his/ her medications safely and securely.
* The individual is taking medications consistent with physician’s orders.
* An assessment should be present noting the individual’s skills and needs.
* Any support needs identified in the assessment should be provided and documented through a corresponding medication support plan.
* The individual is assessed regularly to determine whether any changes are needed to the medication support plan.

If someone is noted to be self-administering their medications, and is being served in a non-MAP site, the following items are required:

* The individual is taking medications consistent with physician’s orders.
* The individual is assessed regularly to determine whether any changes are needed to the medication support plan.

**DOMAIN: HUMAN RIGHTS (L48 – L73, L89, L90)**

**I****ndicator: L48 – The agency has an effective Human Rights Committee.**

**Date:** 1/20

**Question 1:**

How is the effectiveness of the agency’s Human Rights Committee evaluated and rated?

**Answer:** The following worksheet is used to evaluate and rate the effectiveness of the HRC in meeting mandated functions and membership.

**ADMINISTRATIVE REVIEW**

**Human Rights Committee**

The general responsibility of the committee shall be to assist the provider to affirm, promote, and protect the human and civil rights of individuals served and to monitor and review the activities of the provider or agency with regard to the human and civil rights of those individuals, consistent with the requirements of 115 CMR 3.09.

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| ***Agency:*** | ***Type of Survey:*** | ***Date:*** |
| ***Team Member(s) Conducting HRC Review:*** |

**HRC Meeting Minutes**

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| **Do HRC meeting minutes include discussion/ review of the following issues?** |
| Date of Meetings |
| **Review and Approval of Level II and III Behavior programs *(Required)*** |  |  |  |  |
| **Human Rights Training Material and Processes *(Required)*** |  |  |  |  |
| **Complaints/Investigations –** Committee should review and discuss initial complaint, results, action plan/follow up. ***(Required)*****(***9.18)* *(1) Responsibilities for Individuals Who Require Assistance.* *(a) The human rights committee shall assist an individual involved in a complaint to ensure that his or her rights are adequately protected.* *(2) The human rights committee of a provider shall be a party to all complaints involving individuals served by the provider, and shall receive copies of the documents distributed to the parties as provided in 115 CMR 9.00.** *List log numbers for the sample (up to 15) and reference the date the HRC reviewed these Complaints and Investigations*
 |  |  |  |  |
| **Review the authorization and use of all emergency restraints and limitations on movement** ***(Required)*** |  |  |  |  |
| **Physical Restraints** |  |  |  |  |
| **Supports/ Health Related Protections** |  |  |  |  |
| **Restrictive Interventions -** Restrictions on personal possessions, visitation, privacy or other restrictive practices. ***(Required)*** |  |  |  |  |
| **Visitation restrictions** *5.04 (3) The human rights committee shall be notified of the intention to deny or restrict visitation.* |  |  |  |  |
| **Personal Possessions***5.10 (a) Any restriction on personal possessions or funds shall be documented in the individual's record, and a copy sent promptly to the provider's human rights committee.* |  |  |  |  |
| **Other Restrictive Practices/Devices (ex. door alarms, locked knives, etc)** |  |  |  |  |
| **Annual review of agency policies and procedures for compliance with the Department's regulations on human rights *(Required)*** |  |  |  |  |
| **Research projects, with approval of DDS (Required)** |  |  |  |  |
| **Other Reviews** |  |  |  |  |
| **Visits – Service Locations***3.09 (1) (b) 7.Visit the location where services are provided while they are being provided, with or without prior notice.* |  |  |  |  |
| Behavior plans level I with aversive interventions  |  |  |  |  |
| Incident reports - If raises to the mandated reporting level then in addition to incident report *13.06:* ***Additional Reporting Responsibilities****: Refer the matter to the provider’s human rights committee when the incident affects the rights and dignity of an individual who is 18 years of age or older* |  |  |  |  |

 **HRC Bylaws**

The Committee has a governing set of By-Laws which address the following areas: Yes No

Membership [ ]  [ ]

Roles & Responsibilities [ ]  [ ]  Frequency of Meetings/Quorums [ ]  [ ]

Terms and Election of Officers [ ]  [ ]

**HRC Membership Requirements:**

Each human rights committee shall be composed of: at least five members, who have experience and knowledge relevant to duties of the committee; and include the following:

* at least 3 individuals receiving supports, and/or parents/ guardians/ advocates
* a physician or nurse;
* a psychologist or masters level practitioner with expertise in intellectual disability and developmental disabilities, mental illness, or applied behavioral analysis; and
* an attorney, law student, or paralegal with relevant expertise.

*3.09 (1) (c) No members may have a direct or indirect financial interest or administrative interest in the provider; and, where the Department is not the provider, not more than one of the members shall have any direct or indirect financial or administrative interest in the* ***Department.***

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| **Member Name** | **Role/****Expertise** | **Voting****Member?** | **Financial or****Admin Conflict?** |
| **Date of Meetings** |
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**Human Rights Committee Review Results**

* Based on the information, does the agency’s HRC meeting minute reflect practices and compliance with the regulatory requirements (i.e., relevant items discussed; recommendations clear, Follow-up on recommendations/actions requested)? Yes [ ]  No [ ]
* The Committee meets the following 115.CMR 3.09(c) membership requirements? Yes [ ]  No [ ]
* Based on the above information, do the HRC’s meeting minutes reflect practices and compliance with the regulatory requirements (i.e., frequency of meetings, quorum requirements, members with necessary expertise for content discussed were present)? Yes [ ]  No [ ]
* Are there any waivers regarding the agency’s HRC submitted as part of this review, and have the conditions of a current waiver been met: Yes [ ]  No [ ]
* Are the meeting minutes submitted to the HR specialist: Yes [ ]  No [ ]

Topic Guidance to inform Ratings

Attendance - MET:

* All attend the majority of the time (75% of the time)

Attendance – NOT MET

* During the last 4 meetings, one people or more missed two or more meetings (attendance at 50% or less).

Membership - MET

* All members in place.
* Vacancies have been filled and the new member(s) have attended at least one meeting in their active role.
* Quorum, defined as a simple majority (eg 4 for a 6 person Committee) occurs for the majority of meetings (75% of the time).
* Meetings occur at least quarterly.
* If a waiver is in place for attorney to be a consultative member and attend once per year, and that occurs.

Membership – NOT MET

* .If a waiver is in place for attorney to be a consultative member and attend once per year, and the committee did not meet the conditions of the waiver.
* Vacancies in required membership have not been filled.
* Quorum, defined as a simple majority (eg 4 for a 6 person Committee) is not occurring at two or more meetings (quorum at 50% or less).
* Meetings are not occurring quarterly..

Content - MET

* Restraints are reviewed,
* Complaints, investigations, and actions that occurred are reviewed at the next scheduled meeting.

Content – NOT MET

* Absence of restraint and/or supports which limit movement reviews over time; unaware of their role to review restraints and/or supports which limit movement. (Review of specific restraints on a timely basis is rated in L66)
* One or more new complaints, investigations, and actions have not been reviewed by the HRC.

**Indicator: L49 - Individuals and guardians have been informed of their human rights and know how to file a grievance or to whom th****ey should talk if they have a concern.**

**Date:** 9/17

**Question 1:**

What documentation is needed relative to informing guardians of human rights?

**Answer:**

Guardians can be informed of human rights and grievance/concern policies through a letter. Documentation of the letter, when and to whom it was sent should be kept. Providers can also inform guardians of human rights in a variety of ways such as through a presentation or training at a family meeting. Regardless as to what mechanism is utilized, there should be documentation to reflect that the guardian was informed of the individuals’ human rights.

**Indicator:** **L55 - Informed consent is obtained from individuals or their guardians when required.**

**Date:** 10/11

**Question 1:**

Is this indicator rated for all individuals?

**Answer:**

If there are no situations requiring consent, and no consent is necessary or present, then this indicator is not rated.

**Date:** 3/12

**Question 2:**

Under what conditions would one expect to see informed consent? What are the requirements for securing consent?

**Answer:**

According to DDS regulations 115 CMR 5.08, informed consent is required in the following circumstances:

1. Prior to admission to a facility,
2. Prior to medical or other treatment (informed consent must be obtained annually for routine medical and preventative treatment as well as prior to specific non-routine or preventative medical care, including use of psychotropic medications).
3. Prior to involvement of an individual in research activities,
4. Prior to initiation of Level II or III behavior modification interventions,
5. Prior to release of personal information to other agencies, providers or individuals.

When securing informed consent, it is the clinician’s responsibility to explain the intended outcome of a procedure/ activity, the risks and side effects of the procedure, and alternatives. The person securing the consent should present the information in a manner that can be easily understood, offer to answer questions and explain that consent can be withheld or withdrawn at any time.

According to DDS regulations, whenever informed consent is required, it must be given freely without coercion or inducements of any kind. The consent should be in writing. It must be dated and will expire after the completion of the specific procedure for which it applies, or after one year for ongoing interventions. The written information should include the process used to obtain the consent, the name, position and affiliation of the person securing the consent, and a summary of the information provided to the individual.

For areas in which the DDS Provider employs the clinician who is securing the consent directly, he/she needs to ensure that the informed consent is obtained and properly documented. Records of informed consent need to be stored in an individual’s confidential files, and renewed annually.

When the treating clinician is a private practitioner, not employed by a DDS Provider, securing consent is the responsibility of the community practitioner, and an individual’s informed consent document is usually found in the medical record in the doctor’s office. Sometimes, however, this consent is obtained verbally. The Provider should make every effort to facilitate the consent process.

**Date:** 3/12; revised 11/14

**Question 3:**

What items get rated within L-55?

**Answer:**

As medical treatment is typically conducted by a community practitioner, and obtaining consent for this treatment is the responsibility of the community practitioner, annual consent for routine medical and preventative health care or consent for surgery or specific treatments, are not usually reviewed here. Informed consent relative to level II behavior intervention plans is evaluated and rated as part of L-59, rather than here.

Therefore, the category noted above requiring consent most often reviewed here is the category release of personal information. Providers may obtain consent from the individual/ guardian for several reasons. Consent for the release of personal information must be secured prior to the distribution to others. The consent should be specific and individualized relative to which personal information is being released to which parties for what purpose. Providers must request that the individual consent to release of personal information to other agencies and providers.

Also reviewed within this indicator is whether written authorization is in place for use of photos, videos and the like. Media and photo consent is covered by a different regulation and there are certain requirements that need to be in place to ensure that the individuals “are not exposed to public view” without written agreement. Please refer to question #5 below for specifics.

If there are no circumstances warranting the pursuit of informed consent or if no consents are present, do not rate this indicator.

**Date:** 3/12; revised 11/14

**Question 4:**

What are the required components of informed consent? Relative to publication and distribution of publicity materials, how does a provider practically allow for the ability of someone to withdraw consent?

**Answer:**

This is a summary of the required criteria as noted in DDS regulations 5.08:

* The consent should be in writing and filed in the individual’s record;
* The consent shall be dated and expire upon completion of the specific procedure for which it applies; in any event shall expire one year after it is signed;
* The written record should detail the procedures utilized to obtain consent, the name and position of the person securing the consent, and a summary of the information provided to the individual from whom consent is being secured (including items listed below);
* The person securing consent shall explain:
	1. The intended outcome and nature of the procedures, treatment, activity;
	2. The risks, benefits, and side effects, including the risks of not proceeding;
	3. The alternatives to the proposed treatment/ activity, including those offering less risk;
	4. That consent may be withheld or withdrawn at any time;
	5. Present the foregoing information in a manner which can be easily understood;
	6. Offer to answer any questions that the person may have.

Consents to Release of information to others should be specific as what information is being released and to who this information will be released/ distributed to.

**Date:** 11/14

**Question 5:**

What are the requirements for consent for media release, such as consent to have one’s photo part of a brochure that gets distributed? Does this type of consent expire after one year?

**Answer:** DDS informed consent regulations, 115 CMR 5.08, note that consent is needed prior to medical or other treatment, research, behavior modification, and release of personal information to others. By regulation, consent for these purposes expires upon the completion of the procedure, and in any event expires after one year.

Media and photo consent is addressed in a separate section of the regulations. The regulation governing this issue is 115 CMR 5.04 (2) which addresses the right to be protected from private and commercial exploitation, and provides that individuals have the right “not to be exposed to public view by photograph, film, videotape, interview, or other means unless prior written consent of the individual or guardian is obtained for each occasion of release, and the right not to be identified publicly by name or address without the prior written consent of the individual or guardian”. This regulation contains no provision for expiration of the media consent after one year, as the consent is limited by the description of “each occasion of release”. However, to the extent that release of the photo, or any additional information with the photo, constitutes a disclosure of personal/protected health information such disclosure requires a valid authorization from the individual or guardian.

For the purposes of obtaining consent to use one’s photo as part of an informational brochure a one-time valid written consent/authorization will suffice provided it explicitly outlines the scope and duration of the consent and the intended usage. Rather than require a separate written consent/authorization each unique time the brochure is distributed, or the video watched, the provider should specifically outline within the original consent, the product/image being produced and prepared, the specific purposes for release, the parties to whom it is proposed for release, the duration for the use of the product/image, and the intended use(s) for the release (e.g. this photo will be used in a marketing brochure distributed to 1,200 Massachusetts businesses and/or the general public over the next two years). This detailed information needs to be explicitly outlined within the written consent/authorization from the guardian or individual to comply with 115 CMR 5.04(2)’s requirement for written consent for “each occasion of release.” If a different product or different use of the same product (video; photo; interview) is later proposed which exceeds the scope of the original consent/authorization, a new release for the new product/purpose is required. For example, re-airing a particular video could be included in an original consent, while the creation and distribution of a new video would require a new consent. Utilizing an existing video for a new purpose or duration may also require a new consent.

For more information on the requirements of informed consent and/or valid authorizations – see 115 CMR 5.08 and HIPAA Regulations, 45 CFR 164.508.

**Indicator: L56 - Restrictive practices intended for one individual that affect all individuals served at a location need to have a written rationale that is reviewed as required and have provisions so as not to unduly restrict the rights of others.**

**Date: 10/16**

**Question 1:**

What are the expectations for the person for whom the restriction is needed, and for those who do not need the restriction?

**Answer:**

**For the one person for whom the restriction is needed:**

* Restrictive practices outlined in writing, identifying the rationale, and outlined as the least restrictive alternative.  Eg door chimes for elopement
* A plan for elimination or fading is included with the rationale as part of the document
* Agreement is needed from the legal decision maker for the individual is being imposed.  Restrictive procedures-  all agreements “through the ISP” are considered annual.
* Inclusion in the ISP
* HRC review of the plan.

**For the other individuals in the location for whom the restriction is not needed:**

* The provider needs to develop provisions for these individuals so as to not unduly restrict them ( a mitigation plan; mitigation practices) Eg door chimes only used when X is home; arrangement with staff to come /go; passcode for chime.  Sometimes these provisions are written right into the above plan, and not as a separate document.
* Guardians/ individuals are informed of the restriction which is in place at the location and understand the mitigation plan for their son/ daughter / ward (eg the plan for their person to use the door and go outside).  QE will **not** be looking for an annual consent or agreement from the guardians of individuals not requiring the restriction.  QE will be looking for some sort of information that the provider has informed the guardians of this practice in the home, and of the mitigation plan/ procedures.  We typically see this information in various forms- sometimes as a signed acknowledgement, sometimes as a signed understanding of the mitigation plan (eg that my ward carries a key to a locked cabinet so that she can use the scissors whenever she wants), and sometimes as an intake sheet notifying the guardian (eg this home is equipped with door chimes, and comings/ goings are handled in the following ways…).

**Date:** 9/17

**Question 2:**

Is a home security system considered a restrictive practice?

**Answer:**

Individual home care providers/ residential homes may have a home security system and this is generally considered normative in that other homes not serving individuals may have them. However, even normative devices and systems can be utilized in such a manner as to limit individuals’ privacy, freedom of movement, possessions, or other rights. It is the responsibility of the Provider to ensure that any such system/device/practice is not used to restrict an individual in any way. For example, while a home security system may be in place in a home and may be activated when people are not at home to protect the home, care should be taken when plans are in place to use this when the individual is home. The Provider needs to ensure that individuals are in no way restricted by the system such as by recording individual’s motions within the home or inadvertently preventing the individual from unrestricted access to the community (e.g. the home care provider could provide the code to the individual).

That being said, any restrictive procedure, such as door alarms used to cue someone that an individual in the home is leaving, needs to be in writing with a written rationale, outlined in the ISP, the least restrictive alternative, and reviewed by the Human Rights Committee (HRC). In addition, the provider needs to mitigate this restriction for others in the home that do not require this restriction.

**Date:** 11/18

**Question 3:**

Are locked thermostats considered a restrictive practice?

**Answer:**

Locked thermostats are not in and of themselves restrictive.  Therefore as long as room temperature was maintained within the range required by the State sanitary code and the sufficient to meet the needs of the individuals, **and each individual could raise or lower temperatures upon request,** it would be acceptable to have locked thermostat covers.

**Details:**

Given that Chapter 7 states that:

(5) The following environmental requirements shall apply to sites owned or leased by providers of residential supports, individualized home supports and 24 hour site based respite supports, and the homes of care providers.

(a) The site shall include complete living accommodations, including its own kitchen, living room, dining area, bedrooms, and bathrooms of typical residential design. The site shall provide for group and individual needs, including opportunities for privacy n clearly defined living, sleeping, and personal care spaces and areas that are accessible and available according to individual needs to enable personal development, the development of personal relationships, and engagement in leisure activities.

(b) **The site shall provide physical comfort** as well as a pleasing style of decor and an external appearance that is typical of other homes in the vicinity, except for accommodations that enhance accessibility for individuals.

(c) The layout of rooms shall permit ready access to common areas, with no intrusion into private bedroom areas.

(d) The site shall provide conveniently located common storage adequate for a reasonable amount of individual and group possessions.

(e) **Major environmental controls, including those for lighting, appliances, plumbing, windows, and shades shall be operable by and accessible to individuals**.

(f) **Heating and plumbing systems shall be installed and maintained for safe, healthy, and comfortable use by the individuals supported by the provider. (g) Heating and ventilation systems shall be adequate to maintain comfortable levels throughout the year.**

**The following guidance is offered:**

* Locked thermostats are not in and of themselves restrictive.  There are many places, such as rental units where heat is supplied by the landlord, or in locations where multiple individuals live where locked thermostats are present.  While the regulations do require that individuals be able to control and access major environmental controls such as lighting, the regulation does not require direct control to operate adjustments to temperature.
* Therefore as long as room temperature was maintained within the range required by the State sanitary code and the sufficient to meet the needs of the individuals, **and each individual could raise or lower temperatures upon request,** it would be acceptable to have locked thermostat covers.
* The state sanitary code has certain requirements for when landlords need to turn on the heat in winter (Eg November 15), and also how hot / or cold.  For example, there is a the requirement that temps be no lower than 68 degrees during the day, no lower than 64 degrees overnight and no higher than 78 degrees in summer.
* Sometimes older less mobile individuals are more comfortable with the home warmer than the legal requirements.  The provider needs to ensure that the health care needs, comfort and mobility of the individuals are taken into consideration when setting the temperatures of the home.  Once set, all individuals need to be educated and informed that they can have the temperatures raised or lowered upon request.
* If however, the thermostat was locked and the temperature controls restricted for a particular individual due to their particular needs, then it would be considered an individual restriction, which would require a rationale as the least restrictive alternative, and also require all the thoughtful safeguards and approvals.  If done for one individual, there needs to be mitigation for the others not needing the restriction.  In this case, mitigation simply means that the **other individuals could be educated and informed that they can have the temperatures raised or lowered upon request**.

