Office for People With Developmental Disabilities

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DIVISION OF QUALITY IMPROVEMENT APPLICATION SITE PROTOCOL MANUAL OCTOBER 1, 2025

NEW YORK STATE | Office for People With Developmental Disabilities

SITE PROTOCOL OVERVIEW

This document provides regulatory and procedural guidance used to conduct site based surveys utilizing the OPWDD Division of Quality Improvement (DQI) Site Review Protocol. It is intended as a reference tool, particularly when access to the DQIA Protocol application is unavailable. It also supports understanding of the standards associated with Risk Stratified Oversight (RSO) Site Review activities and incorporates all revisions made to the Site Protocol process for the survey cycle beginning in October 2025.

The Site Protocol Manual is comprised of five sections (5) Sections:

A. Comprehensive Protocol and Guidance:
    a. All required information collection activities, documentation submissions, and criteria included in the protocol;
        i. For each criterion:
            • The relevant program types to which it applies;
            • The corresponding regulatory citation, compliance obligation, or designation as a quality indicator;
            • Evaluation guidance, including a rationale-based framework for determining whether the criterion is Met or Not Met.
        ii. The activities and areas of review described in the protocol have been identified as essential elements of the review process.
B. RSO Standards adjusted for 10/1/25 survey cycle:
    a. Truncated
    b. Remote
C. Standards Separated by Type of Program Site (i.e., Day hab vs. IRA)
D. Partial drop-down clarification for survey staff
E. Acronym Glossary

Section Topic:	
Section 1: Heightened Scrutiny Triggers	Section 10c: Risk Area – Current Illness
Section 2: Health Support & Medications	Section 10d: Risk Area – Diabetes
Section 2a: Health Support & Medications	Section 10e: Risk Area – Fluid Intake
Section 3: Personal Funds	Section 10f: Risk Area – Oxygen Use
Section 3a: Personal Funds	Section 10g: Risk Area – Supervision
Section 4: General Operations For: Individualize Choice, Autonomy & Satisfaction	Section 10h: Risk Area – All Rights Limitation/Restrictions
Section 5: Delivery of Safeguards, Services, Supports	Section 10i: Risk Area – Behavior Supports - General
Section 6: Rights Protections	Section 10j: Risk Area – Mechanical Restraints
Section 7: Site & Safety	Section 10k: Risk Area – Time Out
Section 8: Fire Safety	Section 10l: Risk Area – Physical Interventions
Section 9: Site Specific Requirements	Section 11: Risk Area – Background Checks
Section 10a: Risk Area – Skin Breakdown	Section 12a: Infection Control
Section 10b: Risk Area – Discharge From Hospital	Section 12b: Infection Control: Active Concern

Section 1: Heightened Scrutiny Triggers
QQ-1: Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?
1-7 The site is in a building that is separate from a publicly or privately-operated facility that provides inpatient institutional treatment.
636-2.5 A Medicaid HCBS setting subject to heightened scrutiny, as defined in subdivision 636-2.3(c) of this Subpart, will be reviewed in the form and format specified by CMS, DOH, and/or OPWDD.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
636-2.3(b)(1-3) (b) Heightened Scrutiny. Review of a setting presumed to be isolating and/or having institutional qualities because it is: (1) located in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment; (2) in a building on the grounds of, or immediately adjacent to, a public institution; or (3) any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ACRONYMS CMS: Centers for Medicaid & Medicare Services HCBS: Home and Community Based Services ICF: Intermediate Care Facility IRA: Individualized Residential Alternative OMH: Office of Mental Health VA: Veterans Affairs The site is in a building that is separate from a publicly or privately operated facility that provides inpatient institutional treatment. **DISCUSSION**

HCBS waiver services cannot be provided in institutional settings or in facilities where inpatient institutional treatment is delivered. Sites located within the same building as an institutional facility are classified by CMS as Prong 1 Heightened Scrutiny settings, meaning they must demonstrate compliance with the HCBS Settings Federal Rule and not operate in an institutional manner.

A public institution is defined as an institution that is the responsibility of a governmental entity and over which a governmental entity exercises control. Inpatient institutional treatment includes all public institutions and any private facilities that provide inpatient care.

Examples of Public Institutions:

- OPWDD ICFs
- OMH psychiatric centers
- Institutions for mental diseases
- Prisons
- Addiction treatment centers
- Nursing homes

Examples of Private Facilities Providing Inpatient Institutional Treatment:

- Private mental health facilities providing inpatient care
- Private nursing homes
- Private addiction treatment centers providing inpatient care

Examples of Locations That Are Not Considered Institutional:

- Medical institutions/hospitals (including VA hospitals)
- Childcare institutions
- Publicly operated non-ICF community residences
- Universities
- Libraries
- Public non-residential schools
- Existing sites certified under OPWDD's HCBS Waiver, such as IRAs and day habilitation programs, were required to be fully compliant with HCBS Settings requirements by March 17, 2021. A site within the same building as an inpatient facility is presumed to have institutional qualities and must demonstrate that it is fully integrated into the community and does not restrict individual rights, choice, or autonomy.

Determine the standard MET if:

- The site is in a separate building and is not co-located with a public or private facility that provides inpatient institutional treatment.

Determine the standard NOT MET if:

- The site is in the same building as a public or private facility that provides inpatient institutional treatment, including but not limited to an ICF, psychiatric center, addiction treatment center, nursing home, or private mental health facility providing inpatient care

1-8 The site is not in a location that is on or immediately adjacent to a public institution property.
636-2.5 A Medicaid HCBS setting subject to heightened scrutiny, as defined in subdivision 636-2.3(c) of this Subpart, will be reviewed in the form and format specified by CMS, DOH, and/or OPWDD.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
636-2.3(b)(1-3) (b) Heightened Scrutiny. Review of a setting presumed to be isolating and/or having institutional qualities because it is: (1) located in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment; (2) in a building on the grounds of, or immediately adjacent to, a public institution; or (3) any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ACRONYMS CMS: Centers for Medicaid & Medicare Services HCBS: Home and Community Based Services ICF: Intermediate Care Facility IRA: Individualized Residential Alternative OMH: Office of Mental Health VA: Veterans Affairs
HCBS services must be delivered in community-based settings and cannot be located within or immediately adjacent to a public institution, as defined by the CMS. Locations classified as Prong 2 Heightened Scrutiny settings may have institutional qualities due to their proximity to public institutions and must demonstrate compliance with the HCBS Settings Federal Rule to ensure they do not function in an institutional manner.

A public institution is an institution that is the responsibility of a governmental entity and over which a governmental entity exercises control.

Examples of Public Institutions:

- OPWDD ICFs
- OMH psychiatric centers
- Institutions for mental diseases
- Prisons
- Addiction treatment centers
- Nursing homes

Examples of Locations That Are Not Public Institutions:

- Medical institutions/hospitals (including VA hospitals)
- Childcare institutions
- Publicly operated non-ICF community residences
- Universities
- Libraries
- Public non-residential schools
- Existing sites certified under OPWDD's HCBS Waiver, such as IRAs and day habilitation programs, were required to be fully compliant with all HCBS Settings requirements by March 17, 2021. Sites that operate on or adjacent to public institutions must demonstrate that they are fully integrated into the community and do not have restrictive or isolating characteristics.

Determine the standard is MET if:

- The site is not located on or immediately adjacent to a public institution and does not have institutional characteristics.

Determine the standard is NOT MET if:

- The site is located on or immediately adjacent to a public institution or provides inpatient institutional treatment (i.e., a psychiatric center, nursing home, addiction treatment center, or private mental health facility delivering inpatient care).

1-9 The site's design, appearance, and location are not institutional and do not isolate people from the broader community.
636-2.5 A Medicaid HCBS setting subject to heightened scrutiny, as defined in subdivision 636-2.3(c) of this Subpart, will be reviewed in the form and format specified by CMS, DOH, and/or OPWDD.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
636-2.3(b)(1-3) (b) Heightened Scrutiny. Review of a setting presumed to be isolating and/or having institutional qualities because it is: (1) located in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment; (2) in a building on the grounds of, or immediately adjacent to, a public institution; or (3) any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ACRONYMS CMS: Centers for Medicaid & Medicare Services HCBS: Home and Community Based Services IRA: Individualized Residential Alternative
DOCUMENTATION REVIEW Documentation review based on surveyor discretion, i.e. policies and procedures related to community integration, site design records, documentation related to community conclusion activities and operational guidelines.
OBSERVATION Verify whether the site is designed to integrate Individuals into the community and does not exhibit institutional characteristics.
ADDITIONAL POINTS FOR CONSIDERATION: HCBS Waiver services cannot be provided in institutional settings or where institutional services are offered.

Settings categorized as Prong 3 Heightened Scrutiny settings by CMS include sites that isolate Individuals receiving Medicaid HCBS from the broader community of Individuals not receiving HCBS.

Sites identified for heightened scrutiny may exhibit institutional characteristics due to their design, operations, or level of community integration. To meet HCBS requirements, these sites must demonstrate compliance with the HCBS Settings Federal Rule and ensure they do not function in an institutional manner.

Existing OPWDD-certified HCBS Waiver sites, such as IRAs and day habilitation programs, were required to comply with all HCBS settings requirements by March 17, 2021.

When determining whether this standard is Met or Not Met, consider how the site's physical structure, operational policies, and level of community integration impact the Individuals receiving services.

Examples of isolating conditions and institutional practices:

- Not enough accessible transportation, resulting in people receiving services having limited chances for interaction with the broader community.
- The site does not effectively support individualized interests and activities. People are not supported in choosing their own activities.
- Planned community activities occur in large groups by design, not by request.
- Activities are selected by staff or the agency. For example, everyone is expected to attend the same day program, everyone goes out for coffee on Tuesday, etc.
- Transportation and staffing are shared among sites, which limits individual choices in activities and schedules.
- The agency/site has rules and restrictions about when and how often individuals can go out.
- Leisure activities and interactions involve only other people with disabilities and paid staff. For example, the agency offers on-site dances and other activities for only people with disabilities. These activities should be in addition to other opportunities to access the broader community and attend community events.

Examples of institutional appearance and institutional practices:

- The home looks and presents like an institution.
- Rigid schedules and/or house rules that limit opportunities for individual choice and autonomy.
- People are denied access to or there are locked areas like cupboards and closets and there are no consents in place justifying this lack of access.
- Other examples of areas that people might not have access to kitchen, linen, and storage closets, laundry room, exterior doors.
- People must ask staff for things rather than be able access items themselves, such as putting items too high up for someone using a wheelchair to reach.
- Space designated for staff only (such as having bathrooms or breakrooms only for staff).

- Use of alarms, interior video surveillance, etc. that are used in areas where there is an expectation of privacy, for staff convenience, and/or without proper consent.
- Exterior signage identifying the home as other than a typical home, such as use of large agency signs.
- Exterior appearance resembles that of an institutional facility. The site/home does not blend into the surrounding community/neighborhood.
- Institutional furniture and arrangement of home. Examples include things like having a “day room” (vs. a living room/den), all furniture is encased in plastic, everyone has the same type of institutional bedroom furniture without individualization. Staff buy clothes for people or use a shopper service, rather than having people go to stores and choose their own clothing.

When sites provide a lot of services at one address, this can increase the effects of isolating and institutional practices. The more services that are brought to people receiving services at the site can mean missed opportunities to access those same activities in their neighborhood community. Some examples of this may include:

- Everyone receives on-site physician care from the same doctor rather than accessing community medical services.
- Haircuts are given at the residence/day program.
- Religious services are provided in the home rather than supporting people to access local religious services of their choosing.
- Schedules are developed for the home or day setting facility without flexibility to accommodate and support individual choices.

Determine the standard is MET if:

- The site is compliant with HCBS settings requirements and is not institutional or isolating in its operations or appearance.

Determine the standard is NOT MET if:

- The site provides people with multiple types of services and activities at the same location, such as medical, day program, recreational, behavioral, and therapeutic services, which has resulted in people at the site having limited chances for interaction and experiences outside of the setting in the broader community. This has also resulted in people at the site having regimented schedules and limited autonomy.
- People receiving services at the site have limited interaction with the broader community (regardless of setting location).

Section 2: Health Support & Medications
2-1 There is a written plan for how the site will respond to life-threatening emergencies.
633.10(b)(2)(i-iii) There is a written plan specifying how the agency/facility will deal with life threatening emergencies. Such a plan shall address: (i) First aid; (ii) CPR; (iii) Access to emergency medical services.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(5) The agency/facility shall develop a plan for addressing the life-threatening emergency needs of the persons served. Such a plan shall be based on the needs of the persons in the facility, and shall address the availability of first aid, cardiopulmonary resuscitation (CPR) techniques and access to emergency medical services. Where staff training is part of the plan, there shall be provision to keep such training up to date.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS: CO: Carbon monoxide CPR: Cardiopulmonary resuscitation **DISCUSSION** N/A **DOCUMENTATION REVIEW** Mandatory: • Review the actual written plan(s) describing how life-threatening emergencies are to be addressed **OBSERVATION** N/A

This standard requires a plan (or plans) to address life threatening emergencies other than fire emergencies, which are addressed in section 8 of this protocol. Such emergencies may include medical emergencies, activation of CO detectors, and weather emergencies (i.e., tornado warning).

Review the facility's plan. Determine if the plan provides necessary information, including but not limited to:

- A communication system for the prompt contacting of emergency personnel in the event of the emergency
- A plan to evacuate the site, including relocation if needed
- A plan to access emergency medical services
- A plan to address/provide CPR/First Aid as needed
- A plan for prompt contact with responsible agency personnel once the immediate needs of the individuals/site are addressed

Assess whether the plan is likely to effectively handle the emergency.

Determine the standard is MET if:

- There is an acceptable plan.

Determine the standard is NOT MET if:

- There is NOT an acceptable plan.

2-2 The staff know actions to take in the event of a medical emergency.
633.10(b)(3) OPWDD shall verify that staff have been made aware of their responsibilities in accordance with the agency/facility plan.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS: CPR: Cardiopulmonary resuscitation **DISCUSSION** Mandatory: • Direct support staff re: understanding of plan • Management staff as needed regarding system to train staff on the plan **DOCUMENTATION REVIEW** As needed: • Training records specific to medical emergencies, if discussion raises concern re: staff understanding of the plan **OBSERVATION** As needed: • Only if an event occurs during visit

Based on discussion with the staff, verify that the staff is aware of the actions to take for life threatening emergencies in accordance with the written plan and that the actions the staff describes are likely to be effective and/or are appropriate to the emergency. Ensure the staff understands specific responsibilities including:

- The actions expected in response to emergencies (i.e., CPR, first aid) and to access emergency medical services, in accordance with the agency/facility plan.
- How to use the communication system for the prompt contact with responsible agency personnel in the event of an emergency.

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

Interviews with staff or a review of records, such as health care or incident management records, may reveal that an emergency occurred during the review period. Determine if the staff took appropriate action to address the emergency.

Determine the standard is MET if:

- The staff can effectively describe the actions to take in an emergency in accordance with the plan.
- Emergencies that occurred during the review period were addressed in accordance with the actions described in the plan.

Determine the standard is NOT MET if:

- The staff cannot effectively describe the actions to take in an emergency in accordance with the plan.
- The staff did not take appropriate action in an emergency that occurred during the review period and no remedial action was taken to prevent recurrence of the failure.

Section 2a: Health Support & Medications
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-1 There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.
635-10.4(b)(1)(xvi)(c)(1)-(3) …residential habilitation services in a supervised IRA include the following clinical services delivered to an individual that are directly related to the individual's residential habilitation plan …(c) nursing services that consist of: (1) training and supervision of direct support staff who perform health-related and delegated nursing tasks that include, but are not limited to, observation for illness and injury, medication administration, tube feeding, and colostomy care; (2) development and monitoring of written plans of nursing services that identify interventions direct support staff carry out to address individuals' health care needs; (3) availability of nursing supervision, by a registered nurse, on site or by telephone, at all times to respond to direct support staff in order to address individuals' ongoing and immediate health care needs
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more
671.5(a)(7)(iii)(a)-(c) … residential habilitation services in a supervised CR include the following clinical services delivered to an individual that are directly related to the individual's residential habilitation plan: …(iii) nursing services that consist of: (a) training and supervision of direct support staff who perform health-related and delegated nursing tasks that include, but are not limited to, observation for illness and injury, medication administration, tube feeding, and colostomy care; (b) development and monitoring of written plans of nursing services that identify interventions direct support staff carry out to address individuals' health care needs; (c) availability of nursing supervision, by a registered nurse, on site or by telephone, at all times to respond to direct support staff in order to address individuals' ongoing and immediate health care needs
Program Class/Type: CR/Supportive Community Residence, CR/Supervised Group Home
ADM #2003-01 Registered Nursing Supervision of Unlicensed Direct Care Staff in Residential Facilities. There shall be an RN available to unlicensed direct care staff 24 hours a day, 7 days a week. The RN must be either on site or immediately available by telephone. The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders … and/or of changes in [an individual's] health status
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
680.8(c)(2) There shall be on duty to provide nursing services during the first and second shift one registered nurse for every 20 individuals; during the third shift, through the hours when individuals are sleeping, there shall be on duty one registered professional nurse for every 30 individuals. The calculation of this ratio shall exclude nurses who serve as supervisors.
Program Class/Type: Specialty Hospital/Inpatient
ADM #2008-01

Registered Nursing Supervision of Unlicensed Direct Care Staff in Free Standing Respite Facilities. There shall be an RN available to unlicensed direct care staff during all hours that they are on duty at the FSR center. The RN must be either on site or immediately available by telephone defined as responding within thirty (30) minutes. The RN assigned to the FSR, or during hours that this RN is not available, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.

Program Class/Type:
IRA/FSR Large 9 or more, IRA/FSR Small 8 or less

ACRONYMS
CR: Community Residence
FSR: Free Standing Respite
IRA: Individualized Residential Alternative
LPN: Licensed Practical Nurse
NP: Nurse Practitioner
PONS: Plan of Nursing Service
RN: Registered Nurse

DISCUSSION
Mandatory:
- Direct support staff and LPNs who carry out delegated nursing services re: RN availability and response time
- RN re: how coverage is provided
- RN and program staff re: required documentation

DOCUMENTATION REVIEW
As needed:
- Written plan on how to contact an RN
- Incident review on effectiveness of agency mechanism for 24/7 RN availability, where applicable
- Communication logs and nursing notes

OBSERVATION
As needed:
- Only if an event occurs during visit

Each facility must have a process to ensure that an RN is available to provide guidance to staff (including LPNs) who carry out delegated nursing services. A NP may be designated to fulfill the RN responsibilities.

All certified residential programs (except IRA/FSRs) with capacities of 2 or more – and, by regulation, all supervised IRAs and CRs, regardless of capacity - must ensure that an RN is immediately available at all times to unlicensed staff and LPNs to provide guidance and oversight of delegated nursing services. In an IRA/FSR, an RN must be available to staff while the staff are providing services. (IRA/FSR hours of operation may vary.) The RN must be immediately available by telephone or other means such as skype that enable the RN and staff to speak with each other when an RN is not on site. Immediately available means reachable for discussion within no more than 30 minutes time. By regulation, the specialty hospital must have an RN on site at all times.

Delegated nursing services include but are not limited to medication administration, diabetic care, tube feeding, and monitoring and care in accordance with PONS. Services also include timely response to staff concerns about changes in an individual's health and treatment.

Direct support staff, LPNs, and RNs must be familiar with process established by the agency for nursing supervision.

Determine if the agency's process for providing nursing oversight is consistently reliable and effective.

Determine the standard is MET if:

- Discussion and documentation review indicate there is an effective process to provide staff with access to supervision by an RN at all times, as required.

Determine the standard is NOT MET if:

- Discussion and documentation review indicate that there is no process, or the process is not effective to guarantee an RN's timely response to staff requests for nursing guidance and supervision.

Select N/A if:

- If this is not applicable.

2a-2 The staff know how to contact the RN using the process established by the agency.
633.17(a)(15)(i)-(ii) Supervision and monitoring of staff. (i) Medical or nursing supervision of those staff responsible for administering medication shall be provided.(ii) Supervision and monitoring shall be in accordance with agency/facility policies/procedures.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.8(b)(1)(viii) Standards of certification. (1) OPWDD shall verify that employees, volunteers, and family care providers have received or will receive training within three months of initial employment, commencing volunteer activities, or initial certification as a family care provider. The training shall be on: viii) other appropriate topics relative to the safety and welfare as may have been specified by the agency.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS RN: Registered Nurse **DISCUSSION** Mandatory: • Direct support staff • RN re how coverage is provided

• RN and program staff to explain how and where nursing guidance and staff actions are documented

DOCUMENTATION REVIEW

As needed:

- Policy and or procedures on how to contact an RN
- Incident review on effectiveness of agency procedures
- Communication logs and nursing notes

OBSERVATION

As needed:

- Only if an event occurs during visit

Standard 2a-1 addresses immediate response by the RN where such response is required. (See regulatory references and guidance for standard 2a-1). This standard addresses staff familiarity with the agency process for contact with the RN.

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

- How to seek RN services during routine agency business hours
- How to seek RN service “after-hours” per agency procedures
- How to document contact with the RN per agency procedure

Determine the standard is MET if:

- Discussion (and documentation review, where applicable) support that staff understand how to contact the RN or RN service in accordance with agency procedures.

Determine the standard is NOT MET if:

- Discussion (and documentation review, where applicable) support that staff do not know how to contact the RN or RN service in accordance with agency procedures.

2a-3 Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.

633.17(a)(14)(iii)
Medication shall be self-administered or administered only by the following:
(a) a person capable of independent self-administration of medication;
(b) a health care professional (a physician, dentist, physician's assistant, registered nurse, or licensed practical nurse holding current New York State licensure);
(c) staff (see glossary) providing direct care services (see glossary), as documented by job description, who have:
(1) successfully completed an OPWDD approved training course in medication; and
(2) successfully completed the required practicum; and
(3) been certified or recertified within the year to administer medication; or
(d) a family care provider whose name appears on the operating certificate for the family care home, and who has received training in medication administration in conformance with an OPWDD approved curriculum; or a sponsoring agency approved substitute, in the absence of the family care provider.

Program Class/Type:
Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS
AMAP: Approved Medication Administration Personnel
MAR: Medication Administration Record
RN: Registered Nurse

DISCUSSION
As needed:

- RN, direct support, and/or management staff to determine how supervision is provided and what mechanisms are used to train staff (especially if problems are noted)

DOCUMENTATION REVIEW
Mandatory:

- AMAP certification records for direct support staff
- MARs for past 6 months
- Medication error records for the past 6 months

OBSERVATION
N/A

Review for at least one individual who does not self-administer medications.

- Review medication administration certification records for direct support staff.
- Review the six (6) most recent (monthly) MARs for at least one individual to verify that parties who administered medications and treatments were/are trained to do so. Signatures/initials on the MARs should only be those of a AMAP certified direct support staff, a licensed health care professional, or an individual receiving services who is capable of self-administration of medication.
- Ensure that specialized training was provided on diabetic care/insulin administration, tube feeding, and catheter care where individuals receiving services require such specialized care.
- Review medication error reports. Be alert to trends in the staff, licensed health care professional, or individual receiving services making errors and see if corrective action is taken to address such performance.

Determine the standard is MET if:

- Staff who administered medications were certified, as required, at the time of administration.

Determine the standard is NOT MET if:

- There is no evidence that staff who administered medications were certified, as required, at the time of administration.

2a-4 The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
633.17(a)(7) All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's [sic]), they shall be controlling.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.17(a)(16)(vi)-(vii) Evaluation of persons for self-administration of medication …(vi) The method used to verify a person's level of self-administration and the documentation required shall be determined by agency/facility policy/procedures. (vii) When a person, designated as capable of independent self-administration of medication, must be frequently reminded to take his or her medication, or there are other indications of lessening of skills related to self-administration, there shall be a reevaluation of the person's ability and a decision made as to whether the degree of supervision or assistance is to be increased.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.17(b)(6) There is documentation that all medication being taken by a person residing in an OPWDD operated or certified facility or attending a nonresidential facility where medication is administered has been prescribed, ordered, or approved by a practitioner (except that in a supportive community residence, a family care home, or nonresidential facility, over-the-counter medication may be taken without a physician's prescription, order, or approval if the person taking the medications is capable of independent self-administration of medication).
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BGL: Blood glucose level BM: Bowel movement

B/P: Blood pressure
MAR: Medication Administration Record
P.O.: *Per os* (by mouth)
PONS: Plan of Nursing Service
PRN: *Pro re nata* (as needed)
RN: Registered Nurse
SAM: Self-Administration of Medication Assessment

DISCUSSION
As needed, for clarification

- Staff who administer medications
- RN
- Individual receiving services

DOCUMENTATION REVIEW
Mandatory:

- MARs
- Medication prescriptions and/or physician's orders
- Bowel tracking record, where applicable
- SAM
- Medication error reporting for past 6 months

As Needed:

- Additional health related documents such as a PONS, physician consults, PRN/health care notes
- Self-administration of medication evaluation

OBSERVATION
Mandatory:

- Medication packaging compared with the MAR and prescriptions/physician's orders
- Medication cabinet or other storage arrangement

As needed:

• Observe a medication pass only if documentation review and discussion are insufficient to assess compliance

This standard is meant to determine whether individuals receive medications/treatments as ordered and as needed. Review for at least one individual who does not self-administer medications. Additionally, in residential programs where one or more individuals self-administer medications, review to determine if oversight provided is sufficient to ensure medication is self-administered in accordance with physicians' orders.

Determining whether individuals received the medications and treatments prescribed by the physician and needed by the individual requires a review of documents listed under Documentation Review above and comparison of the information found in those documents.

- Compare the current MAR with the physician's prescription/order. The MAR must accurately reflect the physician's order, identifying the correct medication, dosage, frequency, time/time of day (if needed), administration method (i.e., p.o., topical, via nebulizer, etc.), and any other special instructions (i.e., 1/2 hour before meals, crush, open capsule and add to food, with vital signs or blood glucose levels in certain range, etc.). If concerns, review/compare for previous months. This will also inform decisions for Standard 2a-5 below
- Review medications at the site in comparison to current physician's orders. Verify that all prescribed medication is available on-site in the correct dosage and form as prescribed and needed by the person. Medication should be in intact original medication packaging (i.e., bottle, blister pack) and correctly labeled per the order.
- Review MARs for the past 6 months:
    - Verify that medication was administered as ordered, or if not administered, there is appropriate justification/explanation documented.
    - Be alert to irregularities in documentation such as blanks spaces where administration should be documented.
    - Ensure that when a medication is not administered, there is documentation of the non-administration on the MAR. Most often this is indicated by a circle in the space where initials would indicate administration, with explanatory note on the back of the MAR. Non-administration may be due to an error or omission. However, there may be acceptable reasons for MARs to reflect non-administration, such as family visits (where the family administered the medication); a physician's instruction to hold a medication if vitals are not within certain parameters; or refusals by the individual. (Note: Persistent problems with administration should be reviewed and addressed.)
    - If medication/treatment orders include special instructions, such as pulse or B/P or BGL checks prior to administration, verify that the instruction was implemented and documented. Medication administration is incorrect if special instructions required prior to administration were not carried out, as ordered. When bowel medications are prescribed, bowel tracking is required (see below).
    - PRNs: Medications ordered "as needed" based on whether certain symptoms or conditions are evident for the individual require review for correct administration. It is necessary to verify that:
        - PRN medication is administered when the need for which it is prescribed is present.
        - PRN medication is administered only when necessary, based on the PRN order.
        - There is documentation supporting the need for administration of the PRN medication.

- BM tracking is required for any individual prescribed routine or PRN bowel regularity medications. Bowel tracking is necessary to determine the effectiveness of bowel regimens that may, in addition to medication include dietary, fluid, and activity interventions. A PONS may be in place consolidating all interventions related to bowel management.
- When PRN bowel management medications are prescribed, the BM tracking record must be reviewed to verify that medications to be administered in the absence of BMs are administered when required (i.e., administer on 3rd day without BM) and not administered when not required.
- BM tracking records should also be reviewed for bowel regularity and provision of appropriate health care if issues are identified. This will be further addressed in standard 2a-11, below. If these records are not kept and used to effectively manage bowel irregularity, serious health consequences, even death, may occur. Poorly controlled constipation can contribute to pain, anxiety, and poor appetite.
- Medications should not be pre-poured, meaning that they should only be removed from packaging to prepare for administration, at the time of administration. If small cups of pre-poured medications are observed in the med cabinet or med area, survey staff should ask questions about the practice (how, why, and how often). Pre-pouring creates risk for errors, especially administration of medication to the wrong person.
- The facility/agency must implement procedures to report and review medication errors when/if they occur.
- Review medication error reports. Be alert to trends in staff making errors and see if corrective action is taken to address the errors. Also be alert to trends involving particular medications or orders that seem to result in errors and trends involving certain med pass times when more errors occur. Determine whether the RN is aware and corrective/preventive actions are taken.
- It is not mandatory for survey staff to observe a medication pass, but survey staff may choose to do given concerns about proper administration that cannot be verified in other ways.
- For an individual who self-administers medications, review records and interview the individual and staff, including the RN, to ensure that oversight provided is sufficient to address the individual's needs and to ensure that the individual self-administers medications in accordance with physicians' orders.

