IMMEDIATE TRANSFER REVIEW

Purpose

An Immediate Transfer Review may be initiated when the Regional and Area Office staff have determined that it is necessary to terminate a provider's contract with or without cause and transition individuals' services to a successor provider in order to ensure basic safeguards are in place as the service transfers to a new agency. It also includes situations in which the services are transferred from one provider to another. A separate review would be completed for each distinct service site for which there is a request, or when a large transfer occurs, for a sample of locations as deemed appropriate. As part of the transition plan, the Area Office notifies the Office of Quality Enhancement.

Prior to the review, the Area Office will work with the exiting and incoming provider on ensuring a smooth transition and the transfer of necessary information. The attached location and individual checklists have been developed to facilitate that process of information transfer.

Initiation of Review

The Immediate Transfer Review will take place within seven days after the transfer of the service. The involved Area or Regional Office will be notified of the date of each review and whenever possible will identify a key staff person with knowledge of the individuals to communicate and interface regarding each review. The receiving agency will be informed of the date of each review. In addition, a modified off-site review will also occur to review information on the locations and individuals whose services are being transferred, prior to conducting the on-site review. For instance, the surveyors will review HCSIS information regarding incidents, complaint, restraints, and medication errors within transferred locations.

Conduct of the Review

The surveyor will complete an enhanced review of the site feasibility/pre-placement requirements for each identified site to ensure that basic safeguards are in place. This includes the following:

Residential/ Home Supports – to be reviewed through an audit of the people in the home

a. Completion of environmental worksheet for the home.
b. Assessment of all components on the Pre-Placement Checklist for the home.
c. Fire drill with individuals supported at each home with 24 hour staffing where the home is leased or owned by the provider and for site-based respite services.
d. A review of the fire drill logs and safety plan to identify any problems with evacuation.
e. Confirmation that medication is being given in accordance with MAP requirements.

f. Review to determine, as much as possible that relevant medical information is available for each individual in the home. This will include:
    i. Available documentation of annual physical and dental examinations.
    ii. Names of physicians, clinicians and specialists involved with the individual(s).
    iii. Medical information and history to inform staff of each individual's current health status– this will need to be confirmed through the area office staff person participating in the review.
    iv. Information outlining procedures to address identified medical needs such as a special diet.

g. Immediate jeopardy/Action Required notices are issued for those safeguard concerns that put individuals at great risk if not corrected quickly.

<u>Day/Employment Supports – to be reviewed through an audit of individuals served</u>

a. Completion of environmental worksheet for the day/work support
b. A review of the fire drill logs, system and safety plan to identify any problems with evacuation.
c. Confirmation that medication is being given in accordance with MAP requirements as outlined on the medication guide of the Health and Medication Worksheet.
d. Review to determine, as much as possible that needed medical information is available for a sample of individuals in a day/work service to include:
    i. Available documentation of annual physical and dental examinations.
    ii. Names of physicians, clinicians, and specialists involved with the individual(s).
    iii. Medical information outlining an individual's current health status – this will need to be confirmed with appropriate area office staff.
    iv. Information outlining procedures to address identified medical needs such as a special diet.
e. Immediate jeopardy/Action Required notices are issued for those safeguard concerns that put individuals at great risk if not corrected quickly.

2. A written report outlining findings will be sent within 1 week of the review. The report will include any areas needing improvement or recommendations generated from the review. Attachments will include the results of the fire drill, and any Notices of Immediate Action Required. The involved Area Office and Regional Office would assume responsibility for following up on any identified issues.

3. If requested by the Area or Regional office, or if this is a new service for the incoming provider, an Initial review of the service will also be completed within 60 days of the transfer.

IMMEDIATE TRANSFER REVIEW REPORT

Provider: _____

Location Address: _____

Type of Service: _____

Team Member(s): _____

Date of Review: _____

Report Date: _____

Attachment: Pre-Placement Requirements Checklist
Fire Drill Report (24 hour residential supports only)

Were any notices of Immediate Action Required Issued? No___ Yes___ (attached)

_____

FINDINGS

Physical Site Issues:

Evacuation Issues:

Health/Medication Issues:

LOCATION TRANSFER INFORMATION COVER SHEET

The following is the list of information the Area Office may want to ensure is present for each of the locations transferring to new Providers. Some of this information is obtained from the exiting Provider during the transfer, and then updated as necessary by the incoming Provider. Training requirements apply to all staff working for the incoming provider.