**Indicator: L60** - Data are consistently maintained and used to determine the efficacy of behavioral interventions.

**Date:** 6/17

**Question 1: Placement services, and also all services**

How much data needs to be collected in a placement service/ other services, and who is responsible?

**Answer:**

Data must be taken and kept in accordance with the specific treatment plan. Data are not always kept each time the intervention occurs. For example, an individual may exhibit the behavior almost daily, but the treating clinician calls for a data to be taken on the number of behaviors per week. The home care providers/ direct support staff often take the raw data. It is then the responsibility of the Provider to ensure oversight of data collection, to summarize the information and to ensure that the data are communicated to the treating clinician so that it can be utilized to determine the efficacy of the plan.

**L61**  Supports and health related protections are included in ISP assessments and the continued need is outlined.

**Date: 9/17**

**Question 1:**

Who is responsible for ensuring that the supports and health related protections are written into the ISP?

**Answer:**

Supports are devices which are needed to achieve proper body position, balance and alignment, to permit the individual to actively participate in ongoing activities without risk of harm, or to prevent re-injury during healing. These items require the specific information and agreement through the ISP process. **Examples:** Standard Walkers; Wheelchairs with no additional attachments; orthopedically prescribed appliances.

The Provider is responsible for ensuring that any supports are included within the ISP and for ensuring that the home care provider has a written protocol for use and cleaning, and is familiar and trained with how to support the individual with the support and health related protection. In essence, while the home care provider is implementing the use of the support, it is the Provider who needs to ensure that the supports are being implemented correctly and are integrated within the ISP.

\*\*Further guidance regarding the requirements for implementation and review are below.

**Indicators**: **L 61 – Supports and health related protections are included in ISPs; and the continued need is outlined.** **& L 62 – Supports and Health related protections are reviewed by the required groups.**

**Date:** 10/11

**Question 1:**

What is considered a support? What is considered a support in need of HRC review?

**Answer:**

In general order of restrictiveness, many devices and equipment seems to fall into the categories listed below. The list includes a general description/ definition of each category, some examples, and what the requirements are for each. The categories are in hierarchical order with most normative and least restrictive groups listed first, and those requiring more safeguards noted later. Normative devices, medical treatment, and adaptive equipment are not considered supports and health related protections and are not rated in L61 or L62. If, however, use of any of these devices or equipment is resisted by the individual and the person needs some sort of holding or physical intervention to enforce the procedures listed below, the device and the plan to implement it over the individual’s resistance would require further review including Human Rights Committee review. Any device or equipment which is utilized as an emergency or behavioral intervention will also have additional requirements.

* **Normative devices**

**Definition:**

Devices, tools, and equipment which are typically used within the community for anyone in the same situation and do not appear to require any unique care, treatment or training to either the individual or staff. These items are not considered supports, and do not require agreement through the ISP process or HRC review.

**Examples:**

Eye glasses; canes; seat belts in cars

**Requirements for implementation and review:**

 Normative devices do not require agreement through the ISP process or HRC

 review.

* **Medical treatment; adaptive equipment**

**Definition:**

Devices and equipment prescribed by a health care professional for the treatment and/or the management of a medical or physical condition. These items are not considered supports. Treatment protocols should be reviewed and rated in L38.

**Examples:**

Sleep apnea equipment; g-tubes; teds; orthopedic shoes; hearing aids; catheters

**Requirements for implementation and review:**

* + Inclusion and statement of agreement within the confidential file
	+ HCP orders outlining rationale for use, criteria for discontinuance
	+ Written directions for supporting the individual to use including items such as when to use, cleaning and care of device
	+ Treatment protocols as appropriate
	+ Evidence of staff training and knowledge
* **Supports; supportive protective devices**

**Definition:**

Supports are devices which are needed to achieve proper body position, balance and alignment, to permit the individual to actively participate in ongoing activities without risk of harm, or to prevent re-injury during healing. These items require the specific information and agreement through the ISP process. As they do not limit movement, HRC review is not required. Review and rate the use of these items within L61 and L62.

**Examples:**

Standard Walkers; Wheelchairs with no additional attachments; orthopedically prescribed appliances

**Requirements for implementation and review:**

* Inclusion and agreement through the ISP
* Determined within the ISP to be the least restrictive alternative
* The continued need for the device is outlined within the ISP
* HCP orders outlining rationale for use, criteria for discontinuance
* With the authorization and supervision of a qualified practitioner
* Written protocol for use including items such as when to use, cleaning and care of device; documentation of use
* Evidence of staff training and knowledge
* **Supports which limit movement**

**Definition:**

These are supports as noted above which are needed to achieve proper body position, balance alignment, to permit the individual to actively participate in ongoing activities without risk of harm, or to prevent re-injury during healing, but which limit movement during the process. A limitation of movement can take several forms – for example, keeping someone from accessing their environment through the use of bedrails to prevent someone from falling/ getting out of bed or limiting movement of a particular body part through use of a some sort of device, such as a brace. These items require agreement through the ISP process and HRC review. Review and rate the use of these items within L61 and L62.

**Examples:**

Bedrails; wheelchairs with seat belts; seatbelts on toilets; gait belts; helmets

**Requirements for implementation and review:**

* Inclusion in the ISP
* Determined within the ISP to be the least restrictive alternative
* The continued need for the device is outlined in the ISP
* HCP orders outlining rationale for use, criteria for discontinuance
* With the authorization and supervision of a qualified practitioner
* Written protocol for use including items such as when to use, cleaning and care of device; documentation of use
* Evidence of staff training and knowledge
* Review by the Human Rights Committee
* **Health Related Protections**

**Definition:**

These are devices which are ordered by a HCP if absolutely necessary during a specific medical or dental procedure or for the individual’s protection during a time that the individual is undergoing treatment pursuant to clinician’s orders. These items require agreement through the ISP process and if the item limits movement, would require HRC review. Review and rate the use of these items within L61 and L62.

**Examples:**

Cast; splints for broken bones

**Requirements for implementation and review:**

* Information on the underlying medical condition for which this is being used and the time-limited nature of the device
* HCP orders rationale for use, criteria for discontinuance
* With the authorization and supervision of a qualified practitioner
* Written protocol for use including items such as when to use, cleaning and care of device; documentation of use
* Evidence of staff training and knowledge
* Review by the Human Rights Committee if the health care protection limits Movement

**Indicator L63– Medication Treatment Plans are in written format with required components.**

**Date:** 9/17

**Question 1:**

**What are the required components and what needs to be included to rate MET?**

**Answer:**

The answer to what needs to be in place relative to compliance with L63, Medication treatment plans are in written format with required components, is found in a number of locations including regulations and a 2007 legal interpretation on psychotropic medication treatment plans.  The following **three components** are required:

* **Description of behavior to be controlled/modified**
* Target behaviors need to be measureable and defined. Outline what the medication is intending to treat in behavioral terms. For example, physical aggression such as slapping and punching.
* A description of symptoms of a psychiatric diagnosis may be used as a substantially equivalent alternative, provided that the Medication Treatment Plan outlines the specific symptoms the medication is intending to control / modify, in measureable behavioral terms. For example, medication prescribed to treat bipolar disorder is focused on reducing the symptoms/ behaviors of mania as evidenced by hurried speech and two or more days of sleeplessness.
* **Data on behavior prior to medication forming basis from which clinical course is evaluated**
* Appropriate data concerning the target behavior or relevant symptoms prior to intervention with the proposed drug therapy, phrased in objective terms, which shall constitute a basis from which the clinical course is evaluated
* It is sometimes not possible to obtain baseline data prior to medication use, as the medication has been utilized for some time. In this situation, data needs to be current. Data on the target behaviors to be decreased needs to be collected so that you have a measurement of success.
* Not only must (baseline) data be present on each behavior for which the MTP is developed, but these data should be “a basis from which the individual’s clinical course is evaluated”.  This means that the Medication Treatment plan should describe the general clinical plan/ course for use of the medication such as criteria for re-evaluating / adjusting the medication based on the treatment data.  For example, medication X is prescribed for aggression which is occurring 4 times per week. When behaviors are reduced to 1 time per week, the team will provide this information to the prescribing physician so that he/she may consider next steps such as terminating/ fading/ reducing the medications.
* The Medication Treatment Plan should specify how often the individual meets with the Psychiatrist, and ensure that the data are also reviewed with the prescribing physician at those times.

**Information about side effects, procedures to minimize risks and a description of any clinical indications for terminating the drug**

1. Information on common risks and side effects:
	* Common risks – Often these are noted within side effect information, referencing the most common risks associated with this medication.
	* Side effects- For each medication that is part of the MTP, the side effects should be known and referenced.  If it is duplicative to other materials, there is no need to repeat it here. The provider can simply refer to an attachment listing the side effects or to this information originating elsewhere (HCR; ISP) and attached.
	* If there are any unique or specific considerations for this person taking this medication these should be noted within the MTP. e.g. someone who is underweight taking a medication which causes a loss of appetite, but is the best one thought to work for his/her aggressive behaviors
2. Procedures to minimize risks:
	* List any general procedures associated with reducing the risk using this particular medication such as blood work weekly, monitoring of blood pressure, blood sugars, or weight, tardive dyskinesia screenings, for example.  As noted above, if this information is located elsewhere, provider need not duplicate, but should ensure that the information is referenced/ attached.
	* Sometimes the MTP includes multiple medications being utilized.  Procedures to minimize risk by outlining a strategy to reduce poly-pharmacy, to the extent possible, should be considered.
	* If applicable, list any specific procedures designed to reduce/ mitigate specific concerns.  In the example above, the individual will be encouraged to eat and she will be weighted weekly.
3. Clinical indications for terminating the drug:
	* Clinical indications for terminating this medication – When addressing this section the team/ psychiatrist should review the behaviors that the MTP is intending to control or reduce, and the baseline data, to design an effective plan and end points. While it is the psychiatrist not the team that must terminate the medication, the team can/ should assist in outlining the indications that should be considered. Indications to consider discontinuing or fading the medication include success/ improvement/ significant decrease in the behavior or an increase in behavior for which the medication is intending to reduce.
	* Sometimes MTPs note that the individual will always require this medication.  Even for individuals who are anticipated to need this medication over the long term, the plan must include some criteria for re-evaluation, including a measure of success, and strategies for what to do at that point.  For example, behaviors remaining consistently low should be a trigger for the team to discuss with the psychiatrist a reduction or a drug holiday trial.  Subsequent to the medication reduction, if the behaviors increase, then the psychiatrist would likely increase the medications again, providing a rationale for continued use.

**Indicator:  L64 - Medication treatment Plans are reviewed by the required review groups.**

Date: 9/17

**Question 1:**

The Medication Treatment Plan needs to be included within the ISP.  How can this be demonstrated?  Given that inclusion within the ISP is a shared responsibility with Service Coordination, what is the provider’s role and expectations?

**Answer:**

Demonstration that the Medication Treatment Plan is included in the ISP can occur in a few different ways:

* The SC notes the presence of a MTP for example, in the Clinical Section.
* The MTP is referenced in the ISP.  For example, the provider can reference that a MTP exists in the Health Care Assessment and note that it has been forwarded to the SC/ is attached.
* When the full ISP is returned to the Provider, the Provider preserves the package in its entirety, noting all attachments that have been incorporated into the ISP, including the MTP.  (The full ISP consists of more than what is in HCSIS).
* Medication treatment plans can now be uploaded by the provider into HCSIS, when service coordinators request assessments for the ISP. This is another means by which a provider may demonstrate that the plan is included in the ISP.

Presence of the MTP within the ISP through any of the above methods would result in a rating of Met.

In the event that none of these items are in place, the provider must share evidence that they have done their due diligence to forward the MTP to the SC to be included in the ISP.  If the provider can demonstrate that the MTP has been sent to the SC (electronically or via mail), this indicator would be rated as not included within the ISP, however the provider would not be penalized as the rating would not be included in scoring, rather it would be listed in the addendum section for issues beyond the control of the provider.

Date: 10/17

**Question 2: Individual Home Supports**

Is a Medication Treatment Plan required for people served within Individual Home Supports?

**Answer:**

For instances in which individuals receive Individual Home Supports, medication treatment plans would not be needed when an individual does not receive support for health care. However, if the provider is administering medications there would need to be a medication treatment plan in place.  A medication treatment plan may also be necessary when support is provided to individuals to manage behavior, as medication treatment plans generally tie in with behavioral interventions and call for data collection, communication with a psychiatrist or other HCP.

* If an individual in DDS licensed residential services does not receive any support for their health care in less than 24 hour services (Activity Code 3798), then, by agreement with the Area Director (see FAQ #3 issued 4/8/2103), a HCR and H&D Assessment **is not** required.
* If an individual in DDS licensed 24 hour residential services DOES require support with their health care, then a HCR and H&D Assessment **is** required as is a Behavior Modifying Medication Treatment plan.
* In all instances, if the individual is NOT Self-Medicating and staff are administering their medication, including behavior modifying and antipsychotic medication and, medications that are necessary to allow and individual to receive medical or dental care then medication treatment plans are required..

**Indicator: L64 - Medication treatment Plans are reviewed by the required review groups.**

**Date:** 10/17

**Question: How does Rogers’ guardianship and Rogers review of Psychotropic Treatment Plans get factored into the rating for this indicator?**

**Answer:** When a competent individual is prescribed antipsychotic medications, informed consent is secured from the individual by the treating clinician. However, when an individual is incompetent, a court must approve the physician’s proposed plan for administration of antipsychotic medication. Therefore it is expected that a Rogers plan will be present for any individual on antipsychotic medication, and that this approval will be reviewed in the context of L64 that all necessary reviews have occurred.

Any individual who is prescribed antipsychotic medication who is under guardianship should be referred to the service coordinator who will assure that the physician’s treatment plan is properly brought to the legal office for approval by the probate court.

In the event that the individual was referred to the area office, but does not yet have a Rogers plan, this will be rated as not met, but do not include in scoring, as it is the responsibility of DDS to pursue.

**Checklist for Rating**

**Medication Treatment Plan**

**(L 63 & L 64)**

*Note: A MTP is not required when the individual is presumed competent and self-medicating.*

| **Medication treatment plans are in written format with required components. (L 63)** | **Yes/No** | **Comments** |
| --- | --- | --- |
| **Person’s name and date of Plan** are present. Not older than 1 year.  |  |  |
| **Medication**: Include the medication name and reason or diagnosis for each medication in the plan? Matches MD order? |  |  |
| **Description of Behavior to be Controlled.** For each medication, are the observable symptoms/behavior(s) to be controlled or modified concrete and measurable and specific to the individual (unique signs and symptoms) *For example, medication prescribed to treat bipolar disorder is focused on reducing the symptoms/ behaviors of mania as evidenced by hurried speech and two or more days of sleeplessness.*  |  |  |
| **Data**:  • Appropriate data concerning the target behavior or relevant symptoms prior to intervention with the proposed drug therapy, phrased in objective terms, which shall constitute a basis from which the clinical course is evaluated• It is sometimes not possible to obtain baseline data prior to medication use, as the medication has been utilized for some time. In this situation, data needs to be current. Data on the target behaviors to be decreased needs to be collected so that you have a measurement of success. • Not only must (baseline) data be present on each behavior for which the MTP is developed, but this data should be “a basis from which the individual’s clinical course is evaluated”. This means that the Medication Treatment plan should describe the general clinical plan/ course for use of the medication such as criteria for re-evaluating / adjusting the medication based on the treatment data. For example, medication X is prescribed for aggression which is occurring 4 times per week. When behaviors are reduced to 1 time per week, the team will provide this information to the prescribing physician so that he/she may consider next steps such as terminating/ fading/ reducing the medications. • **The Medication Treatment Plan should specify how often the individual meets with the Psychiatrist, and how the data collected is presented and reviewed with the prescribing physician at those times.** |  |  |
| **Intended Effects/Benefits of Medication.** For each medication, what are the intended benefits or effects of the medication? What is the ideal impact on the person’s quality of life |  |  |
| **Information on common risks and side effects:** • Common risks – Often these are noted within side effect information, referencing the most common risks associated with this medication.• Side effects- For each medication that is part of the MTP, the side effects should be known and referenced. If it is duplicative to other materials, there is no need to repeat it here. The provider can simply refer to an attachment listing the side effects or to this information originating elsewhere (HCR; ISP) and attached. • If there are any unique or specific considerations for this person taking this medication these should be noted within the MTP. e.g. someone who is underweight taking a medication which causes a loss of appetite, but is the best one thought to work for his/her aggressive behaviors |  |  |
| **Procedures to Minimize Risks:** **•** List any general procedures associated with reducing the risk using this particular medication such as blood work weekly, monitoring of blood pressure, blood sugars, or weight, tardive dyskinesia screenings, for example. As noted above, if this information is located elsewhere, provider need not duplicate, but should ensure that the information is referenced/ attached. • Sometimes the MTP includes multiple medications being utilized. Procedures to minimize risk by outlining a strategy to reduce poly-pharmacy, to the extent possible, should be considered. • If applicable, list any specific procedures designed to reduce/ mitigate specific concerns. In the example above, the individual will be encouraged to eat and she will be weighted weekly. |  |  |
| **Indicators for Suspension or Termination:** * When addressing this section the team/ psychiatrist should review the behaviors that the MTP is intending to control or reduce, and the baseline data, to design an effective plan and end points. While it is the psychiatrist not the team that must terminate the medication, the team can/ should assist in outlining the indications that should be considered. Indications to consider discontinuing or fading the medication include both success/ improvement/ significant decrease in the behavior or an increase in behavior for which the medication is intending to reduce.

• Sometimes MTPs note that the individual will always require this medication. Even for individuals who are anticipated to need this medication over the long term, the plan must include some criteria for re-evaluation, including a measure of success, and strategies for what to do at that point. For example, behaviors remaining consistently low should be a trigger for the team to discuss with the psychiatrist a reduction or a drug holiday trial. Subsequent to the medication reduction, if the behaviors increase, then the psychiatrist would likely increase the medications again, providing a rationale for continued use.  |  |  |
| **Chemical Relaxation for Medical or Dental Treatment.** For any dental or medical pre-sedation medication, is the plan to assist the individual to learn how to cope with medical treatments and that lead to the decrease or elimination of medication for chemical relaxation incidental to treatment |  |  |
| **Medication treatment plans are reviewed by the required groups. (L 64)** |  |  |
| **Is the Medication Treatment Plan identified in the ISP**ISP should state more than just the name of the medications that the person is prescribed. The MTP should be submitted for inclusion in the ISP as an “other assessment”. \*\*The Clinical section should note that the individual has a MTP briefly mentioning for which symptoms/behaviors with which meds or referring to an attachment. |  |  |
| **Court approved plan and Roger’s Monitor:**When a competent individual is prescribed antipsychotic medications, informed consent is secured from the individual by the treating clinician. However, when an individual is incompetent, a court must approve the physician’s proposed plan for administration of antipsychotic medication. Therefore it is expected that a court approved plan and a Roger’s Monitor is in place for any individual on antipsychotic medication |  |  |

**Indicator**: **L65- Restraint reports are submitted within the required timelines.**

**Date:** 10/11

**Question:**

Must this indicator be rated for all providers and for all locations? How is this indicator rated?