Determine the standard is MET if:

- There is evidence of correct administration of routine and PRN medications as prescribed and needed by individual(s).
- Any medication errors that do occur are reported, documented, and competently addressed.

Determine the standard is NOT MET if any of the following are present:

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

2a-5 Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
633.17(b)(3)(i)-(iv) Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; (iii) time and date of administration; and (iv) signature or initials of the party who supervised, assisted or administered the medication; or of the person who independently self-administered medication. If initials are used, there is a corresponding signature sheet.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.17(b) (4)(i)-(ii) there is a record as specified in paragraph (3) of this subdivision; or (ii) for persons who are capable of independent self-administration, there is documentation of the supervision provided by the agency/facility to ensure that the person is taking medication as required.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BGL: Blood glucose level MAR: Medication Administration Record O2: Oxygen P.O.: *Per os* (by mouth) PRN: *Pro re nata* (as needed) **DISCUSSION** As needed for clarification • RN

DOCUMENTATION REVIEW
Mandatory:
- MAR
- Copies of doctor's orders (may be handwritten or electronic)

OBSERVATION
N/A

This standard is meant to determine that MARs contain accurate information about the orders, and accurately and clearly document administration.

Review for at least one person.

Review for the following:
- Compare the current MAR with the physician's prescription/order. The MAR must accurately reflect the physician's order, identifying the correct medication, dosage, frequency, administration method (i.e., p.o., topical, via nebulizer, etc.) and any other special instructions (such as to crush, open capsule and add to food, etc.). If concerns, review/compare for previous months. This will also inform decisions for standard 2a-4, above.
- The MAR must include the following:
  - name of person receiving the medication
  - name of medication, dosage, and route of administration
  - time/time of day and date of administration
  - signature of the party who supervised, assisted or administered (or initials that correspond to those on a signature sheet)
- Review the MAR for accuracy, legibility, and the absence of illegible cross-outs, erasures, or use of "white-out".
- There should be documentation of the effectiveness of a PRN medication following its administration to the person.

Determine the standard is MET if all of the following are present:
- The physician's order is correctly transcribed to the MAR.
- Documentation necessary to evidence administration is present & legible including pre-assessment (vital signs, O2 levels, BGLs, etc.).
- Effectiveness of PRN medications is documented, where needed.

Determine the standard is NOT MET if any of the following are present:

- The physician's order is incorrectly transcribed to the MAR.
- Documentation necessary to show the medication was administered is absent/incomplete/illegible.
- Documentation of physician ordered pre-assessment is not consistently present.
- Effectiveness of PRN medication was not documented following administration where needed.

2a-6 Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
633.17(a)(17)(iii)(a)-(g) For the safety of the people residing in or attending a facility and as a support to those staff who have medication administration related responsibilities, there shall be information specific to each person on all medications to be administered to that person while at or under the supervision of the facility and its staff. The sponsoring agency shall ensure maintenance of this information for people in family care homes and provide the information to the family care provider. For each medication a person is taking, this information shall include: (a) name of person taking the medication; (b) name of medication; (c) directions with regard to correct dose, form, method/route of administration, time of administration; (d) start and stop dates, if applicable; (e) expected therapeutic effects for the person taking the medication; (f) possible side effects to the person taking the medication; and (g) name of prescribing, ordering or approving practitioner
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.17(b)(9)(i)-(vii) OPWDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person, the information is available to staff or the family care provider, and it includes: (i) name of person taking the medication; (ii) name of medication; (iii) directions with regard to correct dose, form, method/route of administration, time of administration; (iv) start and stop dates, if applicable; (v) expected therapeutic effects for the person taking the medication; (vi) possible side effects to the person taking the medication; and (vii) name of prescribing, ordering, or approving practitioner.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

633.17(a)(13)(iv)
Nothing in this section shall prevent a person residing in a supportive community residence or a family care home, who is capable of independent self-administration of medication, from obtaining and using over-the-counter medication at his or her discretion. However, the individual shall be given appropriate guidance relative to obtaining and self- administering over-the-counter medications.

Program Class/Type:
CR/Supportive Community Residence

ACRONYMS
MAR: Medication Administration Record
OTC: Over-the-counter
RN: Registered Nurse

DISCUSSION
As needed for clarification

- RN
- Direct support staff
- Individuals receiving services who are self-medicating

DOCUMENTATION REVIEW
Mandatory:
Review document(s) pertaining to each medication prescribed to each individual receiving services. Common methods are:

- Medication Information Forms
- Inclusion on the MAR
- Pharmacy med information sheet may be used only if adapted and supplemented to provide only the information specific to the individual. Reference to a generic medication formulary book is not acceptable

OBSERVATION
N/A

Review for at least one person:

Easily accessible, individual-specific, written information on intended effects and possible side effects for all prescribed medications, including OTC, must be available to the staff. For example, if a medication may or is known to cause drowsiness in a particular person, that should be noted here for the staff to respond accordingly. This information must be available for all medications prescribed for the person, including PRNs and over the counter medications.

An individual who resides in a supportive community residence or and is capable of independent self-administration of medication may obtain and use OTC medication at his or her discretion. However, the facility must provide the individual with appropriate guidance relative to obtaining and self- administering over-the-counter medications.

Determine the standard is MET if:

- Staff has access to required person-specific information on medications prescribed for individuals receiving services.

Determine the standard is NOT MET if:

- Medication information is limited to general drug information that is available to the public from the pharmacist or drug manufacturer; or
- There is a pattern of missing drug information on medications prescribed for individuals receiving services.

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

633.17(a)(19)(ii)(a)-(e)

Safe, secure, appropriate, and adequate storage space shall be provided.

(a) Other than in a supportive community residence or a family care home, medication shall be kept in a secure, locked storage area.

(b) Persons who are capable of independent self-administration of medication may have their medication stored so as to be personally accessible to themselves and staff who are currently certified to administer medication, those who are health care professionals and family care providers, or their substitutes, if such a procedure does not expose other residents to harm.

(c) Other than in a supportive community residence or a family care home, medication stored in a refrigerator containing food shall be placed in a separate locked container clearly marked to indicate that it contains medication.

(d) Other than in a supportive community residence [or] a family care home, or as specified in clause (e) of this subparagraph, all medication packaged and labeled by the issuing pharmacy as a "controlled substance," and syringes and needles, shall be kept in secure, double-locked storage unless all persons in the residence are capable of independent self-administration of medication, and such a procedure does not expose other residents to harm. In family care homes, controlled substances and syringes and needles shall be kept in locked storage.

(e) In all facilities other than supportive community residences, when all persons in the residence are capable of independent self-administration of medication, a controlled substance, syringes, and needles shall be stored in a locked area or container so as to be accessible only to the person for whom it was prescribed, staff who are currently certified to administer medication or who are health care professionals, and family care providers or their substitutes.

Program Class/Type:

Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS

IRMA: Incident Reporting and Management Application
RN: Registered Nurse

DISCUSSION

Mandatory:

- Direct support staff

As needed:

- Individuals who self-administer medications

DOCUMENTATION REVIEW
As needed:
The following may reveal practices that evidence inadequate medication security:

- Review of medication error documentation
- IRMA/Incident Reports
- Communication logs

OBSERVATION
Mandatory:

- Observe medication storage area
- Observe as opportunity presents, access to and security of medications

In all facilities where medications are administered, medications must be:

- Maintained in their original containers: prescription medications in the pharmacy labelled containers they came in and over-the-counter medications in the original containers labelled by the manufacturer.
- Stored in a manner that does not expose individuals receiving services to harm.

However, there are additional storage and security requirements that are not the same in every type of certified facility.

In facilities other than supportive community residences, the following additional storage and security requirements apply:

- Medications must be stored in adequately tamperproof, locked, safe, and secure space.
- Keys to medication storage areas must only be available to staff who are certified to administer medications or licensed medical professionals.
- Medication requiring refrigeration must be:
  - Stored in a locked refrigerator that is not used for food storage or any other purpose; or
  - Stored in a locked receptacle labelled as a medication container inside a refrigerator that is used for other purposes.
- Medication packaged and labeled by the issuing pharmacy as a “controlled substance” and syringes and needles must be:
  - Stored in a secure, double-locked area unless all individuals in the residence are capable of independent self-administration of medication.
  - Stored in a secure, single-locked area when all individuals in the residence are capable of independent self-administration of medication. In this circumstance, the controlled substance, needles, or syringes must be accessible only to the individual for whom it was prescribed or staff who are certified to administer medication or licensed medical professionals, and the facility must ensure that the storage arrangement does not expose other residents to harm.

- Medication may be stored in personally accessible space for individuals who are capable of independent self-administration of medication but must be stored in a manner that is accessible to staff currently certified to administer medications and health care professionals, if such a procedure does not expose other residents to harm.

In all facilities other than supportive community residences, when all individuals in the residence are capable of independent self-administration of medication, a controlled substance, syringes, and needles must be stored in a locked area or container so as to be accessible only to the person for whom it was prescribed and staff who are currently certified to administer medication or who are health care professionals.

Determine the standard is MET if:

• Medications are stored in a manner that does not expose individuals receiving services to harm.
• Where applicable, security of access to the medication storage area/cabinet is maintained. Keys are held by staff who are certified to administer medications (and/or others authorized to administer medications) and the RN or keys are secured in an in a manner that is not accessible to others who are not authorized to administer medications. Where combination locks are used for access to medication storage areas or to keys to the storage areas, the combinations are known only to parties authorized to access the medications.
• Controlled substances and syringes/needles are secured in locked storage as required for the facility.
• Where applicable, medication storage areas are observed to be secured, locked, and inaccessible individuals and other parties who are not authorized to access them.

Determine the standard is NOT MET if any of the following are present:

• Medications are stored in a manner that exposes individuals receiving services to harm.
• Where applicable, medication cabinets are left open and unattended, unlocked, and/or accessible to individuals and parties not authorized to access medication or medication is left unattended by parties authorized to administer medication.
• Where applicable, keys or combinations meant to secure medications are accessible to parties not authorized to access medication.
• Where applicable, parties who are not authorized to access medication are observed to access med storage rooms/cabinets.
• Controlled substances and syringes are not secured in locked storage where at least one individual receiving services is not capable of self-administration.
• There are repeat incidents involving failure to properly secure medications.

2a-8 Medication that is discontinued or outdated is not retained at the site.
633.17(b)(13)- (14) OPWDD shall verify that there are no outdated medications in designated medication storage areas in the facility. (14) OPWDD shall verify that there are no discontinued medications in designated storage areas in the facility, unless a prescribing practitioner has specifically instructed that a medication be retained for possible future use; or the agency/facility, under the Department of Health dispensing license, is waiting for authorization from the Department of Health to destroy the medication.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS MAR: Medication Administration Record RN: Registered Nurse **DISCUSSION** As needed • Direct support staff re: handling of discontinued and outdated medications and treatments • RN **DOCUMENTATION REVIEW** Mandatory: • MAR • Medication orders As Needed: • Physician’s consults **OBSERVATION** Mandatory: • Review of medication storage area(s)

Review for at least one person:

- Outdated medication refers to medications and treatments that have an expiration date, use by date, and/or discard date. Take note of such dates on medication bottles, tubes, boxes, etc.
- Discontinued medication/treatments refer to medications /treatments that were discontinued (stopped) by the physician or prescribing practitioner or were prescribed for a time-limited period and that period has ended. Current medication prescriptions/orders and accurate MARs are references to identify medications that are currently needed by the person. Discontinued medications may be retained on site if there are specific instructions from a prescribing practitioner to do so.
- If outdated or discontinued medications/treatments are discovered, discuss this with the staff and RN, if needed, to determine agency procedures for disposal and the staff's understanding of the procedures.

Determine the standard is MET if ANY of the following are present:

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

Determine the standard is NOT MET if ANY of the following are present:

- There is a pattern of retention of discontinued/outdated medications/treatments as evidenced by discovery on site (pattern described as anything other than "anomalies" described above).
- There are outdated or discontinued medications present and staff does not know what to do with medications/treatments when they are discontinued/outdated.
- There are outdated or discontinued medications present and agency processes do not address or do not adequately address removal/disposal of discontinued/outdated medications/treatments.

2a-9 Used needles and syringes are disposed of in puncture resistant containers.
633.17(a)(20)(iii) Needles and syringes. All needles and syringes are to be placed in puncture resistant containers immediately after use. When filled, the container should be taken or sent to an approved site for incineration. The disposal shall be documented.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS RN: Registered Nurse **DISCUSSION** As Needed • RN as needed • Direct support staff **DOCUMENTATION REVIEW** N/A **OBSERVATION** If applicable (needles & syringes are on sight even infrequently for vaccines, bloodwork, etc.), observe disposal receptacle: • All needles and syringes are to be placed in a leak proof, puncture resistant containers immediately after use. The container should be designed to prevent easy removal of the items from the container. • When filled (approximately 2/3 full by accepted practice), the container should be taken or sent to an approved site for incineration. Discussion with the staff about this process and policy/procedure review should validate compliance. **Determine the standard is MET if the following are present:** • There is an appropriate disposal container for needles/syringes. • Full containers are not on site for extended time periods. • Needles/syringes are disposed of properly using disposal container or there is no evidence of inappropriate disposal.

Determine the standard is NOT MET if ANY of the following are present:

- Needles/syringes are not disposed of properly.
- Needles/syringes are not in an appropriate container.
- Full containers are retained on site for extended periods of time.

Select N/A if:

- No needles or syringes are used at the facility.

2a-10 The site ensures that individuals access professional health care services in accordance with their needs, physicians' recommendations, and informed choice.

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

Program Class/Type:
IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School

633.10(a)(2)(iii)
For persons in a residential facility, at least a medical/dental evaluation by a physician or registered physician's assistant addressing the person's need for an examination or specific medical/dental services; or by a dentist for dental services. The determination of the basis for such evaluation (e.g., appraisal of the person through records and previous contacts) shall be that of the qualified professional.

Program Class/Type:
IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS
IRMA: Incident Reporting and Management Application
PRN: *Pro re nata* (as needed)
RN: Registered Nurse

DISCUSSION
As needed
- RN
- Direct support staff
- Individuals receiving services

DOCUMENTATION REVIEW
Mandatory
- Request all records the facility uses to document evaluation, planning, provision, and receipt of health care services. Agencies have different mechanisms. This may include physician consults, PRN notes, nursing notes, Individual progress notes
- Communication log
- PRN notes as needed

• IRMA/Incidents Reports

OBSERVATION
As needed

This standard is intended to verify that individuals see a doctor/practitioner/dentist/specialist when needed and recommended, and undergo recommended testing, evaluation, blood work as needed.

Review for at least one person:

- Through record review, discussion, and observation, verify that the individual is supported to access medical assessment and treatment for acute and emerging illness and symptoms.
- Through record review and discussion, ensure that the individual is attending all required and recommended appointments for routine care and monitoring and for treatment and monitoring of chronic conditions, as needed. This includes appointments with primary physician, nurse practitioner, physician's assistant, specialists (as needed), dentist, and clinicians (as needed).
- Verify that recommendations made by health care practitioners for appointments with specialists, lab work, and diagnostic tests are completed and implemented.
- If an individual is not accessing the necessary health care services, take action to determine contributing factors (look at facility tracking and monitoring of needed appointments, scheduling practices for needed appointments and assigned responsibility, RN oversight, etc.).
- Cancelled appointments by practitioner, individual, or facility are documented (with reasons for cancellation noted) and are rescheduled.
- Consider whether the individual is documented, reported, or observed to have a chronic condition that is not improving. Review whether advocacy for health care and further assessment is occurring.

NOTE: An individual may make an informed choice to refuse an appointment, treatment, evaluation, medical test, etc. If the reason a person is not accessing needed profession medical services routinely is reported as due to refusal:

- Speak to the individual (and the individual's advocate, as needed) to determine that this is an informed choice and that the individual received clear information about health issues and understandable information about the risks and benefits of recommended medical oversight and services.
- Speak to facility RN or other health care professionals and review documentation regarding agency actions to review risks, discuss alternate solutions, and communicate clearly with the individual. This should include a review of the risk to the person presented by refusal and efforts taken to educate the individual regarding health issues and need for services.

Determine the standard is MET if two of the following are present:

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

Determine the standard is NOT MET if:

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

2a-11 The site ensures that in-home routine support/care necessary for individuals' health needs is provided in accordance with their service plans.
633.17(a)(17)(iii)(a)-(g) For the safety of the people residing in or attending a facility and as a support to those staff who have medication administration related responsibilities, there shall be information specific to each person on all medications to be administered to that person while at or under the supervision of the facility and its staff. The sponsoring agency shall ensure maintenance of this information for people in family care homes and provide the information to the family care provider. For each medication a person is taking, this information shall include: (a) name of person taking the medication; (b) name of medication; (c) directions with regard to correct dose, form, method/route of administration, time of administration; (d) start and stop dates, if applicable; (e) expected therapeutic effects for the person taking the medication; (f) possible side effects to the person taking the medication; and (g) name of prescribing, ordering or approving practitioner.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BM: Bowel movement IPOP: Individualized Plan of Protective Oversight IRMA: Incident Reporting and Management Application MAR: Medication Administration Record OT: Occupational therapy PONS: Plan of Nursing Service PT: Physical therapy RN: Registered Nurse ST: Speech therapy **DISCUSSION**

As needed
- RN
- Individuals receiving services
- Direct support staff

DOCUMENTATION REVIEW
Mandatory, where applicable
- Individual health care records
- MAR
- PONS
- IPOP
- Clinical assessments (i.e., OT, PT, ST)
- IMRA/Incident Reports
- Life Plan
- Training records specific to individuals' health care needs

OBSERVATION
As needed:
- As possible during observation, ascertain whether health care interventions are provided in accordance with service implementation plans

Review for at least one person:
This standard is intended to verify that individuals receive needed health care interventions and/or are supported to attend to their own routine care needs.

Where possible, observe for implementation of health care supports, such as dietary modifications, application of splints or hearing aids, or implementation of other physician-ordered or clinician-recommended health care interventions.

Verify that the individual's need for routine health care is documented and there are written instructions on how and when to provide the supports the individual needs. Sources for this information may include physician visit reports and nursing, dietary, and other clinical assessments, and instructions for implementation may be found in plans of nursing services, medication administration and treatment records, and other care plans.

Service implementation plans and service documentation instructions need to be written in a manner that is clear and understandable to the staff.

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

Through documentation review, discussion, and observation, determine if the individual is maintaining or improving in health. If an individual's health is declining, determine if action was taken to modify or seek additional services. Ask the staff about the individual's health care needs. And ask the individual and/or the individual's advocate if they believe competent and desired health care supports are being provided to assist the individual to feel well.

Provision of health-related services must be documented in accordance with service implementation plans. Review to determine if the individual receives ordered and/or needed interventions and support. Such care and support may include, but not be limited to the following:

- Contact with the RN or physician is made in accordance with a service plan or PONS as warranted by the person's health, conditions, vital sign parameters.
- Bowel management regimens are implemented correctly.
- BM tracking records kept for people with histories of constipation and/or who receive bowel management medication(s). BM records are monitored for "regularity" and action is taken when needed based on those results. Note that poorly controlled constipation can contribute to pain, anxiety, poor appetite, and serious health concerns, even death.
- Oxygen is administered as ordered.
- Blood pressure is monitored as ordered.
- Assistance is provided with equipment, braces, hearing aids, glasses, needed by the person.
- Dietary interventions are followed.
- Diabetic care and monitoring are provided per PONS and medical orders.
- Care and support are provided following injuries, surgery, or hospitalization.
- Skin integrity care and monitoring are provided as needed.
- Colostomy care or catheterization are implemented as ordered.

If omissions in care are noted, review training records to ensure that the staff was trained to implement needed supports.

Determine the standard is MET if:

- Documentation, observation, and discussion indicate the individual received necessary care and supports to address health care needs.

Determine the standard is NOT MET if:

- Documentation, observation, and discussion indicate the individual did not receive necessary care and supports to address health care needs.

Section 3: Personal Funds
3-1 Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
636-2.4(a)(1) a) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan:(1)The setting must be integrated and support full access of individuals receiving HCBS to the broader community. It must support opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community with the same degree of access as the broader community
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Day Hab
633.15(k)(1) Present allowance funds shall be made readily accessible to the person.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS ATM: Automated Teller Machine **DISCUSSION** Mandatory • Individuals receiving services • Direct support staff • Management staff **DOCUMENTATION REVIEW** Mandatory • Personal expenditure ledgers As needed: • Recreation/inclusion activity logs

OBSERVATION
Mandatory
- Cash on hand at the residence

Review one individual's personal expenditure ledgers for the last six months and cash on hand for the individual on the day of the visit.
- The amount of funds available should be in accordance with individual's routine expenditure pattern and/or in accordance with requests from the individual or from the staff or the individual's advocate on the individual's behalf.
- Review ledgers and cash on hand to determine if funds are kept at the residence in order to meet the individual's day-to-day and incidental needs and preferences.
- If agency policy is to keep minimal funds on-site, but it is compensated with procedures to access funds at an ATM as part of the activity or make payment for activity or purchase using a debit card, this can also meet the intent if having personal allowance consistently available. In this case verify that the debit account is maintained with adequate funds.
- Through interviews with staff and the individual, verify that sufficient funds are available when the individual wants or needs funds and verify that the individual is satisfied with the effectiveness of the home's money disbursement system.
- It is not the expectation that funds be immediately at hand for major expenditures, but rather that there is enough personal allowance money to allow for impromptu recreational activities, dining out, and shopping, etc.
- Reports of repeat occasions of limited or no funds on-site would require further inquiry into the agency practices for distribution of personal allowance funds to individuals.

Determine the standard is MET if two of the following are present:
- Ledgers and cash on hand indicate adequate funds are maintained at the residence to allow for routine purchases and activities.
- If applicable per agency policy/practice, debit accounts maintain sufficient funds to allow for routine purchases and activities by the individual.
- The individual reports that money is available for routine and spontaneous expenditures, and gives examples, if applicable.
- The staff reports that there are adequate funds for the individual for routine and spontaneous purchases and activities and can give examples of such expenditures.
- Funds are low, but there is evidence that additional funds are requested and expected on site/available within 24 hours.

Determine the standard is NOT MET if any of the following are present:
- Funds on site are low and do not appear adequate for the individual's routine weekly purchases and spontaneous requests/purchases/activities.
- If applicable per agency policy/practice, debit accounts have insufficient funds to allow for routine purchases and activities by the person.

- If there is sufficient money available at time of review, but there appears to be a pattern of not ensuring that sufficient funds are maintained at the residence:
  - Ledger review indicates a pattern of time lags before personal funds are replenished.
  - The individual reports examples of occasions when participation in an activity or ability make a small purchase were limited because funds were not available.
  - The staff report examples of occasions when the individual could not participate in activity or make a small purchase because funds were not available.

Section 3a: Personal Funds
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-1 An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + $20.
633.15(h)(4)(iii) When an agency or sponsoring agency has the responsibility of overseeing personal allowance funds, it shall use the following accounts to maintain those funds: (4) Cash accounts - residence. Cash to meet the person's day-to-day and/or incidental needs may be maintained at the place of residence in accordance with agency or sponsoring agency policies and procedures: (iii)The personal expenditure plan shall specify an upper limit on the amount of cash that shall routinely be maintained under the control of staff at the residence for each resident. The routine upper limit specified in the PEP and/or the cash actually maintained at the residence for any individual shall not exceed the monthly personal allowance amount established in section 131- o of the Social Services Law for individuals receiving enhanced residential care (Congregate Care Level III), plus $20. However, this routine upper limit may be exceeded by any amount, so long as documentation of the specific amount, time and purpose for the excess amount is included in the cash account record. Cash in excess of the routine upper limit for each resident may only be held at the residence for a period not to go beyond 14 calendar days.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS PA: Personal Allowance PEP: Personal Expenditure Plan SSI: Social Security Income **DISCUSSION** As needed • Individuals, family, advocates • Direct support staff • Management staff **DOCUMENTATION REVIEW** Mandatory: • Personal Allowance expenditure ledgers • PEP and related materials if maximum is exceeded

OBSERVATION
Mandatory:
- Cash on hand at the home
- Gift card value

Review for the following:
Through a review of ledgers and cash on hand determine if the total amount of cash (see Note* below) does not exceed the Congregate Care Level 3 PA payment plus $20 (except when there is documentation of the purpose and time frame for expenditure of any additional amount). Short term (maximum two weeks) overages may be acceptable for known upcoming expenditures. Ask the facility staff to explain the reason for any overage and agency's expectations for monitoring the amount of cash on hand, and timely return of additional funds to savings should plans for the expenditure change.

*Note: 633.15(h)(5) specifies that, "For the purposes of this section, cash shall mean currency, coins, or anything that can be easily converted into cash (e.g., checks)." Gift cards may also be easily converted to cash.

Minimum SSI benefit amounts may change on an annual basis. Information on the current congregate care minimum SSI personal allowance benefit (along with other benefit information) can be found on the OPWDD website at: Benefit Development Resource Toolkit: Supplemental Security Income | Office for People With Developmental Disabilities (ny.gov).

Determine the standard is MET if all of the following are present:
- Funds on site do not exceed the allowed maximum amount.
- Funds on site exceed the allowed maximum but it is short term and justified based on the planned purchase or use of the excess funds by the person.
- Ledgers for previous months demonstrate that total cash on hand typically does not exceed the maximum amount, or when funds exceed the maximum allowed amount, the presence of additional funds is short term and justified, as required.

Determine the standard is NOT MET if either of the following are present:
- Funds on site exceed the appropriate limit by more than a very small amount, and there is no short-term plan for the excess money.
- Ledgers demonstrate a pattern of cash on hand exceeding allowed maximum without justification.

3a-2 Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
633.15(d)(3) Policies and procedures shall address, at a minimum: security; accountability of staff, volunteers, and/or family care providers; recordkeeping both on paper and electronically; usage; and monitoring of all personal allowance monies and other income of residences received by the agency. Policies and procedures shall include specific measures that will be taken to safeguard cash, including location maintained and restrictions on access.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS IRMA: Incident Reporting and Management Application PA: Personal Allowance PIN: Personal Identification Number **DISCUSSION** Mandatory: • Direct support and management staff for their knowledge and practice of financial safeguards • Individuals, family, and advocates for their satisfaction/concerns with financial safeguards **DOCUMENTATION REVIEW** Mandatory: • IRMA* for any history of financial theft at setting • Personal expenditure ledgers If used by site: • Communication log **OBSERVATION** Mandatory: • Observation of means of storage of and access to cash, debit cards, check books on hand

As needed:

- Observe staff distributing PA funds
- Corrective actions implemented as a result of any theft investigations

Review for the following:

Interview the facility staff and observe routine operations. Verify that money and/or debit cards are only accessible to authorized facility employees in accordance with agency procedures.

Ensure that money/debit cards are securely located and that means of access (i.e., keys, lock combinations) are also secure.

If debit cards are used, ensure that PIN codes are not accessible and are secured separately from the cards.

While there is no specific requirement for the number of people who have access funds, consider who has access to funds and if this has contributed to any poor accounting, mismanagement, or theft.

If any incidents of theft or fiscal mismanagement noted in IRMA* since last review resulted in corrective actions related to security or access, verify implementation of such actions. Reimbursement of funds will be verified and noted in 3a-9.

*Note: A voluntary agency may document a written incident report (rather than enter in IRMA) and a written investigation and review of theft or financial exploitation that meets the definition of a minor notable occurrence in clause 624.4(2)(ii)(a): "… Any suspected theft of a service recipient's personal property (including personal funds or belongings) or financial exploitation, involving values of more than $15.00 and less than or equal to $100.00, that does not involve a credit, debit, or public benefit card, and that is an isolated event."

Also note: Funds include cash (currency, coins), or anything that can be easily converted into cash (i.e., checks, debit cards).

Determine the standard is MET if:

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

Determine the standard is NOT MET if any of the following are present:

- Money, debit cards, or other cash equivalents are observed to be unattended or unsecured.