Location Address: _____ Date of Transfer: _____

Previous Provider: _____ New Provider: _____

Number of Individuals: _____ Approved Capacity of Home: _____ (Please note that capacity waivers, if in effect for the exiting provider, will need to be resubmitted by the incoming provider)

Number of Staff on duty: Day: _____ Overnight: # Awake ___ # Asleep ____ (Attach staff schedule)

Staffing/ training status:

Emergency Evacuation Safety Plan and Assurance Form Completed?
☐ Yes **(Attach)** ☐ No

Fire Drill conducted by incoming provider? ☐ Yes **(Attach)** ☐ No

New Provider staff trained in Safety Plan implementation? ☐ Yes ☐ No

Will Medications be administered by Staff? ☐ Yes ☐ No
If yes: ☐ Site is registered with DPH (new Provider must apply)
☐ MAP Certified Staff available
☐ Will specialized training be needed? (G-Tube, epipens)

Staff are trained in First Aid? ☐ Yes ☐ No

Staff have training in Fire Safety? ☐ Yes ☐ No

At least one staff has training in Fire Safety by DMR, an approved training agency, or the local fire department. ☐ Yes ☐ No

At least one staff on duty has training in CPR? ☐ Yes ☐ No

Any Investigations, pending or completed, involving this location? ☐ Yes ☐ No

Human Rights Officer available to home?
☐ Yes, Name:_____ ☐ No

Location relevant information:

Lease/ rental/ownership information _____ lease costs (last yr _____)

If remaining at current location, utility information including insurance, water, gas, oil, phone, cable, lawn and other (**attach** bills)

_____

Site condition _____
Repairs needed? ☐ Yes ☐ No
If yes, of an immediate nature? ☐ Yes ☐ No

Is any equipment also being transferred? ☐ Yes ☐ No
If yes, what_____

Groceries and other goods being transferred are present and accounted for? ☐ Yes☐ No

Have all prescriptions been transferred to the new pharmacy, if applicable?
☐ Yes ☐ No ☐ N/A

Keys **(attach**), if being transferred. Alternatively, if locks are being changed, please note when_____

Vehicle information:
Lease/ rental information (**attach** bill) If not, transferring lease, note when and to whom new lease arrangement is being developed _____

Description/ condition of vehicle; Keys **(attach)** _____

INDIVIDUAL TRANSFER INFORMATION COVER SHEET

The following is a list of individualized necessary information and/or materials to obtain from the exiting Provider. These items and/or information need to be received and then transferred to the incoming Provider. In some cases, the incoming Provider also needs to provide the Area Office with updated information (for example, by updating the Emergency Fact Sheet).

Name: _____ DOB: _____

Address: _____

Family Contact: ☐ Yes ☐ No
If yes, Name: _____ Phone: _____

Legal Status: ☐ Competent in Fact ☐ Presumed Competent ☐ Under Guardianship

If Guardian: Name: _____ Phone: _____
☐ Full
(**Attach** legal documents) ☐ Of Estate ☐ Of Person
☐ Medical
☐ Conservator
☐ Health Care Proxy

Does Individual Have Rep-payee? ☐ Yes, Name: _____ ☐ No
Will there be a change in Representative Payee initiated? ☐ Yes ☐ No
If yes, when/ with whom? _____
(**Attach** financial information inc. Charges for Care and Funds Management Plan and any spending money stored at the home)

Individual Safety Assessment completed and **attached**? ☐ Yes ☐ No

Communication: ☐ Verbal ☐ Non-Verbal
☐ Augmented: ☐ Gestures ☐ ASL
☐ Communication Book /Device
Staff are available who can utilize the method used? ☐ Yes ☐ No

Primary Care Physician: _____ Phone: _____
Does individual have current annual Physical Exam? ☐ Yes ☐ No
Does individual have current dental exam? ☐ Yes ☐ No
Any upcoming medical appointments scheduled? ☐ Yes ☐ No If yes, when/ with whom? _____
Will there be a transfer of medical / dental service delivery? ☐ Yes ☐ No
If yes, when / with whom? _____

Does individual take medications? ☐ Yes ☐ No
If yes, current Drs. Orders **attached**? ☐ Yes ☐ No ☐ N/A
If yes, medications are available and accounted for? ☐ Yes ☐ No ☐ N/A

Specialized Medical Condition or Considerations (e.g., allergies, diet) ☐ Yes ☐ No
Additional clinical services; health care professionals involved? ☐ Yes ☐ No
Health Care Summary/Medical History **Attached**? ☐ Yes ☐ No

Confidential file **Attached**? ☐ Yes ☐ No

ISP (including Health Care Record) **Attached** ☐ Yes ☐ No

Nursing assessment, if available **attached?** ☐ Yes ☐ No
(Note: Health Care Record must have been updated with the past 30 days)

Programmatic and support strategy information **attached** ☐ Yes ☐ No

Individual utilizes the following supports: (Check all that apply and **attach** relevant documentation)
☐ Behavior Plan ☐ Supports & Health Related Protections ☐ Psychotropic Medications ☐ Medications requiring special care (e.g. Coumadin, Lithium, Cardiac) ☐ Physical Restraint (use within the past year) ☐ Medications to calm or relax prior to medical or dental treatment.

Are there any special safety considerations, specialized diets, treatment plans, or protocols needed? ☐ Yes ☐ No
Incoming Provider staff have been trained in the supports/protocols indicated above? ☐ Yes ☐ No

Day service and transportation information present? ☐ Yes ☐ No
Any proposed changes? ☐ Yes ☐ No
If yes, when/ and with whom_____

Updated Emergency Fact Sheet is **attached**? ☐ Yes ☐ No
(Reflecting new provider and accurate information)