**Answer:**

If the provider does not serve individuals requiring restraints, there were no restraints submitted for the past year and there were no identified restraints applied but not reported, do not rate this indicator.

Rating this indicator starts with a report of information pulled from HCSIS to review all the restraints filed in the past year. The report outlines four dates: the event date; the date the report was created; the date the report was submitted to the Area Office; the Human Rights Committee review date. This report is used to rate L65 and L66. In L65 an assessment of the submission and finalization timeliness occurs, while an assessment of HRC review occurs in L66.

Each restraint report must be created in 3 calendar days and finalized for area office review in 5 calendar days to be considered met. To arrive at the overall rating for the agency, the number of restraint reports where standard was met is divided by the number of restraints which occurred during the past year. Information is also collected at the locations. For example, when each location is visited, if there were restraints identified at the location as occurring but these had not been filed at all, these should be added in. For example, 100 restraints were pulled from HCSIS, 90 of which were submitted on time according to the report, and 5 additional restraints were revealed in the field and had not been reported. This would result in a score of 90 out of 105 restraints standard met. If 80% of restraints have been submitted within required timelines, the Provider would receive a standard met for this indicator.

**Indicator:** **L66 - All restraints are reviewed by the Human Rights Committee.**

**Date:** 10/11

**Question:**

Must this indicator be rated for all providers and for all locations? How is this indicator rated?

**Answer:**

Rating this indicator starts with a report of information pulled from HCSIS to review all the restraint reports filed in the past year. The report outlines four dates: the event date; the date created; the date to the Area Office; the Human Rights Committee review date.

For L66, the date of HRC review is compared to the event date. As the HRC is expected to meet quarterly, but there needs to be time built in for forwarding the restraint reports, each restraint report should be reviewed by the HRC within 120 calendar days of the event date. The information received through this report can be validated at the Administrative Review when reviewing Human Rights Committee minutes. If 80% of restraint reports have been reviewed by the Human Rights Committee within required timelines, the Provider would receive a standard met for this indicator.

**Indicator: L67 - There is a written plan in place accompanied by a training plan when the agency has shared or delegated money management responsibility.**

**Date:** 12/12 revised 1/20

**Question 1:**

How will this be reviewed within all services, including Placement Services? What are the current expectations for providers with respect to financial management of client funds and support to individuals to manage their money**?**

**Answer:**

Documentation requirements-

These three items do not necessarily need to be contained within three separate documents. If all the components below are present within one larger comprehensive document, the expectations should be considered to be satisfied.

#### 1. Money Management Skills Assessment (please utilize the new standardized DDS Financial Assessment for ISP)

* Assessment matches the skills and ability of the person
* Information/ explanation on individual’s abilities and needs
* Identifies when prompts are needed and when an individual is dependent on staff
* If cannot benefit from a training plan is checked, sufficient information on why this is the case.

#### 2. Shared/ Delegated Money Management Plan

In general, this document outlines the specific supports that the individual requires to manage his/her own money. While the training plan is intended to outline the educational type of supports provided to the person, this document reflects the specifics related to access, responsibilities, safeguards, and protections. Unrestricted access to one’s own funds is presumed unless this document indicates otherwise***.*** The plan should include:

* Relate to skills and abilities identified in the assessment
* Spell out what supports the Provider is delivering. Assisting an individual to open and manage a bank account, depositing earnings, managing the house account where cash is secured, etc. are examples of what should be included within funds management plans.
* Be the least restrictive necessary to meet the individual’s needs
* Identify the amount of money that the team agrees the individual is capable of managing independently
* Identify the general mechanisms for the individual to access their money
* Be in accordance with the individuals’ interests and desires (e.g. the Provider is familiar with which specific portions of money management the individual desires assistance on)
* Outline the details of how the individual will be assisted to manage and spend their funds, noting specifics such as where money is stored, and how it is accessed, and how the responsibilities are shared, such as the support that is given to the individual to spend money weekly on dining out, entertainment etc.
* Have written agreement to this plan
* Be incorporated into the ISP (e.g. linked/referenced within the ISP)

#### 3. Training Plan

A Training Plan is required unless a clinicalevaluation has determined otherwise. The plan should:

* Address / focus on areas noted in the assessment where the individual is not determined independent (e.g. budgeting, learning denominations, understanding how much change to receive from a purchase, etc.)
* Include learning objectives to promote independence to the fullest extent possible
* Match the information in the ISP
* Outline teaching strategies, prompts, and steps that will be used to promote further independence
* Be designed to decrease the individual’s need for assistance over time
* While a formal ISP goal is often not identified, the training plan should identify a desired outcome of training/an informal goal.

Further clarification on rating, 12/19

|  |  |
| --- | --- |
| CRITERIA FOR MET | CRITERIA FOR NOT MET |
| Training plan is present and there is a plan to reduce or eliminate assistance or clinical evaluation and agreement is present as required. | Training plan not present and/or no plan to reduce or eliminate without clinical confirmation and/or agreement has not been obtained. |
| Training plan fully addresses bullets above AND is being implemented OREvaluation that plan would not benefit individualANDShared and delegated money management fully addresses bullets above | Training plan does not fully address bullets above AND/ORTraining plan is not being implemented AND/OR Shared and delegated money management plan does not fully address bullets above  |

**Date: 1//20**

**Question 2:**

Under what conditions do we evaluate the presence of a training plan?

**Answer:**

* Per 3.08 The provider needs to develop a plan to teach or assist the individual to manage all or a portion of his or her own funds according to his or her capabilities and the levels of support provided to him or her unless the evaluation establishes that the individual cannot beneficially use his or her money to satisfy his or her needs and desires, even with teaching and support.
* The issue of inappropriately checking off that a training plan is not needed will be set aside and addressed with DDS Operations and Service Coordination.
* Sometimes the “no plan needed” box is checked but the assessment notes areas for growth, such as areas where prompts are needed could be used to develop a training plan to focus on training in these specific areas. \*

This section completed by the SC:

**Legal/Benefits/Financial Status**

**(Full Year)**

|  |  |
| --- | --- |
| **Has the ISP Team recommended that the individual would benefit from a financial training plan?** | No\* |
| **Financial Comments:** |

This is completed by the Provider:

|  |  |  |
| --- | --- | --- |
|  | *The Commonwealth of Massachusetts*Department of Developmental Services |  |
|  |  | **Individual's Name:** | John, John |  |  |
|  |  | **Date of Meeting:** |  |  |  |
|  |  | **Submitted to DDS by:** |  |  |  |
|  |  | **Agency Responsible:** | Agency  |  |  |
| **Part III - (Shared and Delegated Management of Funds)** |
| **Does your agency assist this individual with Financial Management? If yes, please complete the following questions. If not, stop here.** | Yes |
| **Does the individual have a funds management plan? (If yes, please submit to DDS Area Office)** | No |
| **If yes, please indicate most recent review date:** |  |
| **If the individual is determined to be able to participate and learn how to manage his/her funds more independently is there training plan in place? (If yes, please submit to DDS Area Office)** | No |

A decision tree has been established to determine what to do:

**If YES a plan is needed per Service Coordinator:**

**If NO plan needed is checked by the Service Coordinator: Look for reason/ comments as to why it would not be of benefit.**

A decision tree has been established to determine wh:

**Financial Assessment completed by the Provider**

**Review the entire assessment to see whether the assessment indicates that a training plan might be beneficial eg prompts needed; references in comments**

**Training Plan is present**

**Training Plan is not present**

**Training Plan is present**

**Training Plan is not present**

**Observe and assess when surveying to determine whether the assessment matches the skills of the individual and whether they could benefit from a training plan**

**Observation indicates that a Training Plan might be of value but a Training Plan is not required per SC nor is it present.**

**Do not factor in the absence of a Training plan into L67. Review Shared and Delegated Money Management Plan only. Share possible need for Training Plan with SC.**

**Training Plan is present and observation indicates that a Training Plan is of benefit, however SC did not require a Training Plan.**

**Do not factor in the presence of a Training plan into L67. Review Shared and Delegated Money Management Plan only.**

**Training plan is NOT present although required.**

**When rating L67 information on shared and delegated money management plan and training plan will be rated.**

**Lack of training plan when needed will be a negative finding; likely to meet Criteria for NOT MET**

**Training plan IS present as required.**

**Use both training plan and shared and delegated information to rate the indicator.**

**Assess the content quality of the training plan. Refer to Interpretations regarding training plan standards. Poor quality can lead to a NOT MET.**

**Indicator: L68 - Expenditures of individual’s funds are made only for purposes that directly benefit the individual.**

**Please refer to** [**Personal Expenses (vs Provider Expenses)- Guidance summary**](#PersoanlvsProviderExpensesGuide) **– 8/15/13.**

**Requirements for Agreements**

#### 1. Agreement to the Shared and delegated money management plan [115 CMR 5.10(3)]

The regulatory source for agreement to the money management plan is 5.10.3(b): ‘The provider shall obtain the agreement of the individual, if not under guardianship or conservatorship, or the guardian or conservator, if any, for any plan involving shared or delegated management responsibilities.’ The licensing standard for evidence of agreement is a written sign-off on the shared management of funds plan by the individual, guardian or conservator. An individual or guardian signature on the ISP/approval for the ISP does not constitute agreement with a shared and delegated money management plan. The ISP includes a financial assessment and may contain an ISP goal related to money management. But the shared and delegated money management plan contains more details and is typically developed separately by the provider.

An individual’s or guardian’s agreement to the money management plan does not give him/her a right to make decisions that are the representative payee’s to make. It is not intended to supersede the role of the representative payee to make decisions and to act on behalf of the individual in financial matters relating to their entitlements. Nor does this agreement take the place of representative payee responsibilities. The requirements of both the Social Security Administration for Representative Payees and the DDS regulations for Shared and Delegated Funds Management need to be met for individuals supported under both sets of requirements.

The 5.10.3 section of the regulations states the plan needs to be developed ‘…in accordance with the individual’s needs, capabilities, interests, and desires’.  This is why it is important to share the details and solicit agreement to the plan, because it should reflect what the person needs and wants. People who benefit from assistance broadly range in their capacities, abilities, and support needs in managing money. Details within the money management plan need to be communicated to the individual or guardian/conservator for their agreement, and will foster an open dialogue with the guardian.

**2. Agreement for joint purchases and/ or non-routine expenses:**

When joint purchases or expenses such as vacations or cable television are present, these need to include a description of the purchase/expense to be shared, and have the agreement/signature of the legal decision-maker. If the individual is incurring responsibility for the expenses of others (e.g. individuals are sharing meal expenses and/or admission for staff supporters for special event, activity, or vacation, the extent of the individual’s responsibility toward these expenses should be established as part of the agreement.

If an individual is responsible for replacement of items in the home due to behavioral issues (Restitution), refer to indicators L57-L60, as there are additional requirements, including Human Rights Committee review.

**L69 – Individual expenditures are documented and tracked.**

**Date:** 12/12

**Question 1:** **Placement Services; all services**

Do shared living homes need receipts?

**Answer:** Receipts for purchases over $25 are necessary, with many providers also expecting receipts for any purchases. There should be a tracking system of what individuals spend their money on. Surveyors should be able to review this documentation to ensure money is tracked accurately.

**Date:** 12/12; revised 9/17

**Question 2:** **Placement Services; all services**

What sort of system is needed in shared living homes?

**Answer:**

For every individual where there is shared and delegated money management support, the provider needs to have a system to support the individual to manage his/her money. This system needs to ensure immediate tracking of cash on hand, and expenses. In other words, when supporting individuals in the management of his/her finances, there needs to be a cash in/ cash out process that occurs at the end of the day for Placement services and at the time of the transaction for all other services. In addition, documentation and tracking needs to be kept in its original form (e.g. Financial Transaction Sheets).

Each location should have at least one level of monitoring/ financial over sight which is above/ separate from staff who are implementing the procedures. Oversight and monitoring should verify the following:

* + - That the accounting of funds is accurate (e.g., the math is correct)
		- That the purchases are appropriate and for the benefit of the individual(s)
		- That the item(s) purchased are present for the individual.

**Date:** 9/17

**Question 3: Placement Services**

What is the essence of what I need to know relative to financial management of client funds and support to individuals in a placement service to manage their money?

**Answer:**

**Summary 9/17, based on excerpted information from 12/12 interpretation above:**

As with many indicators, the development of a systemic approach is necessary. For every individual where there is shared and delegated money management support, the Provider needs to have a system to support the individual to manage his/her money. This system needs to ensure that the home care provider is tracking cash on hand and expenses daily, and that expenses that are made benefit the individual.

The Provider needs to have a system to ensure that each home care provider home supports individuals in the management of his/her finances, by tabulating and tracking transactions on a daily basis.

The Provider needs to have at least one level of monitoring/ financial over sight which is above/ separate from the home care provider. Oversight and monitoring should verify the following:

* + - That the accounting of funds is accurate (e.g., the math is correct)
		- That the purchases are appropriate and for the benefit of the individual(s)
		- That the item(s) purchased are present for the individual.

At the home, the last current full month’s information will be audited. The review will focus on the current practices of the home care provider:

* + Review of FTRs or other daily log, Cash-on-hand (COH), bankbooks, receipts held (e.g. for purchases >$25).
	+ A cross-check of each item to ensure that they interconnect and relate (E.g. COH matches what FTR/ log states is present).
	+ Review of types of expenditures that have been made to distinguish between individual expenses and expenses that other parties should have been obligated to pay for.
	+ Review of any joint purchases/ shared expenses to ensure that they have been made with the individual’s (or guardian’s) consent and interests in mind.
	+ An assessment of storage and security measures that are being taken.
	+ An assessment to ensure that there are no borrowing processes in place. (For example, practices should not involve reimbursement to the home care provider or a housemate for purchases made on his/her behalf)

**Date:** 9/17

**Question 4: (Placement services and for all services)**

How is the score determined given that the review of money consists of a 3 month period?

**Answer:**

Criteria for met according to the tool is: Money is tracked with receipts and cash in/ out is accurate and timely. Criteria for not met is: Money is not tracked accurately, and /or receipts are not available and /or tracking is not accurate and/or timely. This does not mean, however, that one minor arithmetic or book keeping error can generate a Not met rating. Below is a decision tree that can assist in determining the rating.

|  |  |  |  |
| --- | --- | --- | --- |
| SIGNIFICANTUncorrected discrepancy resulted in or has clear potential for missing large amount of moniesORNumerous (3 or more) discrepancies that appear recurrent and/or unresolved and/or not followed up by the ProviderORNumerous (3 or more) instances of missing monies, inappropriate expenditures and/or it cannot be verified that the money was distributed/ spent correctly |  |  | NOT SIGNIFICANTDiscrepancy or occasional tracking gaps not likely to result in the misadministration of the moniesOROne or two discrepancies that can be verified that the discrepancies were not indicative of missing monies and the issue is being addressedORFew receipts missing (1-2) but there was no evidence that the money was missing or taken or spent incorrectly. |

**Indicator: L70 - Charges for care are calculated appropriately.**

**Date:** 12/12

#### Question: What are the specific requirements?

**Answer:**

#### Charges For Care [115 CMR 3.05]. The requirements for charges for care are as follows:

* Written notice of the charge needs to be sent to each fee‑payor (per 3.05(4)(a)) and to the individual and guardian (per 5.10(c)8):
* Prior to the individual receiving residential services and supports
* Prior to a change in the charge;
* Needs to show how the charges were determined

⦁ Formula is correct. (Calculations are present)

* 75% of Entitlements; or other recurrent income,
* If wages are used in the calculation, amount counted is not more than 50% after first $65 the individual is paid.
	+ - * Recommend a quarterly review of this amount when individual has wages which fluctuate.
* The charge must be updated Annually or as circumstances change
	+ Changes in recurrent income
	+ Adjusted when individual incurs applicable expenses as outlined in regulations
* Needs to explain the appeal process and who to contact.
* Placement service locations often have Room and Board notification which are either an arrangement with the Placement provider or with the individual care provider as a subcontracted entity. Room and board notifications should:
	+ Be sent to the individual/ guardian
	+ Be updated annually
	+ Not exceed 75% of the individual’s entitlements/ recurrent income
	+ Have provision to dispute or revisit the room and board notification, with an explanation of how to do this and who to contact provided to the individual/ guardian

**Process:** **Review of supports to individuals to manage their monies (moved up from process section)**

**Date:** 10/11

**Question 1:**

When the Provider is the Representative Payee for the individual, it seems that money information is present both at the site as well as at the administrative offices. How can the review be conducted comprehensively but efficiently without having to return each time to the administrative offices? Where is the indicator rated when the information is collected at different locations?

**Answer:**

As the provider is only notified of the specific sites and individuals in non-site based services to be audited on the first day of the survey, the provider cannot wait until the names have been identified to arrange for each individual’s financial information to be located in one place. Starting with the initial planning process the provider must be encouraged to make all individual information for the past year available at the sites. The 45 day letter references this need. In addition the team leader needs to work with the provider liaison to ensure that all information is present at the locations so that a complete and efficient review of the individual’s financial information can take place on site. At the orientation meeting, the provider will also be encouraged to begin preparations as early as possible.

In the event that the provider does not have all information available at the sites, the Team Leader will assign one or more surveyors to return to the administrative office on the last date of the survey to review each individual’s financial information for rating. This will reduce the necessity of all surveyors returning. As the survey visits occur, the names of the individuals audited will be shared with the provider, so that the provider can better prepare. The expectation is that the on-site time will still be limited to five days, even if a return visit to the administrative office is necessary. Regardless of where the information is assessed, the indicators will be rated through the individual audit process/ scoring screens.

**Date:** 12/12

**Question 2:**

What is the process that surveyors use to review a provider’s funds management system?