• Access to funds is available to unauthorized people such as to keys, combination codes, or PIN code to access funds or associated bank accounts. • Ledgers indicate a pattern of missing or unaccounted for money and the agency has not responded with corrective action to change procedures to provide security/safeguarding and accounting for funds.

3a-3 There are ledgers for the accounting of individuals' personal allowance.
633.15(h)(4)(i) When an agency or sponsoring agency has the responsibility of overseeing personal allowance funds, it shall use the following accounts to maintain those funds: (4) Cash accounts - residence. Cash to meet the person's day-to-day and/or incidental needs may be maintained at the place of residence in accordance with agency or sponsoring agency policies and procedures: (i)There shall be an up-to-date person-specific cash account ledger card or equivalent maintained at the residential facility that documents the receipt, disbursement, and balance of all cash.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS PA: Personal Allowance **DISCUSSION** N/A **DOCUMENTATION REVIEW** Mandatory: • Personal expenditure ledgers **OBSERVATION** N/A This standard requires that there is a ledger/means to ledger and ledgering is evident. This standard is not meant to comment on the accuracy or sufficiency of the ledgering/accounting for funds. That is reviewed elsewhere. Review on-site documentation for accounting of personal allowance. Verify that there are means to document PA activity on separate ledgers for each individual. Some agencies use electronic spreadsheets instead of paper ledgers. This is acceptable and simplifies accurate computations.

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

Determine the standard is MET if:

- Paper or electronic ledgers are kept and maintained consistently.
- If debit cards are used, there are means to record/monitor deposits and withdrawals consistently.

Determine the standard is NOT MET if either are present:

- Paper or electronic ledgers are not kept, not available/missing, or there are gaps in maintenance of ledgers (i.e., missing for some months).
- If debit cards are used, there are no means to record/monitor deposits and withdrawals consistently.

3a-4 The ledgers clearly document receipt of funds on site.
633.15(h)(4)(i) When an agency or sponsoring agency has the responsibility of overseeing personal allowance funds, it shall use the following accounts to maintain those funds: (4) Cash accounts - residence. Cash to meet the person's day-to-day and/or incidental needs may be maintained at the place of residence in accordance with agency or sponsoring agency policies and procedures: (i)There shall be an up-to-date person-specific cash account ledger card or equivalent maintained at the residential facility that documents the receipt, disbursement, and balance of all cash.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS PA: Personal allowance **DISCUSSION** N/A **DOCUMENTATION REVIEW** Mandatory: • Personal expenditure ledgers • Agency managed savings and banking records **OBSERVATION** N/A This standard verifies accurate ledgering. Review on-site documentation. Verify that the receipt of personal funds into the site is documented on each individual’s ledger as a deposit. This may include PA funds from agency or bank-maintained accounts, change from money spent for recreation or personal purchases, monetary gift, paychecks, and other checks.

Gift cards and their values should also be documented on a ledger or accounted for in another manner. This documentation should occur at the time of receipt of money and not be delayed to a later time.

Ledger entries must be clearly written and accurate as to the amount and type of each transaction.

Ledger entries must be accurately dated, include a brief description of each transaction, and identify the exact amount of funds deposited and the person responsible for each transaction/ledger entry.

Banking records must be reviewed to verify that any funds transferred from a savings or other account where PA funds are maintained to in-house funds are accurately accounted for. In–house ledgers (cash-on-hand or debit card) must be checked against the savings records for accuracy and to reconcile balances. Review a minimum of three months' savings records, and expand the review, when necessary, to ensure personal allowance funds can be accounted for as intended.

Note: Funds include cash (currency, coins), or anything that can be easily converted into cash (i.e., checks, debit cards).

Determine the standard is MET if:

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

Determine the standard is NOT MET if:

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

3a-5 The ledgers clearly document disbursement of funds including their purpose for the individual.
633.15(h)(4)(i) When an agency or sponsoring agency has the responsibility of overseeing personal allowance funds, it shall use the following accounts to maintain those funds: (4) Cash accounts - residence. Cash to meet the person's day-to-day and/or incidental needs may be maintained at the place of residence in accordance with agency or sponsoring agency policies and procedures: (i)There shall be an up-to-date person-specific cash account ledger card or equivalent maintained at the residential facility that documents the receipt, disbursement, and balance of all cash.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS MMA: Money Management Assessment PA: Personal Allowance PEP: Personal Expenditure Plan **DISCUSSION** N/A **DOCUMENTATION REVIEW** • Personal expenditure ledgers • MMA • PEP **OBSERVATION** As needed: • Purchased items (i.e., TV set or computer) are available to individual whose funds were used to purchase the items This standard verifies accurate ledgering of PA Review on-site documentation.

Each withdrawal of personal funds from the house account must be documented, including the date of withdrawal. This documentation should occur at the time of disbursement of money.

- For example, if $50 is withdrawn for shopping, the withdrawal and purpose should be documented immediately upon disbursement, rather than waiting until after the funds are spent. The $50 should be entered as a withdrawal, with description of purpose and following purchases, any change should be entered as a deposit of remaining funds along with description of purchases (deposit) of funds (see standard 3a-4 above).

The purpose for the withdrawal (i.e., personal spending allowance, dinner out, craft supplies, clothes shopping, football game tickets, gift for grandma, day program spending) must be documented on the individual's ledger card for each withdrawal. The residential program agency is also responsible to ensure that money disbursed to day program is accounted for in the same manner on a quarterly basis.

*Note: Cash may be disbursed to an individual for independent personal spending when the amount disbursed is in keeping with the amount the individual is capable of managing in accordance with the individual's MMA. These disbursements may be identified as personal spending.

Gift card withdrawals and any associated benefits and usage should also be tracked on a ledger or accounted for in another manner, such as maintaining documentation and receipts for each expenditure. Such documentation must include the balance of funds remaining on the card.

Use of sub-ledgering is allowable. The system should clearly document the exchange of funds and the purpose. This is often used to ensure money is accessible to individuals for routine purchases at all times. For example: A person may have $160 of PA funds in a safe or other secured area. The staff may place $50 in a lock box (or other secure location) accessible to another staff over the weekend. The individual's ledger shows $50 withdraw to the lock box. The lock box sub-ledger shows a $50 deposit. When any portion of the $50 is accessed for recreation activities over the weekend, the amount and purpose of the withdrawal is documented on the sub-ledger. Both ledgers become part of the documentation demonstrating the accounting for the funds.

Ledger entries must be clearly written and accurate as to amount and type of transaction.

Ledger entries must be accurately dated, include a brief description of each transaction, and identify the exact amount of funds withdrawn/disbursed and the staff responsible for each transaction/ledger entry.

Banking records should be reviewed to verify that funds transferred from bank account to in-house funds or from in-house funds to bank account are accurately accounted for. In-house ledgers (cash-on-hand or debit card) should be checked against the savings records for accuracy and to reconcile the balances.

To verify a large purchase, such as a TV set or computer, observe for the item in the individual's room and interview staff if its presence is not evident.

Note: Requirements for documentation of expenditures with receipts are addressed in standard 3a-8, below

Determine the standard is MET if:

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

Determine the standard is NOT MET if:

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

3a-6 Ledgers accurately reflect the total amount of funds available to the individual on site.
633.15(h)(4)(i) When an agency or sponsoring agency has the responsibility of overseeing personal allowance funds, it shall use the following accounts to maintain those funds: (4) Cash accounts - residence. Cash to meet the person's day-to-day and/or incidental needs may be maintained at the place of residence in accordance with agency or sponsoring agency policies and procedures: (i)There shall be an up-to-date person-specific cash account ledger card or equivalent maintained at the residential facility that documents the receipt, disbursement, and balance of all cash.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS ATM: Automated Teller Machine MMA: Money Management Assessment PA: Personal Allowance PEP: Personal Expenditure Plan **DISCUSSION** N/A **DOCUMENTATION REVIEW** Mandatory: • Personal expenditure ledgers As needed: • PEP • MMA **OBSERVATION** Mandatory: • Count of cash by staff with access to individuals' funds

Review for the following:
Ask the staff to count all the personal allowance funds currently on-site in your presence. Also ask the staff to show evidence of anything that can be converted to cash, such as checks, gift cards, ATM/debit cards. Verify that the total of all cash in the residence matches the amount indicated as the total current balance on the ledger.

Sometimes there is more than one ledger for a person. The site may keep one to record general transactions and a sub-ledger (see guidance for standard 3a-5, above) to record day-to-day activities with the cash on hand. Cash should be counted and reconciled with each ledger.

Some agencies use electronic spreadsheets instead of paper ledgers. The spreadsheets are set-up to automatically calculate the personal allowance balance after each transaction. The balance is also carried over from month to month, which helps eliminate errors.

Funds that an individual has in his/her possession and manages independently in accordance with his/her money management assessment are not to be counted to determine compliance with this standard.

Note: 633.15(h)(5) specifies that, “For the purposes of this section, cash shall mean currency, coins, or anything that can be easily converted into cash (i.e., checks).” Gift cards and ATM/debit cards may also be easily converted to cash.

Determine the standard is MET if:

- Total cash on site per count is same amount as the balance documented on ledgers.
- Total cash on site per count is not same amount as the balance documented on ledgers, but discrepancies are resolved with correction of arithmetic errors during the review visit.

Determine the standard is NOT MET if:

- Total cash on site per count is different from balance amounts documented on ledgers and discrepancies are due to more than simple arithmetic errors.

3a-7 Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
633.15(p)(4) An agency or a sponsoring agency shall not: (4) demand, require, beneficially receive, or contract for all or any part of anyone's personal allowance to pay for expenses or supplies and services which the agency is mandated to provide in accordance with Subpart 635-9 of this Title.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS CR: Community Residence ICF(/DD): Intermediate Care Facility (for the Developmentally Disabled) IRA: Individualized Residential Alternative PA: Personal Allowance **DISCUSSION** Mandatory • Individuals, to verify funds are spent only on preferred/chosen items and activities, and not items/expenses the facility/agency is responsible to pay for • Facility staff to verify their knowledge of allowed use of PA funds As Needed: • Agency staff if any concerns arise regarding use of PA funds for general goods/services **DOCUMENTATION REVIEW** Mandatory: • Personal expenditure ledgers **OBSERVATION** As needed: • Observe to see that certain items purchased with the individual’s funds were appropriate personal allowance expenditures

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

Subpart 635-9 identifies expenses, supplies, and services the facility/agency is expected to pay for as follows.

In Non-ICF residences, the following requirements apply:

- 635-9.1(a)(1) Intermediate care facilities for persons with developmental disabilities (ICF/DDs), community residences including Individualized Residential Alternatives (IRAs), private schools, and specialty hospitals shall assume the cost of:
  - (i) Any item or service for which local, State, or Federal funds are provided; or for which reimbursement is made through a rate, fee, or grant-in-aid.
  - (ii) All staff personal service costs and staff expenses incurred in the provision of services and activities which are specified in a person's plan of service or part of the facility's recreation program.
  - (iii) Physical plant maintenance and improvements.
  - (iv) All utilities including heat, light, power, water, and sewer.
  - (v) Phone service. Persons at the facility shall not be charged for local phone calls. Long distance calls made by a person residing in the facility may be paid for from his or her personal allowance.
  - (vi) The purchase, operation, and maintenance of all equipment and furniture necessary to operate the facility in accordance with regulations of the applicable facility class, and any other applicable regulations.
  - (vii) Special equipment necessary to meet the developmental needs of persons at the facility.
  - (viii) Items required to meet the special, clinically determined, individual needs of persons where such items are costly and/or are used on an ongoing basis (e.g., adult diapers) and are not covered by Medicaid, Medicare, or other health insurance.
  - (ix) Environmental adaptions made to the facility to meet the needs of persons at the facility.
  - (x) Three well-balanced meals, or equivalent, and an appropriate number of snacks and any special foods required to meet the nutritional needs of persons in the facility. An exception to the meal/snack requirement is made where a person attends a day program which receives specific funds to cover the cost of a specified daily meal and/or snack. An exception to the meal/snack requirement is also made where, and to the extent that, a person and the community residence or IRA in which the person lives agree that the person will pay for, obtain and prepare some or all of his or her own food.
  - (xi) Basic bedding and towels (see glossary).
  - (xii) The purchase, operation, and maintenance of all laundry equipment and supplies, as well as laundromat and laundry service charges and the cost of basic dry cleaning (see glossary).
  - (xiii) Hygiene supplies and services.
    - (a) ICF/DDs and specialty hospitals are responsible for all basic grooming and personal hygiene items and services. This includes, but is not limited to toilet paper, tissues, soap, deodorant, shampoo, paper cups, band-aids, and other first aid supplies, as well as such personal items as shaving equipment, toothbrush, comb and brush, haircuts, and sanitary napkins.

The exception to this would be when a preference for personal selection is indicated by a resident (see section 633.15[c][5] of this Title).
- (b) Community residences and private schools are responsible for those grooming and personal hygiene items customarily shared by a family. This includes, but is not limited to, toilet paper, tissues, soap, shampoo, a supply of sanitary napkins, band-aids, and other items for home first aid. The exception to this would be when a preference for personal selection is indicated by a resident (see section 633.15[c][5] of this Title).

- (xiv) For persons who are Medicaid recipients, all necessary medical/dental/clinical supplies and services (see glossary) not available under Medicaid.
- (xv) For persons who are not Medicaid recipients, all necessary medical/dental/clinical supplies and services not available under Medicare or other health insurance. An exception is made where a person has excess resources (see glossary) which, based on a medical/dental payment review (see glossary), have been determined to be available for this use.
- (xvi) Basic clothing (see glossary).
  - (a) ICF/DDs, private schools, and specialty hospitals assume the cost of basic clothing, except where the following funds are available:
    - (1) Personal allowance (see glossary) not required for a person's current and foreseeable future individualized needs. In all cases, a $100 personal allowance balance must be reserved for purposes other than basic clothing purchases.
    - (b) Community residences assume the cost of basic clothing, except where the following funds are available:
      - (1) section 41.36(n) funds (see glossary); and
      - (2) personal allowance not required for a person's current and foreseeable future individualized needs. In all cases, a $100 personal allowance balance must be reserved for purposes other than basic clothing purchases.
- (xvii) Travel expenses, except those:
  - (a) covered by Medicaid;
  - (b) payable from a person's work-related exemption (see glossary) for the month; and
  - (c) associated with a person's individual participation in social or recreational activities, where such activities are neither specified in his or her plan of services, nor part of the facility's recreational program.
- (xviii) Materials and all other expenses associated with the facility's programmatic recreational activities, whether conducted in-house or out in the community.
- (xix) All items required to meet treatment needs specified in a person's plan of services.
- (xx) Work-related expenses (e.g., taxes, union dues, health insurance, uniforms, lunches and transportation) not covered by the person's work-related exemption for the month.
- (xxi) Damage caused by a person residing in a facility, other than that portion of the expense:
  - (a) covered by insurance; and

- (b) received from a person as part of a meaningful restitution process as devised by the program planning team (see glossary); approved in writing by the person's payee, if any; and approved by a committee, or part thereof, charged with protecting the rights of persons residing in the facility.

- (xxii) Supervised community residences (CRs) and supervised individualized residential alternatives (IRAs) are responsible for the cost of:
  - (a) services that are necessary to meet the needs of individuals while in the residence;
  - (b) services that, prior to August 1, 2004, could have been met by home health aide or personal care services separately billed to Medicaid; and (c) services specified in section 635-10.4(b)(1)(xvi) of this Part and section 671.5(a)(7) of this Title that, prior to October 1, 2015, may have been separately billed to Medicaid.
- (xxiii) Supportive CRs and supportive IRAs are responsible for the cost of services that, prior to October 1, 2015, could have been met by a home health aide or personal care services separately billed to Medicaid, as specified in section 635-10.4(b)
  - (1)(xvii) of this Part and section 671.5(a)(8) of this Title.
  - (2) A supportive community residence or an individualized residential alternative (IRA) may meet the above obligations in a different manner. Based on a written agreement, a person may retain all or a portion of countable income (see glossary) to purchase specified supplies or services which the agency/facility would otherwise purchase in fulfillment of the requirements of paragraph (1) of this subdivision. Such an agreement must specify:
    - (i) those supplies and services the person will purchase with countable income;
    - (ii) that any and all countable income remaining after such purchases, up to the amount of the community residence provider payment (see glossary), will be paid to the agency/ facility; and
    - (iii) that if, in any given month, a person's countable income is such that the person cannot pay for the specified supplies and services, the agency/facility shall make up the difference. In no instance shall personal allowances be used to make up this difference.

In non-residential facilities following requirements apply:

- 635-9.2(a)(1) Nonresidential facilities shall assume the cost of:
  - (i) Any item or service for which local, State, or Federal funds are provided; or for which reimbursement is made through a rate, fee, or grant-in-aid.
  - (ii) All staff personal service costs and staff expenses incurred in the provision of services and activities which are specified in a person's plan of service or are part of the facility's recreational program.
  - (iii) Physical plant maintenance and improvements.
  - (iv) All utilities including heat, light, power, water and sewer.
  - (v) The purchase, operation and/or maintenance of all equipment, furniture, or supplies necessary to operate the facility in accordance with the regulations for the class of facility or any other applicable regulations.
  - (vi) Special equipment necessary to meet the developmental needs of persons at the facility.

- (vii) Environmental adaptations made to the facility to meet the needs of persons while there. (viii) Any item required to meet treatment needs at the facility as specified in a person's plan of services.
- (ix) Damage caused by a person other than the portion of the expense:
  - (a) Covered by insurance.
  - (b) Received from a person as part of a meaningful restitution process as devised by the program planning team, approved in writing by the person's payee, if any, and approved by a committee, or part thereof, charged with protecting the rights of the person at the nonresidential facility.
- (x) Nonresidential facilities providing day treatment and day habilitation services shall assume the cost of service which:
  - (a) are necessary to meet the needs of individuals while attending their programs; and
  - (b) prior to August 1, 2004 could have been met by home health aide or personal care services separately billed to Medicaid.

Determine the standard is MET if:

• Purchases made using personal allowance funds are in accordance with a person's interests and choices, and/or benefit the person, and are allowable.

• There is no evidence that a person has paid for items that are the responsibility of the provider agency or insurance (i.e., Medicaid, Medicare, private insurance).

Determine the standard is NOT MET if:

• Personal allowance funds were used to purchase items or services that the service provider, or other support such as insurance, is responsible to pay for. Examples include but are not limited to:

- Personal allowance funds were used to pay for items that are clinically necessary or required by the person's service plan, such as adaptive equipment or reinforcements used as behavioral supports.
- Personal allowance funds were used to pay for medically necessary health care services or supplies.
- Personal allowance funds were used to pay for basic hygiene items such as adult incontinence pads, hand soap, toothpaste, etc.
- Personal allowance funds were used to pay for home maintenance or cleaning items.
- Personal allowance funds were used to pay for provider expenses except when allowable per regulation.

Note: Use of PA for staff expenses to assist individuals on chosen vacations and recreational experiences is allowable when certain conditions are met. However, no PA funds can ever be used to pay State-employed staff expenses.

See the PA Manual for more information on allowable staff expenses. There is also an Agency Review question regarding the agency's procedures in this area.

3a-8 Receipts required (by regulation) for items or services purchased reconcile with ledger entries.
633.15(l)(1) Documentation with receipt is required if personal allowance monies are used to purchase any items or services by agency/facility or sponsoring agency staff or family care providers acting upon their own discretion. However, receipts are not required for expenditures under $15 per person for, and related to, routine recreational activities. In such cases, the expenditures shall be noted in the ledger or other record.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS MMA: Money Management Assessment PEP: Personal Expenditure Plan **DISCUSSION** N/A **DOCUMENTATION REVIEW** Mandatory: • Personal expenditure ledgers • Receipts for purchase of goods and services, described below • MMA • PEP **OBSERVATION** N/A Verify through review of ledgers and associated receipts that required receipts are present. Receipts should be present in the following situations: • For items or services purchased by agency staff acting upon their own discretion. (Note: Receipts are not required for expenditures under $15 per person related to routine recreational activities. In such cases, the expenditures, amount and purpose, must be noted in the ledger or other record.) • For purchases made by the individual in excess of the individual's assessed money handling ability

- Receipts for purchases/expenditures should identify:
  - the item(s) purchased/expenditure(s)
  - the cost of each item
  - the vendor
  - the date of purchase
- Receipts are required for all group purchases. The receipt should include the information required for any receipt (above) and list the people in the group who participated in the purchase. The receipt should show that the amount each individual spent relative to his or her use of the purchase. For example, if three individuals had dinner at a restaurant and ordered different foods at different costs, each individual would pay only the amount of his or her order, and a commensurate amount of the tax and tip.)

Determine the standard is MET if:

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

Determine the standard is NOT MET if:

- There is a pattern of unreceipted expenditures where receipts are required.
- Receipts are not available for large disbursements of funds and/or large purchases.

NOTE: It is not necessary to verify receipts for each and every ledgered expenditure. Select a sample of purchases from each monthly ledger for the accounts reviewed. This sampling should always include expenditures of significant amounts/value. If the sampled expenditures have been documented and receipted appropriately, there is no need to continue. However, if problems are noted, it may be necessary to expand the expenditure sampling for the individuals already being reviewed and/or add additional individuals to determine the extent of the problem.

In addition, no receipts are required for certain personal expenditures made by an individual when the individual is capable of managing funds disbursed to him/her in accordance with the individual's MMA.

3a-9 Individuals are reimbursed for any loss of money managed by the agency.
633.15(h)(4)(iv) When an agency or sponsoring agency has the responsibility of overseeing personal allowance funds, it shall use the following accounts to maintain those funds:(4) Cash accounts - residence. Cash to meet the person's day-to-day and/or incidental needs may be maintained at the place of residence in accordance with agency or sponsoring agency policies and procedures.(iv) The agency/sponsoring agency is responsible in all instances for any loss of cash maintained at the residence or at the non-residential program until the cash is properly disbursed to the person
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS IRMA: Incident Reporting and Management Application **DISCUSSION** As needed: • If a loss occurred: o Individual receiving services o Family and/or advocates **DOCUMENTATION REVIEW** Mandatory: • IRMA/minor occurrence review for theft or any finance-associated incidents since prior visit • Personal expenditure ledgers As needed: • Bank/account statements if reimbursement occurred at agency level to person’s account rather than residence **OBSERVATION** N/A

All reportable significant incidents of theft or financial exploitation must be reported in IRMA. State-operated programs must also enter incidents of theft or financial exploitation classified as minor notable occurrences in IRMA. However, a voluntary agency may document a written incident report (rather than an IRMA entry) and a written investigation and review of theft or financial exploitation that meets the definition of a minor notable occurrence in section 624.4. Corrective actions in these cases often result in reimbursement. Review for implementation of such reimbursements.

Review required for Standards 3a-2 through 3a-8 may also identify occasions of misuse, mismanagement, inaccurate accounting and/or inappropriate purchases that may have required the individual to be reimbursed.

When performing the review of ledgers, ensure restitution occurred. Verify, by both interview and documentation review, that any losses to individuals were reimbursed fully and timely.

Missing, stolen, or wrongfully withheld funds must be returned to the individual's personal allowance account at the earliest possible date. This is as soon as the amount to be returned is known. The agency cannot hold off repayment of the individual until the investigation has been completed.

Determine the standard is MET if:

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

Determine the standard is NOT MET if ANY of the following are present:

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

Select N/A if:

- Not applicable at this site.

Section 4: General Operations For: Individualize Choice, Autonomy & Satisfaction
4-1 Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
633.4(a)(4)(viii) No person shall be denied: (viii) a written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Private School/Private School
635-10.2(a) The intent of home and community-based waiver services (hereinafter referred to a “HCBS waiver services”) is to create an individualized service environment (see glossary). The purpose of the individualized service environment is to provide, consistent with meeting the person's needs, preferences and personal goals, the supports or services necessary to enable a person with a developmental disability to live, work, socialize and participate in the community. Each support or service is expected to contribute to the person's current or future capacity for self- determination, integration with the community, independence and productivity. Specific services and the intensity with which they are delivered will be set forth in an individualized service plan (see glossary), and will vary according to individual functional capacities, skill levels, other supports available and the person's personal goals and desires.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
636-2.4(a)(4) and (6) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan: (4) The setting must optimize, and not regiment, individual initiative, autonomy, and independence in making life choices including, but not limited to, the individual’s decisions regarding daily activities, physical environment, and with whom to interact… (6) The individual must have freedom and support to control his or her own schedules and activities, consistent with the same or similar settings for the broader community
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
DISCUSSION Mandatory: • Individuals receiving services

- Direct support staff

As needed
- Family/advocates if needed to support input from individual
- Management staff

DOCUMENTATION REVIEW
As needed:
- Documentation that includes information about community activities. This may vary based on agency practices. Documentation includes community logs, activity logs and calendars, individual service notes, etc.

OBSERVATION
As needed for clarification

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

Interview individuals, advocates, staff at the site regarding desired activities occurring outside of the program and how sufficient transportation is arranged to ensure that individuals are able to participate in community and social activities, especially when several choices are requested during the same or overlapping time periods.

Transportation may include use of the provider's vehicles, public transportation, or transportation arranged with volunteers and natural supports Consider availability of accessible transportation sources if needed by individuals.

Review documentation such as activity logs, daily notes, and transportation logs, where applicable.

Consider whether insufficient transportation results in predominantly large group activities and/or an inability to accommodate unscheduled/spontaneous community activities.

Determine the standard is MET if all of the following are present:

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

Determine the standard is NOT MET if ANY of the following are present:

- Individuals' priorities for meaningful community inclusion activities are hampered by lack of transportation based on discussion and documentation review.
- Transportation is not provided by the facility, and individuals are not provided support to access other transportation sources to accomplish their community inclusion priorities.
- The only times transportation is facilitated is for group trips of four or more individuals receiving services and not based on individuals' priorities for community inclusion activities.
- Impromptu activities cannot occur due to transportation issues.

4-2 The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
633.4(a)(4)(viii) No person shall be denied: (viii) a written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-10.2(a) The intent of home and community-based waiver services (hereinafter referred to a "HCBS waiver services") is to create an individualized service environment (see glossary). The purpose of the individualized service environment is to provide, consistent with meeting the person's needs, preferences and personal goals, the supports or services necessary to enable a person with a developmental disability to live, work, socialize and participate in the community. Each support or service is expected to contribute to the person's current or future capacity for self- determination, integration with the community, independence and productivity. Specific services and the intensity with which they are delivered will be set forth in an individualized service plan (see glossary), and will vary according to individual functional capacities, skill levels, other supports available and the person's personal goals and desires.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
636-2.4(a)(4) and (6) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan: ... (4) The setting must optimize, and not regiment, individual initiative, autonomy, and independence in making life choices including, but not limited to, the individual's decisions regarding daily activities, physical environment, and with whom to interact… (6) The individual must have freedom and support to control his or her own schedules and activities, consistent with the same or similar settings for the broader community.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
DISCUSSION

Mandatory:
- Individuals receiving services
- Direct support staff

As needed
- Family/advocates, if needed, to support input from individual
- Management staff

DOCUMENTATION REVIEW
Mandatory:
- Site staffing schedule
- Staff assignments
- Documentation that includes information about community activities. This may vary based on agency practices. Documentation includes community logs, activity logs and calendars, individual service notes, etc.

As needed:
- Life Plan/Program planning records

OBSERVATION
As needed

This standard determines whether resources, schedules, and site operations are sufficient to arrange supports for individualized and meaningful community activities. Determine whether community activities are limited due to staffing availability issues or due to failure of the site and/or staff to support the individual and resolve other barriers to participation. Supports can include efforts to arrange for use of natural supports and other resources to ensure that an individual's choices are accommodated. Activities should not routinely occur in groups due to lack of sufficient resources to provide individualized activities as required.

Determine the standard is MET if:
- Staffing resources and other arranged supports are sufficient to support the individuals in their priority/chosen community activities.
- Survey activities verify that the facility is responsive to make staffing changes, scheduling adjustments, and other accommodations so that individuals' priorities for meaningful community activity are addressed in accordance with their program plans.

Determine the standard is NOT MET if either the following apply:

- Community activities are limited to group activities due to staffing issues, rather than accommodating the interests of individuals receiving services.
- Based on interview, observation, and documentation, staffing and other accommodations appear to be insufficient to support individualized and personally meaningful community activities and there are recent examples that support this finding.

4-3 The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
636-1.2(a)(3) The person-centered planning process requires that: (i) supports and services are based on the individual's interests, preferences, strengths, capacities, and needs; (ii) supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and (iii) the individual is satisfied with activities, supports, and services.
Program Class/Type: Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
DISCUSSION Mandatory: • Individuals receiving services • Direct support staff As needed: • Management and clinical staff • Family members/advocates **DOCUMENTATION REVIEW** Mandatory: • Life Plans • Staff Action Plans • Service delivery documentation As needed: • Assessments • Clinical records **OBSERVATION** Mandatory: • Observe service delivery

Review for individuals in the survey sample.

Observe program activities in locations that represent the types of activities provided at the program.

Interview individuals about their interests and activity preferences and ask about their participation in activities observed.

Ask individuals if they are satisfied with services and determine if they are able to make changes when desired.

Ask staff about how individuals' choices are addressed in staff action plans and in activity planning.

Review records to determine if individuals' choices, preferences, and needs are addressed in staff action plans and consult with relevant clinical and management staff as needed.

Review records to determine if plans were implemented as intended. Are patterns of individuals declining services addressed in a timely manner?

Determine the standard is MET if:

- Individuals were satisfied with services and supports provided at the site.
- Individuals had expressed dissatisfaction, but dissatisfaction was addressed with the planning team in a timely manner.
- Supports and services were appropriate to meet the individuals' preferences and choices.

Determine the standard is NOT MET if:

- An individual communicated dissatisfaction with supports or services, verbally or behaviorally by repeatedly declining them, but no action was taken (or taken timely) by the site to address the dissatisfaction.
- Services and/or supports were not sufficient to address individuals' preferences and choices.

4-4 The site has a mechanism to assess living arrangement choice and satisfaction, including satisfaction with the residential site, characteristics of the home environment, selection of bedrooms, and roommate assignments.
636-1.2(a)(3) The person-centered planning process requires that: (i) supports and services are based on the individual's interests, preferences, strengths, capacities, and needs; (ii) supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and (iii) the individual is satisfied with activities, supports, and services.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
636-2.4 (a)(2),(4)-(5) (a)Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan: … (2) The setting must be selected by the individual from among setting options, including non-disability specific settings, and an option for a private home or private bedroom in a residential setting, where applicable. The setting options must be identified and documented in the person-centered service plan or other planning/service-related documents and must be based on the individual's needs, preferences and, for residential settings, resources available for room and board. (4) The setting must optimize, and not regiment, individual initiative, autonomy, and independence in making life choices including, but not limited to, the individual's decisions regarding daily activities, physical environment, and with whom to interact. (5) The setting must facilitate individual choice regarding services and supports and who provides them.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
636-2.4(b)(ii) (b) In addition to those qualities and conditions described in paragraphs (a)(1) through (9) of this section, all the following conditions must be met in OPWDD-operated or provider owned or controlled residential settings: (ii) The individual sharing a bedroom in an OPWDD-operated, provider owned or controlled, or certified residential setting must have a choice of roommates in that setting. In non-certified provider owned or controlled residential settings, individuals must freely choose to share their residence and have a choice of roommates in the residence and in bedrooms, where applicable.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS HCBS: Home and Community Based Services

DISCUSSION
Mandatory:
- Individuals receiving services
- Program staff
- Management staff

As needed:
- Families & advocates

DOCUMENTATION REVIEW
Mandatory:
- Review documentation per agency practice specific to discussion of living arrangement options and decisions/choice of living arrangement

OBSERVATION
N/A

This standard examines whether the facility has a clear process in place to ensure that individuals are satisfied with their current living arrangements.

Assess whether the facility has a mechanism to obtain input from individuals to determine whether the individuals are happy with their current living situations.

The mechanism does not have to fit a particular template. It can be a formal agency assessment focused on satisfaction with living arrangements, or a component of routinely scheduled service planning activities, or another mechanism, or multiple mechanisms.

There must be evidence that this topic of satisfaction is specifically and thoroughly assessed and addressed. It should not be a simple question asking, “Do you like living here? or “Do you like your home?”.

The mechanism should include documentation of the individual’s response.

Assessing satisfaction includes providing the individual with information on other living arrangements options. This means offering other options whether or not those options are currently available or need to be developed and arranged.

HCBS Settings requirements specify that these alternative living arrangement choices offered to individuals must include the choice of a non-disability specific setting, and an option for a private home or private bedroom in a residential setting. Individuals must be given the choice of a private bedroom if they do not want a roommate. They also have the right to live elsewhere if they are not satisfied.

It is the provider's responsibility to offer and discuss these alternative choices with individuals on an ongoing basis and not just upon request
A non-disability specific setting is a noncertified residence or site that is not provider controlled or operated.

Determine the standard is MET if:

- The facility has a mechanism in place to assess satisfaction with the living situation and there is documentation of implementation.
- The process includes discussion with the individual about the individual's choice of living arrangement and options that are possible, including a non-disability specific setting.

Determine the standard is NOT MET if either of the following is present:

- Satisfaction/choice of living arrangements is not evaluated by the facility.
- There is no documentation available to show that a mechanism to assess satisfaction with living arrangements was implemented.

4-6 The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
633.4(a)(4)(xxii) No person shall be denied (viii) a written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible. Such right also includes: …(b) the opportunity to object to any provision within an individualized plan of services, and the opportunity to appeal any decision with which the person disagrees, made in relation to his or her objection to the plan
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(viii)(b) No person shall be denied:(xxii) the opportunity to request an alternative residential setting, whether a new residence or change of room, and involvement in the decisions regarding such changes
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
636-1.2(a)(3)(ii)-(iii) The person-centered planning process requires that) supports and services are based on the individual's interests, preferences, strengths, capacities, and needs; …(ii) supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and (iii) the individual is satisfied with activities, supports, and services.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
DISCUSSION Mandatory: • Individuals receiving services • Program staff • Management staff As needed: • Families & advocates **DOCUMENTATION REVIEW**

As needed:

- Review documents specific to agency's response to the individual's dissatisfaction with the living arrangement, noting the timeliness of the agency's response

OBSERVATION

N/A

Review for at least one person.

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

The facility should have means to address an individual's identified dissatisfaction with living arrangements in a timely manner. The facility/agency may address factors in the current home (i.e., conflict resolution for roommate problems) or, if necessary, support the individual to pursue alternative living arrangements. If dissatisfaction has been reported, verify that the agency has taken steps to evaluate the reasons for the individual's dissatisfaction, address any issues identified, and propose possible solutions.

If an individual is unhappy with his/her current living arrangement, there should be documentation to show that the facility/agency is assisting the individual in looking for/arranging an alternative setting or option that better meets the individual's needs and preferences.

The facility/agency may work with the individual's service coordinator, family members, and others to assist the individual and facilitate solutions.

The facility/agency should ensure that actions are taken to address the individual's dissatisfaction and monitor to ensure the actions taken are effective.

Sometimes options are limited, but the facility/agency should be making sustained efforts to find creative solutions to honor individual preferences.

Determine the standard is MET if:

- There was no evidence of dissatisfaction with the living service environment.
- Dissatisfaction had been expressed or documented during the year but has since been resolved to the individual's satisfaction.

• Dissatisfaction had been expressed or documented, but there was evidence of active and continuous actions underway to resolve the dissatisfaction, through changes in the current living arrangement or pursuit of a new living arrangement, in accordance with the individual's preferences and wishes.
• If the first discovery of dissatisfaction occurs during the review visit and the facility/agency has implemented a mechanism to assess satisfaction, select MET if there were no indicators would have alerted agency staff to the individual's dissatisfaction.

Determine the standard is NOT MET if any of the following are present:

• While action is initially taken to address dissatisfaction, there is not monitoring of progress and actions taken until longer term resolutions can be provided.
• Interviews reveal that one or more residents are unsatisfied with the current living arrangement and the concern has gone unaddressed, with no documentation or explanation why.
• If the first discovery of dissatisfaction occurs during the review visit and the agency has no mechanism to assess satisfaction, but you determine that there were clear indicators of dissatisfaction the last year and those indicators were not recognized and addressed by the agency.

4-7 The agency has an effective mechanism to offer individuals keys to enter the home or other means to enter the home independently.
636-2.4(b)(2)(i) In addition to those qualities and conditions described in paragraphs (a)(1) through (9) of this section, all the following conditions must be met in OPWDD-operated or provider owned or controlled residential settings: (2) The individual must have privacy in his or her residence and bedroom to the extent applicable. (i) Residences and bedrooms within residences must have entrance doors lockable by the individual, with only appropriate parties having keys/access to doors as needed.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
636-2.4(c) In OPWDD-operated or certified settings and other provider owned or controlled residential and non-residential settings, any modification to the qualities or conditions in paragraph (a)(6), (7), or (8) or subdivision (b) of this section must be supported by a specific assessed need, justified, and documented in the individual's person-centered service plan or other internal guidance document(s) pursuant to section 636-1.4 of this Part. The Medicaid HCBS provider agency must maintain such documentation as required by OPWDD. Note: Providers subject to section 633.16 of this Title must consult that section for additional documentation requirements concerning person-centered behavioral intervention. Providers subject to section 633.4 of this Title must consult that section for documentation requirements concerning modifications of rights of individuals receiving services that are not duplicated in paragraphs (a)(6), (7), (8) and subdivision (b) of this section.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS HCBS: Home and Community Based Services **DISCUSSION** Mandatory: • Individuals receiving services • Program staff • Management/Clinical staff As needed: • Families & advocates

DOCUMENTATION REVIEW
Mandatory:

- Review documents specific to offering keys, or other means of access to all individuals so they may enter their home independently

OBSERVATION
Mandatory:

- Observe how individuals access and enter their home

Individuals receiving services should have means to control access to their homes as all other people have access to their homes in the community. Having access to keys is a personal freedom and right for individuals residing in an HCBS setting. Such access reduces individuals' reliance on others, encourages independence, enhances personal autonomy regarding entrance, security, and use of the home. Accordingly, the facility should have a mechanism to inform individuals that they may have a key (or other access) to the home and to verify whether the individuals would like such access. This is most frequently addressed by offering individuals a key to the home. The challenge to both providers and reviewers is to ensure that judgments regarding individuals' cognitive and/or physical abilities, and resultant ability to use/benefit from access to the home, do not result in decisions to not make the offer. While a key is the most common and understandable form of access, lock codes, card swipes, automatic sensors, and other means of access should be considered as acceptable means to provide individuals with more independent entry into the home. The facility's/agency's mechanism for offering a key should include other means of entry based on an individual's unique circumstances and needs. Access is dependent both on house design and needs of the individuals receiving services. If an individual wants a key or other means to access the home the agency must work with the individual and the individual's circle of support to implement a meaningful solution, even if the individual will likely never use a key independently.

Verify that the facility and/or agency implements procedures to offer each individual a key or other autonomy-oriented access to the home. It is simply not enough for the facility and/or agency to provide keys/access to an individual only "upon request." The option to have a key or more independent access must be explicitly offered to each individual living in the home. Confirm through interviews with individuals, and advocates where needed, that appropriate offers were made.

The facility and/or agency should ensure that all individuals receiving services are informed about and offered keys (or other access to the home) without making an assumption about an individual's choice or capability. Some individuals may require training, support and guidance in making a decision on whether they would like more autonomy to enter their homes.

Providers should not develop “key assessments” or other methods intended to screen individuals to determine that their right to a key should be denied. Any instance where an individual is denied the right to have their own key, for any reason, is considered a modification of the individual’s rights. Any modification to an individual’s right to a key must be supported by a specific assessed need, justified, and documented in the individual’s person-centered service plan or other internal guidance document in accordance with OPWDD regulations in 14 NYCRR sections 636-1.4 and 636-2.4.

Determine the standard is MET if:

- There is evidence that the facility and/or agency has a mechanism to offer all individuals receiving services the opportunity for more independent access (i.e., a key) to the home on a routine and ongoing basis.
- There is evidence that the mechanism is implemented.

Determine the standard is NOT MET if ANY of the following is present

- The facility and/or agency lacks any verifiable mechanism or system to offer individuals the option of having a key or other means of access to their home.
- There is evidence that the facility and/or agency only provides keys or other access upon the independent unprompted request of an individual.
- Based on interviews, there are indications that the facility and/or agency is dismissive of individuals’ capabilities to use keys or have more independent access and restrict the implementation of the mechanism to offer such access to a select few, rather than all individuals receiving services.
- It is evident individuals are not offered opportunities to possess keys or have more independent access to the home and/or are not provided keys to the home even when requested.
- Individuals are denied keys without required justification for the rights limitation.

4-8 The agency has an effective mechanism to offer individuals keys to their bedrooms or other means to secure their bedrooms with independence or increased autonomy.
636-2.4(b)(2)(i) In addition to those qualities and conditions described in paragraphs (a)(1) through (9) of this section, all the following conditions must be met in OPWDD-operated or provider owned or controlled residential settings: … (2) The individual must have privacy in his or her residence and bedroom to the extent applicable. (i) Residences and bedrooms within residences must have entrance doors lockable by the individual, with only appropriate parties having keys/access to doors as needed.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
636-2.4(c) In OPWDD-operated or certified settings and other provider owned or controlled residential and non-residential settings, any modification to the qualities or conditions in paragraph (a)(6), (7), or (8) or subdivision (b) of this section must be supported by a specific assessed need, justified, and documented in the individual's person-centered service plan or other internal guidance document(s) pursuant to section 636-1.4 of this Part. The Medicaid HCBS provider agency must maintain such documentation as required by OPWDD. Note: Providers subject to section 633.16 of this Title must consult that section for additional documentation requirements concerning person-centered behavioral intervention. Providers subject to section 633.4 of this Title must consult that section for documentation requirements concerning modifications of rights of individuals receiving services that are not duplicated in paragraphs (a)(6), (7), (8) and subdivision (b) of this section.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS BSP: Behavior Support Plan HCBS: Home and Community Based Services IPOP: Individualized Plan of Protective Oversight SAP: Staff Action Plan **DISCUSSION** Mandatory: • Individuals receiving services • Program staff • Management/Clinical staff

As needed:
- Families & advocates

DOCUMENTATION REVIEW
Mandatory:
- Life Plans
- SAPs
- BSPs, if applicable
- IPOPs
- Residential settings should have written policies in place. These written policies pertain to the distribution and use of keys or locking mechanisms, staff access to keys, and documentation of staff training to indicate how compliance will be maintained

OBSERVATION
Mandatory:
- Observe how individuals access and enter their home

The requirement to have keys or control of a locking mechanism supports an individual's rights to privacy, dignity, and respect. It is expected that people will have control of the locking mechanisms on bathroom doors, their bedroom doors, and the entrance doors to their home. If an individual is unable to have control of the locking mechanisms to their home, they are still entitled to have access and therefore efforts must be taken to lessen the impact of the rights modification and documented in the individual's person-centered plan. Having access to keys is a personal freedom and right for people residing in an HCBS Waiver certified residence.

If an individual does not want to use a locking mechanism:
An individual has the right to choose not to use locking mechanisms but that does NOT remove the provider's responsibility from installing locks. This refusal should be documented in their plan.

If an individual is not able to manage a key:
The residential site should ensure that all individuals receiving services are informed about and offered keys (or other access to the home) without making an arbitrary assumption about an individual's choice or capability level. Some individuals may require training, support and guidance in making a decision on whether they would like more autonomy to enter their homes. Should an individual express interest in learning how to operate a lock, their SAP should include goals related to training to be able to use the locks or locking mechanism and the skills to acquire the

ability to lock the door. If a person has been assessed as not having the physical or mental capacity to utilize a locking mechanism, this must be documented within an individual's person-centered plan documents. The facility's/agency's mechanism for offering a key should include other means of entry based on an individual's unique circumstances and needs. Access is dependent both on house design and needs of the individuals receiving services. If an individual expresses interest in the offer of more independent access to the home, the provider and agency should MUST work with the individual and the individual's circle of support to implement a meaningful solution, even if the individual will likely never use a key independently.

Types of Acceptable Locking Mechanisms:

- Locks that disengage with the turn of the inside knob or vel are recommended. Locks should allow a person to exit the residence or bedroom without delay.
- Keyed doorknobs: turning the knob from the inside disengages the latch
- Double function locks
- Keyed door levers: pushing down on the level handle from the inside disengages the latch
- Dual chamber locks: locks with a separate keyhole on the lock that allows a different key to be used to override the lock/unlock function
- Card-based entry system: can be disengaged with a computer
- Electronic door locks: can be disengaged with a computer

Verify that the provider and/or agency implements procedures to offer each individual a key/or other autonomy-oriented access to the home. It is simply not enough for the facility and/or agency to provide keys/access to an individual only "upon request." The option to have a key or more independent access must be explicitly offered to each individual living in the home.

Determine the standard is MET if:

- There is evidence that the facility and/or agency offers all individuals the right to have a key or other independent access (i.e., a key) to the home on a routine and ongoing basis.
- There is evidence that the residential site has policies and staff training pertaining to access to keys and locking mechanisms.

Determine the standard is NOT MET if ANY of the following are present:

- The facility and/or agency lacks any verifiable mechanism or system to offer individuals the option of having a key or other means of access to their home.
- There is evidence that the facility and/or agency only provides keys or other access upon the independent unprompted request of an individual.
- Based on interviews, there are indications that the residential site is dismissive of individuals' capabilities to use keys or have more independent access and restrict the implementation of the mechanism to offer such access to a select few, rather than all individuals receiving services.

• It is evident individuals are not offered opportunities to possess keys or have more independent access to the home and/or are not provided keys to the home even when requested. • Individuals are denied keys without justification for the rights limitation.

4-10 The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
633.4(a)(4)(viii) No person shall be denied: (viii) a written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible.
Program Class/Type: IRA/FSR Large 9 or more, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-10.2(a) The intent of home and community-based waiver services (hereinafter referred to a “HCBS waiver services”) is to create an individualized service environment (see glossary). The purpose of the individualized service environment is to provide, consistent with meeting the person's needs, preferences and personal goals, the supports or services necessary to enable a person with a developmental disability to live, work, socialize and participate in the community. Each support or service is expected to contribute to the person's current or future capacity for self- determination, integration with the community, independence and productivity. Specific services and the intensity with which they are delivered will be set forth in an individualized service plan (see glossary), and will vary according to individual functional capacities, skill levels, other supports available and the person's personal goals and desires.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
636-2.4(a)(4) and (6) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan:.. (4) The setting must optimize, and not regiment, individual initiative, autonomy, and independence in making life choices including, but not limited to, the individual’s decisions regarding daily activities, physical environment, and with whom to interact… (6) The individual must have freedom and support to control his or her own schedules and activities, consistent with the same or similar settings for the broader community
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
DISCUSSION

- Individuals receiving services
- Program staff
- Management/Clinical staff
- Families & advocates

DOCUMENTATION REVIEW

- Schedules
- Community Inclusion Logs
- Individual Allowance
- Life Plan

OBSERVATION

- Observe activities and interactions onsite
- Check for posted scheduled and analogous documentation

This standard considers whether the program operationally supports individualized schedules and routines. This includes activities of daily living as well as recreational and leisure activities. Interviews both with Individuals receiving services and staff are important aspects of reviewing this standard in order to determine whether it is met or not met.

Determine how Individuals are accommodated to live their life and complete activities at times and in a manner that is meaningful and preferred. Gauge whether there are opportunities for Individuals to make choices about their day-to-day schedules, in the same way that Individuals who do not receive HCBS can do.

Consider whether the site promotes and enables Individuals to follow an individualized daily routine without having to adhere to general rules and schedules. A "house/program schedule" may be written, or it may only be evident through observation of the operations and flow of activities in the program.

Evaluate whether the program uses a set routine that is strictly followed. It is natural in most households as well as certified residences to have some general routines, such as offering routine meals within a certain time frame, but the residence should also demonstrate accommodations in those routines when Individuals either verbally or behaviorally demonstrate that they would prefer not to engage in them at a set time.

Aspects to consider when evaluating this standard:

Schedules should be individualized, rather than everyone following the same schedule, and when accessing community activities and events.

Observations on site should provide examples of staff willingness to offer choice and accommodate individualized preferences or requests regarding daily activities.

Interviews and observations demonstrate that staffing is sufficient and flexible to accommodate, optimize, and support individual choice.

The facility is operated optimizing the choice, autonomy, and satisfaction of Individuals rather than for the convenience and efficiency of staff. Examples of individualized routines and schedules include:

- When an Individual is not feeling well, he/she can choose to stay home from work or day program on that day.
- Everyone does not and/or is not expected to participate in the same regimented mealtimes, activities, bed times, waking times, leisure activities, television time, etc. Individuals are instead supported to eat when and where they want to, at times convenient to them.
- Residents know they have a choice, or they have been given a choice regarding how to schedule their activities. There should not be one posted schedule that everyone is expected to follow: e.g. group outing at 4pm, dinner at 5, showers at 6, meds at 7, without any indication of choice or the right of the Individual to refuse.
- Individuals are supported to participate in spontaneous events of their choosing (versus having to plan all community activities days/weeks in advance due to staffing or transportation limitations). There should be evidence that the site supports both planned and unplanned activities.
- There should not be a house curfew or scheduled time that Individuals have to return to the residence.
- There should not be blanket house or program rules at the site. Any modifications or restrictions on rights present at the setting must be thoroughly justified and documented as well as unique to each Individual.

Questions to consider with this standard based on interviews, observations, and review of documentation:

- Does everyone have to take a shower at night even if someone prefers taking them in the morning?
- Can Individuals stay home during the day if they want to? Do Individuals have the option to retire?
- Are Individuals at the residence able to work alternative work schedules, such as evenings and weekends, or are they only able to work Monday-Friday during the day due to limited transportation and/or staffing at the site?
- Does everyone have to eat dinner together and at the same time?
- Does everyone have to be in their bedrooms or in their beds by a specific time very night?
- Are there any blanket restrictions on visitors and visiting hours?
- Any schedule of activities posted/available should make clear that Individuals have a choice to participate. Such schedules should offer multiple options based on the interests and preferences of the residents.
- With HCBS Day Programs, can Individuals choose their schedules and whether they want to go out that day? Can they eat lunch when and where they want to?

Important: This HCBS Settings standard, if determined to be not met, could warrant a deeper dive into additional standards related to adequate staffing, transportation, and support of individual rights. When citing this tag, consider cross-referencing other applicable standards that may also apply in this protocol.

Determine the standard is MET if:

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

Determine the standard is NOT MET if any of the following are present:

- Activity schedules are regimented with little individualized choice or decision-making evident.
- There are blanket house rules about watching TV, curfews, playing music, phone calls and using computers, etc.
- The Individual expresses dissatisfaction with the opportunity to control his/her own schedule and make choices about activities.
- There are daily schedules posted that everyone is required to follow with no individualization.
- Most activities occur in groups and are based on convenience rather than request.
- Individuals report/display dissatisfaction with the schedule that they follow, and this has been unaddressed by the staff.
- Individual's schedules of Individuals appear identical or very similar to one another.
- The site or program follows the same routine daily, with little variance of day-to-day activities.
- Individuals are not offered opportunities to make informed choices regarding free time, mealtime, etc.
- Staffing schedules are rigid, resulting in Individuals not being provided with the supports that are needed so that Individuals can engage in routines and leisure activities at a time and manner that benefits them. For example, staffing and/or transportation constraints at the program do not allow Individuals to make individualized choices of what they would like to do for leisure activities or when Individuals want to stay home from their day program or other scheduled activity if they do not feel well, just like anyone else in the broader community can choose to do.

4-12 Individuals are encouraged and supported to participate in the routine of their homes (e.g., cooking, menu planning, routine chores, etc.)
633.4(a)(4)(viii)(c) No person shall be denied: (viii) a written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible. Such right also includes:(c) the provision for meaningful and productive activities within the person's capacity although some risk may be involved, and which take into account his or her interests
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
DISCUSSION Mandatory: • Individuals receiving services • Program staff • Management/Clinical staff As needed: • Families & advocates **DOCUMENTATION REVIEW** N/A **OBSERVATION** Mandatory: • Observe the home routine, noting individual participation in activities as desired Through observation validate that: • Individuals recognize and/or are supported to recognize that this is their home and that they have an active role in the home's routines • Even if an individual will probably not achieve total independence at a certain activity, the individual is encouraged and supported to be as independent as possible by participating in routine activities in the home. • Individuals participate, to the extent they are able, in the routine tasks of the household instead of having things done for them (i.e., breakfast prepared and served by the staff when individuals are able to participate).

• Individuals receive support when appropriate, in “teachable moments”.

Determine the standard is MET if:

• Observations verify that individuals are supported to actively participate in routines of the home including but not limited to meal planning, preparation, and serving, routine chores, gardening, and organizing/planning for events/holidays/special occasions, etc.

Determine the standard is NOT MET if:

• The staff are observed to complete tasks and activities for the individuals, rather than encouraging individuals to participate in household routines.

4-13 Individuals are encouraged and supported to have full access and be participating members within the broader community.
635-10.2(a) The intent of home and community-based waiver services (hereinafter referred to a “HCBS waiver services”) is to create an individualized service environment (see glossary). The purpose of the individualized service environment is to provide, consistent with meeting the person's needs, preferences and personal goals, the supports or services necessary to enable a person with a developmental disability to live, work, socialize and participate in the community. Each support or service is expected to contribute to the person's current or future capacity for self- determination, integration with the community, independence and productivity. Specific services and the intensity with which they are delivered will be set forth in an individualized service plan (see glossary), and will vary according to individual functional capacities, skill levels, other supports available and the person's personal goals and desires.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
633.4(a)(4)(viii) No person shall be denied: (viii) a written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-2.4 (a)(1) (a) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan: (1) The setting must be integrated and support full access of individuals receiving HCBS to the broader community. It must support opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community with the same degree of access as the broader community
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ACRONYMS SAP: Staff Action Plan **DISCUSSION**

Mandatory:
- Individuals receiving services
- Facility staff

As needed:
- Families & advocates

DOCUMENTATION REVIEW

As needed:
- Life Plan
- SAPs
- Community activities records
- Personal funds records

OBSERVATION

Mandatory:
- Observe to see if individuals are encouraged & supported to have full access to the broader community (as described below)
- Confirm documentation & interview

Having “FULL ACCESS” to the community means:
- Supports and services do not segregate or isolate people from their own neighborhoods.
- The expectations for individuals with disabilities should be the same as expectations for any other people living in their community.
- Individuals are encouraged and supported to interact with others who do not have disabilities.
- Community activities do not require individuals to stay as an entire group of others with disabilities that are insulated/isolated from the public at large.
- Group community activities may be chosen by an individual among other activity options, but group activities are not the only types of activity that the individual experiences in the broader community.
- Individuals are provided options for community activities other than group activities.

Note: Individuals may not be able to access their local communities as often as they like in very rural settings, but this may also be true for the public at large in those rural settings.

Survey Activities and Considerations:

- The service plan must identify the individual's choices for meaningful community inclusion activities and the desired frequency/duration of these activities. The service plan may include staff action plans or other applicable attachments.
- Verify that the individual's priorities and preferences and desired frequency for community activities are individually assessed and supported
- Verify that the community activities identified in the plan are provided as described.
- There should also be evidence that individuals have opportunities to participate in unscheduled community activities.
- Indications of community involvement may be identified through review of personal allowance records and community logs/activity logs or daily notes kept by the program.
- Interview the individual and other parties who can provide accurate information regarding the individual's interest in community and integrated activities and the individual's participation in such activities.
- Verify that individuals are sufficiently "supported." Individuals who have less experience with community life may need more supports and exposure to new opportunities. The staff or other arranged supports should encourage individuals to take part in the community in a way that is experiential or meaningful to each individual person. When uncovering personal interests and preferences, the staff should be attentive to non-verbal cues, especially for those who are unable to communicate verbally. Supports could also include providing assistance and training in identifying activity options, identifying what is occurring in their community, navigating public transportation, and arranging access to get to the activities. Where public transportation (i.e., bus, subway, cab) is not available, the individual should be supported by using other resources to access the broader community, such as volunteers and natural supports.

Determine the standard is MET if:

- The individuals' priorities and preferences for community engagement identified in their written plan are provided as described.
- The individual experiences both planned/scheduled and spontaneous community activities.
- The individual receives needed assistance and supports to engage in community activities and perform social roles that are of interest. Supports can include but are not limited to volunteers, choir members, neighbors, and siblings. (Community supports may be developed by serving on a committee, joining a club, becoming an active church member, etc.).
- The program supports the person to discover and participate in new experiences and activities, and facilitates access to information (flyers, newspapers, internet, and/or word of mouth) to learn of activities occurring outside in the community There are specific and recent examples of occasions when the individual was encouraged and supported to have full access to the community and/or supported through a discovery process in the community (within the past 2-3 weeks).