**Answer:**

**A. Financial review/ audit:** The following are the steps in conducting the audit:

1. The surveyor reviews documentation and agreements (A and B above) as part of the review for the applicable indicators.
2. The provider makes available one year’s worth of financial transaction records. The surveyor reviews these for a general sense of consistent practice and to identify any obvious issues, such as use of white-out, or purchase that seems out of line with policy. The surveyor then selects three months for a more extensive review.
3. Within the past year, Financial Transaction Records (FTRs) for three months will be more closely audited. The review for these three months includes:
	1. Review of FTRs, Cash-on-hand (COH), bankbooks, receipts held (e.g. for purchases >$25).
	2. A cross-check of each item to ensure that they interconnect and relate (E.g. COH matches what FTR states is present).
	3. Review of information concerning incoming monies such as entitlements, wages, gift checks, interest on accounts, savings bonds, gift certificates, and cash received from families or friends.
	4. A check of the names on the accounts to ensure that there are not any ownership or survivorship benefits to Provider staff from the account.
	5. Review of types of expenditures that have been made during these three months to distinguish between individual expenses and expenses that other parties should have been obligated to pay for.
	6. Review of joint purchases/ shared expenses to ensure that they have been made with the individual’s (or guardian’s) consent and interests in mind.
	7. An assessment of storage and security measures that are being taken including those in place for ATM cards, credit cards, and signature stamps.
	8. An assessment of the timing of transactions and the recording thereof. (E.g. are work and other checks deposited in a timely manner? Are transactions logged in and signed off (onto the FTR) when they occur (cash in/cash out)? Are bills paid on time? Any repercussions (e.g. late fees, bounced checks) as a result of bills not being paid promptly?
	9. Review of the completion of FTRs and whether these include all the information as required per regulations. (E.g. The surveyor will check to see that the staff person involved in the transaction is initialing the form (form must also have a signature key) and that the type of purchase is recorded.)
	10. Review to ensure that there are no out-of-sequence checks or transactions.
	11. An assessment to ensure that there are no borrowing processes in place. (For example, practices should not involve reimbursement to staff or a housemate for purchases made on his/her behalf)
	12. If the surveyor identifies issues requiring additional information in order to determine a rating, the surveyor may expand his or her review beyond the three months selected for auditing.
4. When the Provider has additional protocols such as keeping receipts for all purchases, or establishing a maximum amount of individuals’ cash kept in the home, the surveyor’s review will then assess whether these additional expectations are in place at this location.
5. Ensure that what is written in the Assessment, Training Plan, and Shared and Delegated Money Management Plan is consistent with specific practices in the home.
6. Assess how much money is typically stored within the home, available and accessible from the bank, and located within individual accounts managed and available through the corporate office.
7. When the individual is paying for additional expenses, does the agency know and have they pursued an Adjustment to the Charges for Care?

 8. Note if there is evidence of the agency’s monitoring/auditing process being

 implemented.

## B. Administrative Review/ discussion and inquiries on money systems

Some information may be obtained during the Administrative Review process, such as charges for care process, representative payee system, or general information on its systems for funds management. If concerns are identified at service locations, additional inquiries may be made of management staff. The following information, questions, and systems should be explored with provider management:

1. Check the agency policies and practices around auditing and monitoring, and assess the effectiveness of these systems. For example, how frequent is the over sight? How effective is this system at revealing and correcting any problems? Is this auditing process regular and ongoing? Does it include a financial/ mathematical check and an appropriateness of expenditures / programmatic quality check as well? Ask about and investigate organizational systems relative to financial safeguards.
2. Inquire about their procedures as Rep payees. How are staff trained and knowledgeable in rep payee information?
3. Assess how staff are supported to become familiar and knowledgeable in money management strategies including both safeguards as well as mechanisms to teach greater independence?
4. When issues occur, or questions arise, the surveyor may ask to see policies and procedures on funds management such as those related to joint purchases and/or financial restitution.

## C. Staff Interviews/ discussion

The review process is based primarily on documentation, and information exchanged with program staff in the course of reviewing the funds management for a person. During the three month audit, the surveyor should explore the following area(s) with program staff:

1. Inquire about access, security and general pattern of financial activities and support.
2. Ask about the oversight, monitoring, and auditing practices of the agency. What is the practice for this location?
3. Ask how joint purchases are made and tracked.
4. Ask about long range and pro-active strategies that are utilized to ensure that bills are paid on time, that benefits/ entitlements are optimally obtained, that individuals do not lose their entitlements (E.g. due to too much in savings),and that individuals long range financial goals are supported.
5. Ask about the education and guidance that is offered to individuals to make purchases and spend money on an ongoing basis. What are the activities in place that support appropriate spending?
6. Ask about money practices’ including any differences in what occurs during the week versus the weekend.

**D. What to do during the survey when:**

**Serious Concerns arise:**

In the event a significant concern is identified (e.g., there is an indication of theft or unaccounted significant amounts of money – e.g., >$100), the surveyor should request a senior administrator from the agency to take possession of the finances and records, and issue a Notice of Immediate Action Required and/or contact the DPPC. Notification to Team Leader and QE Director is also made. When in doubt, the surveyor should contact DPPC.

**Missing information/ lack of clarity regarding the scope of the problem:**

In the event that the financial information is not present (e.g. FTRs not available or minimally present), or there is an indication of inappropriate ongoing practices (e.g. individual paid for several appliances and pieces of living room furniture in three month audit), the survey should issue a Notice of Immediate Action Required, instructing the Provider to conduct an audit for the past year for all individuals living in the home, assess the current status, and reimburse the individual(s) for all expenses that are considered the responsibility of others to make. Notification to Team Leader, QE Director is also made.

**Date:** 9/17

**Question 3: Placement Services**

How should the financial review occur when the individual is served in a Placement Service? Sometimes the Provider is the Representative Payee for the individual, and the home care provider is assisting the individual in money management for a portion of their monies. Often money information is present both at the home as well as at the administrative offices. How can the review be conducted comprehensively but as unobtrusively as possible?

**Answer:**

The surveyors randomly select three months within the past year of financial records to audit. At the Administrative Review meeting, the surveyors should ask the Provider to describe their system for money management and oversight. Starting with the initial planning process the Provider must be encouraged to make all individual information for the past year available. The surveyor will review the last full month’s information at the home, and the two randomly selected past months information at the Administrative offices. The team will work with the Provider liaison to ensure that all information is present so that a complete and efficient review of the individual’s financial management can occur.

**Personal Expenses- Guidance summary – 8/15/13; revised 1/20**

**I. Background and Introduction**

Protecting individuals’ funds and utilizing them appropriately is one of the most important safeguards that DDS and its providers assure for the individuals we support. Surveyors conducting licensure and certification reviews include a review of individual expenditures and systems that providers have in place to assure that an individual’s funds are used for acceptable and appropriate expenses.

What is appropriate and acceptable, however, is not always clear and unambiguous. While in many cases what is an appropriate use of individual funds is fairly straightforward, there are circumstances where the responsibility is less clear. Sometimes the distinction is whether the cost involved is a routine and standard expense as opposed to an additional one time event/ expense, or an expense solely for the benefit of the individual v. a programmatic expense.

What follows, is a set of guidelines for DDS staff and providers to assist in making fair and appropriate determinations regarding utilization of individuals’ funds. While it is not possible to account for every instance, there are some principles, however, that should guide our thinking and actions:

* All provider policies and practices should be geared at preventing the possibility of financial exploitation or the misuse of individuals’ funds.
* An individual’s financial status and personal assets should not dictate the basic services and supports they receive that are the responsibility of the provider.
* Providers should clearly delineate through policies and procedures, those items which exceed its contractual obligations and should have a process in place for obtaining separate agreements for expenses that are considered “special”, “one time” or “over and above.”

While many situations will need to be dealt with on a case by case basis, following are general categories of expenditures that should be considered the provider’s contractual responsibility and typically are included in the charges for care collected from individuals. It is followed by examples of expenses that are the responsibility of the individual outside of those collected as part of charges for care.

**II. Expense Responsibilities**

**Expenses that are the responsibility of the Provider**

1. **Upkeep and maintenance of the household.**

Examples include:

* 1. Cleaning services
	2. Yard services
	3. Trash removal
	4. General household supplies
1. **Basic household furnishings**

Examples include:

* 1. Furnishings for common spaces
	2. Dishes, flatware, utensils, cooking equipment
	3. Floor Coverings
	4. Adaptive equipment (typically covered by the individual’s health insurance)
1. **Food**
2. **Communication systems**

Examples include:

* 1. House phone service
	2. Basic Internet access for the home
1. **Transportation**

Examples include:

* 1. Transportation to medical/dental appointments
	2. Transportation for community outings
	3. Parking for appointments and community outings
1. **Community Outings**

Examples include:

* 1. Staff meals and entertainment when engaging in routine community activities
1. **Services and supports**

Examples include:

* 1. Staffing pattern as outlined in the current site specific safety plan
	2. Services and supports to implement the individual’s ISP
	3. Staffing levels defined through the agency’s contract with DDS

**Expenses that are the responsibility of the individual:**

* Furnishings for the individual’s bedroom that go above and beyond the standard
* Cable television (individuals can jointly share)\*\*If there is a “bundled” internet, phone and cable television bill, only the portion related to cable television should be considered an individual expense.(1/20)
* Cost of own meals and entertainment when out in the community
* Clothing
* Individual costs incurred on vacation
* Personal care items, such as shampoo, deodorant and toothpaste

**Expenses that may be considered above and beyond the provider’s responsibility for which the guardian/ individual could agree to pay:**

While there is no way to account for every circumstance which is considered “additional” , “above and beyond” , “special”, or “one time” events, the following are general expenses that typically arise for which a separate agreement with the individual/ guardian would be necessary.

* Staff expenses for special occasions, activities or entertainment such as admission tickets to events that exceed the provider’s routine supports to the individual for regular community events and entertainment. For example, purchase of premium seats for the individual and a staff member to attend a sports event or concert, would be considered “above and beyond”.
* Staff travel, accommodations and entertainment expenses when on vacation together – For example, four individuals and two staff are planning to share a vacation cottage and want to split the cost of the cottage rental and food across the four individuals going. When a vacation involves additional staffing hours to the base staffing pattern, individuals can pay for this extra time, but should not be paying for the portion of staffing that is included as part of the base staffing pattern.
* Additional staff time (e.g. hourly rate to one person) when above and beyond what is provided through contract, safety plan and ISP. For example, the provider is contracted to assist the individual with medical appointments and the individual wants to go to a theme park for the day. If the contract allows for additional supports, and there are sufficient hours available within the contract, then the staff time should be charged to the contract rather than the individual. If the contract does not include provision for other supports, or there are not enough hours available within the contract for this outing, and the individual is willing to pay for supplemental services to engage in a special activity, then the option should be presented for agreement beforehand, with the provider outlining what is being offered, and the individual/ guardian is presented with information and knowingly agrees to this arrangement, such as “to go to a theme park with a staff person for 8 hours at a rate of $x/ hr pay”.

**III. Principles and guidelines relative to “above and beyond” requests to individuals/ guardians**

Provider’s policies and procedures regarding financial management should be detailed, outlining who pays for what, and clear information should be disclosed to individuals, families, and guardians when the individual begins to be served as well as when a special event/ purchase is planned. Written agreement for additional expenses must be obtained prior to occurrence.

**Provider written policies and procedures should include the following:**

* A clear delineation of provider and individual responsibility for items/ services.
* A clear delineation of what items/ services would be considered “above and beyond”.
* The process used to inform the individual/ guardian regarding expenses
* The requirement to obtain written agreement for any additional expenses

**Any written request for agreement should be presented in advance and include:**

* The specific details regarding the scope/ parameters of the request and the projected cost to the individual.
* The specific details regarding the individual’s responsibility for staff’s expenses, if applicable. (including, for example the number of meals and cost cap per meal)
* The individual’s portion of contribution to shared expenses, if applicable

**Indicator: L90 - Individuals are able to have privacy in their own personal space.**

**Date:** 8/16

**Applicability: Residential Services**

The CMS HCBS Community Rule requires that each individual has privacy in their sleeping or living unit:   (1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. (**§ 441.301**)

Privacy applies primarily to the individual when in his/her room as well as secondarily to the assurance that an individual’s possessions can be safeguarded when they are away from the home.   This is important as it affects the decision as to what kind of lock is installed. There are locks that only work from the “inside”, such as the push button locks present on most typical bedrooms and bathrooms. At a minimum, all individuals need to be provided with a means to lock their door from the inside.

While affording individuals privacy in their living space is a principle that we all support, several questions have arisen with respect to implementation of this requirement which are clarified below:

1. The requirement that individuals have a lock on their bedroom doors, does not mean that it be used at all times.  It simply provides individuals with an additional measure of privacy should they choose to use it.
2. There cannot be a lock on a bedroom door that leads to an egress.  For these doors, individuals / guardians need to understand and agree to accept a bedroom which cannot have a lock on the door as it serves as an egress in the event of a fire emergency.
3. Locks that are on doors should be able to be easily opened by the individual.  Many such types of locks are available.
4. Relative to licensure and certification, the inclusion of the requirement for locks on bedroom doors is not intended to be the sole determinant of whether an individual has privacy.  It is in addition to all of the other elements such as asking for permission prior to entering personal space, promoting use of personal space, and fostering privacy that are also in the indicator “Individuals are able to have privacy in their own personal space”.

In terms of implementation and application of these new CMS requirements, DDS suggests the following sequential process:

1. Providers should determine whether the individual would like to lock their door when they leave for work/ day service and based on discussion with each individual, determine what type of lock needs to be installed. Individuals who prefer to lock their possessions when outside their bedroom will need to have a key lock installed on their bedroom door and be provided with a key.
2. Providers that have not already done so should begin to install locks on all bedroom doors (unless there is an egress from the bedroom).  Appropriate staff can have a key to each bedroom or a master key or master pin which opens all bedroom doors. So, individuals do not need to be the only people with keys to their doors.
3. Once the locks are in place, individuals’ patterns of door use should then be reviewed.  eg Does the individual choose to lock or merely close their door when they are out of the bedroom?  In of the bedroom?
4. It is important to note that the requirement is around having a door that is lockable, not necessarily that the door is locked at all times. There will be many individuals who will choose NOT to lock their doors.  The individual may close their door, but never lock it when they are in his/her room.  Having a lock on their bedroom door, and choosing not to use it, satisfies the individual’s need for privacy and, as long as the door is lockable (whether or not an individual locks it), satisfies CMS requirements.
5. There will be those individuals that choose to lock their doors when they are inside the bedroom as an addition assurance of privacy.
6. There will be those individuals for whom choosing to use the lock may be contraindicated. In these circumstances, the determination as to whether it is contraindicated needs to be discussed, agreed to and documented in the ISP. For example, locking a bedroom door by an individual who needs increased supervision by staff due to risk of pica may be contraindicated.
7. For those that choose to lock their doors and for whom it is not contra-indicated, the provider needs to plan and thoughtfully consider safety in general, balancing the need for privacy and safety, including fire safety.  In relation to the need for privacy, if an individual who chooses to lock their door at night requires night-time checks for incontinence, the provider should have a conversation with the individual to discuss and agree on the least intrusive way to assure that the check occurs.   For safety, if individuals choose to lock their doors at night when in bed, fire drills would need to be practiced with the additional nighttime steps that would need to be taken to evacuate such as unlocking doors.

**DOMAIN: COMPETENT WORKFORCE (L74 – L85)**

**Indicator: L76 The agency has and utilizes a system to track required trainings.**

**Date:** 10/11

**Question 1:**

How is the indicator rated? Is it necessary to double check shift (e.g. CPR) and location (e.g. Formal Fire Safety –one per home) trainings at each of the locations as well? What happens when different information is found in the field?

**Answer:**

About one month prior to the Administrative Review the Provider is asked to provide a staff roster to the team which lists all employees including relief and care providers, specifying staff name, position, job title, work location, shift, and whether the employee has a specific role e.g. Formal Fire Safety Officer, CPR shift person. The Provider is expected to return this information to the team within two weeks.

A 10% sample of staff is randomly selected from this roster (up to 20 staff), and submitted to the Provider about one week in advance of the Administrative Review. This sample should include both staff with key roles (e.g. the Human Rights Officer) as well as staff that do not have a specific role. The Provider has one week to compile the direct training information on all trainings as listed below, and make that available to the team at the Administrative Review. For example, if an agency has 200 employees, 20 staff names will be given to the agency, and the review includes the following:

**TRAINING REQUIREMENTS CHART**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Indicator** | ***Training******Required*** | **Residential****24 hour** | **Individual****Home Supports** **< 24 hour** | **Placement****Services** | **Respite** | **Work/****Community Based Support** |
| L76 | ***First Aid*** | All staff | All staff | Home Provider(s) | All staff | All staff |
| L76 | ***CPR*** | 1 staff on dutyeach shift | N/A | Home Provider(s) | 1 staff on duty each shift | 1 staff on duty |
| L76 | ***Formal Fire Safety*** | 1 staff per home | 1 staff in service | N/A | 1 staff at location | 1 staff at location |
| L76 | ***Fire Safety strategies*** | All staff | All staff  | Home Provider(s) | All staff | All staff |
| L76 | ***Human Rights Officer*** | 1 staff per home | 1 staff in service | At least 1 staff for all the homes | 1 staff at location | 1 staff at location |
| L83 | ***Human Rights & DPPC Reporting*** | All staff | All staff | Home Provider(s) | All staff | All staff |
|  | ***Additional trainings and competencies evaluated on site***  | **Residential****24 hour** | **Individual****Home Supports** **< 24 hour** | **Placement****Services** | **Respite** | **Work/****Community Support** |
| L5 | ***Safety Plan*** | All staff | All staff  | Home Provider(s) | All staff | All staff |
| L77 |  ***Unique needs*** ***of individuals******(e.g. diabetes; ASL)*** | All relevant staff  | All relevant staff  | All relevant Home Provider(s) | All relevant staff  | All relevant staff  |
| L78 | ***Restrictive interventions*** | All staff implementing restrictive interventions | All staff implementing restrictive interventions | All Home ProvidersImplementing restrictive interventions | All staff implementing restrictive interventions | All staff implementing restrictive interventions |
|   L79 | ***Restraint-******Authorizers******Restraint - implementers*** | All designated authorizersAll implementingrestraint | All designated authorizersAll implementingrestraint | All designated authorizersAll implementingrestraint | All designated authorizersAll implementingrestraint | All designated authorizersAll implementingrestraint |
| L80 | ***Signs and symptoms of illness*** | All staff  | All relevant staff | Home Provider(s) | All staff | All staff |
| L81 | ***Handling medical emergency*** | All staff | All relevant staff | Home Provider(s) | All staff | All staff |
| L82 | ***Medications administered***  | All staff administering medication | All staff administering medication | N/A | All staff administering medication | All staff administering medication |
| L84 | ***Utilization of health related protections*** | All staff implementing health related protections | All staff implementing health related protections | All Home ProvidersHealth related protections | All staff implementing health related protections  | All staff implementing health related protections |

At the Administrative Review, the team assesses the presence of all trainings for all staff in the sample. The scores for the indicator are: # met / # rated. For example, 20 staff’s training information was reviewed and 16 had been trained in mandated topics. Of the four staff that were not trained in everything necessary, two were missing First Aid, and two were missing fire safety. This would be scored as 16/20. If 80% or more have received all required trainings, it would be rated as standard met for the indicator.

There is no need to validate on site as shift and location information is identified earlier and reviewed at the Administrative Review. For example, when selecting staff to sample, if the designated Human Rights Officer, Formal Fire Safety Officer, CPR shift staff are not trained in that topic, this would be reflected as a not met for this person’s training.