Determine the standard is NOT MET if ANY of the following is present:

- The individual is not supported to participate in community and social activities identified in the individual's written plans.
- The individual is not supported to participate in preferred, chosen, and/or requested community or social activities.

• There are obstructions that serve to isolate the individual from full access to the community, and there has been no effort to address these barriers/obstacles in a timely manner. • The individual cannot access the community independently and nothing is done to help the individual access or discover interests in the broader community. • The individual appears isolated from full access to the broader community, (i.e., the individual reports that the only community activities he/she engages in are group activities involving only other housemates or the staff.) • If all individuals receiving services attend the same types of activities with little choice of options or evidence of individualized interests. • Documentation and interviews reveal that individuals only frequent the community through the same limited set of activities, with little variation or options offered and usually with other individuals receiving services.

4-14 Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
635-10.2(a) The intent of home and community-based waiver services (hereinafter referred to a "HCBS waiver services") is to create an individualized service environment (see glossary). The purpose of the individualized service environment is to provide, consistent with meeting the person's needs, preferences and personal goals, the supports or services necessary to enable a person with a developmental disability to live, work, socialize and participate in the community. Each support or service is expected to contribute to the person's current or future capacity for self- determination, integration with the community, independence and productivity. Specific services and the intensity with which they are delivered will be set forth in an individualized service plan (see glossary), and will vary according to individual functional capacities, skill levels, other supports available and the person's personal goals and desires.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
633.4(a)(4)(xii) No person shall be denied (xii) observance and participation in the religion of his or her choice, through the means of his or her choice, including the right of choice not to participate
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(ix) No person shall be denied: (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-1.2(a)(3)(i)-(iii) The person-centered planning process requires that: (i) supports and services are based on the individual's interests, preferences, strengths, capacities, and needs; (ii) supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and (iii) the individual is satisfied with activities, supports, and services.

Program Class/Type:
IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab

636-1.2(b)(3)
A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service plan, with the individual and parties chosen by the individual. The person-centered planning process involves: …
(3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual

Program Class/Type:
IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab

DISCUSSION
Mandatory:
- Individuals receiving services
- Facility staff

As needed:
- Families & advocates

DOCUMENTATION REVIEW
As needed:
- Life Plan
- Service plans
- Individual service documentation
- Community activities records

OBSERVATION
Mandatory:
- Observe the staff demonstrating support & respect toward individuals
- Bedroom and home are appointed as appropriate per the cultural, spiritual and lifestyle preferences
- Observe Individuals wearing the clothes, hair, makeup, etc. as they choose

There should be evidence that staff make efforts to respect and offer opportunities for individuals to understand their ethnic and cultural backgrounds and offers individuals cultural, religious, or ethnic experiences. People who function as natural supports for individuals may also have family traditions and favorite food dishes, etc. that the staff should be aware of. Individuals should have opportunities to participate in the traditions and activities with their peers that are of interest to them and to share personal values and beliefs. If people have not previously made decisions related to learning about or expression of cultural backgrounds, efforts should be made to determine the individual's interest in exploring cultural, religious, or ethnic experiences.

Note: There may also be circumstances where the values and beliefs of an individual's family members may conflict with the individual's own values and beliefs. It is important that the program staff assess and respect the wishes of the individual.

Determine the standard is MET if most of the following are present:

- Individuals may choose room decorations in accordance with their own lifestyle, spiritual, and cultural interests and preferences
- There is evidence that individuals attend religious activities of their choice that are important to them.
- Individuals are able to visit ethnic shops, attend ethnic festivals, and follow international sports in accordance with their interests and preferences.
- Menus reflect ethnic diversity reflective of the individuals living in the home.
- The program offers opportunities for unique experiences based on the cultural, religious, and ethnic backgrounds of the individuals receiving services. This includes supporting exploration of options if an individual expresses interest in such experiences.
- Clothing and grooming are appropriate to religious or cultural choices of the individual.
- The sexual preferences and gender identities of individuals are respected.
- There is evidence that the program staff communicate with individuals' natural supports and are sensitive to fostering family traditions and values.

Determine the standard is NOT MET if any of the following is present:

- No action is taken to discover and explore the backgrounds of individuals and support them in this discovery if an individual is interested to do so.
- Interviews with the staff and/or individuals reveal that there are missed opportunities for individuals to participate in religious, cultural, or ethnic events of interest due to inattentiveness to requests or opportunities.
- Observation and interviews reveal that individual preferences for ethnic foods are ignored or denied by the program.
- Holiday decorations do not reflect the cultures of individuals receiving services.
- There is evidence that the values, beliefs, and traditions of the staff or the agency directly conflict with those of individuals receiving services and have resulted in the individuals being unable to participate in activities important to them or express themselves the way that they choose.

• Individuals who are interested to do so are denied participation in celebrations of other cultures or religions, because those celebrations are not associated with the individuals' own ethnic or spiritual origins and therefore are considered by the staff to be inappropriate.
• The diversity of individuals' cultural and religious beliefs is not equally promoted and supported.

Examples of circumstances resulting in a NOT MET answer:

• Carlos is originally from the Philippines. He visits his family in NYC on a routine basis. His family sends him back to the facility with his favorite foods, which include dishes with ingredients that are unusual to the staff, such as fisheyes. The staff routinely dispose of the food upon receipt, finding the food to be unappealing, and provide Carlos with excuses like the food was not chilled enough on the trip (spoiled) or contains too much sodium for his diet. Carlos complains to agency staff or other staff on a routine basis that he is not able to eat the food that he wants to because the staff "won't let him."
• An individual receiving services who observes kosher dietary rules is not supported or allowed to have appropriate dishes/utensils and storage for food because no one else in the home observes the same dietary rules.
• An individual routinely attends the church that the staff or a housemate attends rather than being supported to attend a church or place of worship based on his or her own religious or spiritual traditions or preferences.

4-15 Individuals are supported by the site to exercise control and choice in their own lives.
635-10.2(a) The intent of home and community-based waiver services (hereinafter referred to a “HCBS waiver services”) is to create an individualized service environment (see glossary). The purpose of the individualized service environment is to provide, consistent with meeting the person's needs, preferences and personal goals, the supports or services necessary to enable a person with a developmental disability to live, work, socialize and participate in the community. Each support or service is expected to contribute to the person's current or future capacity for self- determination, integration with the community, independence and productivity. Specific services and the intensity with which they are delivered will be set forth in an individualized service plan (see glossary), and will vary according to individual functional capacities, skill levels, other supports available and the person's personal goals and desires.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
633.4(a)(4)(viii) No person shall be denied: (viii) a written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-1.2(a)(3)(i)-(iii) The person-centered planning process requires that: (i) supports and services are based on the individual’s interests, preferences, strengths, capacities, and needs; (ii) supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and (iii) the individual is satisfied with activities, supports, and services.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ACRONYMS LGBTQ: Lesbian, Gay, Bi, Transgender & Queer/Questioning

DISCUSSION
Mandatory:
- Individuals receiving services
- Facility staff

As needed:
- Families & advocates

DOCUMENTATION REVIEW
As needed:
- Life Plan
- Service plans
- Individual's notes
- Community activities records
- Individual's daily schedules

OBSERVATION
Mandatory:
- Observe if Individuals are being supported to exercise control and choice (as described below)
- Confirm with interview as needed

This standard is a global one and should be based on overall findings from Section 4. It looks at whether individuals are empowered to exercise choice and control over their own lives. There should be evidence, and observations should show that the program actively promotes individual choice, autonomy, and decision-making. This includes having meaningful community inclusion and being able to form and maintain relationships with people of their choosing. This also means that their religious and spiritual preferences are respected. The program should not be quick to make decisions for individuals without engaging them and ensuring that each individual has an active role in making choices to the highest degree possible.

Determine the standard is MET if:
- There is documentation of membership in community groups and organizations.

- Community activities that the individual participates in are meaningful to the individual.
- Sexual preferences and gender identities are respected.
- Individuals direct their own schedules whether or not they make and schedule their own plans independently.
- There are mechanisms in place to ensure that individuals provide input in activity planning and choose activities that they would like to participate in.
- Personal decisions related to relationships are respected.
- Religious/spiritual preferences are honored.
- There are examples of individuals demonstrating choice and control and interviews with individuals support these examples.

Determine the standard is NOT MET if:

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

Section 5: Delivery of Safeguards, Services, Supports
5-1 Staff can describe the individuals' supervision needs.
633.4(a)(4)(ix) No person shall be denied: (ix)services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.16(b)(4)(i)-(ii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following:(i) any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid; (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more
ADM 2022-01 Levels of Supervision (LOS)
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS IPOP: Individualized Plan of Protective Oversight LOS: Level of Supervision
DISCUSSION Mandatory: • Direct support staff to discuss individuals and their supervision needs. The intent is not necessarily to quiz the staff on each and every individual, but rather to get a sense that the staff is competent to provide the routine supervision individuals need • Individuals, to discuss when the staff must be with them and when the individuals may be independent

As needed:
- Family and/or advocate
- Program management staff

DOCUMENTATION REVIEW

As Needed:
- Review of this standard relies on the reviewer's assessment of what the staff explained in conjunction with observations. If observations reveal something that raises concerns and/or contradicts what staff reported, check how an individual's plan describes the individual's need for supervision and supports. Review of documentation is only necessary in such scenarios.
- Life Plan
- IPOP
- Other plans that may answer concerns regarding supervision needs

OBSERVATION

Mandatory:
- Review of this standard is expected to be based on observations paired with interviews. Observe individuals in the home and during activities that occur during the visit. Observe the environment and interactions with the staff. Make a determination based on the observed needs and abilities of the individuals and the staff knowledge of the supervision/support individuals need

The staff should be able to describe and give examples of the supervision and supports they provide to individuals receiving services. The staff need to know the safeguards and supervision they are expected to provide to individuals. The staff may describe supervision and supports individuals need, including certain types of assistance or oversight, for the following:
- General activities in the home and leisure time
- Personal hygiene, dressing, and grooming activities
- Communication, coping skills and positive behavior supports
- Activities of daily living such as dining, ambulation, household chores.
- Community based activities, including community safety
- Health care and medication administration

Effective 9/1/2023, the staff should be able to describe and reference examples of specific levels of supervision individuals receive in accordance with ADM 2022-01.

Many individuals receiving services can have their needs met without the need for a defined LOS.
The ADM does not apply to situations where the care needs of an individual do not need to be specifically supported with a defined LOS. (Programs may have structures, supports, and staffing such that specifically articulated supervision levels are not needed. In addition, some individuals receiving services may be able to seek out staff assistance or additional supports when needed. However, where the planning team specifies that an individual requires specific levels of supervision, the following terminology must be used:

- One-to-One (1:1) Supervision or another similar higher ratio of staff assigned to one individual (i.e., 2:1 Supervision or 3:1 Supervision)
- Range of Sight or Scan
- Periodic Checks
- Independent with Staff Present
- Independent

Once providers identify the minimum specified level of supervision needs of an individual, it is critical to ensure staff:

- Can easily understand the individual's supervision needs
- Know their specific responsibilities when providing the LOS
- Have sufficient resources and administrative support to implement the LOS in the context of all their other responsibilities
- Have the training and skills necessary to implement the LOS
- Understand how to properly transfer supervision duties

Determine the standard is MET if both of the following are present:

- The staff are knowledgeable regarding levels of supervision individuals need.
- The staff gave individuals the supervision and supports the individuals needed during observed activities.

Determine the standard is NOT MET if ANY of the following is present:

- The staff did not know/ could not explain the supervision and supports the individuals need.
- The staff did not provide the supervision/supports individuals needed during observed activities.
- Service plans were not updated to include levels of supervision in accordance with ADM 2022-01, where applicable, effective 9/1/2023.

5-2 Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
633.4(a)(4)(ix) No person shall be denied: (ix)services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.16(b)(4)(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more
ADM 2023-04 Choking Prevention Initiative
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS CPI: Choking Prevention Initiative IPOP: Individualized Plan of Protective Oversight
DISCUSSION As needed: • Direct support staff to determine or clarify the staff knowledge of the food and beverage consistencies the individuals need • Individuals re their food and beverage consistency needs and whether they receive help they need from the staff • Program management staff, including the nurse as needed, regarding oversight provided if the review revealed serious concerns

DOCUMENTATION REVIEW

Mandatory:

- For at least one (1) individual, review service plan documentation that describes the services and supports the individual needs while eating and drinking (i.e., Life Plan, IPOP, specialized dining plan, current clinical assessments)

As Needed:

- If observations of individuals eating resulted in reviewer concerns about any individual's well-being while eating/drinking

OBSERVATION

Mandatory:

Observe any mealtime for the one individual whose records were reviewed for this standard to:

- Verify that food and beverages were provided in the consistency/form described in the individual's records
- Verify that food/beverage consistencies appear to be appropriate based on the individual's observed dining behavior and needs
- For other individuals, verify that they appear to receive food/beverages in consistencies that they can manage safely and appropriately based on observations of the individuals'
- Dining behaviors and skills
- Physical needs

SAMPLE: For at least one individual present at the site, conduct a meal observation and review the individual's records to verify that the consistencies and preparation of the food and beverages they eat/drink are provided in accordance with the individual's written plan/diet order.

Review the individual's written plan (i.e., Life Plan, service plan, and/or a dining plan if one was developed for the individual and relevant assessments and diet orders). The plan should identify the consistencies of the food and beverages the individual needs. The descriptions of the food and beverage consistencies must be in accordance with terminology approved in the OPWDD Choking Prevention Initiative (CPI). See Choking Prevention Training Resources | OPWDD at Choking Prevention Initiative ADM 2023-04 (ny.gov).

Food consistency may be described as:

- Whole
- 1-inch pieces cut to size
- ½ inch pieces cut to size
- ¼ inch pieces cut to size
- Ground
- Puree

- Liquidized

Beverage/Liquid consistency may be described as:
- Thin
- Nectar Thick
- Honey Thick
- Pudding Thick

Other terminology for these consistencies must not be used. Clarification descriptors may be added if they lend to better understanding, but other descriptors may not be substituted for CPI consistency terminology.

If clinicians external to the agency are involved in recommending/determining the food or beverage consistency for the individual, the facility or agency must ensure that recommendations result in terminology consistent with CPI requirements.

Observe and verify:
For Sample:
- That the appearance of the food and beverage provided/available for the sampled individuals is consistent with the individuals' written plans and CPI description of food/beverage consistencies.
- The food and beverage appear to be appropriate and managed safely based on the individuals' eating/drinking behaviors and abilities.

For other individuals participating in the meal:
- Individuals safely eat and swallow the food and beverages in the consistencies provided to them. For example, individuals did not cough frequently while eating/drinking, ate manageable bites of food at an appropriate pace, and chewed food sufficiently before swallowing.

If meal observations reveal an unmet eating/drinking need (i.e., an individual was eating food rapidly and coughing, and staff did not intervene prevent choking or aspiration) the reviewer must take action to address the safety of the individual receiving services. The concern should be calmly and immediately be brought to the attention of the staff.

Determine the standard is MET if:
- The individual sampled for this standard received food and beverages in the consistencies described in the individual's written plan, and based on observation, consistencies appeared to be appropriate to meet the individual's needs.
- The written description of the sampled individual's food and beverage consistencies is consistent with CPI terminology.
- Other individuals present during the meal appeared to receive food and beverages in consistencies appropriate to their observed needs and eating habits.

Determine the standard is NOT MET if ANY of the following is present:

- The individual sampled for this standard did not receive food and/or beverages in the consistencies described in the individual's written plan.
- The individual sampled for this standard could not manage the consistencies of food and/or beverages provided based on observations.
- Any individual present during the meal appeared unable to manage the consistencies of food and/or beverages provided based on observations.

Select N/A ONLY if:

- Individuals do not eat or have meals at the facility during hours of service delivery.

5-3 Individuals receive support while eating in accordance with their assessed and observed needs.
633.4(a)(4)(ix), (x), and (xvii) No person shall be denied: (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; (xvii) a balanced and nutritious diet.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.16(b)(4)(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more
ACRONYMS IPOP: Individualized Plan of Protective Oversight **DISCUSSION** As Needed: • Direct support staff to determine the staff knowledge of supports and supervision individuals need while eating • Individuals, to clarify the supports they receive and require while dining • Family and/or advocate • Program management or clinical staff **DOCUMENTATION REVIEW** Mandatory: • Written plans (i.e., Life Plan, IPOP and any dining-related service plan) • Diet Order • Nutritional assessment, where needed • Other clinical assessments, as needed

As needed:

- Agency policy and procedure on nutritional/clinical assessment services, if any

OBSERVATION

Mandatory:

- While individuals are eating in the setting, observe to verify that dining supervision, supports, and monitoring are provided effectively and respectfully

SAMPLE: For at least one individual present at the home, conduct a meal observation and review the individual's records to verify the individual is provided needed supervision and supports during the meal.

Verify that the individual received:

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

Review the individual's written plan (i.e., Life Plan, service plan, and/or a dining plan if applicable, and relevant assessments and diet orders). The plan should identify the supervision, support, and equipment the individual needs during meals. The written plan should identify an individual's need for support from the staff, such as the level and type of assistance the individual needs (i.e., pacing supports, staff proximity such as arm's length supervision, or specific hands-on assistance for eating and/or drinking). The written plan should also identify an individual's need for adaptive dishes or utensils or equipment to maintain an appropriately upright position, where applicable. When an individual is able to eat independently and without specific mealtime supports, this capability should also be noted in the individual's plan. The plan must specify the type of diet the individual needs (i.e., regular, calorie or other limitation) and consistency modification and any supports the individual needs to follow the diet.

Determine the standard is MET if:

- The staff gave the individual in the sample the supervision, supports, and equipment described in individual's plan.
- The written plan to address the individual's mealtime needs was observed to be appropriate.
- Other individuals present during the meal appeared to receive supports and supervision appropriate to their observed needs and eating habits.

Determine the standard is NOT MET if any of the following are present:

- The staff did not give the individual in the sample the supervision, supports, and equipment described in the individual's written plan.
- Although the staff implemented the sample individual's plan as written, the supervision, supports, and/or equipment were not effective or sufficient to address the individual's observed mealtime needs.
- Other individuals observed appeared to need additional supervision, supports, and/or equipment, and based on review, it was confirmed there was a need for further assessment of individuals' needs and/or supports.

Select N/A ONLY if:

- Individuals do not eat or have meals at the facility during hours of service delivery.

5-4 Individuals receive support for mobility in accordance with observed needs.
633.4(a)(4)(ix)-(x) No person shall be denied: (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.16(b)(4)(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more
ACRONYMS IPOP: Individualized Plan of Protective Oversight **DISCUSSION** As needed: • Direct support staff to determine the staff's knowledge of supports and supervision individuals need for mobility • Individuals, to verify that they are receiving the supervision and supports they need for mobility • Family and/or advocate • Program management or clinical staff **DOCUMENTATION REVIEW** As needed, if concerns or questions are raised during observation: • Life Plan or other plan of services and any associated mobility service plan • IPOP, where applicable, and any associated ambulation or mobility plans • Orders for mobility supports or equipment • Assessment by a physical or occupational therapist, if applicable

OBSERVATION

Mandatory:

- While Individuals are moving about in the setting, observe to verify that any needed mobility supervision, supports, and monitoring are provided effectively

Review this standard based on observations of routine activities, including individuals' movement around the environment and/or to and from transportation sources.

While observing, reviewers should be attentive to individuals' mobility skills and use of any assistive equipment, such as a wheelchair, rollator, walker, cane, or braces. Ensure that individuals appear to be safe during ambulation, movement, and transfers.

Observe individuals who are ambulatory with or without assistive equipment. Watch for steadiness, pace, appropriate use of equipment, and any actions that may indicate desire for support, such as leaning against the wall or using furniture as support to get from one place to another.

Observe individuals using wheelchairs independently. Verify that they are able to move throughout the environment, as needed, and do so in a manner that is attentive to others in paths of travel.

If an individual is observed to have a need for support for mobility, verify that staff is available, nearby, and attentive to provide the level of assistance that appears appropriate to maintain the individual's well-being. Observe for the staff to be attentive to each individual's need for supervision, contact guarding, or other assistance to navigate the environment.

Only if an individual is observed to have mobility needs and does not appear to have equipment or other supports he/she needs, discuss this concern with the staff and/or agency staff and review the individual's plan for any written strategy to provide mobility support.

Determine the standard is MET if:

- Individuals moved safely and independently in the in the environment.
- The staff gave individuals adequate support and/or the individuals have adaptive equipment to move safely in the service environment, as needed.

Determine the standard is NOT MET if either is present:

• An individual was observed to be at risk for falls or injury but not receive support/assistance from the staff appropriate to the individual's observed needs. • Concerns about an individual's safe navigation in the environment led to review the individual's written plan and a determination that the individual did not receive needed supports/supervision based on observations and review of the written plan.

5-5 Individuals receive appropriate support and supervision based on other observed needs for support.
633.4(a)(4)(ix)-(x) No person shall be denied: (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.16(b)(4)(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more
ACRONYMS BSP: Behavior Support Plan IPOP: Individualized Plan of Protective Oversight
DISCUSSION As needed: • Direct support staff to determine the staff's knowledge of general supports and supervision individuals need • Individuals, to verify that they are receiving the general supervision and supports they need • Family and/or advocate • Program management or clinical staff
DOCUMENTATION REVIEW Only As needed: • Life Plan or other plan of services and any associated service plan (i.e., BSP) • IPOP and associated plans, where applicable • Other clinical assessments (i.e., speech or occupational therapy) that may identify support needs

OBSERVATION

Mandatory:

- While individuals are in the setting, observe to determine if they are receiving supports and supervision in accordance with their demonstrated needs

Review this standard based on observations during routine activities in the setting. While standards 5-1 through 5-4 focus on specific activities and needs, this standard requires surveyor observations and other review activities to determine whether services and supports adequately address health and safety needs other than those in specified in standards 5-1 through 5-4.

Consider whether the staff monitor the individuals for changing supervision and support needs. If an individual had a change in physical or mental health, was the individual's need for support and supervision reassessed? Was the plan of care revised to address the individual's changing needs? Were staff trained to implement changes to the plan? Did staff demonstrate proper implementation of the plan?

Were there other unmet health and safety needs? What is the facility or agency process to ensure that ongoing assessments are completed to identify and address individuals' health and safety needs?

Determine the standard is MET if:

- The staff gave each individual sufficient supports and supervision to maintain the individual's safety and wellbeing.
- Reassessments were completed in response to individuals' unmet and/or changing needs.
- No concerns about individuals' safety and wellbeing were noted during observations.

Determine the standard is NOT MET if either of the following is present:

- Individuals' health and safety needs were not supported or met during observations.
- Individuals were at risk for harm due to lack of supervision and/or supports from the staff.

5-6 There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
633.4(a)(4)(ix)-(x) No person shall be denied: (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.16(b)(4)(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more
ACRONYMS BSP: Behavior Support Plan HCBS: Home and Community Based Services IPOP: Individualized Plan of Protective Oversight IRMA: Incident Reporting and Management Application LOS: Level(s) of Supervision
DISCUSSION Mandatory: • Direct support staff, to discuss individuals' needs and staff perceptions about the adequacy of staffing to meet those needs • Individuals, to discuss their perceptions about the adequacy of facility staffing As needed: • Family and/or advocate, to discuss their perceptions about the adequacy of facility staffing • Program management staff, to discuss concerns that arose from staff, individual, family interviews

DOCUMENTATION REVIEW
Mandatory:

- IRMA and, where applicable, other incident management information*
- Communication log
- Staff schedule

Only as needed, unless previously reviewed to address other standards in the protocol (i.e., information on dining needs, mobility, special risk areas):

- Life Plan and any related service plans
- IPOP containing required LOS
- Physicians' orders
- Clinical assessments
- BSPs
- Staff schedules

OBSERVATION
Mandatory:

- While individuals are in the setting, observe to determine if they are receiving supports and supervision in accordance with their demonstrated needs

Review this standard based on observations during routine activities in the setting and other information gathered in advance of and during the visit.

Review incidents in IRMA before the visit to see if insufficient staffing was a factor in any incidents. (*Note: A voluntary agency may document a written incident report (rather than enter in IRMA) and a written investigation and review any minor notable occurrences as defined in and paragraph 624.4(c)(2); documentation of these incidents will be reviewed, where applicable, during the visit.)

Review the site communication log or similar documentation that could provide evidence of staffing practices.

Review the staffing plan and staffing schedules for the facility.

Determine if staffing during the visit is in accordance with the staffing plan.

Ascertain if the number of staff is sufficient to supervise individuals and attend to their needs for support.

Ascertain if there is an effective system to replace staff who are out sick or on vacation and to cover staffing vacancies.

Ask staff and individuals if they believe that staffing is sufficient to provide support and supervision to individuals in the facility and during community activities.

Determine whether staffing is sufficient to implement individuals' person-centered plans, and where applicable, meet HCBS requirements.

Determine whether individuals have to wait for long periods of time to receive attention from staff.

Determine whether staffing is sufficient to accommodate individuals' schedules and choices.

Determine if mealtimes are well organized, with sufficient staffing to address individuals' needs and preferences.

Determine if recreational activities and/or medical appointments are canceled due to insufficient staffing.

Determine if incidents show a high number of elopements, accidents, or injuries of unknown origin, or incidents of substantiated neglect, that may indicate staffing is inadequate to protect individuals.

Determine if individuals are appropriately groomed and dressed.

A negative answer to any of these questions may be an indication that staffing is not sufficient to meet individuals' needs for basic care, protection, and habilitation.

Note that in a residential program mealtimes, late afternoons, and the early morning periods are good times to observe and determine whether staffing is adequate to address individuals' health and safety needs.

Determine the standard is MET if:

- Based on observations and documentation review described above, staffing levels during the visit appeared adequate to provide needed supervision and supports and were in keeping with the site's staffing plan.
- Staffing levels allowed for effective responsiveness to individuals' needs and routines.

Determine the standard is NOT MET if any of the following is present:

• Based on observations and documentation review as described above, staffing levels during the visit appeared inadequate to meet individuals' needs for support and supervision. • Staffing levels were not sufficient to deliver services and supports included in individuals' plans of care. • Staffing levels did not allow for effective responsiveness to individuals' needs and routines.

5-7 The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
635-7.4(b)(3)(iii)(a)-(d) (iii)The home must have and maintain active telephone service. (a) Cellular and/or landline services must be used to meet this requirement. (b) If cellular telephone service is not available at a location at all times, landline telephone service is required. (c) Landline telephone service, where provided, must consist of one or more of the following types of land based transmission: cable, microwave, fiber optic, or copper wire. (d) Landline telephone service must remain in working order and function during power outages or be backed up by immediately available cellular service.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
635-7.3(c)(6)(i)-(iv) The facility must have and maintain active telephone service. (i) Cellular and/or landline services must be used to meet this requirement. (ii) If cellular telephone service is not available at a location at all times, landline telephone service is required. (iii) Landline telephone service, where provided, must consist of one or more of the following types of land based transmission: cable, microwave, fiber optic, or copper wire. (iv) Landline telephone service must remain in working order and function during power outages or be backed up by immediately available cellular service.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.3(h)(11)(i)-(ii) All facilities, except family care homes and IRAs for eight or fewer persons, shall comply with the following requirements (11) There is a communication system which ensures the following: (i) the prompt contacting of on-duty personnel; and (ii) the prompt notification of responsible personnel in the event of an emergency.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(5) The agency/facility shall develop a plan for addressing the life threatening emergency needs of the persons served. Such a plan shall be based on the needs of the persons in the facility, and shall address the availability of first aid, cardiopulmonary resuscitation (CPR) techniques and access to emergency medical services. Where staff training is part of the plan, there shall be provision to keep such training up to date. For family care homes, the relevant sponsoring agency shall be responsible for addressing this requirement.
Program Class/Type:

Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS

IRMA: Incident Reporting and Management Application

DISCUSSION

As needed:

- Direct support staff to determine the staff's knowledge of general supports and supervision individuals need
- Individuals, to verify that they are receiving the general supervision and supports they need
- Family and/or advocate
- Program management or clinical staff

DOCUMENTATION REVIEW

Mandatory:

- IRMA review before visit
- The home's plan to address life threatening emergencies

OBSERVATION

Mandatory:

- Check the phone to make sure the phone service is working

Discuss with the staff the procedures they would follow to contact agency staff when needed, especially in an emergency. Review the emergency plan. Consider the following:

- Ask the staff about circumstances when they must contact agency staff and how effective the communication system has been in those circumstances. Verify that there is a system for the prompt contacting of responsible agency personnel in the event of an emergency or incident.
- Based on document review, interviews with individuals, the staff, agency staff, and any other relevant parties, determine if the plan is effective to prevent negative outcomes. Review incidents in IRMA before the visit and ascertain if any weakness in the communication system contributed to the occurrence of an incident.