**Indicator: L77 - The agency assures that staff are familiar with and trained to support the unique needs of individuals.**

**Date:** 10/11; revised 9/17

**Question 1:**

Indicator L38, “Physicians’ orders and treatment protocols are followed. (when agreement for treatment has been reached by the individual/ guardian/ team)” seems to have some overlap with this indicator. What is the difference? How is L77 assessed?

**Answer:**

The focus of L77 is on workforce competence, staff training, home care provider knowledge and familiarity with the individual’s unique needs. Staff / home care provider knowledge and training in various topics such as physical disabilities, mental health conditions, syndromes and teaching techniques is assessed here. In addition, staff / home care provider must be able to communicate an understanding of the unique aspects of the individual and be able to incorporate this general training information into everyday practices. For example, when working with someone who has cerebral palsy, staff must be trained in cerebral palsy and be also must be knowledgeable in unique ways to support the individual in everyday life.

L77 encompasses an evaluation of staff’s / home care provider’s training and understanding of the entire array of individual’s unique needs, inclusive of training and familiarity with someone’s non-medical needs. For example, review of staff’s knowledge and training in how to consistently teach appropriate social skills at the dinner table would be assessed in L77 while specific protocols related to swallowing disorders would be assessed in L38.

While there is some overlap between the indicators, the primary emphasis here is training and staff/ home care provider competence rather than implementation of specific medical protocols. Therefore diabetes training to staff would be evaluated here, and if the individual had any specific protocols to address this diagnosis, implementation would be rated elsewhere.

**Indicator: L78 - Staff are trained to safely and consistently implement restrictive interventions.**

**Date:** 10/11

**Question 1:**

Mandated training is reviewed organizationally through a 10% training sample. For training indicators which are reviewed at the various locations, how does the training review occur and how many staff are reviewed to ensure that staff are adequately trained?

**Answer:**

These indicators require the surveyor to review training for staff working at the location but not through a review of each staff person’s separate training certificates in each of his/her record. Typically, training relative to the unique needs of each person, is maintained in a retrievable format within the confidential file such as through sign-offs on the specific plans and protocols, e.g. social skills plan or behavior intervention plan. In addition, staff meeting minutes, staff logs, clinical meeting notes, with attendance noted, and other such forums, are documentation that can be utilized to assess staff training. Given this, the surveyor would look for documentation that all staff have been trained in these areas through documentation which is maintained either at the individual and/or the site level. In addition to assessment of staff training, one staff is required to be interviewed to answer several of the indicators within this competent workforce section. The interview is conducted to assess that staff are able to communicate and demonstrate knowledge and familiarity with the interventions that they have been trained in.

**Indicator: L80: Support staff are trained to recognize signs and symptoms of illness.**

**Date:** 9/17

**Question 1: All services**

How is this indicator assessed for locations in general and for home care provider homes?

**Answer:**

The staff/ home care providers are often the first line of defense for individuals, particularly for individuals who may not be able to describe their symptoms of illness. It is critical therefore, that the staff/ home care provider is knowledgeable about general signs and symptoms of illness. General signs and symptoms of illness are outlined in the Health Promotion and Coordination Initiative Training and Resource Manual under “signs and symptoms of illness”, which includes signs and symptoms of illness and health observation guidelines. A placement service’s success in addressing this standard is optimized when a systemic approach in taken to ensuring that all home care providers are trained in signs and symptoms of illness.

**Date:** 1/20

**Question 2: All services**

How is this indicator now assessed given that there are multiple items listed on Guidelines for Observable Signs and Symptoms web link?

**Answer:**

The staff/ home care providers are often the first line of defense for individuals, particularly for individuals who may not be able to describe their symptoms of illness. It is critical, therefore, that the staff/ home care provider is knowledgeable about general signs and symptoms of illness. Guidelines for Observable Signs & Symptoms of Illness can be found at the link: <https://www.mass.gov/lists/health-and-safety-guidelines#guidelines-for-observable-signs-&-symptoms-of-illness-> In order to successfully meet this indicator staff need to be trained in two particular topics: “Health Observation Guidelines” and “Just Not Right”. Providers are free to use their own curriculum provided that it covers these two topics.

**Indicator: L84** - Staff / home care providers are trained in the correct utilization of health related protections per regulation.

Date: 9/17

**Question 1: Placement Services**

How does the survey team evaluate whether the home care provider is meeting this indicator in shared living?

**Answer:**

This is an area that can be more challenging to evaluate for individuals residing in shared living. The Provider needs to ensure that the home care providers are knowledgeable about how to implement any supports and health related protections in place. Documentation outlining the use of the health related protection needs to be present. The home care provider and Provider should then be interviewed to determine whether the home care provider has been trained in utilization in accordance with the instructions. The home care provider should be able to describe what supports an individual has, what the purpose of such supports are, the frequency of use, and how the supports are cleaned and maintained on an ongoing basis. The Provider needs to establish a system to ensure that the home care provider continues to implement the supports as indicated within the ISP.

**Indicator: L85- The agency provides on-going supervision and staff development.**

**Date:** 3/12

**Question 1:**

How is this indicator assessed for locations in general and for care provider homes?

**Answer:**

Multiple pieces of information are collected and utilized to assess this indicator. This indicator assesses whether the overall coordination, supervision, and support for the specific location is occurring. For example, is the (house) manager providing support to direct service staff on a regular and ongoing basis such that communication is clear and systems and routines are consistently implemented? The agency is expected to ensure that policies and procedures and systems that are established on an agency-wide basis, are being implemented across each location. Often agencies have established protocols and procedures in the following areas: money management, medication administration, maintenance and repair, health care, communication, human rights, staff training, supervision and individual support strategy implementation. Monthly financial audits of homes, medication reviews, individual supervision, and monthly group staff meetings are some of the mechanisms generally established to ensure that direct support staff receive the ongoing support and supervision to perform their job duties. A rating of not met would be appropriate if there was evidence that the location did not have an adequate system of supervision, management, and over sight in place. For example, staff meetings, routine medication, maintenance, and financial over sight and staff supervision were not occurring at this location. Another example, if the House manager did not identify that numerous errors within the home were attributable to one or two particular staff members, and did not provide sufficient supervision to improve the performance of these staff, this indicator should be rated not met.

**Placement Services:** The Placement Service is expected to visit each care provider home at least monthly. Monthly visits should include a review of the general environment, as well as health and safety. In addition to monthly visits, the agency has a key role to provide over sight, establish frameworks and systems, and review of such items as medications and money management in each home. The agency is also expected to ensure that each care provider is trained in mandated areas, and is supported on an ongoing basis through supervision, guidance, and communication. Monthly visits, and adequate over sight, monitoring, and training must be in place.

**5/20/15 Additional information:** The placement agency shall demonstrate that it has systems in place to monitor and assure that home care providers document and track the following:

1) financial transactions on behalf of the individual living in the home,

2) safe administration and storage of medications

3) health care information

4) progress towards meeting ISP goals and objectives

5) environmental oversight to ensure that the home is well maintained and continues to meet the individuals’ needs. The placement agency shall assure that the home care provider keeps the home clean, safe and in good repair and shall notify the Department as soon as there is a reason to believe (or determines) that the placement can no longer meet the individuals’ assessed needs.

In addition, the agency must regularly assess the training, knowledge and competence of home care providers, including conducting an annual assessment of the skills of the home care providers.

**Date:** 9/17

**Question 2:** **Placement Services**

How does the Provider ensure that each placement home is meeting all contractual and regulatory obligations?

**Answer:**

Providers need to establish systems to provide routine and regular oversight to the home care providers. The Providers can encourage use of a particular system, but cannot always prescribe the exact system that is implemented within each home care provider home. However, the Provider needs to be instructive to the home care providers in terms of the contractual and the regulatory standards, and expectations for what each home care provider home is required to meet, and can suggest systems that can be used in the home to facilitate success with meeting these standards. Providers must take an active role in recruiting and supporting the home care providers to meet all obligations. The role of the Provider Manager is critical in the operation of high quality shared living services across various shared living homes. In addition to monthly visits, other systems and mechanism for support can be established.

**DOMAIN: GOAL DEVELOPMENT AND IMPLEMENTATION (L86 – L88)**

**Indicator: L86 - Assessments are submitted on time.**

**Date:** 10/11; replaced 10/14

**Question 1:**

How is the determination made that assessments were completed and sent on time?

**Answer:**

Notification of the ISP is completed no later than 30 days in advance of the ISP. This allows the Provider at least 15 days to complete the assessments, which must be submitted at least 15 days prior to the ISP meeting. Surveyors will review the notification date, the date that the assessments were submitted, and the ISP date. If there is evidence that the assessments were submitted at least fifteen (15) days prior to the ISP, then the indicator is rated “standard met.” Rating on this indicator is based on information obtained from HCSIS for all ISPs performed after February 2, 2014. For ISPs performed between September 2013 and February 2014, we will continue to rely on the Provider to point us to documentation that reflects the date of Provider submission, the notification date, and the ISP date.

In the event that notification of the ISP is not on time, and as a result the provider completes the assessments less than 15 days prior to the ISP, the provider will not be penalized for this.

This has been the practice since 2011, and will continue to be the practice - In the event that the Notification (letter) was either not present or provided less than 30 days notification of the ISP, the Provider would not have been able to submit any assessments because the Service Coordinators must send the request before providers can begin the assessment. Therefore, in this situation, the surveyor should “not include in scoring”. While reference will be made that the assessment was not on time, this score will not be included in the provider report, and the issue of late notification will be referred back to DDS to resolve.

**Indicator: L87- Support Strategies necessary to assist an individual to meet their goals and objectives are completed and submitted as part of the ISP.**

**Date:** 10/14

**Question 1:**

How is the determination made that the proposed objectives and support strategies were completed and sent on time?

**Answer:**

Notification of the ISP is completed no later than 30 days in advance of the ISP. This allows the Provider at least 15 days to complete the proposed objectives and support strategies, which must be submitted 15 days prior to the ISP meeting. Surveyors will review the notification date, the date that the proposed objectives and support strategies were submitted, and the ISP date. If there is evidence that the proposed objectives and support strategies were submitted at least fifteen (15) days prior to the ISP, then the indicator is rated “standard met.” Rating on this indicator is based on information obtained from HCSIS for all ISPs performed after February 2, 2014. For ISPs performed between September 2013 and February 2014, we will continue to rely on the Provider to point us to documentation that reflects the date of Provider submission, the notification date, and the ISP date.

In the event that notification of the ISP is not on time, and as a result the provider completes the proposed support strategies less than 15 days prior to the ISP, the provider will not be penalized for this.

Although Providers are not dependent on the notification to begin creating the proposed objectives as HCSIS allows support strategies to be entered 90 days in advance of the meeting, consistent with past practice the provider will not be penalized in the event that the Notification (letter) was either not present or provided less than 30 days notification of the ISP. Reference will be made that the proposed support strategies were not on time, and this score will not be included in the provider report.

**Indicator: L88 – Services and support strategies identified and agreed upon in the ISP for which the provider has designated responsibility are being implemented.**

**Date:** 9/17

**Question 1: Placement Services**

How are data being collected, documented and tracked in placement services? What is the role of the Provider vs the home care provider?

**Answer:**

Data collection and analysis needs to occur on two levels- both with the home care provider, and with Providers. In other words, the Provider needs to assist the home care providers to ensure that strategies are in place to support an individual to work on his/her ISP objectives and develop awareness and strategies for the home care providers to easily collect data. It is important that the Provider has systems of oversight to ensure data collection, implementation of strategies, analyzing and summarizing this data, and bringing this information to the ISP team.

Home care providers must be knowledgeable about the services and support strategies in the ISP and what their role is in implementing these services. Documentation needs to be present to determine if goals are being worked on as identified in the ISP. Documentation at a minimum should identify when the goals are being addressed, what goals are being worked on, and the results of the support. There is no standardized format for data collection and each shared living home is free to develop their system of raw data collection. However, the Provider need to ensure that correct data are being collected on services and supports identified and agreed to within the ISP. The Provider may review the raw data, and then summarize the raw data as part of their monthly visits. For example, a home care provider takes data on community trips and records this information on a calendar. At the end of the month, the Provider tabulates the data, reviews the information and summarizes progress in a monthly progress note. The Provider needs to ensure that the data are being kept and recorded and reviewed.

Development of goals consistent with the individual and guardian input, and goals which are meaningful and person-centered is essential but is not the scope of this indicator. Once goals, objectives and support strategies have been developed, the provider needs to assure those that they have designated responsibility for, are being implemented.

**CERTIFICATION INDICATORS**

**DOMAIN: PLANNING AND QUALITY MANAGEMENT (C1-C6)**

**Indicators:**

**C1 - The provider collects data regarding program quality including but not limited to incidents, investigations, restraints, and medication occurrences.**

**C2 - The Provider analyzes information gathered from all sources and identifies patterns and trends.**

**C3 – The provider actively solicits and utilizes input from the individuals and families regarding satisfaction with services.**

**C4 – The provider receives and utilizes input received from internal systems, DDS and other stakeholders to inform service improvement efforts.**

**C5 – The provider has a process to measure progress towards achieving service improvement goals.**

**C6 – The provider has mechanisms to plan for future directions in service delivery and implements strategies to actualize these plans.**

**Date:** 10/11

**Question 1:**

How are these organizational indicators which are based on one standard met vs. standard not met evaluated for the organization? Unlike the past organizational rating where a score of partially achieved could be given, scoring is now either met or not met. It is therefore hard to rate for providers in situations when some aspects are in place while others are not. Also, it is hard to assess these indicators for smaller agencies who may demonstrate positive outcomes but do not always have established planning activities, have not formally identified patterns and trends, and/or have not clearly documented service improvement goals and strategies to actualize these goals.

**Answer:**

The planning and quality management indicators follow a general service improvement cycle in which data is collected on quality, standards and goals are set for improvement (design), an assessment is performed to compare performance with goals and standards (discovery), actions are taken to improve quality (remediation), and re-assessment to compare new performance with standards occurs (improvement). The cycle then repeats, such that new data might prompt new quality goals and actions. For the most part, each of the certification indicators assesses the provider’s ability to take actions on each of these various aspects of the quality cycle. While there is currently no partially achieved rating, the discrete nature of the indicators makes it possible to rate some indicators standard met, while others are not met, when some aspects are in place while others are not.

Many of these indicators rely on documentation, for example the criterion for standard met in C6 is “There are **documented** mechanisms in place to plan for future directions in service delivery and strategies are in place to actualize plans”. Documentation does not have to be in a specific form nor does it need to be particularly elaborate. However items such as future goals and current strategies to meet these goals should be outlined and clearly delineated in writing. In addition, there should be some sort of information loop and process, in other words the agency needs to measure progress towards service improvement goals, and then utilize this information. Strategies can then be altered as needed to improve effectiveness in meeting goals. This should not adversely impact smaller agencies as long as the agency has established planning activities, identified patterns and trends in writing, and has clearly documented service improvement goals and strategies to actualize these goals.

**Date:** 10/11

**Question 2:**

There seems to be tremendous overlap between each of these indicators. Can you summarize what each indicator is intending to measure? In particular, some indicators focus on the provider’s internal quality improvement process, while others focus on long-term strategic planning. Both are recognized as important and should be measured. For example, there are agencies who make exceptional improvements to systems subsequent to a problem but have not established formal goals, developed planning activities, and/or have not clearly documented strategies to actualize these goals.

**Answer:**

Recognizing that there is some overlap, the following is a brief summary of the focus for each indicator:

* **C1 –** Internal data collection including data on program quality. As noted above, the provider needs to have some mechanism to collect information on service quality. The tool notes that there is no specific requirement for the type or format of programmatic data that needs to be collected, but that this should be additional information beyond that which is collected through the incident management process.
* **C2** - Provider analyzes information gathered from all sources. This indicator begins where C1 leaves off and is not about gathering data, but rather this indicator focuses on the Provider’s ability to analyze the information and to identify patterns and themes. This indicator measures the provider’s ability to prioritize areas and design service improvement goals. For example, as a result of determining that individuals were using the community only once per month, the agency reviewed community activity systems, identified several gaps, designed a service improvement goal to increase the number of community activities that individuals were offered in the future through increases in training and over sight.
* **C3** – This indicator appears similar to C1 and C2, as it is both about gathering and about utilizing information. However, the focus for C3 is on how the Provider receives and uses input from their primary stakeholders – the individuals and families. For instance, is the provider actively soliciting input from the individuals and families through use of satisfaction surveys, family forums, self-advocacy initiatives and /or other informal mechanisms, to learn about and improve their satisfaction with services? In addition, once information is collected does the provider utilize this family/ guardian feedback to identify patterns and then to establish service improvement goals based on guardian feedback. It is important to note that the provider needs to make efforts to obtain information regarding satisfaction with **each type** **of services** from all individuals and guardians.
* **C4 –** This indicator appears to overlap with both C1 and C2, as it is both about gathering and about utilizing information. However, the focus for C4 is on how the Provider gathers and uses input from external sources such as DDS and other stakeholders to inform service improvement efforts. The provider is evaluated to determine whether it uses the information shared in annual contract reviews, feedback from site visits and development of performance based objectives in on-going service improvement efforts. For example, DDS often provides input to providers to expand service improvement efforts in the areas of increasing employment opportunities and community activities. An assessment of the how the provider is acting on this information is made here.
* **C5** – Once information is obtained from the analysis done within C2 through C4, (through utilization of internal information, and guardian and DDS input), this indicator looks at whether the provider has a process to set specific service improvement targets and to measure progress towards achieving these goals. An agency need not address all areas identified at once, but need to focus their efforts on those they consider priorities. The agency should have a process for determining service improvement targets. Regardless which service improvement targets have been selected, the provider’s ability to improve quality over time and across the provider’s entire compliment of services is evaluated within this indicator. For example, once the provider has identified issues with the management of people’s money, targeted a decrease in financial incidents, and set up better systems, how does the provider measure their success, for instance, is the provider tracking progress to ensure that there is a decrease in the number of thefts? In another example, the provider develops and implements fall prevention strategies and measures the number of falls as a result of this continuous quality improvement efforts. Also reviewed within this indicator is the provider’s ability to make mid-course corrections should the necessity arise.
* **C6** – The provider has mechanisms to plan for future directions in service delivery and implements strategies to actualize these plans. This indicator assesses the provider’s ability to and conduct long range planning by setting and following a strategic plan. For example, a provider may establish and implement a five year plan to close their sheltered workshops and provide a greater focus on competitive employment. This indicator stands separate from the continuous improvement cycle, and measures the provider’s ability to engage in long range planning activities, project a future vision to improve service quality, and implement a strategic plan which includes programmatic improvements.

The following summarized example is offered to assist in decreasing confusion concerning the overlap of indicators. The provider gathers MORs from the HCSIS system (C1). The provider reviews the MOR data, analyzes it, and discovers that most MORs occur at 3pm to 4pm when individuals return from work and are very busy (C2). In C5, the provider sets a goal of reducing the occurrence of MORs and measures progress in reaching the goal after 6 months. After 6 months, the provider reviews the data and discovers that MORs have been reduced by 30%.

**C7 – Individuals have opportunities to provide feedback at the time of hire/ time of match and on an ongoing basis on the performance of staff/ actions of home care providers that support them.**

**Date:** 9/17

**Question 1: Placement Services**

How can Placement service locations be successful in meeting this indicator?

**Answer:**

This indicator establishes a two-fold expectation that Providers have an affirmative obligation to enable individuals to participate in the process of selecting home care providers and in providing feedback on their ongoing performance. The Provider has a role in providing individuals with the opportunity to offer their opinions when decisions are made about the recruiting and selection of home care providers. When an individual is moving into shared living, his/her opinions concerning the potential home care provider should be strongly considered in designing a good match and creating a placement with a preferred home care provider. Individuals’ feedback should be obtained at the time new home care providers are being considered. There should also be a process in place that assures, on an ongoing basis, that information is sought from the individuals on the home care providers’ performance. The agency needs to conduct an annual assessment of skills on home care providers. Individuals need to have input into these annual reviews of the home care providers they live with. A Provider’s success in addressing this standard of support is optimized when the following practices are in place:

The most common approach used by Providers to make decisions about contracting is one of “matching” an individual with a prospective home care provider. The procedures should include provisions that allow individuals to meet with a prospective home care provider. The process should incorporate a practice of soliciting individuals for their opinion and views on the prospective home care provider. If the individual’s input is difficult to discern because there are challenges in understanding his/her form of communication, the process should include the observation of the prospective home care provider’s interactions with the individual(s). Finally, the decision should be informed by what information is gathered from the individual. The Provider’s procedures should detail how feedback from individuals about a prospective home care provider is reflected at the time of the match;

* The Provider needs to have procedures in place to gather input and feedback from the individual(s) on their home care providers on a periodic and ongoing basis. One way to do this is to check in with the individual during the monthly visits, and to integrate this information into working with the home care provider;
* The steps to check in with individuals and gather their comments should be a feature of the agency’s assessment system. It is expected that the Provider will be conducting annual assessments on each home care provider; the input of individuals should be solicited prior to this; and
* Whatever measures the Provider employs to gather and reflect individuals’ comments, the input dovetails with the expectations of a formal assessment, and therefore should be documented.

**Date:** **1/20**

**Question 2: All Services**

Please explain how agencies can be successful in meeting this indicator.

**Answer:**

This is an indicator applied to the sampled individual and assesses feedback on staffing at two separate and distinct intervals – prior to hire and as part of the ongoing evaluation process. In addition to two separate levels of input, information to inform the rating on this indicator comes from two different places – the administrative offices as well as the site. Questions should focus on opportunities afforded the individual to provide feedback on his/her support staff as well as opportunities for input into hiring staff who will support the person.

Information on ways the organization supports individuals in this area should be obtained during the administrative overview so that team members have a broad understanding of agency supports in the areas of hiring and evaluating staff. The agency needs to have a formal process for documenting individual feedback on staff performance. Guidelines and regulations also require that staff evaluations include comments from individuals. Therefore, when at the administration offices, surveyors should review the agency’s process, including forms used to document individual feedback as well as methods used to incorporate this feedback into employee’s performance reviews. At the administrative office or at the locations, we need to ensure that that this system/ forms are being used and implemented. Note: Review of staff evaluations will be confined to review and validate individual input only, and any copies of staff evaluations retained by surveyors should be redacted.

Agency methods of gaining input from individuals into the hiring process should be determined during the administrative overview. The agency’s process and forms used to document this input should be reviewed. When at the sites, surveyors need to confirm and validate that these practices were in place and occurred with input. There might be a variety of methods that can be employed to succeed in this area. Direct participation of an individual on an interview committee evaluating and selecting between several candidates is one way. Meeting the candidates during a tour of the home/ service location and providing formal input is another way. Staff and the individual themselves should be able to confirm that this observation visit occurred and staff should describe how input from individuals was obtained and used in the hiring process. Information on hiring is reliant on information obtained through staff and individual interviews as well as any documentation the agency might use to document individual participation. Ask about recent hires and what the process was for obtaining input. If the staffing has been stable with no hiring, the surveyor would only factor the individual’s ongoing input on staff performance into the rating.

Although direct involvement of the individual in the agency’s hiring and performance review processes is ideal, this might not be feasible for individuals who cannot readily communicate or identify their preferences. In other situations, direct participation of each person might not be practical for services where staff are responsible for larger numbers of individuals such as Individual Home Supports, Community-Based Day Supports or Employment Support services. In these situations, surveyors must assess how the individual’s input and preferences are gathered and used. Look for methods of soliciting feedback that accommodate the individual’s style of learning or communicating such as use of pictures or direct observation for individuals who are not verbal. Other methods can be employed to succeed in gaining individual input into the hiring when staff is intended to be hired for multiple individuals. For instance, an individual representative can be designated to collect preferences from other individuals and to vet candidates for these preferences, providing formal input to the provider as to the preferred candidate(s).

For IHS and day services, one or more individuals might serve as a proxy representative for a larger group, provided there is a mechanism for gathering input from each person for hiring and feedback on staff performance that is made available to the proxy representative(s). Regarding obtaining on-going feedback on staff performance, an agency might choose to interview a certain percentage of a staff person’s caseload for feedback and rotate those interviewed so that all are included at a certain point in time. Whatever strategy is employed, it should have a mechanism to account for everyone’s direct or indirect participation.

**DOMAIN: SUPPORTING AND ENHANCING RELATIONSHIPS (C9 – C12)**

**Indicator: C12 – Individuals are supported to explore, define, and express their need for intimacy and companionship**

**Date:** 9/17

**Question 1: Placement Services**

How can Placement Service locations be successful in meeting this indicator?

**Answer:**

The desire for intimacy and companionship is a very important aspect of life for all people. Individuals with intellectual disability benefit from support to address their interests in areas of human sexuality and developing romantic relationships. To be responsive to individuals’ needs in this area, it would be beneficial for placement agencies to focus efforts on the following:

* To ensure a systemic approach to supporting all individuals served by the agency, a human sexuality education curriculum should be put in place. This curriculum should be utilized by the agency as the foundation for providing individuals and their respective home care providers with ongoing support and education;
* Some type of evaluative process should be used to assess the interests, abilities and support needs of individuals, as it relates to the various aspects of intimacy and companionship;
* The needs and interests of the individual should be well understood by the home care provider and by the placement agency staff overseeing the home care arrangement;
* The needs and interests of the individual should serve as the basis for a course of action (further education, training and support);
* Based on the individuals’ needs and interests, an informal intimacy goal and home care provider steps for supporting the individual may be identified. It may be articulated via the ISP planning process wherein objectives/support strategies are identified for the individual;
* Training and support should be individualized and considerate of the unique needs of the person across the broad area of intimacy; and
* The placement service agency needs to support the home care provider to take steps to address each person’s wishes and desires when it comes to sexual self-expression and romantic relationship development.

**Date:** 1/20

**Question 2: Residential Services**

Please provide great detail as to what to look for and how agencies successfully meet and demonstrate their work in supporting individuals in this indicator.

**Answer:**

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| --- | --- |
| **CRITERIA FOR MET** | **CRITERIA FOR NOT MET** |
| There is evidence that the needs and/or desires of the individual in the area of sexuality/ romantic relationship development have been reviewed (formal or informal evaluation process), that staff are aware of and can describe individual’s needs and interests, in the areas noted above, that support is given to the individual, and that support and education is geared to the individual’s learning style. The provider utilizes a curriculum and has appropriately trained staff or has access to resourcesthat supports learning in this area. | There is no evidence that an individual’s needs and/or desires in the area of sexuality/ romantic relationship development have been reviewed and/or there is an identified need in this area with no support provided and/or that support and education geared to the individual’s learning style has not been provided. The provider does not have a preferred curriculum or access to resources that it utilizes. |

**C 12 – Additional Guidance on Process for review and determination of rating (12/19)**

|  |  |  |
| --- | --- | --- |
| **Regulations 7.03 (1) (d): Relationships … Included is support and education to individuals in expressing intimacy and sexuality in an appropriate and safe manner.** The perspective is that all adults are sexual beings, and while not always verbally expressing a specific need, often need support in this area. The provider must review the individual’s interest and need for support in the area of intimacy and companionship, and then design and implement actions to support these identified interests and needs. As needs are expressed to have specific close relationships (such as romantic/companionship relationships) including the need and desire for privacy to conduct relationships, staff /home providers should support individuals relative to these needs.If individuals have an identified ISP objective or an identified training need relative to intimacy, the provider must develop and implement support strategies and/or provide training.For others while an annual objective or formal training may not be necessary, individuals may still require ongoing support and education on some aspect of the very broad topic of intimacy. This could include guidance, support and/or education on matters related to recognizing and preventing sexual abuse, gender identity, health, safety, self-expression, physical and romantic relationships, and appropriate boundaries. For example, as necessary, education/training/skills and support may be needed related to how to proceed when an individual wishes to take a relationship to a different level, to formally pursue or date another individual or when an individual wishes to embark on a more romantic relationship with a person who is a friend. Any education/ training must be geared to the learning style and needs of the individual. While not required, having a Sexuality Educator(s) on staff or being familiar with one that is available to consult can assist the provider to promote training to individuals and staff (home providers) in this area. In addition, there are a number of curriculums available that can be utilized to train staff (home providers) and individuals in this topic.At a minimum, basic education needs to be offered to staff/ home providers to ensure that staff / home providers are supporting and recognizing individuals as sexual beings who have a basic human right to engage in relationships of their own choosing. Staff/ home providers need to be able to evaluate and articulate each individual’s needs and interests in this area and not merely automatically conclude that the individual is “not interested”.  | Staff Interview – on siteStaff log/individual record – on siteIndividual Interview Sexuality curriculum for staff and individuals; documentation regarding training to both staff and individuals. (if present) | Review staff knowledge in this area and how individuals needs/desires are being explored and/or supported. Review individual record and staff log to identify needs in this area, which must then be reviewed with staff during staff interview. Review if individual feels that s/he is being supported by staff in this area. Inquire as to whether there are concerns/ questions/ interest in this area that are/are not being addressed.Review of organizational systems including curriculum, resources utilized, and support in the area of intimacy.  |

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| **Process: Items to check for; Lines of inquiry; Documentation to Review**  |
|  | **Please refer to Admin Interview guide for overall admin interview questions where we may want to reference a question specific for C12** |
| **Documentation And Interview with Administrative Staff** | Does that agency have a training curriculum for staff and individual? Is the curriculum applicable to staff AND individual? Does the curriculum accommodate different communication, learning styles?If so, what is the curriculum(s)? Evaluate to ensure that it goes beyond sex and includes intimacy/companionship. Curriculum addresses sex, intimacy, companionship and risk. |
| Does the agency have sexuality educators? What other resources such as consultants are accessed? |
| Who receives sexuality/intimacy training and how is this tracked?Any education/training around Social Media? How monitor for safety or appropriate use.  |
| Does the agency have a policy or practices in this area? Has this been shared with guardians? |
| Are individual’s interests assessed and/or addressed regarding sexuality/intimacy? If so, who administers? How frequently revisited? Are formats of assessment tool available for review? (If yes, where is the assessment available for an individual?) |
| What are training/supervision requirements + structures within each of the services eg placement services? |
| **Training documentation** | Review staff training records + staff meeting minutes |
| **Documentation (on-site; sometimes at admin.)** | * Individual assessment in this area
* Has there been an assessment of Risk?
* Progress Notes
 |
| **Interview with staff** | How do you address the C12 indicator about sexuality and intimacy?  |
| What are the person’s intimacy and companionship needs and interests? What about sexual interests and needs? |
| Have you assessed his interests/needs in the area of sexuality/intimacy? How do they make their preferences known to you if not verbal? How acted upon? |
| How do you support individuals to express their identities, what form does their self-expression take? |
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| Start by asking about friendships and preferences of the individual and then drill down to companion. Who does the individual gravitate to? |
| Have you had training in this area? Do you feel comfortable supporting /him/her? What type of support does she/he need to address sexuality issues? |

 |
| What strategies are in place to enable him/her to participate in intimate relationships? What are his/her intimacy needs and current relationships? Is there anyone in their life? |
| What is their risk? Knowledge of any risk management strategies or plan? (behavior plan) |
| + questions unique to person |
| **Interview with the individual** | Would you like to spend more time with anyone? |
| Are you interested in a relationship with anybody? Interested in dating? Interested in continuing previous relationships (i.e., ABI)? |
| Do staff help you get together with people you want to spend time with? |
| Do you have private time in your bedroom? |
| Are staff respectful of you preferences regarding your relationships? |
| Can you talk with staff about your sexual preferences? |
| How has staff helped you make connections? |
| + questions unique to person |
| **Observation** | **Collateral information not primary information**Observe whether the individual is social and engaged.Observe whether the individual’s observed skills and interests “jive with” the staff report of individual.Observe whether the individual has privacy. |

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| **The criteria for met and not met noted above remain in effect. The following additional guidance helps define the** **findings that should be present to derive at a particular rating. The presence of staff’s knowledge regarding a** **person’s unique interest and needs and the provision of support/resources in this area should be the primary focus.** **Whether or not an agency has a curriculum/training materials is not sufficient to determine a rating, but rather should** **be seen as a potential resource and lays a foundation to assist in success. Ultimately, the surveyor needs to assess what** **supports are in place for the individual.** |
| **Met** |  **Not met** |
|  | Individual and/or staff have Resources (other knowledgeable staff, training, practice, external counselor, etc.) Agency culture promotes all types of relationships |  | No agency policy and/or practices and/or curriculum for training of staff or individuals |
| **Training documentation** | The provider utilizes a curriculum and has appropriately trained staff OR has access to resourcesthat supports learning in this area. | **Training documentation** | No curriculum or no curriculum that meets the person’s style of learning |
| **Documentation (on-site)** | A general (formal or informal) assessment/information around interests and preferences in this area.  | **Documentation (on-site)** |  |
| **Interview with staff** | Demonstrated Support and Education provided for the person based on assessments and information (unique learning style). | **Interview with staff** | The individual’s interests or preferences are not known or are known but have not been explored or supported.  |
| Support to work with family and help person to discover self and express preferences in identity and relationships. |  |  |
| Demonstrated ongoing support and progress based on ongoing evaluation process |  |  |
| **Interview with the individual** | Person is satisfied with the support he/she has received in this area. | **Interview with the individual** | Person identifies an unmet need |

**DOMAIN: CHOICE, CONTROL AND GROWTH (C13, C14, C15, C18 – C21, C51, C52, C53, C54)**

**C16 – Staff (home providers) support individuals to explore, discover and connect with their interests for cultural, social, recreational, and spiritual activities.**

**Date:** 9/17

**Question 1: Placement Services**

How can Placement Service locations be successful in meeting this indicator?

**Answer:**

Supporting individuals to be a part of community life has been a longstanding key area of focus. This is a pathway to opportunities for individuals to establish relationships with others, based on mutual interests. This indicator can be viewed as a starting point in terms of the work that needs to occur to support individuals to establish meaningful connections within their communities. It addresses the important role the placement service agency and the home care provider play in supporting individuals to explore and participate in the broad range of activities that are available in the community. Individuals will experience success when the following elements are in place:

* The placement agency has promoted an understanding of the importance of community integration within the organization, and implements strategies to pro-actively address this expectation with home care providers through training/development. Typically home care providers are quite active participants in community life; training and development might focus on the home care provider’s need to concentrate their efforts on actualizing the particular cultural, social, recreational and spiritual activities that are of interest to the individual;
* Placing the individual at the center of these efforts, by fully assessing their interest in the wide variety of activity options available in the community at large. This is best accomplished when the placement agency takes a systemic approach to supporting individuals by promoting the home care provider to learn about the individuals’ particular interests. This can be accomplished through use of methods such as interest inventories, “mapping”, person-centered-planning tools, and a deliberate course of engaging the individual in frequent exploration of community activities;
* The efforts above are intended to enable the home care provider to understand where an individual’s interests lie, and to support the individual in a further course of discovery of, and participation in, integrated activities;
* The scope of exploration should cover the broad range of community activities and resources that bring people together (e.g. – cultural, social recreational, spiritual); and
* The placement service agency will want to establish some sort of oversight and monitoring procedures and have some understanding of the efficacy of the efforts it has made to promote the expectation that individuals explore and participate in the life of the community, on a consistent and sustained basis. Tracking of exploratory efforts and community activities through the agency’s monthly home care provider visits might be one mechanism the agency could employ to monitor and oversee success in this area.

**C20.** The provider has emergency back-up plans to assist the individual to plan for emergencies and/or disasters.

**Date: 9/17**

**Question 1:**

What is this indicator measuring, and how does it pertain to a Placement Service?

**Answer:**

An emergency back- up plan is the Provider’s plan that guides each location’s actions in the event of any emergency. The Provider needs to have policies, procedures and guidelines in place to instruct home care providers as to who to call when. Home care providers need to be aware of when to call 911, but then when shortly thereafter to contact the Provider and inform them as to what occurred.

This indicator is NOT about the presence of a Safety Plan. The Safety Plan’s primary purpose is to outline the fire safety strategies for a particular location, and is evaluated within another licensure indicator.

**Indicator: C51 - Staff/ Home providers are knowledgeable about individual’s satisfactions with services and supports and support individuals to make changes as desired.**

**Date:** 9/17

**Question 1: Placement Services**

How is this indicator looked at within a Placement Service? How is this different from feedback on the home care provider (C7)?

**Answer:**

C7 is evaluating to what extent the Provider’s engages the individual in the matching and assessment process for the home care provider, while this indicator addresses the individual’s feedback and satisfaction with the placement and living situation as a whole. This indicator looks at the individual’s satisfaction with services and supports within the shared living home, and the Provider’s responsiveness to the individual’s feedback. Per regulations, on quarterly basis the Provider needs to contact the individual and his or her family or other primary care provider to obtain a written evaluation of the arrangement which includes an assessment of the individual's and family's satisfaction with the supports and services provided by the placement agency and the home care provider and with the degree to which the services meet the individual's needs. The surveyors will assess to what degree people are knowledgeable about the individual’s concerns and desires, and how the Provider is responsive to any issues shared.

**Indicator: C53 – Individuals are supported to have choice and control over what, when, where and with whom to eat.**

**Date:** 9/17

**Question 1: Placement Services**

How can Placement Service locations be successful in meeting this indicator?

**Answer:**

This indicator is one of several new or strengthened certification indicators that emphasize the importance of providing individuals with the locus of control over aspects of their life. This indicator specifically focuses on food choices and dining preferences.

Placement Services: In addition to familiarity with this indicator and expectations on the part of the home care provider, the placement provider will want to consider the following:

* The placement agency will want to develop home care providers’ understanding of the service principle of promoting individual control, and how it relates to food and dining choices, such as through the agency’s training and oversight mechanisms;
* Home care providers should be knowledgeable about individuals’ meal preferences. Supporting individuals to make informed decisions about food choices is best accomplished through encouraging them to be involved in the household menu planning, food shopping and meal preparation routines;
* On occasions when an individual would choose not to eat the meal that’s been prepared for the household, he/she should be accommodated with a readily available alternative meal, consistent with the person’s food preferences;
* Another key facet of promoting people’s control over dining options is the need to consider their choices about when and where to eat, and with whom. Home care providers should be both knowledgeable of individuals’ preferences in this regard, and genuinely supportive of their choices. For example, it would be important to understand whether the individual prefers have a fixed dinner mealtime and a shared dining experience within the family/household setting, or does she/he prefer to eat alone, later hour, while watching television instead of in the dining room, etc.