• Analyze to determine if the mechanisms of the communication system, if implemented correctly, have the potential to effectively handle or prevent, an emergency situation.

Note: The content of the plan to address life threatening emergencies is reviewed in standard 2-1 and implementation of the plan to address medical emergencies is reviewed in standard 2-2. This standard reviews the plan to address life threatening emergencies in the context of the communication between the staff and program management staff in such an emergency as well as the effectiveness of other procedures established for communication between the staff and the agency in emergencies that may not be considered life-threatening.

Advise the staff that you would like to check the telephone service and ask if there have been any problems with the phone service. Active telephone service is required at all times and especially necessary in emergencies. If the reviewer suspects problems with access to communication with the agency, ask the staff to call the agency's emergency contact to determine if the agency contact can be reached in accordance with the emergency contact plan.

Determine the standard is MET if:

- There is an adequate and effective communication plan.
- The staff know the communication plan.

Determine the standard is NOT MET if any of the following are present:

- The home does not have a communication plan.
- The staff do not know the plan for communication in an emergency.
- There is evidence that the communication plan is ineffective.

Section 6: Rights Protections
6-1 Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
633.4(a)(4)(ix) No person shall be denied:(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-2.4(a)(3) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan: (3) The setting must ensure the individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ACRONYMS IRMA: Incident Reporting and Management Application **DISCUSSION** Mandatory: Individuals receiving services As needed: • Families & advocates • Program staff **DOCUMENTATION REVIEW** Mandatory: • Review of incidents in IRMA. Ensure there is no pattern of disrespectful interactions and/or psychological abuse from staff (whether one employee or multiple) toward any individual (one or multiple). If problems are noted, verify that contributing factors have been satisfactorily addressed

• Communication log if present

As needed

• If concerns, sample of daily notes used to record day to day activities, status of individuals, and/or service delivery

OBSERVATION

Mandatory:

• Observe interactions/communications between staff and individuals

Verify that staff interact with individuals humanely and with full respect for the individual's dignity and personal integrity through observing interactions and activities among staff and individuals. While not inclusive of all considerations, assessment of this standard should include but not be limited to the following:

• Consider whether staff use a tone of voice or display affect toward individuals appropriate to the situation and current activity.
• Individuals should be addressed using their preferred names in a respectful and age-appropriate manner.
• Interactions should be collegial and non-parental and should not set a tone of hierarchy or power over individuals.
• Consider whether staff communicate and engage with individuals regardless of their communication abilities. When staff is supporting the individuals, the staff should be focused on and engaged with the individuals.
• Consider the appropriateness and intensity of physical supports. Individuals should be guided and physically assisted supportively as needed in accordance with their plans of services. Staff should advise or inform an individual before making physical contact with the individual and the individual's equipment and belongings.
• If observations or results of interviews raise concern regarding interactions, conversation content, tone of voice, or specific styles of engagement, ask about the individual's service plan and to determine if there is an explanation or justification for the interaction in question.

Determine the standard is MET if:

• Staff interact in a supportive matter with verbal and gestural communication as described above.
• Interactions are supportive and responsive to individuals' observed or expressed preferences.
• Individuals and their interests and needs are the primary focus vs. the interests of staff members.

Determine the standard is NOT MET if any of the following are present:

• The interactions and communication are not age appropriate (i.e., adults are interacted with as though they are children).
• Interactions and/or communications are staff-focused versus individual-focused. Staff members do not engage individuals while working with them. Staff talk among themselves rather than engaging individuals in the conversations.

- Staff is rude, unkind, harsh and/or intimidating toward individuals.

Note that if staff behavior rises to the level of abuse, neglect or intimidation, the surveyor must intervene appropriately and notify facility management.

6-2 The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
633.4(a)(3) The rights set forth in this section are intended to establish the living and/or program environment that protects individuals and contributes to providing an environment in keeping with the community at large, to the extent possible, given the degree of the disabilities of those individuals. Rights that are self-initiated or involve privacy or sexuality issues may need to be adapted to meet the need of certain persons with the most severe disabilities and/or persons whose need for protection, safety and health care will justify such adaptation. It is the responsibility of the agency/facility or the sponsoring agency to ensure that rights are not arbitrarily denied. Rights limitations must be documented and must be on an individual basis, for a specific period of time, and for clinical purposes only. (Note: See section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-2.2(b)(1)-(3) HCBS supports and services must encourage individuals to take part in the broader community in a way that is meaningful to the individual, in accordance with: (1) a person-centered service plan developed, implemented, and reviewed in compliance with Subpart 636-1 of this Part; (2) applicable HCBS requirements in Subpart 635-10 of this Title; and (3) sections 636-2.3, 636-2.4, and 636-2.5 of this Subpart.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
636-2.4(c) In OPWDD-operated or certified settings and other provider owned or controlled residential and non-residential settings, any modification to the qualities or conditions in paragraph (a)(6), (7), or (8) or subdivision (b) of this section must be supported by a specific assessed need, justified, and documented in the individual's person-centered service plan or other internal guidance document(s) pursuant to section 636-1.4 of this Part. The Medicaid HCBS provider agency must maintain such documentation as required by OPWDD. Note: Providers subject to section 633.16 of this Title must consult that section for additional documentation requirements concerning person-centered behavioral intervention. Providers subject to section 633.4 of this Title must consult that section for documentation requirements concerning modifications of rights of individuals receiving services that are not duplicated in paragraphs (a)(6), (7), (8) and subdivision (b) of this section.
Program Class/Type:

IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab

ACRONYMS

HCBS: Home and Community Based Services

DISCUSSION

Mandatory:

- Individuals receiving services
- Program staff

As needed:

- Families & advocates

DOCUMENTATION REVIEW

Mandatory:

- Communication log, where applicable

As needed:

- Posted information about home operations/rules
- Site policy/procedures or rules if applicable

OBSERVATION

Mandatory:

- Observe site routine to assess if any site rules are communicated and/or encouraged that individuals are expected to follow which limit independent activities and choices

This standard is focused on how the site operates, rather than on how the site's practices specifically affect each individual receiving services. This standard is reviewed to ensure the site does not apply facility/house rules or policies, procedures, and practices that systemically limit or restrict individuals' rights.

Ask staff and individuals if there are any general facility/house rules. Look for any blanket restrictions on any of the HCBS settings rights (where applicable) or limits on other individual rights (including those in section 633.4). In some cases, the agency may have written policies and procedures for house/program that place limits on rights, but there may also be unwritten rules followed by practice.

Generalized program rules can result in unnecessary or inappropriate restrictions on individuals' personal autonomy. Examples of such rules include, but are not limited to rigidly scheduled mealtimes, bedtimes, and curfews. Rules might also be imposed to limit when televisions, computers, phones, other devices can be used. Routines may be established to facilitate activities and respect for others in group living arrangements; however, such routines must not become or be perceived as unbending rules. Limitations on specific individuals' rights may only be imposed in accordance with rules in 14 NYCRR sections 633.4, and 633.16, and – in HCBS Settings - 636-2.4.

Determine the standard is MET if:

- There are no blanket rules, policies/procedures, or expectations that restrict individuals from determining their own "schedules" for activities in and outside of the setting.
- Observations and documentation demonstrate, and interviews verify, that individuals are free to determine their activities and activity times.

Determine the standard is NOT MET if either of the following is present:

- There is house or site rules/policies/procedures or expectations that restrict people. (This does not include rules that are expectations of mutual respect and polite behavior among housemates).
- While not written explicitly, there is evidence through observation or interview that there are general understandings of blanket rules that result in restricting individuals without justification.

6-3 Individuals are supported to engage in activities in accordance with their interests and preferences.
633.4(a)(3) The rights set forth in this section are intended to establish the living and/or program environment that protects individuals and contributes to providing an environment in keeping with the community at large, to the extent possible, given the degree of the disabilities of those individuals. Rights that are self-initiated or involve privacy or sexuality issues may need to be adapted to meet the need of certain persons with the most severe disabilities and/or persons whose need for protection, safety and health care will justify such adaptation. It is the responsibility of the agency/facility or the sponsoring agency to ensure that rights are not arbitrarily denied. Rights limitations must be documented and must be on an individual basis, for a specific period of time, and for clinical purposes only. (Note: See section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-2.2(b)(1)-(3) HCBS supports and services must encourage individuals to take part in the broader community in a way that is meaningful to the individual, in accordance with: (1) a person-centered service plan developed, implemented, and reviewed in compliance with Subpart 636-1 of this Part; (2) applicable HCBS requirements in Subpart 635-10 of this Title; and (3) sections 636-2.3, 636-2.4, and 636-2.5 of this Subpart.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
DISCUSSION Mandatory: • Individuals receiving services • Program staff As needed: • Families & advocates • Executive staff **DOCUMENTATION REVIEW**

Mandatory:
- Communication log, where applicable

As needed:
- Posted information about home operations/rules
- Site policy/procedures or rules, if applicable

OBSERVATION

Mandatory:
- Observe site routine to assess if the site follows generally applied rules
- Observe if “house” or “site” or “program” rules are posted

This standard verifies that practices, policies, and procedures in place at the setting do not prohibit the rights of individuals to participate in activities of their choosing (as long as the activity is legal). The residence and staff do not necessarily have to agree or believe in the choice of the individual, but it is important that the choice is still honored.

Support for activities of choice requires that meaningful discussions on risks and safeguards occur, and that individuals are making informed choices.

Are the rights of individuals to make choices regarding their activities and associations honored?

Are choices arbitrarily restricted or limited because of value judgments or beliefs of staff?

Did reviewer observe instances in which the choices of individuals were not honored?

Policies and procedures or rules do not bar an individual’s engagement in legal activities.

Examples of legal activities include but are not limited to: gambling, alcohol use, sexual activity, pornography, attendance at movies with “R” ratings as allowed by law applicable to all citizens, etc.

Determine the standard is MET if:

- There is evidence that individuals are engaging in legal activities of their choosing and are not arbitrarily prohibited from participation in those activities.
- If individuals engage in legal activities that present risk to their well-being, their involvement is based on informed decision-making that includes discussion of risks, safeguards, and alternatives.
- If restrictions to engage in legal activities are imposed by the facility or program, the restrictions, limitations, or modifications to rights are justified with documentation in accordance with applicable OPWDD regulations in 633.4, 633.16, and/or 636-2.

Determine the standard is NOT MET if either of the following is present:

- There are indications that individuals are denied opportunities to engage in legal activities without justification and required documentation.
- The facility or agency has policies and procedures or rules that prohibit legal activities.

6-4 Individuals have full access to all areas without restrictions or barriers.
633.4(a)(3) **The rights set forth in this section are intended to establish the living and/or program environment that protects individuals and** contributes to providing an environment in keeping with the community at large, to the extent possible, given the degree of the disabilities of those individuals. Rights that are self-initiated or involve privacy or sexuality issues may need to be adapted to meet the need of certain persons with the most severe disabilities and/or persons whose need for protection, safety and health care will justify such adaptation. It is the responsibility of the agency/facility or the sponsoring agency to ensure that rights are not arbitrarily denied. Rights limitations must be documented and must be on an individual basis, for a specific period of time, and for clinical purposes only. (Note: See section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-2.4(a)(4) (a) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan: (4)The setting must optimize, and not regiment, individual initiative, autonomy, and independence in making life choices including, but not limited to, the individual's decisions regarding daily activities, physical environment, and with whom to interact.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
636-2.4(a)(9) (a) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan (9)The setting must be physically accessible to the individual
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
DISCUSSION As needed for clarification: • Individuals receiving services • Program staff

DOCUMENTATION REVIEW
As needed:
- Service plans addressing specific restrictions

OBSERVATION
Mandatory:
- Observe for environmental factors that enhance independence or impose limitations and/or dependencies as described below

Individuals should have full and independent access to all areas and routine living spaces of the setting without restrictions or barriers. (If rights are modified for a specific individual's clinical needs, modifications meet requirements for such modification). Individuals should have access to their home and service sites and to all typical spaces in the settings, with as much independence as possible, determined by an individual's skills, and individualized needs for environmental, adaptive, and human supports. Environmental modifications, use of technology, and personal assistance from staff are all supports that enable an individual to have greater control over and more independent access to the environment. Some individuals may need specialized training and encouragement to feel comfortable fully accessing and using the setting and its features. In some cases, a residence or other setting may have unnecessary locked areas, and other practices that prevent an individual's access to the environment.

The following considerations should be used to determine if the individual is being supported to increase his/her independence to move about his/her home and community.
- Individuals should have full and independent access to all areas and routine living spaces of the residence/site without restrictions or barriers (i.e., locks, gates, requiring permission, etc.).
- Individuals should have access to and are supported to access the bathroom, kitchen, laundry, cupboards/closets for supplies and activity materials, and areas where any personal possessions are stored (i.e., off-season clothing, seasonal room decorations, etc.). Individuals should also have access to commonly used appliances in the setting.
- The setting should be physically accessible according to the needs of the individuals.
- If needed, the home or site provides environmental supports and adaptations to assist people to use and access the environment. Adaptations may include: grab bars, wheelchair accessibility, ramps, modified equipment, and features that support individuals' use of the setting. For example, if an individual uses a wheelchair, consider whether closets are arranged so that the belongings and commonly used objects are reachable, or a counter-top in the kitchen modified to support an individual's interest in preparing meals and accessing the food and utensils.

• In a residence, if the laundry supplies and or storage are on another floor (i.e., basement or attic, or 2nd floor that is non-accessible) consider whether the residence takes action to facilitate access in a manner that does not limit autonomy or creates a staff dependent situation.
• Determine whether house/site rules and practices limit or interfere with individuals' access to the environment.
• Determine if individuals receive education and support to use equipment such as stoves, microwaves, and washer/dryer.
• Ask individuals and staff if any modifications to the setting are needed or have been made to increase individuals' access to their environment.

Determine the standard is MET if:

• Individuals have full access to and use of the site and its features and appliances.
• The site is arranged and designed to facilitate independence.
• Individuals are observed to and supported to function as independently as possible within the environment and/or supported toward independence as needed.
• If barriers are in place due the needs of one or a few, the individuals who can have free access are accommodated in effective ways
• Barriers and limited access occur only with clear clinical justification, and documentation that alternative methodologies were ineffective.

Determine the standard is NOT MET if:

• Areas of the home or site are "off limits" to individuals receiving services either by physical barriers or rules, policies, and procedures without justification and protections required in accordance 633.4(a) with required and related rights limitations evidence and documentation.
• Areas of the home or site are accessible only for limited time periods without justification and related rights limitation evidence and documentation.
• Individuals are not encouraged or supported to function independently in the site or home.
• The setting is not conducive to ensuring independence, resulting in dependence on staff.

6-5 Individuals' health and other protected information is kept private/protected.
633.4(a)(4)(vii) (vii)No person shall be denied: confidentiality with regard to all information contained in the person's record, and access to such information, subject to the provisions of article 33 of the Mental Hygiene Law and the commissioner's regulations. In addition, confidentiality with regard to HIV-related information shall be maintained in accordance with article 27-F of the Public Health Law, 10 NYCRR Part 63 and the provisions of section 633.19 of this Part
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-2.4(a)(3) (a) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan: (3)The setting must ensure the individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ACRONYMS ID/DD: Intellectual Disability/Developmental Disability **DISCUSSION** As needed: • Individuals receiving services • Program staff • Clinical staff • Families & advocates **DOCUMENTATION REVIEW** As needed: • Documents posted and in plain view

OBSERVATION

Mandatory:

- Observe where Individual health information & protected information is stored
- Observe for any Individual health or private information being posted at site (as described below)

The standard addresses both protection of an individual's personal information as well as whether the facility is creating a homelike environment (residences) or a community friendly environment (day settings). Having protected health information and other personal information publicly posted is a violation of an individual's s right to privacy. Besides violating the individual's right to privacy, it also contributes toward creating a more clinical and institutional atmosphere more like that of a hospital/clinic than that of someone's home or integrated service environment. This type of personal information should be discreetly available only to relevant staff who need access to the information.

Things to consider:

- Are diagnoses, heath care regimens, or other personal information related to the person's ID/DD services in view of others?
- Are individual-specific diet orders and food consistency requirements posted visibly for anyone to see?
- Are bowel management regimens posted publicly in the program?
- Are medical appointment notices, changes in medications, and other private and personal health care information posted publicly and visibly?
- Do the bulletin boards in common areas include posting of individual names and personal information?

Determine the standard is MET if:

- There is no evidence of private information being accessible to other residents, visitors, etc., in the site based on observation and walk through.

Determine the standard is NOT MET if any of the following are present:

- Schedules for individuals' private medical appointments and medical information are posted in the site visible to anyone.
- Individuals' dietary restrictions/modifications are posted and visible to anyone.
- Other information considered private is not secured but posted, visible, and/or available to others to view.

6-6 Individuals have privacy in their home and service environments as appropriate to the situation.
633.4(a)(4)(xx) No person shall be denied: (xx) a reasonable degree of privacy in sleeping, bathing and toileting areas
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(xxiv) No person shall be denied: (xxiv) the opportunity to receive visitors at reasonable times; to have privacy when visited, provided such visits avoid infringement on the rights of others, and to communicate freely with anyone within or outside the facility; except that in settings where Medicaid Home and Community Based Services (HCBS) are delivered, rights regarding visitors shall be governed by Subparts 636-1 and 636-2 of this Title;
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-2.4(a)(3) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan: (3) The setting must ensure the individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
636-2.4(b)(2)(i) In addition to those qualities and conditions described in paragraphs (a)(1) through (9) of this section, all the following conditions must be met in OPWDD-operated or provider owned or controlled residential settings: (2) The individual must have privacy in his or her residence and bedroom to the extent applicable. (i) Residences and bedrooms within residences must have entrance doors lockable by the individual, with only appropriate parties having keys/access to doors as needed.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
DISCUSSION Mandatory: • Individuals receiving services

- Program staff

As needed:
- Families & advocates
- Clinical staff

DOCUMENTATION REVIEW
As needed:
- Service plans addressing specifics of a person not having privacy in their living quarters

OBSERVATION
Mandatory:
- Observe for any breaches in privacy (as described below)

The privacy of individuals receiving services must be respected. This includes being able to have private conversations, having a say in who has access to their personal possessions and living space, as well as having privacy in bathing, grooming, and dressing. This question must be answered through observation of the residence and interviews with individuals.

By observation, verify the following:
- Staff do not talk with individuals about private issues in front of others.
- Staff do not communicate among themselves about any individual in front of others.
- Staff respect the individuals' privacy by asking permission (i.e., knocking and making request), waiting for a response, before entering their bedrooms or living space.
- Individuals can find space to have hold private conversations with others present or communication mechanisms.
- Bedroom doors close and latch. Individuals who wish to, can lock their bedroom doors and have keys (or modified secure entry method) to their bedrooms, with only appropriate staff also having access to a 'key'.
- Bathrooms provide privacy for individuals. The doors can be closed and locked.
- Individuals are afforded privacy in bathrooms and bedrooms, except where assistance or supervision are required to address clinically identified health and safety needs.
- In shared bedrooms, individuals are provided the degree of privacy desired and possible.
- Individuals have opportunities to be alone by choice.
- Individuals are provided opportunities to take medications and receive treatments privately.

- Individuals are supported, assisted, and reminded to facilitate their own privacy.
- Individuals are supported, reminded, and assisted to respect each other's privacy.
- There are no other observed potential barriers to privacy.

By discussions with individuals, verify the following:

- They have enough privacy when dressing, using the bathroom, or bathing.
- They can decide who can enter their bedroom.
- They have their own keys (or other modified secure access) to their bedrooms. They know which staff also has a key.
- They can be alone when they want to be.
- Individuals believe that staff respect their privacy.

Determine the standard is MET if:

- Observations show that individuals' privacy is respected as described above.
- Individuals, as capable, report that their privacy is assured according to their needs.
- Staff take action to maintain the privacy of individuals in their daily activities and social interactions (phone use, social media and computer use, conversations) as needed.

Determine the standard is NOT MET if either of the following is present:

- The privacy of individuals (as described above) is not considered or respected as observed in the actions of staff and operations of the home.
- Documentation or interview revealed a pattern of disregard or lack of support for individuals' privacy within the residence, in their conversations and social interactions, and/or in the personal care provided to individuals in the residence.

6-7 Individuals have access to food at any time.
633.4(a)(3) The rights set forth in this section are intended to establish the living and/or program environment that protects individuals and contributes to providing an environment in keeping with the community at large, to the extent possible, given the degree of the disabilities of those individuals. Rights that are self-initiated or involve privacy or sexuality issues may need to be adapted to meet the need of certain persons with the most severe handicaps and/or persons whose need for protection, safety and health care will justify such adaptation. It is the responsibility of the agency/facility or the sponsoring agency to ensure that rights are not arbitrarily denied. Rights limitations must be documented and must be on an individual basis, for a specific period of time, and for clinical purposes only. Note: See section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(xvii)(a)-(b) No person shall be denied: (xvii) a balanced and nutritious diet. This right shall provide that: (a) meals are served at appropriate times and in as normal as manner as possible; and (b) altering the composition or timing of regularly served meals for disciplinary or punishment purposes, for the convenience of staff, or for behavior modification shall be prohibited;
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-2.4(a)(7) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan: (7) The individual must have access to food at any time, consistent with the same or similar settings for the broader community.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ACRONYMS BSP: Behavior Support Plan IPOP: Individualized Plan of Protective Oversight

DISCUSSION
Mandatory:
- Individuals receiving services
- Program/Agency/Clinical staff

DOCUMENTATION REVIEW
As needed:
- If there are limitations on access to food or if compliance cannot be assessed through interview and observation, review service plans or plan components addressing specifics of behavioral and/or dietary needs for support and guidelines (including consistencies) such as IPOPs, BSPs, or dietary support plans

OBSERVATION
Mandatory:
- Observe for any limitations on individuals having access to food, including limits on choices during meals (as described below)

This requirement means that individuals should have opportunities to choose the foods they want to eat, store food or eat in their rooms if they choose to and decide when to eat. Presenting individuals with narrow food choice options, without their input, does NOT satisfy this requirement. Having access to food at any time does NOT mean that FULL dining services or meals should be available 24 hours a day; it means having ACCESS to food at any time.

Rights Modifications: Through interviews and review of an individual's record, determine if there have been any restrictions placed on the individual's access to food. Any modification or restriction to food choices or choice of mealtimes is considered a restriction of the individual's rights. If there is an appropriate rights modification documented that restricts the right of an individual to have access to food at any time, the rights modification must have been discussed and reviewed as part of the person-centered planning process and must be supported by a specific assessed need. If related to an assessed behavioral need, it must be documented in a BSP in accordance with all of the requirements of 633.16 (Review separately as needed, see section 10h).

Note: If other individuals are affected by a restriction that is necessary for another individual, it is expected that reasonable approaches are taken to support these individuals so they can have access food at any time. This might means including ways that they can request and have access to food when they want it. In a residential program this could include having a secure locked pantry in their own rooms or having a key to access a locked kitchen or pantry in the home. In a day program, there must be accommodations for access to lunch and snacks. For those affected by a rights restriction for someone else, documentation of the following is required in their person-centered service plan (or attachments):

1. The impact that the rights modification has on the individual.
2. The efforts taken to lessen the impact on the individual.
3. The written informed consent of the individual.

Determine the standard is MET if:

- In residences, individuals have access to food at all times, access to a refrigerator, cabinets, or pantry, or other individualized means in accordance with their person-centered plans. In day settings, individuals should have access to lunch and snacks consistent with access provided to others in similar environments who are not receiving services.
- If an individual does not have access to food, there is an appropriate rights modification in place through the person-centered planning process that includes all the required elements.

Determine the standard is NOT MET if:

- Individuals do not have access to food at any time.
- There are program rules, policies or operational practices in place that are obstacles/barriers to this right.
- Rights modifications do not include required elements.
- Preferred food and snack choices are stored or locked in inaccessible locations that require staff assistance to access.

6-9 Events that meet the definition of reportable incident or notable occurrence have been reported.
624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part. Custodians of programs and facilities certified or operated by OPWDD are mandated reporters and are also required to report reportable incidents pursuant to section 491 of the Social Services Law. Reports shall be made in accordance with agency policies/procedures.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
625.4(a)(1)-(4) Reporting to OPWDD. The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (a)(1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA).(a)(2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. (a)(3) The agency must report updates on the event or situation in IRMA on a monthly basis or more frequently upon the request of OPWDD until the event or situation is resolved. Such updates must include information about subsequent interventions (see section 625.3[b] of this Part) and must include information about the resolution of the event or situation.(a)(4) Requirements concerning OPWDD involvement in deaths that are not under the auspices of an agency are in section 625.5 of this Part.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS IRMA: Incident Reporting and Management Application **DISCUSSION** Mandatory: • Individuals receiving services • Program staff • Families & advocates

As Needed:
- Management and/or clinical staff

DOCUMENTATION REVIEW
Mandatory:
- IRMA/minor notable occurrences*
- Review site documents/records for the previous three (3) months such as any daily logs, communication logs, nursing logs, accident reports, etc., as well as behavior data and health care records reviewed for the sample, in order to verify that all events that should have been reported as incidents or notable occurrences were reported, as required. If a minor notable occurrence* is discovered, and the incident was not entered in IRMA, request the form OPWDD 147 and evidence that the chief executive officer was notified within 48 hours as required

As needed for clarification:
- Accident/Injury reports
- Service notes
- Health care documentation

OBSERVATION
As needed
- If an incident is observed during visit, verify that the event was reported as prerequired once the individuals' protection and care needs are addressed.

Reportable incidents and notable occurrences are incidents that may affect the health and wellbeing of an individual receiving services.

Verify that agency staff who are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence, have reported incidents and occurrences, as required.

Speak with staff, individuals receiving services, and family members regarding incidents and occurrences involving individuals receiving services. Ask if there have been any recent circumstances, injuries, medication errors that placed individuals at risk for harm. Follow up on any information provided to determine whether the circumstances should have been reported as incidents or notable occurrences and whether incidents and occurrences were reported as required.

Health care records, behavior management records, or logbooks may reference emergency room trips, injuries, medication administration issues. Ensure those circumstances that occur under the auspices of the agency that meet definitions of reportable incidents and notable occurrences in sections 624.3 and 624.4 are reported in accordance with section 624.5.

Determine the standard is MET if:

- Incidents and occurrences were reported to the chief executive officer and OPWDD, where applicable, and the Justice Center, where applicable, as required.

Determine the standard is NOT MET if:

- An incident or occurrence identified during the review was not reported to the agency administrator and/or OPWDD, where applicable, and/or the Justice Center, where applicable, as required.

Select N/A if:

- No incidents or occurrences requiring reporting occurred based on review findings.

NOTE: A voluntary agency may document a written incident report (rather than enter in IRMA) and a written investigation and review for any minor notable occurrences as defined in paragraph 624.4(c)(2)(ii).

6-10 Events and situations defined in Part 625 have been reported to OPWDD, as required.
625.5(c)(2) (c) The death of any individual who had received services certified, operated, or funded by OPWDD, within 30 days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows:(2)The agency must submit an initial report about the death in IRMA within 24 hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS IRMA: Incident Reporting and Management Application **DISCUSSION** Mandatory: • Individuals receiving services • Program staff • Families & advocates As needed: • Management and/or clinical staff **DOCUMENTATION REVIEW** Mandatory: • IRMA • Review site documents/records for the previous three (3) months such as daily logs, house logs, communication logs, nursing logs, accident reports, etc. as well as health care records reviewed for the sample., in order to verify that all circumstances that should have been reported as Part 625 events and situations were reported as required • If event/situation is discovered, request verification of form OPWDD 150 and/or recheck IRMA if applicable to the type of event As needed for clarification: • Accident/Injury reports

- Service notes
- Health care documentation

OBSERVATION
N/A

This standard applies to events and situations that are not under the auspices of a provider agency. Events and situations to be reported include those that meet the definitions of physical, sexual, or emotional abuse; active, passive, or self-neglect; financial exploitation, or death as defined in 625.2.

Speak with staff, individuals receiving services, and family members regarding significant events involving individuals. Ask staff if there have been any recent events or situations involving individuals receiving services that occurred when the individuals were not under the supervision of the agency (i.e., during home visits for individuals who reside in certified residential programs, or during non-program hours for individuals who receive day services). Follow up on any information provided by staff or during the documentation review to determine if events and situations defined in were reported in IRMA in accordance with 625.4(a).

Determine the standard is MET if:
- Events/situations known to the program/agency were reported as required.

Determine the standard is NOT MET if:
- Events/situations known to the program/agency were not reported as required.

Select N/A if:
- No events or situations requiring reporting occurred based on review findings.

6-11 Immediate care and treatment was provided to the individual involved in the incident.
624.5(g)(1) (g) Immediate protections.(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
624.5(g)(4) (g) Immediate protections.(4) If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS CR: Community Residence FSR: Free Standing Respite IRA: Individualized Residential Alternative IRMA: Incident Reporting and Management Application RI: Reportable Incident RN: Registered Nurse **DISCUSSION** As Needed: • Individuals receiving services • Staff • Families & advocates • Management and/or Clinical staff

DOCUMENTATION REVIEW
Mandatory:
- IRMA

As needed:
- Incident documentation not required to be entered into IRMA due to classification of event
- Service notes
- Health care, clinical documentation

OBSERVATION
N/A

SAMPLING For IRAs/CRs, FSRs, Day Programs, Clinics, Specialty Hospitals, and Private Schools <20 capacity
- Review this standard for the 5 most recent RIs and 3 most recent Notable Occurrences reported for the site

SAMPLING For Day Programs, Clinics, Specialty Hospitals, and Private Schools >20 capacity
- Review this standard for 10% sample of RIs maximum 10
- Review this standard for the five most recent Notable Occurrences

An individual's safety must always be the primary concern of the chief executive officer (or designee). The agency must take the necessary and reasonable steps to ensure that an individual receiving services who has been affected by the event receives any necessary treatment or care whether medical, clinical, or supportive.

In a circumstance where an individual may have been injured, determine if an assessment was completed by a nurse or other medical professional. If an individual was physically injured, an appropriate medical examination of the individual must be completed. The name of the examiner must be recorded, and their written findings must be maintained in accordance with 624.5(g)(4). The examiner could be an RN at the facility. However, if the injury required treatment beyond first aid by another practitioner, there must also be documentation of that examination and treatment rendered.

Reporting of the event in IRMA should include the initial treatment and care provided to the person. Verify that the individual was provided timely assessment and treatment through documentation review and interview.

Determine the standard is MET if:

- There was documented evidence to show that immediate care and treatment were provided in response to incidents as required.

Determine the standard is NOT MET if:

- There was no evidence to demonstrate that immediate care and treatment were provided in response to incidents as required.

Select N/A if:

- There were no incidents or occurrences.

6-12 Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
624.5(g)(1-3) (g) Immediate protections. (1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (2) When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (3) When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS CR: Community Residence FSR: Free Standing Respite IRA: Individualized Residential Alternative IRMA: Incident Reporting and Management Application RI: Reportable Incident RN: Registered Nurse **DISCUSSION** As Needed: • Individuals receiving services • Staff • Families & advocates • Management and/or Clinical staff **DOCUMENTATION REVIEW** Mandatory: • IRMA

As needed
- Incident documentation not required to be entered into IRMA due to classification of event
- Documentation of initial training, increased supervision, or other initial protective or corrective actions

OBSERVATION
N/A

SAMPLING For IRAs/CRs, FSRs, Day Programs, Clinics, Specialty Hospitals, and Private Schools <20 capacity
- Review this standard for the 5 most recent RIs and 3 most recent Notable Occurrences reported for the site

SAMPLING For Day Programs, Clinics, Specialty Hospitals, and Private Schools >20 capacity
- Review this standard for 10% sample of RIs maximum 10
- Review this standard for the five most recent Notable Occurrences

The IRMA reporting of the event should document initial actions taken to protect the individuals. Verify that this was implemented through documentation review and interview. Ensure that the actions taken appear to be adequate.

An employee, intern, volunteer, consultant, or contractor alleged to have abused an individual person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency.

An individual receiving services must be removed from a facility when it is determined that there is a risk to the individual if the individual continues to remain in the facility.

Immediate protections in response to abuse or neglect may also include provision of increased staff support, staff training, and/or supervision, specialized equipment, and/or immediate changes in safeguards provided to the individual.

Determine the standard is MET if:
- There was documented evidence to show that initial protective and corrective actions were implemented immediately, as required.

Determine the standard is NOT MET if:
- There was no evidence to demonstrate that initial protective and corrective actions were implemented immediately, as required.

Select N/A if:

- There were no incidents or occurrences.

6-13 Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
624.5(h)(1) General investigation requirements. (1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section).
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
624.5(h)(4)(i)-(ii) General investigation requirements. When an agency is responsible for the investigation, the investigation must be documented. Such documentation must include an investigative report. (i) For all reportable incidents and notable occurrences, investigative reports must be in the form and format specified by OPWDD. (ii) For reportable incidents and serious notable occurrences, the full text of the investigative report must be entered/uploaded into IRMA pursuant to subparagraph (f)(1)(iii) of this section. Note: In the event that the central office of OPWDD conducts an investigation of an incident or notable occurrence, the central office of OPWDD will make the investigative report available through IRMA.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
624.5(h)(5) General investigation requirements. (5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS
BSP: Behavior Support Plan
CR: Community Residence
FSR: Free Standing Respite
IPOP: Individualized Plan of Protective Oversight
IRA: Individualized Residential Alternative
IRMA: Incident Reporting and Management Application
MNO: Minor Notable Occurrence
OIIA: Office of Investigations and Internal Affairs
PRN: *Pro re nata* (as needed)
RI: Reportable Incident
RN: Registered Nurse

DISCUSSION
As Needed:
- Agency investigator
- Individuals receiving services
- Staff
- Families & advocates
- Management and/or clinical staff

DOCUMENTATION REVIEW
Mandatory:
- IRMA

As needed
- Incident documentation not required to be entered into IRMA due to classification of event
- Logbooks
- Plans of care, including safeguards
- Medical and other clinical records, etc.

OBSERVATION

As Needed:

- To verify information in the report

SAMPLING For IRAs/CRs, FSRs, Day Programs, Clinics, Specialty Hospitals, and Private Schools <20 capacity

- Review this standard for the 5 most recent RIs that were investigated by the agency (not investigated by OIIA or The Justice Center) and 3 most recent Notable Occurrences reported for the site (except for deaths investigated by OIIA or Justice Center)

SAMPLING For Day Programs, Clinics, Specialty Hospitals, and Private Schools >20 capacity

- Review this standard for 10% sample of RIs maximum 10 that were investigated by the agency (not investigated by OIIA or The Justice Center)
- Review this standard for the five most recent Notable Occurrences (except for deaths investigated by OIIA or The Justice Center)

Review investigation reports and investigative records when available as entered into IRMA. Request and review additional documentation from the provider agency for events that do not require record upload and/or entry into IRMA (i.e., MNOs).

Investigations may vary in scope and intensity depending on the event, location, and circumstances. In all cases, investigation reports and records should demonstrate efforts made to determine what happened. In some cases, the investigation may need to determine whether the event actually occurred. Investigative reports should include specifics such as what happened, when it happened, who was involved, who was present, where the situation occurred, and whether the event is indicative of abuse, neglect or mistreatment. Staffing levels, environmental factors, and immediate and protective actions implemented and/or care provided. Relevant information from the individual's program plan and health care plan should also be considered. Based on analysis of that information, the investigation report should provide an explanation of why the event happened by identifying probable causes and contributing factors. Appropriate recommendations must be made to address findings of the investigation. Recommendations must also be directed toward preventing similar future incidents.

A thorough investigation should consider the following:

- Were the circumstances of the event (i.e., timeframe, place, people present, activity, etc.) established?
- Did the investigation include a review of immediate care provided to individuals subsequent to the incident?
- Was information (i.e., statements and/or interviews) gathered from witnesses and all other relevant parties? These parties may include clinical service providers or others who can provide relevant information, but who did not witness the incident.
- Were relevant medical and clinical assessments reviewed and included in the investigation?
- Was other documentation reviewed based on the nature of the event? These records may include staff communication logs, staff schedules, service plans, IPOPs, BSPs and behavior documentation, PRN notes, medication records, and training records
- Were conclusions made based on the findings?
- Were recommendations made to address causes of the incident and to prevent of similar future incidents?

Paragraph 624.5(h)(4)(i) requires that the investigative report must be in the form and format specified by OPWDD. The Form OPWDD 149 is the required form and format specified by OPWDD. The form must be completed for all investigations that a provider agency is required to complete, including reportable incidents and all notable occurrences.

The form is designed to document a detailed record of an investigation, including specific information about evidence collected and interviews conducted during the investigation. All fields of the report must be completed as applicable to each investigation

Determine the standard is MET if:

- The investigative process included the collection and review of all relevant evidence associated with the event.
- The investigation identified the root causes and contributing factors of the event.
- Conclusions are based on supported findings.
- Recommendations are sufficient to address investigative findings.
- The OPWDD form was used to document the investigative report.

Determine the standard is NOT MET if any of the following is present:

- The investigative process did not include the collection and review of all relevant evidence associated with the event.
- The investigation did not identify the root causes and contributing factors of the event.
- Conclusions were not supported by findings.
- Recommendations were not sufficient to address investigative findings.
- The OPWDD form was not used to document the investigation report.

Select N/A if:

- There were no incidents or occurrences.

6-14 Measures identified to prevent future similar events were developed and implemented.
624.5(h)(4)(i) General investigation requirements. (4) When an agency is responsible for the investigation, the investigation shall be documented. Such documentation shall include an investigative report. (i) For all reportable incidents and notable occurrences, investigative reports shall be in the form and format specified by OPWDD.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
624.5(i)(2)(i)-(ii) (i) Review/investigation by OPWDD and the Justice Center. (2) When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either: (i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
624.7(b)(2)-(5) (b) An IRC must review reportable incidents and notable occurrences to: … (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (3) ascertain if further investigation or if additional corrective, preventive, remedial, and/or disciplinary action is necessary, and if so, to make appropriate written recommendations to the chief executive officer relative to the reportable incident or notable occurrences; (4) identify trends in reportable incidents and notable occurrences (e.g., by type, person, site, employee involvement, time, date, circumstances, etc.), and to recommend appropriate corrective, preventive, remedial, and/or disciplinary action to the chief executive officer to safeguard against such recurring situations or reportable incidents and notable occurrences; and (5) ascertain and ensure the adequacy of the agency's reporting and review practices, including the monitoring of the implementation of approved recommendations for corrective, preventive, and remedial action.
Program Class/Type:

Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
624.5(k)(1)-(5) (k) Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (4) Such plan must be entered into IRMA by the close of the fifth working day after the development of the plan (see subparagraph 624.5(f)(1)(iii)). (5) OPWDD will inform the Justice Center about plans developed pursuant to this subdivision.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS CR: Community Residence DQI: Division of Quality Improvement FSR: Free Standing Respite IPOP: Individualized Plan of Protective Oversight IRA: Individualized Residential Alternative IRC: Incident Review Committee IRMA: Incident Reporting and Management Application OIIA: Office of Investigations and Internal Affairs RI: Reportable Incident **DISCUSSION** As needed: • Program staff

- Individuals receiving services
- Families & advocates
- Management and clinical staff

DOCUMENTATION REVIEW

Mandatory:

- IRMA, as needed depending on the recommendations related to the incident or occurrence
- Communication logs
- Service documentation
- Health care documentation
- Clinical assessments
- Service plans
- IPOP
- Life Plan
- Staff training documentation
- Revised written policy/procedure

OBSERVATION

Mandatory, if visual verification of corrective and/or preventative action is necessary (i.e., installation of grab bars, physical plant renovations)

This standard is intended to verify implementation of actions recommended by non-Justice Center sources (i.e., an agency investigator, OPWDD OIIA, and/or the agency's IRC). Implementation of Justice Center recommendations are reviewed in Standard 6-14, below.

SAMPLING For IRAs/CRs, FSRs, Day Programs, Clinics, Specialty Hospitals, and Private Schools <20 capacity

- Review this standard for the 5 most recent RIs (except for those investigated by the Justice Center) and 3 most recent Notable Occurrences reported for the site (except for deaths investigated by the Justice Center)

SAMPLING For Day Programs, Clinics, Specialty Hospitals, and Private Schools >20 capacity

- Review this standard for 10% sample of RIs maximum 10
- Review this standard for the five most recent Notable Occurrences

Corrective and preventive actions may be identified by an agency investigator, OIIA, or the agency's Incident Review Committee. (Recommendations made by a Justice Center investigator or Letter of Determination are reviewed under Standard 6-14, below.) The corrective and/or preventive recommendations and or actions will be documented in the investigative report, IRC minutes or may be identified as a separate plan for prevention/correction/remediation. The actions may include site and support staff training, staffing issues, supervision and oversight, service plan clarifications, revision of the Life Plan/program plan related to changes in the services, supports or care; etc.

While documentation of actions taken will be available in IRMA, DQI surveyors may need to complete additional activities on survey to verify that actions required were implemented and effective, (i.e., verify that staff understand their responsibilities related to training, new procedures, new service plan result in improved supervision or better strategies to address behaviors, verify that equipment has been provided and helpful, verify that medical interventions are provided, etc.). Take action to verify those actions related to the person, the site and or the service. This should be verifiable through observation, interview and additional (if necessary) documentation review.

Some systemic agency corrective actions that would not be verifiable in the site or service level operations will be reviewed during a separate process during agency reviews.

The regulatory references below indicate the requirements of the agency to take action to implement actions and recommendations to prevent further incidence of similar events.

- Paragraph 624.7(b)(2) applies to all incidents and occurrences. As the incident review committee must "ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences…",
- Paragraphs 624.5(k)(1)-(3) apply to plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (The plans must be developed within 10 days of IRC review.)
- Paragraph 624.5(i)(2) applies to incidents or occurrences that are investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities). (Recommendation must be implemented or justification for not implementing recommendation and alternative plan must be submitted to OPWDD within a month after the recommendation is made.)

Determine the standard is MET if:

- There is evidence verifying that preventive/corrective actions were implemented.

Determine the standard is NOT MET if:

- There was no evidence or insufficient evidence that preventive/corrective actions were implemented.

Select N/A if:

• There were no incidents or occurrences.

6-15 Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
624.5(l)(1)-(2) (l) Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
624.5(k)(1)-(5) (k) Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (4) Such plan must be entered into IRMA by the close of the fifth working day after the development of the plan (see subparagraph [f][1][iii] of this section). (5) OPWDD will inform the Justice Center about plans developed pursuant to this subdivision.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS CAP: Corrective Action Plan IPOP: Individualized Plan of Protective Oversight

IRMA: Incident Reporting and Management Application

DISCUSSION
As needed:
- Program staff
- Individuals receiving services
- Families & advocates
- Management and clinical staff

DOCUMENTATION REVIEW
Mandatory:
- IRMA

As needed, depending on the recommendations:
- Communication logs
- Service documentation
- Health care documentation
- Clinical assessments
- Service plans
- IPOP
- Life Plan
- Staff training documentation
- Revised written policy/procedure

OBSERVATION
Mandatory if visual verification of corrective and/or preventative action is necessary (i.e., installation of grab bars, physical plant renovations)

Review CAPs submitted to the Justice Center. This standard is intended to review only CAPs submitted in response to recommendations from an investigation completed by the Justice Center or a Letter of Determination issued by the Justice Center.

Identify all reportable incidents of abuse and neglect that required a CAP to be submitted to the Justice Center. CAPs for reportable incidents of abuse and neglect, including documentation related to implementation, are available for review in IRMA. Only a CAP in IRMA, rather than a paper copy available on site, will be reviewed to determine compliance with this standard. IRMA documentation review must include:

- The completed OPWDD 161 Corrective Action Plan Submission Form. The OPWDD 161 will identify all corrective actions recommended and the agency response, including actions to be taken in response to each recommendation.
- Documentation to show implementation of each recommendation (i.e., staff training sign-in sheets, revised service plans, memos, revised policy and procedures, and evidence of equipment purchases).

During the site visit, verify that CAPs were implemented. Documentation of actions taken will be available in IRMA, but survey staff may need to complete additional activities to verify that actions were implemented and effective (i.e., interviews to verify that staff understand responsibilities presented in training, record review to determine program plan revisions were implemented and effective, observations to verify equipment was purchased and is used as intended).

Some systemic agency corrective actions that would not be verifiable in the site or service level operations will be reviewed during OPWDD's agency review process.

Determine the standard is MET if:

- There is evidence verifying that corrective actions reported in CAPs were implemented.

Determine the standard is NOT MET if:

- There is no evidence or insufficient evidence to verify that the corrective actions in CAPs were implemented.

Select N/A if:

- There were no incidents or occurrences.

6-16 The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
625.4 (b)(2)(i)-(ii) (b) Review/investigation by OPWDD. (2) When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency shall either: (i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS IPOP: Individualized Plan of Protective Oversight IRMA: Incident Reporting and Management Application **DISCUSSION** As needed: • Program staff • Individuals receiving services • Families & advocates • Management and clinical staff **DOCUMENTATION REVIEW** Mandatory: • IRMA As Needed: • Communication logs • Service documentation • Health care documentation

- Clinical assessments
- Service plans
- IPOP
- Life Plan
- Staff training documentation
- Revised written policy/procedure

OBSERVATION
Mandatory if visual verification of corrective and/or preventative action is necessary (i.e., installation of grab bars, physical plant renovations)

Review the 5 most recent Part 625 events/situations.

IRMA information may include OPWDD recommendations to address an event or situation reported in IRMA.

Review the information in IRMA and conduct interviews and/or review records at the site to determine if the agency followed up to address any recommendations made by OPWDD. Since Part 625 events and situations do not occur under the auspices of the agency, recommendations may include outreach to other government agencies or other providers of services, or increased oversight in the community for an individual who spends independent time away from a certified residence.

Determine the standard is MET if:
- There is evidence verifying that OPWDD recommendations were implemented or responded to, as required.

Determine the standard is NOT MET if:
- There is no evidence or insufficient evidence to verify that OPWDD recommendations were implemented or responded to, as required.

Select N/A if:
- There were no Part 625 events or situations or OPWDD made no recommendations.

Section 7: Site & Safety
7-1 The residence appears "home-like", rather than institutional.
686.3 (a)(1)-(3) (a) Principles of compliance (1) A community residence shall provide an environment that ensures individual's rights, promotes freedom of movement, and increases opportunities for individuals to make decisions and to participate in regular community activities consistent with their needs and capability. A community residence shall allow for the maximum level of independence consistent with an individual's disability and functional level. (2) A community residence shall be a home for individuals that is safe, comfortable and clean. (3) A community residence, through both staff and individual activities, shall endeavor to become an integral part of the neighborhood and community. Individuals of a community residence shall be encouraged to become participating members of the community in which they live. Accordingly, community residence staff are responsible for facilitating access to the appropriate community resources. The range of opportunities shall be sufficiently variable to meet the needs and interests of all individuals, and, wherever possible, utilize the same community resources as used by persons who do not have disabilities.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
636-2.4(a)(9) (a) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan:(9) The setting must be physically accessible to the individual
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
636-2.4(b)(2)(iii) (b) In addition to those qualities and conditions described in paragraphs (a)(1) through (9) of this section, all the following conditions must be met in OPWDD-operated or provider owned or controlled residential settings:(2) The individual must have privacy in his or her residence and bedroom to the extent applicable (iii) The individual must have freedom to furnish and decorate his or her residence and bedroom within the lease or other agreement.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
81.6(a)(4) (a) General:(4) The school shall maintain a congenial group living spirit and shall encourage those activities which contribute to personal development and satisfaction and are common in normal homes.
Program Class/Type:

Private School/Private School

DISCUSSION

As needed:

- Program staff
- Individuals receiving services
- Families & advocates
- Management and clinical staff

DOCUMENTATION REVIEW

N/A

OBSERVATION

Mandatory:

To observe the appearance of the home

Review for the following:

- The site reflects the interests and needs of the people living there.
- Communal living spaces, such as living rooms, are comfortably furnished and decorated per the interests and needs of the residents
- Personal living spaces such as bedrooms are individualized to the person's tastes and preferences.
- The home is decorated and furnished in a comfortable, pleasant manner rather than an institutional manner (i.e., furniture is closer to what a family would choose for pleasure, rather than what a clinical setting would choose for ease of sanitation).
- There are sufficient accommodations and seating for leisure, dining, and other routine activities when people are home.
- When therapeutic equipment is required by people in the home, it is evident that efforts are made to place/store/arrange it in a manner that minimizes its impact on the appearance of the home. If adaptive equipment, lifts, shower chairs, etc. are commonly kept in hallways and living rooms when not in use or needed in those locations, this standard may not be met.
- Location and display of equipment and documentation related to operations of the home (i.e., file cabinets, binders, medication storage) should not result in an institutional or unhomelike appearance.
- Clinically justified door alarms or annunciators that sound every time doors are opened are permissible if they are not overly loud, imposing and distracting to the people living there.
- Efforts are made to maintain the exterior and outside of the residence to blend in with the rest of the neighborhood, to the extent possible. (For example, garbage dumpsters, or smoking receptacles placed conspicuously in a front yard present an institutional appearance in a residential neighborhood. It may be that the program did not make sufficient effort to maintain a home-like environment, as intended.)

Determine the standard is MET if:

- The setting is "home-like" in appearance and features.
- The home is not institutional in appearance and features.
- People appear comfortable in their home.

Determine the standard is NOT MET if:

- The home is institutional or office-like in appearance inside and/or outside.
- The home is not personalized in accordance with the people living there.
- The home/physical environment does not meet the needs of the people living there.

7-2 Surveillance cameras are not present in the site, except as allowed by OPWDD.
633.4(a)(4)(xx) No person shall be denied: (xx) a reasonable degree of privacy in sleeping, bathing and toileting areas;
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(3) The rights set forth in this section are intended to establish the living and/or program environment that protects individuals and contributes to providing an environment in keeping with the community at large, to the extent possible, given the degree of the disabilities of those individuals. Rights that are self-initiated or involve privacy or sexuality issues may need to be adapted to meet the need of certain persons with the most severe disabilities and/or persons whose need for protection, safety and health care will justify such adaptation. It is the responsibility of the agency/facility or the sponsoring agency to ensure that rights are not arbitrarily denied. Rights limitations must be documented and must be on an individual basis, for a specific period of time, and for clinical purposes only. (Note: See section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.16(j)(2)(i)-(iv) (j) Specific interventions. (2) Rights limitations. (i) The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision. (ii) In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.

(iii) The emergency or unplanned limitation of a person's rights more than four times in a 30 day period, or an ongoing limitation in place for more than 30 days, shall require a comprehensive documented review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, psychiatrist, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future. (iv) Where applicable, documentation of rights modifications in the person-centered service plan is required in accordance with section 636-1.4 of this Title.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.16(c)(5) (c) General provisions. (5) OPWDD discourages the use of restrictive/intrusive interventions. General and specific requirements regarding the use of restrictive/intrusive interventions are imposed in order to limit the use of these interventions to those situations when necessary. Unless there is a clear risk to the health or safety of the person or others, or a violation of others' basic personal rights, any restrictive/intrusive intervention or limitation on a person's rights as specified in a behavior support plan shall be employed only after less intrusive or more positive interventions have been tried and have not been sufficiently successful.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-2.4(b)(2) (b) In addition to those qualities and conditions described in paragraphs (a)(1) through (9) of this section, all the following conditions must be met in OPWDD-operated or provider owned or controlled residential settings: (2) The individual must have privacy in his or her residence and bedroom to the extent applicable.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ADM 2019-01 Video Cameras, Monitoring and Recording in Home and Community-Based Services (HCBS) Residential Settings
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS

BSP: Behavior Support Plan
CR: Community Residence
FSR: Free Standing Respite
HCBS: Home and Community Based Services
IRA: Individualized Residential Alternative
IRMA: Incident Reporting and Management Application

DISCUSSION
As needed:
- Staff at setting, to confirm if cameras are, or are not present, based on observation.

DOCUMENTATION REVIEW
As needed:
- Life Plans or other service planning records
- Plans for Protective Oversight, where applicable
- BSPs

OBSERVATION
Mandatory:
- To discern if cameras are present in the setting

Through observation and interview, determine whether one or more surveillance cameras are used inside the program. Video cameras are not allowed inside OPWDD certified programs except in accordance with regulations in Part 633, and in programs providing HCBS (except IRA/FSRs), in accordance with Subpart 636-2. This means that they are generally prohibited in bedrooms, bathrooms, kitchens, and other common living and activity areas of the program. IRAs, CRs, and IRA/FSRs must also comply with the requirements of ADM 2019-01.

Use of surveillance cameras presents a risk to individuals' rights to privacy - not just during bathing, sleeping, and toileting, but also during activities of daily living, treatment, and general socialization and leisure. Surveillance may only be used in limited circumstances with clinical justification and during a specified period of time and documented in accordance with applicable regulations and requirements.

Behavior management plans including limitations on rights, in applicable settings, including residential settings and day treatment, day training, day habilitation, and site-based prevocational settings, must be in accordance with requirements in 633.16(e)(3)(ii).

In residential settings providing HCBS, the following requirements in ADM 2019-01 must also be met:
ADM 2019-01 specifies that although use of monitoring and/or recording technology is generally not permitted in the interior of OPWDD operated, OPWDD certified and provider-owned or controlled residential settings, such monitoring and/or recording technology may be permissible in the following limited circumstances when necessary to meet specific medical and/or behavioral needs of an individual:

- The use of monitoring/recording devices for medical purposes requires the following:
  - A need for the monitoring and/or recording technology is determined to be clinically necessary by an individual's treatment team;
  - The reason(s) for use of the monitoring and/or recording technology is incorporated as a right's limitation into the individual's person-centered service plan (i.e., Life Plan) pursuant to 14 NYCRR Subdivision 636-1.4; and
  - The limitation is documented and consents are obtained as required pursuant to 14 NYCRR Subdivision 636-1.4.

- The use of monitoring/recording devices for behavioral purposes, requires the following:
  - A need for the monitoring and/or recording technology is determined to be clinically necessary by an individual's treatment team;
  - The reason(s) for use of the monitoring and/or recording technology is incorporated as a right's limitation into the individual's BSP pursuant to 14 NYCRR Subdivision 633.16; and
  - The limitation is documented, and consents are obtained as required pursuant to 14 NYCRR Subdivision 633.16.

Monitoring and/or recording technology shall not be used for the convenience of staff or in lieu of adequate staffing levels. Individuals, their guardians/involved family members, other residents, visitors and facility employees must be informed of the presence of monitoring and/or recording technology. Under no circumstances may monitoring and/or recording technology be used without consent from all individuals residing in the home that are impacted by any monitoring and/or recording technology.

If a monitoring and/or recording technology has been deemed necessary to meet an individual's assessed need, per his or her Life Plan/BSP, there must be clearly visible signage posted in the residence indicating that video and/or audio technology for purposes of monitoring or recording is in use.

Individuals must provide consent to being monitored or recorded. Additionally, the individual being recorded must be informed as to:

- The reasons why the monitoring/recording is taking place
- When the monitoring/recording by video camera or device will be used
- Who can listen to audio monitoring or view video monitoring
- Who can review audio/video recordings
- When audio/video recordings can be reviewed
- When audio/video recordings may be released and for what purposes
- How long audio/video recordings will be retained

This surveillance prohibition does not apply to security cameras used outside of a residence, such as an apartment building owned by a landlord who uses surveillance cameras at entryways and public hallways. This also does not apply to security systems like ADT that use surveillance cameras for security purposes that monitor outside of the residence and are typical in residential communities. Additionally, this does not apply to hallways, entries, or other space, including public space, shared with businesses in day program environments.

Determine the standard is MET if:

- No surveillance cameras are in use inside of the residence, except as allowed by OPWDD.

Determine the standard is NOT MET if:

- Surveillance cameras are present inside the residence, for any reason, except as allowed by OPWDD.

7-3 There is evidence that individuals are allowed to have visitors of their choosing at any time.
636-2.4 (a)(8) (a) Any setting where Medicaid HCBS are delivered must have all the following qualities and meet all the following conditions based on the needs and goals of the individual receiving HCBS as identified in his/her person-centered service plan: …(8) The individual must be able to have visitors of his or her choosing at any time, consistent with the same or similar settings for the broader community.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
633.4(a)(4)(xxiv) (a) Principles of compliance. (4) No person shall be denied: …(xxiv) the opportunity to receive visitors at reasonable times; to have privacy when visited, provided such visits avoid infringement on the rights of others, and to communicate freely with anyone within or outside the facility; except that in settings where Medicaid Home and Community Based Services (HCBS) are delivered, rights regarding visitors shall be governed by Subparts 636-1 and 636-2 of this Title
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS HCBS: Home and Community Based Services **DISCUSSION** Mandatory: • Individuals receiving services • Direct support • Families & advocates As needed: • Program management staff **DOCUMENTATION REVIEW** As applicable:

- Visitors logs

As needed:
- Service or activity notes
- Service plans addressing specifics re limitations on individual(s) having visitors

OBSERVATION
Mandatory:
- Observe for any limitations on individual(s) having visitors (as described below)

As needed:
- Verify service plan limiting visitors

Assess through interview with the person and staff and review of documentation.