**DOMAIN: CAREER PLANNING, DEVELOPMENT, AND EMPLOYMENT (C22 – C39)**

**Indicators:** **All -C22-C37 (Please note that CBW has been eliminated as a serviced as of 7/16)**

**Date:** 3/12

**Question 1:**

How are these indicators further defined as there seems to be significant overlap in them?

**Answer:**

Providers of employment and center based work services are expected to provide a broad range of supports as outlined in Indicators C22 – C37. Each indicator outlines expectations for the provider to meet. For instance, there are separate standards relative to job assessment, acquisition, and retention. Where an individual is on the continuum of having a job of interest will determine which of the indicators apply to a specific individual’s situation. Please see Work Indicator Scenarios section of this Interpretations guideline document (page 30) which identifies which indicators apply to different situations. There is no additional guidance on C26, C2, C31 and C33 beyond that which is outlined in the tool.

**Indicator C22 – *Staff have effective methods to assist individuals to explore their job interests*.**

This indicator focuses on assessment of job/employment interests –**applies to** **Employment and CBW**

1. Interest assessments completed or updated within the past year.
2. Discovery process to help person get to know herself/himself in terms of job interests
3. Use variety of means to explore job interests including interest inventories, job tours, informational interviews, job shadows, etc.
4. The exploration process needs to be purposely broad so that the process truly identifies the person’s strongest job interest. Assessments should go beyond an agency’s available job options. If the assessment is not comprehensive, it would affect the ratings in C22, C23 and C24.
5. Methods of exploration must be customized to the specific needs of the individual, such as communication style and preferences.
6. A wide array of possible jobs and careers must be explored based on the person’s interest.

**Indicator C23 - *Staff utilize a variety of methods to assess an individual’s skills, interests, career goals and training and support needs in employment.***

This indicator focuses on assessment of skills and training needs –**applies to Employment and CBW**

1. Skill assessments completed or updated within the past year.
2. Discovery process to determine individual’s strengths and abilities
3. Skills assessments must focus on both what a person can do and not only on what they cannot do.
4. Must assess both skills and support needs.
5. Need to use a variety of means, which could include assessments, discussions with the individual, behavioral observations, results of any testing, previous performance history, assistive technology information, etc.
6. Assessments must accommodate person’s unique learning and communication styles
7. Assessments must identify both work skills and training needs as well as identify settings that the individual is more competent in and therefore be settings that would further promote learning and skill development.

**Indicator C24 – *There is a plan developed to identify job goals and support needs.***

This indicator focuses on development of a plan based on skills, needs and employment interests –**applies to Employment and CBW**

1. A well thought out plan is the foundation to success in finding and obtaining employment
2. The plan must be based on the assessments of job/employment interests and of skills and training needs
3. The plan should identify job goals and support needs.
4. The plan must be tailored to the skill set of the job/career interest.
5. Employment goals addressed in the plan must also be identified within the individual’s ISP.

**Indicator C25 – *Staff assist individuals to work on skills development for job attainment and success.***

This indicator focuses on plan implementation **– Applies to Employment and CBW**

1. Focuses on skill acquisition occurring within the program site, such as practicing/improving skills to obtain employment of choice.
2. Strategies need to be put in place to implement the plan and meet the identified goals
3. Strategies should include guidance and education to learn, master and refine job skills.
4. There needs to be evidence that strategies are consistently being implemented on a regular and ongoing basis.

**Indicator C27 – *Individuals and families are encouraged and supported to understand the benefits of integrated employment.***

This indicator focuses on support to understand the benefits of integrated employment – **Applies to Employment and CBW**

1. Both individuals and families should receive basic education about the benefits.
2. If concern is noted, a variety of methods for discussion should be utilized, such as ongoing conversations, presentations, talking with other individuals successfully employed, etc.
3. Efforts should be made to address any issues raised.
4. If the family remains opposed to an individual working, there must be ongoing efforts to address their concerns, as opinions may change over time. Efforts should not cease just because the family says they are opposed.

**Indicator C29 – *Individuals are supported to obtain employment that matches their skills and interests.***

This indicator focuses on obtaining employment **– Applies to Employment**

1. Typically one would hope to see an individual actively pursuing employment after 3-4 months of beginning an employment service.
2. If the individual has previously been employed but is now unemployed, the provider may need to quickly reassess the person’s skills and interests at this point in time and then based on current information, renew the employment search.
3. Individual is supported to pursue actual job acquisition. This includes researching the types of jobs that would be in line with the person’s interests, going on job interviews, distributing resumes and applications, making phone calls, etc. Although some activities might occur in-house, such as looking for job postings in the newspaper, the focus is on what is occurring toward obtaining outside employment and should include outreach and networking efforts.
4. Support job acquisition in line with each individual’s interests and talents. Job exploration should also include the individual’s desired amount of time to work (2 hours a day or week vs. a 40 hour week), how far they want to travel, and the times they want to work (mornings vs. afternoons, etc.), attributes of company.

**Indicator C30 – *Individuals are supported to work in integrated job settings.***

This indicator focuses on support to work in integrated settings **– applies to Employment**

1. Evidence of individual being supported to work in an integrated setting. If the individual is not yet working in an integrated setting this would be rated “not met.”
2. Should include regular contact with co-workers who are not disabled in line with the same opportunities of others employed in a similar position (landscape crew or motel cleaner may have less opportunities by virtue of the job).
3. Should include social interactions with co-workers at the work site in line with others in a similar position.

**Indicator C32 - *wages earned are in accordance with at least minimum wage or the prevailing wage rate*.**

This indicator focuses on support to be paid the prevailing pay rate under DOL or minimum wage. -  **Applies to Employment**

1. If the individual is doing 100% of the job they should be paid a comparable wage as others doing the same job, in line with the company’s pay scale; e.g. entry level pay vs. 5 years in the job. Providers should be knowledgeable about the salaries of others in a comparable position in the company and the schedule for pay raises.
2. If the individual is not able to do 100% of the job and is paid less than minimum wage, they should be paid the prevailing wage rate as determined under DOL requirements. This should be rated under L72

**Indicator C34 – *The agency provides the optimal level of support to promote success with a specific plan for minimizing supports.***

This indicator focuses on promoting success in least intrusive manner possible **– Applies to Employment and CBW**

1. Individual is receiving the necessary support to be successful at this time.
2. There is a plan for how support can be reduced while maintaining success. There must be a well thought out plan for fading job supports developed from the beginning of employment so that the individual can perform the current job with greater independence.
3. The plan is being implemented as needed.
4. The individual is a partner in determining the level of support needed.

**Indicator C35 –*Individuals are given feedback on job performance by their employer.***

This indicator focuses on the provision of timely, documented feedback to the individual on their performance. – **Applies to Employment and CBW**

1. Feedback should be given at a minimum, annually, and more frequently if this is consistent with feedback to other employees.
2. Feedback should be clearly documented.
3. If the provider is the employer, they are responsible for providing the feedback.
4. If the provider is not the employer, there should be evidence of an evaluation by that employer or evidence of advocacy on the part of the agency that a job performance evaluation be conducted on the same timeline as for other employees of that employer.

**Indicator C36 – *Ongoing supports are provided to enhance job retention and advancement.***

This indicator focuses on ongoing support to enhance job retention and advancement **– Applies to Employment**

1. Focuses on security and movement within the place of employment.
2. Employer needs to know how to contact the agency if additional or renewed supports are needed.
3. There must be a schedule of on-going check-ins with the employer and individual to monitor status and performance issues in a timely manner.
4. If the agency is still working on C34, there should be a plan of how contact is maintained to ensure success once the least intrusive level of support is achieved.
5. At a minimum, the provider should have periodic discussions with the individual as to whether the job is still of interest, the number of hours of employment meets the individual’s needs, the work schedule is satisfactory, and whether the individual wants to work in a different type of job at the company or with another company, should the opportunity arise. This should occur at least annually, such as through an annual evaluation or feedback on performance or vetted through the ISP.
6. This indicator also focuses on issues like seniority, pay increases, increase in hours and/or promotions. There should be documented evidence that these areas are reviewed. The agency needs to be knowledgeable about the company’s schedule and requirements for pay raises and possible advancement.

**Indicator C37 – *There is support to develop appropriate work related interpersonal skills.***

This indicator focuses on support to develop appropriate work related interpersonal skills **– Applies to Employment, CBW and CBDS**

1. Interpersonal/social skills may have been evaluated in C23
2. When identified, there are clear strategies for supporting the individual to develop appropriate interpersonal skills
3. If there is a specific ISP objective relative to social skills, the provider must develop and implement support strategies to meet that objective.
4. The agency must have developed strategies for generally supporting individuals to enhance work related interpersonal skills when needed. This might be more necessary in center based work and community based day supports.
5. If an individual is employed or in the process of being employed, the agency should be cognizant of the specific social culture and climate of that workplace
6. If the employer indicates difficulties in interpersonal interactions, the agency develops and implements strategies to address.
7. Areas of support may include, but not be limited to attire for work, interpersonal skills with co-workers/supervisors, discrimination and sexual harassment.

**Indicators:**

**C-22 Staff have effective methods to assist individuals to explore their job interest.**

**C-23 Staff utilize a variety of methods to assess an individual’s skills, interests, career goals and training and support needs in employment.**

**C-24 There is a plan developed to identify job goals and support needs.**

**C-25 Staff assist individuals to work on skill development for job attainment and success.**

**Date:** 3/12

**Question 2:**

These indicators seem integrally related such that if one is not in place, the others are also likely to be not met. Can you explain?

**Answer:**

Rating Hierarchy

When an individual does not yet have employment in a job of choice, the series of work indicators (C22 – C25) have the foundational indicators of:

* C22 – Staff have effective methods to assist individuals to explore their job interests.
* C23 – Staff utilize a variety of methods to assess an individual’s skills and training needs in employment.

C22 and C23 provide the foundation for developing a good plan and strategy implementation for employment success. Therefore, if either of these indicators are rated “standard not met” the indicators following them (C24 and C25) must also be rated “standard not met.”

**Indicators: All C22-C37**

**Date:** 3/12

**Question 3:**

These indicators seem to reflect various components in the hierarchy from job assessment, to job attainment, to job independence and growth. Are all indicators rated for all individuals?

**Answer:**

The employment indicators in the tool are generally outlined in sequential order going from assessment indicators to job pursuit activities and to job placement in a job of interest followed by job retention and advancement indicators. An employment service must be able to provide support in all these areas. However, every indicator may not apply to every individual. Where a particular individual is in the job placement continuum will affect which indicators apply.

Where an individual is on the continuum will determine which of the indicators apply as services to individuals who are just beginning to develop job skills and explore their job interests will differ from services to those who are competitively employed but need additional support to acquire a better job. Therefore, several scenarios were developed to describe typical situations and offer guidance on considerations for rating and the indicators that may be applicable.

**Scenario #1**

The individual is currently in a job in his/her area of interest and has been in the job more than 2 years.

***Indicators in this scenario focus on job retention and advancement. If the individual has been in a job for over 2 years surveyors would not necessarily need or expect to see the assessments when evaluating this scenario. However, it would be important for providers to proactively check in, through their on-going follow-up to determine whether an individual remains content with their job or is interested in something else such as a change in their job the job location, number of hours, work hours, etc. This should be done at least annually, possibly through the annual review, although a provider may have other mechanisms for obtaining this information such as vetting through the ISP.***

Relevant indicators are:

* C28 - Staff maintain and develop relationships with local businesses in order to facilitate job development opportunities.
* C30 – Individuals are supported to work in integrated job settings.
* C31 – Accommodations and adjustments are made to enable an individual to perform his/her job functions.
* C32 - Wages earned are in accordance at least minimum wage or the prevailing wage rate.
* C33 – Employee benefits and rights are clearly explained to the individual.
* C34 – The agency provides the optimal level of support to promote success with a specific plan for minimizing supports.
* C35 – Individuals are given feedback on job performance by their employer.
* C36 – Ongoing supports are provided to enhance job retention and advancement. *This should include determining whether an individual remains happy with the various aspects in their employment and/or current career.*
* C37 – There is support to develop appropriate work related interpersonal skills.

**Scenario #2**

The individual is currently in a job in his/her area of interest and has been in the job less than 2 years.

***Indicators for this scenario focus on all of the activities on the continuum of successfully having a job of interest.***

Relevant indicators are:

* C22 – Staff have effective methods to assist individuals to explore their job interests.
* C23 – Staff utilize a variety of methods to assess an individual’s skills, interests, career goals and training and support needs in employment.
* C24 – There is a plan developed to identify job goals and support needs.
* C25 – Staff assist individuals to work on skills development for job attainment and success.
* C28 - Staff maintain and develop relationships with local businesses in order to facilitate job development opportunities.
* C29 – Individuals are supported to obtain employment that matches their skills and interests.
* C30– Individuals are supported to work in integrated job settings.
* C31 – Accommodations and adjustments are made to enable an individual to perform his/her job functions.
* C32 - Wages earned are in accordance at least minimum wage or the prevailing wage rate.
* C33 – Employee benefits and rights are clearly explained to the individual.
* C34 – The agency provides the optimal level of support to promote success with a specific plan for minimizing supports.
* C35 – Individuals are given feedback on job performance by their employer.
* C36 – Ongoing supports are provided to enhance job retention and advancement.
* C37 – There is support to develop appropriate work related interpersonal skills.

**Scenario #3**

The individual is in a job, but not in his/her area of interest, the area of interest is not known by the agency, or the job does not meet the individual’s interests in other aspects, such as number of hours employed.

***Staff should be knowledgeable or learning (if the individual recently came to the agency with their job) about the individual’s specific job interests and skills and actively working towards moving the individual into a job of interest. There should be evidence that the person is not dead ended in a job just because it is a job, although not one that meets the individual’s specific interests.***

Relevant indicators are:

* C22 – Staff have effective methods to assist individuals to explore their job interests.
* C23 – Staff utilize a variety of methods to assess an individual’s skills, interests, career goals and training and support needs in employment.
* C24 – There is a plan developed to identify job goals and support needs.
* C25 – Staff assist individuals to work on skills development for job attainment and success.
* C28 - Staff maintain and develop relationships with local businesses in order to facilitate job development opportunities.
* C29 – Individuals are supported to obtain employment that matches their skills and interests.
* C30– Individuals are supported to work in integrated job settings.
* C31 – Accommodations and adjustments are made to enable an individual to perform his/her job functions.
* C32 - Wages earned are in accordance at least minimum wage or the prevailing wage rate.
* C33 – Employee benefits and rights are clearly explained to the individual.
* C34 – The agency provides the optimal level of support to promote success with a specific plan for minimizing supports.
* C35 – Individuals are given feedback on job performance by their employer.
* C36 – Ongoing supports are provided to enhance job retention and advancement.
* C37 – There is support to develop appropriate work related interpersonal skills.

**Scenario #4**

The individual is not yet in a job as he/she is new and has been with the agency for less than 3 – 4 months and is in the initial process of assessment and job exploration.

***This would be the time when the provider should be focusing on getting to know the individual, their interests, skills and support needs.***

 Applicable indicators are:

* C22 – Staff have effective methods to assist individuals to explore their job interests.
* C23 – Staff utilize a variety of methods to assess an individual’s skills, interests, career goals and training and support needs in employment.
* C24 – There is a plan developed to identify job goals and support needs.
* C25 – Staff assist individuals to work on skills development for job attainment and success
* C26 – Career planning includes an analysis of how an individual’s entitlements can be managed in a way that allows them to work successfully in the community.
* C27 – Individuals and families are encouraged and supported to understand the benefits of integrated employment.
* C28 – Staff maintain and develop relationships with local businesses in order to facilitate job development opportunities.
* C37 – There is support to develop appropriate work related interpersonal skills.

**Scenario #5**

The individual has been with the provider longer than 3 -4 months but is not yet employed or is again unemployed.

***Indicators focus on all activity over the past 2 years. The provider should have well developed assessments for the individual (or reassessments if the individual previously had a job), and clear evidence of activity to find the person a job that meets their interest. If the original assessments occurred prior to one year, this should have been revisited within the past year, in line with the ISP timeline, to ensure support is based on current information. The extent of the job procurement activity would depend on how long the person has been out of the assessment and planning stage. Indicator C30 would always be rated “not met” since the individual is not working in an integrated setting.***

Applicable indicators are:

* C22 – Staff have effective methods to assist individuals to explore their job interests.
* C23 – Staff utilize a variety of methods to assess an individual’s skills, interests, career goals and training and support needs in employment.
* C24 – There is a plan developed to identify job goals and support needs.
* C25 – Staff assist individuals to work on skills development for job attainment and success
* C26 – Career planning includes an analysis of how an individual’s entitlements can be managed in a way that allows them to work successfully in the community.
* C27 – Individuals and families are encouraged and supported to understand the benefits of integrated employment.
* C28 – Staff maintain and develop relationships with local businesses in order to facilitate job development opportunities.
* C29 – Individuals are supported to obtain employment that matches their skills and interests.
* C30– Individuals are supported to work in integrated job settings.
* C31 – Accommodations and adjustments are made to enable an individual to perform his/her job functions.
* C32 - Wages earned are in accordance at least minimum wage or the prevailing wage rate.
* C33 – Employee benefits and rights are clearly explained to the individual.
* C34 – The agency provides the optimal level of support to promote success with a specific plan for minimizing supports.
* C35 – Individuals are given feedback on job performance by their employer.

**Scenario #6**

The individual graduates out of the school system and comes to the agency with a job for which they need support.

***Indicators in this scenario focus on both assessment and job support. Even though the agency’s job is to support the individual in their current employment, it is important that the agency have a good understanding of the individual and whether this job meets their interests. The individual may come with comprehensive assessments done within the past year, so that additional comprehensive assessments are not needed. However, if they do not come with timely comprehensive information, the agency should complete new assessments so they can best support the individual in employment of interest.***

Applicable indicators are:

* C22 – Staff have effective methods to assist individuals to explore their job interests. *(Indicators C22 – C23 should be rated and could receive a rating of “meets” even if the assessments were done by the school system.*
* C23 – Staff utilize a variety of methods to assess an individual’s skills, interests, career goals and training and support needs in employment.
* C28 – Staff maintain and develop relationships with local businesses in order to facilitate job development opportunities.
* C29 – Individuals are supported to obtain employment that matches their skills and interests.
* C30– Individuals are supported to work in integrated job settings.
* C31 – Accommodations and adjustments are made to enable an individual to perform his/her job functions.
* C32 - Wages earned are in accordance at least minimum wage or the prevailing wage rate.
* C33 – Employee benefits and rights are clearly explained to the individual.
* C34 – The agency provides the optimal level of support to promote success with a specific plan for minimizing supports.
* C35 – Individuals are given feedback on job performance by their employer.
* C36 – Ongoing supports are provided to enhance job retention and advancement.
* C37 – There is support to develop appropriate work related interpersonal skills.

**DOMAIN: MEANINGFUL AND SATISFYING DAY ACTIVITIES (C40 – C45)**

1. **INTERPRETATIONS TO THE RATINGS**

**TOPIC:** **RATING INDICATORS THAT RELATE TO EACH OTHER**

**Date:** 10/11

**Question 1:**

Sometimes information can be rated in more than one place. Is information rated every place it applies? Alternatively, if rated only once, how is a determination made as to where something should be rated?

**Answer:**

Information typically is utilized once in rating by selecting the relevant indicator to rate. However, at times information collected in one area may affect the rating of several indicators. For example, there are some indicators that are foundational from which, if that indicator is not met it, more than likely it will mean that the standard will not be met for other subsequent indicators. Indicator L57 states that “All behavior plans are in a written plan.” Other indicators relating to behavior plans and restrictive interventions include: L58 (all behavior plans contain the required components), L59 (behavior plans have received all the required reviews), and L60 (data are consistently maintained and used to determine the efficacy of behavioral interventions). Of these, L57 (all behavior plans are in a written plan) is the foundational indicator from which other indicators are built upon. If evidence is discovered that a behavior plan has not been developed as required, L57 would be rated “standard not met”. Chances are strong that the other indicators would not be present (e.g. no review by the HRC) and as such should also be rated not met. When scoring, comments should reflect that the standard was not met on these other indicators as a result of the plan not being present.

The same interpretation holds when evaluating and rating indicators such as supports and health related protections and medication treatment plans.

It is also possible that information will be obtained once but utilized in rating more than one indicator, each of which gets rated independently. For example, if an individual has a feeding tube used for both medication and nutrition, information collected on the use of this device might be factored into rating separate items, such as rating L39 (special dietary requirements are followed) when the feeding tube is used for nutrition, and rating L82 (medications are administered by licensed professional staff, MAP certified staff … for individuals unable to administer their own medication) when indicating whether staff have the proper training to administer the medication, and rating L46 (all prescription medications are administered according to the written order of a practitioner and are properly documented on a Medication Treatment Sheet) when assessing whether the medication was administered properly.

**TOPIC:** **WHEN LICENSURE INDICATORS ARE NOT APPLICABLE**

**Date:** 10/11

**Question 1:**

When is it appropriate not to rate a licensure indicator?

**Answer:**

Many indicators are designated for specific services. Indicators and service applicability are clearly outlined on the “Indicator with Applicability by Service Type” chart. However, there has been confusion as to whether some indicators could be rated “not applicable.” There are times when an indicator that applies to all services or within a specific service type could potentially be rated as “not applicable.” To the extent possible, every effort must be made to collect information and rate the indicator. The following is a list of indicators that potentially could be “not rated”, when the indicator does not apply and/ or when there is not sufficient information to assess the indicator.

L3 – Immediate action is taken to protect the health and safety of individuals when potential abuse/neglect is reported. – (organizational indicator). This indicator is only rated when there are Complaints that have been filed in the past year. If there were no complaints filed, this indicator would not be rated. All Immediate Actions on Complaints filed in the past year are reviewed organizationally up to a cap of 15.

L4 – Action is taken when an individual is subject to abuse or neglect. – (organizational indicator) This indicator is rated when Actions on Complaints filed have been issued in the past year, up to a cap of 15. Complaints with Action Plans are reviewed to ensure that Actions are carried out. In the event that there were no Complaints for the past year, or no Action Plans issued, this indicator would not be rated.

L19 – Bedrooms for individuals requiring hands on physical assistance to evacuate or who have mobility impairments are on a floor at grade or with a horizontal exit. – This indicator is only rated when the location supports individuals who require physical assistance to evacuate or who have mobility impairments.

L27 – Swimming pools are safe and secure according to policy – This indicator is only rated when the location has a swimming pool.

L36 – Recommended tests and appointments with specialists are made and kept – This indicator is rated when specialty test, lab work, and appointments have been recommended. It is not rated when there have been no recommendations made.

L38 – Physicians’ orders and treatment protocols are followed (when agreement for treatment has been reached by the individual/guardian/team – This indicator is rated when there are orders and/or treatment protocols to be followed or there is evidence that there should be a written protocol in place.

L39 – Special dietary requirements are followed – This indicator is rated when an individual supported at a site has special dietary requirements.

L56 – Restrictive practices intended for one individual that affect all individuals served at a location need to have a written rationale that is reviewed as required and have provisions so as not to unduly restrict the rights of others – This indicator is rated when there is a restrictive practice in place affecting more than one individual.

L57 – All behavior plans are in a written plan – This indicator is rated when there is a behavior plan or there is evidence that there should be a behavior plan.

L61 – Supports and health related protections are included in ISP assessments and the continued need is outlined. – This indicator is rated when there is an identified support and/or health related protection or one that should have been identified.

L63 – Medication treatment plans are in written format with required components – This indicator is rated when there is a medication treatment plan or evidence that there should be one.

L65 – Restraint reports are submitted within required timelines – (organizational indicator) This indicator is rated when restraint reports have been completed or should have been completed in the past year.

L66 – All restraints are reviewed by the Human Rights Committee – (organizational indicator) This indicator is rated when restraint reports has been completed or should have been completed.

L67 – There is a written plan in place accompanied by a training plan when the agency has shared or delegated money management responsibility – This indicator is rated when there is or should be a written money management plan.

L72 – Sub-minimum wages are earned in accordance with Department of Labor (DOL) requirements for compensation – This indicator is rated when individuals are earning sub-minimum wages.

L73 – The provider has a current DOL certificate - This indicator is rated when individuals are earning sub-minimum wages.

L82 – Medications are administered by licensed professional staff or by MAP certified staff (or by authorized PCA staff) for individuals unable to administer their own medications – This indicator is rated when individuals are unable to administer their own medications.

L84 – Staff are trained in the correct utilization of health related protections per regulation – This indicator is rated when there is an identified health related protection.

**TOPIC: LICENSURE ADMINISTRATIVE REVIEW INDICATORS**

**Date:** 10/11

**Question 1:**

Sometimes information is collected in one place, but rated in another. For instance, sometimes information is collected at the corporate address but used to inform a rating for each of the locations audited. Sometimes the reverse is true such that the information is collected at the various locations but rated once for the organization. Can this be explained more simply?

**Answer:**

The following indicators are the only ones rated administratively. All other indicators are rated either for the location or the individual audited. Often information is collected and/ or validated in several places before rating it once for the organization, therefore specific instructions for collection of information is noted below.

**Organizational:**

|  |  |  |
| --- | --- | --- |
|  |  | **Specific instructions**  |
| **🏳 L2** | **Abuse /neglect reporting** | Collect info. On siteReview organizational info. To determine whether any unreported complaintsRate: no. of sites and situations met/ no. of sites and situations reviewed |
| L3 | Immediate action | Collect info. On the allegations reported and immediate actions takenRate: no. where immediate actions met/ no. reviewed |
| L4 | Action taken | Collect info. On the no. action plans issued and takenRate: no. actions met/ no. reviewed |
| L48 | HRC | Rate: no. HRCs met/ no. reviewed(some providers have more than one HRC) |
| L65 | Restraint report submission | Collect HCSIS info. On the no. of restraints reported to dateReview sites to determine whether there are any unreported restraintsRate: no. timely restraints/ no. restraints and situations reviewed |
| L66 | HRC restraint review | Collect HCSIS info. On the no. of restraints reported up to 120 days priorRate: no. timely restraints/ no. restraints reviewed |
| L74 | Screen employees  | Take 10% sample of new employeesRate: no. of people met/ no. people reviewed |
| L75 | Qualified staff | Take 10% sample of credentialed/ licensed employeesRate: no. of people met/ no. people reviewed |
| L76 | Track trainings | Take 10% sample of employeesRate Here: no. of people met/ no. people reviewed |
| L83 | HR training | Take 10% sample of employeesRate: no. of people met/ no. people reviewed |

**TOPIC: FOLLOW-UP ON LICENSURE ADMINISTRATIVE REVIEW INDICATORS**

**Date:** 10/11

**Question 1:**

The ten indicators above are rated once and then used to determine the licensure level for each service grouping (e.g. Residential / Individual Home Supports and Employment / Day Supports). The Provider conducts follow-up if the Service Grouping receives 90% or more indicators standard met, while DDS conducts follow-up in all other situations. When follow-up is being conducted for one service grouping by QE and for another service grouping by the Provider, who performs follow-up on the administrative indicators and how is this rated at follow-up?

**Answer:**

When follow-up is conducted by both QE and the Provider, QE will assess the progress and rate the organizational indicators. For example, if the indicator related to staff training (L76) required follow-up, QE would re-sample staff across the entire provider to ensure that staff were now adequately trained. The provider, in conducting follow-up should also note their progress on meeting the organizational indicators and make note of activities performed subsequent to the Service Enhancement meeting within the section “process utilized to correct and review indicator”, but do not need to rate the indicator.

**TOPIC:** **INFORMATION ABOUT A PROVIDER’S NON-LICENSED SERVICES**

**Date:** 10/11

**Question 1:**

When pulling information out of HCSIS  e.g. Investigations; MORs, information about a Provider’s Day Hab. Services/ individuals is also included.  Sometimes the incident report, investigation, MOR, etc. pertains to individuals also served within other licensed services e.g. a person served in CBDS and Day Hab.   However, sometimes it does not e.g. Investigations concerning a day habilitation program located separately and serving different individuals.   Should information derived from non-licensed services be included in the review?

**Answer:**

If the service is not licensed, surveyors have no authority to review information pertaining to that service.  Should there be a question about this delineation, e.g. incidents for individuals who also spend time at the CBDS, the surveyor would look for information from the Provider to demonstrate that these occurred within the non-licensed program. Alternatively if it is clear that these occurred at / during a licensed service, or if some ambiguity still remains that these occurred within a licensed service, the information would be incorporated in the review.

**III. INTERPRETATIONS TO THE PROCESS**

**SEQUENCE: ON-SITE**

**Process: Selection of alternate individual to rate “specialty indicators”**

**Date:** 10/11

**Question 1:**

What should occur when the individual whose services are being audited does not contain information to answer the indicator or the set of indicators? For example, if auditing one person’s health care and the individual selected is not on a special diet (as measured in L39).

**Answer:**

Most indicators will relate to anyone randomly selected, while there are several indicators in which selection will need to be made from a subset of individuals served. When the surveyor arrives at the location, surveyor should ask for a list of individuals, with references to who is on a special diet, behavior treatment plan, restrictive practice, medication treatment plan, and/or support and health related protections. In this example, the surveyor should ask the Provider who in this location is on a special diet, and randomly select an alternative individual to evaluate this indicator. When entering a day service location serving a large number of individuals, for example, it would be important to obtain a list of individuals receiving medication and money support when arriving on-site. One can then easily and efficiently randomly select an additional individual to inform these particular indicators when needed.

**SEQUENCE:** **ON-SITE**

**Process:** **Critical indicators - Immediate Jeopardy; rating the standard not met**

**Date:** 10/11

**Question 1:**

When does an Immediate Jeopardyget issuedand how does this relate to also rating the standard not met? Should corrected issues be changed to standard met?

**Answer:**

When reviewing indicator information, each situation needs to be evaluated to determine whether to issue an immediate jeopardy, to rate the standard as not met, or take to both actions. An Immediate Jeopardy notice is issued when a team member encounters a situation that poses an immediate and serious threat to the health and safety of the individual, or could place an individual in harm’s way if actions are not taken in a timely manner (within 24- 48 hours for an immediate jeopardy; within 30 days for an action required). Criteria to rate the indicator as standard met is outlined in the tool and is specific to each indicator. When there is a preponderance of evidence that the indicator is not in place, a rating of standard not met is issued. Not all Immediate Jeopardies warrant a rating of standard not met for the indicator. In addition, rating the indicator as standard not met is not sufficient to warrant issuance of an Immediate Jeopardy. For example, the lack of a heating / boiler inspection would result in a not met rating (indicator L11), but does not in and of itself constitute sufficient information to issue an immediate jeopardy.

If a situation is corrected after the surveyor’s visit, the score should remain not met, but noting parenthetically that it has been corrected, and listing the date corrected. For example, the fire alarm system which was not operational has been corrected and was inspected subsequent to the survey visit. A rating of not met should be made, as mentioned above, when the evidence indicates that the criterion was not met, at the time of the survey visit. If however, the indicator appears to have been met, but there is not sufficient documentary evidence to support a rating of met, the provider may be offered one to two days to produce and forward the documentation supporting a met rating. For example, the location is receiving regular insect control services, but information on service visits is stored at the corporate address.

**SEQUENCE:** **ON-SITE**

**Process:** **Issuing of Immediate Jeopardy / Action Required – Hot Water**

**Date:** revised and replaces 3/12 version- 1/14

**Question 1:**

When does an Immediate Jeopardyget issuedfor water temperature and how many days should be allotted to correct this issue?

**Answer:**

Immediate Jeopardy should be issued and the Provider given 1 day to correct the situation when the residential water temperature exceeds 120 degrees at either the sink or shower and the individuals are not independent. While the Provider has up to a day to correct the deliverable water temperature, they need to take immediate preventative actions to ensure that all individuals are safe in the interim and that the water temperature is regulated and adjusted to safe and comfortable levels prior to utilization/showering/ bathing.

Unlike residential faucets which have an allowable range (110-120 degrees), water temperatures at the faucets at employment sites are required to be at 110 degrees.  For consistency, Immediate Jeopardy will be issued and the Provider given 1 day to correct the situation when the employment/day water temperature exceeds 120 degrees.  Regardless of the independence level of the individuals, if the employment/ day water temperature tests above 120, an IJ will be issued.

An Action Required should be issued and the Provider given 7 days to correct the situation when the water temperature exceeds 120 degrees and the individuals are independent. If the water temperature is below 110, the provider will be instructed to seek adjustment.  Only when the temperature of the water is significantly low such as an absence of sufficient hot water to bath/ shower, will an Action required be issued.

If the residential sinks are below 100 or above 120 degrees, this will be rated as a not met.  Regarding day programs or employment training sites operated by DDS providers employment / day services, if the faucets test below 100 or above 120 degrees, this will be considered not met.

**SEQUENCE:** **ON SITE**

**Process: Site feasibility; on site surveying**

**Date:** 3/12

**Question 1:**

Several years ago the standards for interconnected smoke detection systems changed, and for homes built or renovated after 1996, interconnected smoke detectors must now be in each bedroom. Under what conditions would a location need a new interconnected smoke detection system?

**Answer:**

Existing interconnected smoke detections systems build to an older building code (pre-1997) suffice (e.g. (smokes located 10 feet from bedroom areas) for homes built prior to 1997.   Homes with interconnected smoke detection systems need to be upgraded and meet current code (one in each bedroom) when the home was built after 1997 or when an existing home undergoes extensive renovations, such as the addition of a new bedroom.

**SEQUENCE:** **ON SITE**

The review of the related indicators is conducted through the review of the site’s DPH registration, the storage and security of medications, and an audit of a person’s medications. The latter component (individual’s medications) will be completed up to the number of audits identified for that home or workplace. In other words, if there is one audit, then the surveyor will review one person’s medications. If there are two audits, then two sets of medication records will occur, and so on. Typically, this review will be conducted on the person identified for Cluster A. If, however, that individual is not administered medications, another individual will be selected for this purpose - if there is another person in this home or workplace that is administered medications.

Prior to the survey, the surveyor reviews HCSIS data for the locations he/she will visit.

The review involves the following steps (although these may not always occur in this order):

**SEQUENCE ON SITE:**

**Process: Review of medication administration**

**Date: 2/15**

**Question 1:**

What is the process for conducting a review of medication administration (L46 and L47)?

**Answer:**

The surveyor will observe where the medications are stored and check the DPH Registration to verify that it is current and obtain the MAP number. This may also be the time that the surveyor asks about the provider’s mechanism for assuring only MAP certified staff administer meds (e.g., whether there a list of med certified staff or the MAP certificates present).

The surveyor will ask about any MORs that were reported in HCSIS and if the provider staff understand the reporting requirements and process for a medication error. The surveyor may identify MORs that have not been closed and inquire if the provider has taken steps to resolve these.

The provider is asked to have the following items:

* Medications
* Physician’s Orders
* Medication Administration Records (The provider is expected to have available one year’s worth of MARs.)
* Emergency Fact Sheet (Note: Reviewed as part of this activity but rated in L8)
* Side Effect information

In a MAP home or workplace, a survey worksheet\* is utilized in which the surveyor will list the medications and note whether the information is correct across the physician’s order, the container label, and the medication administration record (MAR). The surveyor also checks that the correct medications are listed on the current Emergency Fact Sheet, that the medication is not expired, and that there is side effect information for these medications available at the home or workplace.

\* Alternate documentation may also be used, so long as the verification of the requisite information is completed and documented. For instance a provider may generate a med list against which the required elements can be verified.

1. Once that is completed, the surveyor will visually scan the MARs for a general sense that the medications have been given correctly across the year. Should there be no obvious problems evident; the surveyor will then randomly select 3 months (the current month and two others) to more thoroughly audit the medication administration records for accuracy. This detailed review looks for such things as missing sign offs, that any PRN medication administered was properly documented, and that if an error occurred the provider identified and addressed the issue.

The review for these three months includes:

1. A cross-check of each medication to ensure that there are current corresponding physician’s orders
2. A cross-check of each medication to ensure that the administration information is consistent across physician’s orders, MARs, Container Labels.
3. The storage of medications and that all medications are properly stored and current (not expired).
4. Review of daily and PRN medication administration
5. An assessment of procedures for administration and for auditing the administration
6. An assessment of the accuracy of administration e.g. medications were given at the intended time; medication were given at the correct dosage and frequency.
7. An assessment to determine that there are no gaps due to medications not being re-filled in a timely manner.
8. An assessment of clear parameters for any medication to be administered PRN and that any special instructions are followed (e.g., taking pulse or blood pressure before administering or crushing medication, etc.).

If the surveyor identifies issues requiring additional information in order to determine a rating, the surveyor may expand his or her review beyond the three months selected for auditing.

1. When the Provider has additional protocols, the surveyor’s review will then assess whether these additional expectations are in place at this location. These protocols may be evaluated as part of the medication review, but rated elsewhere. For example, bowel regimes, seizure protocols, and medication treatment plans.
2. Ensure that what is written about an individual’s health care status, medication needs, side effects to be aware of, is consistent with specific practices in the home.

For the purpose of evaluating L47, the surveyor will ask the provider how it supports the person to be involved in taking his or her medication with the ultimate goal of becoming self-medicating. Please refer to additional interpretation of this indicator within the Interpretive Guidelines.

Upon the completion of these tasks, the surveyor will then begin determining the rating for each applicable indicator. As the most complex decision rests with the assessment of any issues noted within L46, more specific guidance is offered relative to that indicator.