Longstanding OPWDD regulations in Part 633 include a general requirements to ensure individuals have opportunities to receive visitors at reasonable times and maintain relationships with others. These regulations apply to all OPWDD certified programs.

OPWDD HCBS settings regulations, effective 10/1/2021, specify that individuals receiving services in HCBS settings must be able to have visitors of their choosing at any time, consistent with the same or similar settings for the broader community.

The staff should be supportive and should encourage an individual receiving services to maintain relationships that are important to the individual, to the extent he/she desires. To answer this standard, determine through interview if the individual is satisfied with his/her ability to foster personal relationships by having friends and family visit in the home. Determine if the individual feels supported by the staff in maintaining relationships. Individuals receiving services should be able to visit with others to the degree and frequency desired. Ask staff to determine how they support and encourage residents to invite friends/family to the home.

Rights Modification: Through review of an individual's record, determine if there have been any restrictions placed on their ability to receive visitors. If there is an appropriate rights modification documented that restricts the right of the person to have a certain visitor or visitors in general, the rights modification must have been discussed and reviewed as part of the person-centered planning process in section 636-2.4. If the rights modification is implemented to address an assessed behavioral need, the modification must be documented in a behavior support plan in accordance with the requirements of 633.16. (See Standards 10h -10l for rights modification documentation requirements).

Determine the standard is MET if:

- There is evidence that people visit the person in his/her home.
- Individuals report that they can have visitors whenever they choose.
- Individuals receive encouragement and support from residential staff to have visitors (such as assistance in scheduling visits).
- Individuals report reports satisfaction with their ability to receive visitors at any time.
- There is good evidence that an individual or individuals have made the decision and are not interested in people visiting at this time, but understand they could have visitors, if desired.

Determine the standard is NOT MET if any of the following are present:

- There are blanket rules/visiting hours restricting the person from having visitors at any time.
- An individual does not receive any support or assistance to have visitors.
- An Individual is dissatisfied, and reports wanting people to visit, but being denied the opportunities and/or assistance to have visitors.
- An individual wants to have visitors but is not supported to invite and receive visitors.
- There is a limitation on visits due to an individual's behavioral needs, but implementation of the limitation is not in accordance with rights protections in sections 636-2.4 and 633.16, where applicable.

7-4 The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
633.4(a)(4)(i) A community residence shall provide an environment that ensures client (see glossary, section 686.99 of this Part) rights, promotes freedom of client movement, and increases opportunities for clients to make decisions and to participate in regular community activities consistent with their needs and capability. A community residence shall allow for the maximum level of independence consistent with a client's disability and functional level.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.3(a)(1) A community residence shall provide an environment that ensures client (see glossary, section 686.99 of this Part) rights, promotes freedom of client movement, and increases opportunities for clients to make decisions and to participate in regular community activities consistent with their needs and capability. A community residence shall allow for the maximum level of independence consistent with a client's disability and functional level.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS CR: Community Residence IRA: Individualized Residential Alternative **DISCUSSION** • Individuals (and/or family/advocates): to know what they think about the comfort and accessibility of the setting As needed: • Agency staff re: their opinion about these characteristics. Determine if they are consistent with those of the Individuals. Efforts taken to make the environment comfortable and appropriate to people's needs/wants **DOCUMENTATION REVIEW** As Needed: • If observations result in concerns/questions that physical environment may NOT be appropriate for people living there

OBSERVATION

Mandatory:

- To discern if the setting is set up to maximize the comfort, independence, and well-being of the Individuals who reside in it

Consider and verify the following:

- Verify that the site's ambient temperature, noise level and lighting is comfortable and adequate for persons supported.
- The environment allows people to be as independent as possible. For example: the floors are kept impediment free for individuals who clinically are appropriate to scoot, crawl on the floor for mobility, there are smooth transitions between rooms for people who use walkers and wheelchairs.
- The physical plant is appropriate or appropriately adapted to meet the needs of Individuals with physical disabilities (i.e., ramps, handrails, sufficient room to maneuver wheelchairs, adaptive appliances and strobes, bed shakers, turnaround space in toilets, keypads, etc.).
- Determine if there is adequate amount of space for planned activities, private phone calls, spending time with visitors and comfort for persons supported.
- The physical plant is easily navigated by Individuals who do, and those who do not, use adaptive equipment.
- Appliances are easily accessible as needed for participating individuals.
- Supplies such as toilet paper, soap and towels for drying are available in bathrooms.
- Furniture accommodates the needs of individuals (i.e., tables with appropriate height for wheelchairs are available if individuals must remain in their chairs for clinical reasons).

Determine the standard is MET if:

- The site is for the most part appropriately comfortable, configured and equipped to meet the needs of the individuals.

Determine the standard is NOT MET if:

NOTE: this is not an assessment of maintenance, which is addressed separately.

- There is any one significant aspect of the site's characteristics that negatively impacts individuals' comfort, use, and navigation of the site routinely.
- There are multiple characteristics of the site that negatively impact individuals' comfort, use, and navigation of the site routinely.

If you have serious concerns about size of rooms or use of space, per Safety and Physical Plant Protocol | OPWDD, consider the following: Based on observation, use your best judgment to determine whether the bedroom size and arrangement appears to be sufficient for the number of individuals using the room. Situations which may require particular attention are bedrooms which have been converted from other uses (i.e., offices, storage). Assess that they provide appropriate bedroom space with natural lighting, adequate ventilation and egress without impediment.

NOTE: There is not an expectation that reviewers routinely measure bedroom size during site visit. This should be an observational assessment. Measure only if room size appears significantly small, strangely configured, or non-homelike and has a negative impact on the individual(s). The exception would be pre-openings. Effective as of 8/1/07, regulation requires that bedrooms in Large IRAs and Supervised CRs provide, exclusive of closets, at least 70 sq. ft. per person in multiple sleeping rooms, and at least 80 sq. ft. in single bedrooms. This is a best practice for Small IRAs.

7-5 All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
635-7.3(h)(3) All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.4(b)(3)(xiv) All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA Small 8 or less
DISCUSSION As needed: • Individuals (and/or family/advocates) and/or staff, if a history of inoperable adaptions is suspected **DOCUMENTATION REVIEW** Mandatory: • Life Plan to know what the adaptive device needs of the persons who receive services there are **OBSERVATION** Mandatory: • To discern if there are any inoperable adaptive devices Adaptive equipment is available if needed, correctly installed and in good working order to maximize individuals' independence in and around their home. Based on observation and interview, verify the condition of special devices and adaptive equipment in place. Examples include but are not limited to:

- Adaptive lifts
- Handrails are secured
- Ramps are in good condition
- Door opening devices are working
- Elevators work
- Phones and associated equipment for people with hearing impairments are operable
- Special adaptive shower, and tubs and their lifts operate properly, and grab bars and shower chairs are secure and safe
- Adaptive and therapeutic tubs, showers, sink are operable and in good repair
- Ask staff and Individuals if the needed and preferred adaptions are meeting the needs of the Individual

Determine the standard is MET if:

- Special adaptations to the site needed by the individuals are present and operational.
- No special adaptations are needed.

Determine the standard is NOT MET if:

- Special adaptations to the site needed by the individuals are not operational or absent due to failure to replace/repair.

7-6 There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
635-9.1(a)(1) Intermediate care facilities for persons with developmental disabilities (ICF/DDs), community residences including Individualized Residential Alternatives (IRAs), private schools, and specialty hospitals shall assume the cost of:(i) Any item or service for which local, State, or Federal funds are provided; or for which reimbursement is made through a rate, fee, or grant-in-aid.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
635-9.2(a)(1) **Nonresidential facilities shall assume the cost of: (i) Any item or service for which local, State, or Federal funds are provided; or for which reimbursement is made through a rate, fee, or grant-in-aid.**
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
DISCUSSION As needed: • Individuals and/or staff based on observation and/or site history. If supplies seem limited ask about next planned shopping trip or delivery of supplies and whether the response seems reasonable **DOCUMENTATION REVIEW** Mandatory: • Communication log if used **OBSERVATION** Mandatory: • To verify adequate supplies Individuals supported must be provided adequate routine supplies for their life necessities and available in the home. These supplies must be available for Individuals to use at their discretion with any needed supports (and not locked away without evidence of due process rights restrictions.) Consider the adequacy and availability of the following based on the program type you are reviewing, services offered by the program type, and needs of the people living in or receiving services from the facility.

Residential may include but is not limited to:

- Adequate amount of nutritious food, including any for prescribed diet orders
- Potable water
- Personal hygiene supplies
- Needed health care supplies
- Linens for bed and bath
- Useful clean furniture for the home
- Storage space for belongings
- Appliances for kitchen and cleaning
- Clothing for all seasons

If you are reviewing a residence and find a pattern of supplies and resources not being provided, you must also make a judgment as to whether or not protective oversight is being provided.

Inadequate food and water supply should be immediately reported to the Area Director when determined to be problematic.

Day Services, Clinics, Educational Environments:

- Nutritious food, including any for prescribed diet orders if providing meals or snacks is the responsibility of the site
- Potable water
- Personal hygiene supplies (i.e., running water, soap, paper products for hygiene, etc.)
- Needed health care supplies if the responsibility of the site
- Useful clean furniture appropriate to activities

If you are reviewing a residence and find a pattern of these rightful supplies and resources not being provided, you must also make a judgment as to whether or not protective oversight is being provided.

Determine the standard is MET if:

- There are adequate supplies and materials to meet the daily/routine need of the individuals for a couple of days.

Determine the standard is NOT MET if:

- There are NOT adequate supplies and materials to meet the daily/routine need of the individuals.

NOTE: If there are serious concerns regarding adequacy of food, potable water, and any other item determined to be an immediate necessity, contact your Area Director.

7-7 Bathrooms provide personal privacy.
633.4(a)(4)(xx) No person shall be denied: a reasonable degree of privacy in sleeping, bathing and toileting areas.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.3(h)(1) Toilet rooms and bathrooms shall provide personal privacy.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.4(b)(3)(xii) Toilet rooms and bathrooms shall provide personal privacy.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA Small 8 or less
DISCUSSION As needed: • Individuals: regarding their comfort and satisfaction with level of privacy provided for bathrooms **DOCUMENTATION REVIEW** N/A **OBSERVATION** Mandatory: • Verify that bathrooms are designed to provide privacy including lockable door • Verify that privacy is provided Through observation, verify that bathrooms are equipped with doors that close fully and are lockable or other means to provide adequate privacy, and window coverings that ensure privacy.

Determine the standard is MET if:

- The bathrooms present no immediate concerns with ability to provide privacy.

Determine the standard is NOT MET if:

- Bathrooms by their design, features or missing features or ill repair cannot provide privacy.

Note: If there is an observed issue with privacy that is NOT due to the physical characteristics of the bathroom it should be addressed as a different issue (i.e., staff training, rights). This is about the bathroom from a physical plant perspective.

7-8 The site is clean.
635-7.3(h)(6) Cleaning and maintenance of the physical plant shall be performed on a regular basis.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.4(b)(3)(xix) The home or IRA shall be clean and well maintained.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
DISCUSSION As needed: • Individuals if concerns regarding cleanliness • Staff if concerns about cleanliness, to verify that staff know and implement, cleaning procedures in the site **DOCUMENTATION REVIEW** As needed **OBSERVATION** Mandatory: • To verify cleanliness of the site During routine observations at the facility and during the formal physical plant "walk through" make note of the condition and cleanliness of the environment. A clean environment should include but is not limited to the following: • Walls, doors, doorknobs are not stained and are free of food or other residues. • Floors surfaces and rugs are clean and free of large or excessive stains. • Furniture is clean, unstained and free of residue. • Bedrooms, allowing for some personal variances are relatively clean, organized, and free of clutter which can impede safe exiting.

- Bathrooms and bathroom fixtures are clean and sanitary, including adaptive equipment needed for hygiene activities.
- Bathrooms are clean and free of visible mold and mildew on walls, ceiling, showers and tubs, shower curtains, toilets, adaptive equipment and non-slip bathmats.
- Kitchen surfaces are clean (include counters, cabinets, pantries, shelving, cupboards, appliances, etc.).
- Appliances (i.e., microwave, refrigerator, freezer, dishwasher etc.) are clean and free of food spillage. Stove or range burners and reflector pans are clean.
- The oven interiors are clean and free from spill-over and burnt on food.
- Exhaust fans and/or filters above the stove are clean.
- Facility grounds are free of litter. Trash is disposed of properly and not littered on the grounds posing a risk for persons with pica or attracting vermin.

All areas of the facility are free of unpleasant odors. During visit to the facility take note of whether any of the following are present:

- Urine odors in bathrooms
- Urine odors in bedrooms (May be a result of incontinence and/or inappropriate urination. Take follow-up action to determine whether the issue has been identified and whether it is being addressed from a service planning and provision perspective)
- Odors emanating from furniture or mattresses
- Odors from uncovered garbage receptacles
- Musty smells associated with mold and mildew; this may be indicative of water leaks or seepage
- Extensive lint accumulation on the lint filter in the dryer and/or at the terminus of the dryer vent arrangement (indicative of infrequent cleaning)

NOTE:
Surveyors are to use their best judgment when assessing for compliance with this requirement. Take into account the environment as a whole and the number and degree of cleaning issues noted. For bedrooms of individuals who make decisions on how to “maintain” their space, there may be a range of “cleanliness”. Consider whether the space represents neglect by the residential staff or personal choice of a “tolerable” level of dust and debris. However, if any issue raises to unhygienic (dirty dishes, half eaten food, sugary drink bottles/can, urine) “personal choice” must be addressed.

Determine the standard is MET if:

- The site is generally clean and hygienic. A few minor non-impactful cleanliness issues need not result in deficiency.

Determine the standard is NOT MET if:

- There are multiple negative findings/unclean areas.

• Findings indicate a pattern of inattention to cleanliness as a whole or a particular area of the site, including inattention to a person's bedroom.
• Unhygienic conditions exist.

7-9 The site is well maintained for the safety and comfort of the individuals receiving services.

633.4(a)(4)(i)
No person shall be denied: (i) a safe and sanitary environment.

Program Class/Type:
Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

635-7.3(h)(6)
Cleaning and maintenance of the physical plant shall be performed on a regular basis.

Program Class/Type:
Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

635-7.4(b)(3)(xix)
The home or IRA shall be clean and well maintained.

Program Class/Type:
IRA/8 or less conversion (from ICF), IRA Small 8 or less

ACRONYMS:
ANSUL: Anhydrous Sulfur Dioxide
GFI: Ground Fault Interrupters

DISCUSSION
Mandatory:
• Individuals if everything they use in the home is working maintenance
• Staff if everything they need and use in the home is in good condition and usable

DOCUMENTATION REVIEW
As needed

OBSERVATION
Mandatory:

- To verify adequate maintenance of the site

During routine observations at the facility and during the formal physical plant 'walk through' make note of the condition of the environment. Ask persons supported and staff about the condition of the site, whether everything (i.e., appliances, plumbing, and lighting) is working properly and whether anything is broken or has a history of being chronically broken.

An adequately maintained environment should include but is not limited to the following:
All Facility Considerations:

- Walls and doors are free from damage and holes.
- Doors fit properly in casing and close and open freely. Doorknobs are firmly installed and work easily.
- Floors surfaces are in good repair without uneven surfaces, chips, loose tiles, bare spots, loose tiles, curled seaming, etc.
- Carpets and area rugs are without bare spots, and lie flat without lumps, bumps, fraying or poor seaming that create trip hazards.
- If throw rugs are used, they should lay on the floor smoothly, without curling or bunching. They should be arranged so that they stay in place and do not easily slide.
- The facility is free of rodent or insect infestation, and the facility has addressed potential entry access points for such vermin.
- Furniture is in good condition. Wooden furniture and chairs are not broken. Upholstery is not ripped. Seat cushions and mattresses are not sagging.
- Light fixtures and lamps are working, and bulbs are not missing or burnt out.
- Lighting is sufficient for the space and activities.
- Bathroom fixtures work properly. Sinks, tubs and showers drain adequately. Toilets flush properly. There is no evidence of leaks
- GFIs in bathrooms, kitchens and laundry rooms are operable. GFIs should be installed within 6 feet of sinks, tubs etc. including laundry sinks.
- Appliances are in good working order and can be used by the facility.
- The stove/range burners and oven are in good working order.
- The over door should close fully and seal.
- Exhaust fans are working.
- If the facility stove(s) has an ANSUL or residential fire suppression system, there is evidence that it is inspected and serviced as needed.

- Without evidence to the contrary, refrigerators and freezers are maintained to ensure that food is stored at appropriate temperatures for safe storage. During routine observation for adequate food supply, verify that the refrigerators appear to be in working appropriately. Evidence to the contrary may include a loose seal when opening, the interior feels warmer than normal, there is water pooling, there are unpleasant odors. Only if such examples or others indicate that there may be a problem, use a thermometer to verify that refrigerators are maintained between 32 – 40 degrees Fahrenheit, and freezers are maintained at 0-degree F or less. It is ideal that refrigerators and freezers should be equipped with thermometers.
- There is no evidence of roof leaks, broken windows.
- Exterior of the facility appears in good repair. Exterior surfaces are appropriately maintained, painted, cleaned and illuminated. Gutters are not sagging and are free from excessive debris. Walkways/driveways are free of large cracks and height changes that may pose trip hazards. Outdoor furniture and picnic tables are in good repair.
- House numbers are clearly visible from the street. This maintenance issue is important for timely 911 responses by emergency services such as ambulance or fire department. Upon arrival to the site, you should be able to identify the address of the site from the road while in your vehicle. Avoid use of numbers similarly colored to the background.

Work Facility (e.g. Day Training, Certified Pre-Voc) Considerations:

- Machines such as packaging and sealing equipment are in good working order.
- There are staff on duty who have expertise in the equipment use.
- The facility adequately vented; there are no odors such as chemical smells.
- The lighting appears sufficient.
- The facility is maintaining minimum paths of travel on the work floor. Pallets do not obstruct paths of travel.
- There are no trip hazards due to wires or other obstructions.
- Means of egress are maintained at all times.

NOTE: The facility is required to ensure that fire protection equipment is in good working order. However, problems with the equipment should be cited elsewhere in this document.

Determine the standard is MET if:

- The site is generally well maintained. A few minor non-impactful maintenance issues need not result in deficiency.

Determine the standard is NOT MET if:

- There are multiple negative findings regarding upkeep and maintenance.
- Findings indicate a pattern of inattention to maintenance of the site as a whole or a particular area of the site.
- An item is in ill-repair, not working properly or inoperable so that it negatively impacts individuals' independent use their environment or requires them to have staff assistance which would not be necessary if item/issue was maintained.

• Poor maintenance creates a potential of injury but would not be considered “hazardous”.

NOTE:
At times, poor maintenance may cause hazardous conditions. Such findings should be cited elsewhere in this document.

7-10 The site operates in accordance with OPWDD smoking requirements.

633.23(d)(1-2)
An agency may prohibit smoking on the grounds of any or all of its certified facilities, including supportive IRAs and supportive CRs. If an agency permits smoking on the grounds of its facilities, the agency must restrict smoking on grounds that the agency is authorized to control, as follows: (1) Location of designated smoking areas: (i) designated outdoor smoking areas must be at least 30 feet from the building which houses a facility that is operated or certified by OPWDD; or (ii) if there is no available space for a designated smoking area at least 30 feet from the building, the designated area must be as far from the building as is practical without infringing on neighboring properties and without putting individuals, or others, in an unsafe location (e.g., in the street). (2) Any designated outdoor smoking area must be equipped with an appropriate and properly maintained non-combustible disposal receptacle in accordance with section 635-7.3(c)(8) or 635-7.4(b)(4) of this Title.

Program Class/Type:
Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS
CR: Community Residence
IRA: Individualized Residential Alternative

DISCUSSION
As needed:
- Staff and possibly Individuals about their understanding of the smoking requirements.

DOCUMENTATION REVIEW
- Communication log if used
- In supportive residences: The site-specific appraisal/decision is documented in the IRA site-specific Plan for Protective Oversight (in IRAs) or CR Policy & Procedure Manual (CRs)

OBSERVATION
Mandatory:
- General home and exterior environment
- Location of smoking area

- Presence and maintenance of appropriate receptacles (availability and emptied when full)
- Correct disposal of smoking waste (use of receptacle as evidenced by LACK of butts, on ground, in landscaping, on sidewalk, around entryways, etc.)
- Evidence of smoking in building

Smoking regulations apply to all facilities operated or certified by OPWDD, except Family Care Homes.

At 24-hour supervised residences, day programs, and clinic treatment facilities, and diagnostic and research clinics, where agencies permit smoking, verify the following through observation and discussion:

- Smoking is NOT permitted inside the certified site buildings, including offices.
- There is a designated smoking area outdoors and it is the only location on premises used for smoking.
- The designated smoking area is at least 30 feet from the facility building; or if space at least 30 feet from the building is not available, the designated smoking area is as far from the building as practical, without putting people in an unsafe location, or infringing on neighboring properties. Placement may also be per recommendation of the local fire authority.
- The designated smoking area is equipped with an appropriate non-combustible receptacle which is used for the disposal of ashes, tobacco, and other smoking remnants. [See also 635-7.3(c)(8) and 635-7.4(b)(4)]. Smoking remnants should not be observed on the walkway, driveway, porch, deck, yard or landscaping.
- The non-combustible receptacle is properly maintained with routine emptying and removal of potential fire hazards (i.e., paper products, cigarette butts). [See also 635-7.3(c)(8) and 635-7.4(b)(4)]

In supportive IRAs and supportive CRs, smoking is allowed at/in the site only in circumstances where all of the following conditions are met:

- A site-specific decision has been made based on an appraisal of the circumstances presented at the particular site.
- The site-specific appraisal/decision is documented in the IRA site specific plan for protective oversight (in IRAs) or CR Policy & Procedure Manual (CRs).

The site-specific appraisal includes minimally a review of:

- Local laws
- Building policies and lease agreements
- Smoking practices of the individual(s) living in the residence (i.e., the individuals smoking behavior/habits, use of appropriate receptacles, disposal practices, etc.)
- Description of each resident's interest in or objection to smoking at the site

NOTE: An agency may choose to have a policy prohibiting smoking on facility grounds including supportive residences.

Determine the standard is MET if:

- Requirements described above appear to be followed as there is no evidence to the contrary as described below in not met.

Determine the standard is NOT MET:

There is evidence of non-compliance with smoking regulations by the facility/facility staff, as evidenced by but not limited to ANY of the following:

- Disallowed smoking is occurring in buildings as evidenced by ashtray, butts, or other tobacco waste smoking in buildings,
- Individuals and/or staff are observed or report that smoking occurs in the building (and this is not a supportive residence with documented appraisal decision to approve).
- Accumulation of cigarette butts are observed to be improperly disposed.
- Receptacles are not appropriate non-combustible types.
- There is evidence of fire damage to the site interior/exterior related to smoking that has not been identified and addressed by the facility.

If evidence of smoking in violation of OPWDD's smoking regulations is found, surveyors will identify deficiencies accordingly. For situations that present an immediate risk to the safety of any individual, contact your regional director & require immediate correction.

7-11 The temperature of the hot water is appropriate to the abilities of people served at the site.
635-7.3(i)(2) The temperature of the hot water at all faucets accessible to persons residing in the facility does not exceed 110 degrees Fahrenheit except in areas utilized to train individuals in the use and control of hot water.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.4(b)(3)(xv) Any hazardous conditions that present a threat to an individual's safety or welfare are repaired in a timely manner.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA Small 8 or less
DISCUSSION Mandatory: • Staff and possibly Individuals about whether water temp too hot/cold/just right **DOCUMENTATION REVIEW** As needed: • Documentation of water temperature check monitoring • Agency policy and procedure on water temperature check monitoring as per below **OBSERVATION** Mandatory: • To verify compliance with water temperature requirements as described below The surveyor should measure the temperature of hot water in a bath or shower, or bathroom sink at every site visit. If more than one hot water source is used for sinks, baths, and showers test water temperature coming from each of the hot water heaters. Verify that the temperature of the hot water is no greater than 110º F where people have not been or are not being trained to use and control water temperature.

Water temperature may ONLY exceed 110 degrees Fahrenheit in areas utilized to train individuals in the use and control of hot water and/or in areas where individuals are able to control/adjust water temperature.

Temperatures in excess of 140 degrees F, or more, are considered to be imminent danger whether or not persons served have been or are being trained and regardless of program type.

Also verify:

- The facility has a thermometer to check water temperature.
- There is facility procedure for regular testing of hot water temperature.
- There are mechanisms to control access to hot water heating equipment and to prevent tampering.

Note: Some day program facilities may have bathing facilities as well.

Determine the standard is MET if:

- Water is measured at appropriate temperature as described above.
- There is no evidence that the facility is having difficulty maintaining the appropriate temperature.

Determine the standard is NOT MET if either of the following are present:

- Water is measured at temperature exceeding maximum for the environment (as described above).
- There is evidence that the facility is having difficulty maintaining the appropriate temperature.

7-12 Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
635-7.3(c)(4) Water shall conform to the chemical and bacteriological quality standards for potable water established by the health authority having jurisdiction. For facilities having a private water source for drinking or cooking purposes, the facility shall test the private water source on at least an annual basis to ensure that the water conforms to such established standards.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.4(b)(3)(xx) In homes or IRAs with private water sources for drinking or cooking purposes, the facility shall test the private water source on at least an annual basis to ensure that the water conforms to the chemical and bacteriological quality standards for potable water established by the health authority having jurisdiction.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA Small 8 or less
DISCUSSION As needed: • Management about their understanding of the process to comply with private water source monitoring requirements **DOCUMENTATION REVIEW** Mandatory: • Documents evidencing private water source testing as required and needed • Agency policy and procedure on private water source monitoring as per below **OBSERVATION** N/A Obtain and review a copy of the facility's well water test reports.

Annual testing is minimally required for the following four (4) parameters. Testing parameters exceeding the maximum contaminant level for that substance in drinking water will require corrective action. This typically is noted on the test report.

- Coliform
- Standard plate count
- Chlorides
- Nitrates

Additional testing may be required if the well is located near potential sources of contamination. If you know or suspect that any of the conditions for additional testing exist, determine whether it has been completed. If testing did not occur, seek clarification from the provider agency regarding why it was not. If the risk is indeed known, and the reason is that it was determined unnecessary, request documentation that was based on sound professional recommendation. Potential additional testing includes:

- Lead: Facilities built prior to 1980 (and not updated) will have a lead test done to determine if there is any lead migrating from lead piping or solder into the water supply. If there is a positive test, a retest should be done six months after corrective action has been taken and annually thereafter. If the lead source is removed and the facility has a subsequent negative test, or if there is no lead noted on the initial test, no further testing would be required.
- Unspecified organic contaminants: This test must be done for wells which are located near farms, old underground gasoline tanks and landfills where there is a high probability of contamination from pesticide spraying or infiltration of the well from contaminates in a landfill. If there is a positive test, corrective actions must have been taken until a negative result is obtained. Thereafter the facility must test for this on an annual basis.
- Heavy Metals: There metal will be tested when the facility is located near a landfill. Minimal testing should include mercury, lead, arsenic and any others recommended by the local county health department. Once corrective measures are taken if needed, the facility must retest on a biannual basis.
- Sodium: This should be tested if the facility has any individual who are on sodium free or sodium restricted diets. If the test is positive, corrective measures should be taken to ensure the sodium level falls within the acceptable limits for the restriction. Retests must be done on a biannual basis thereafter.

Refer to ADM 96-02 “Revised Testing Standards for Private Wells” dated April 8, 1996. The memo is applicable to all OPWDD-certified facilities that have wells as their source of potable water.

Determine the standard is MET if:

There is documentation that to evidence ALL of the following:

- Required testing has occurred.
- Testing occurs with appropriate frequency.
- Unacceptable Levels or positives have been corrected/are being corrected.

OR
- The standard is N/A as the site has a public water source.

Determine the standard is NOT MET if ANY of the following are present:
- Required testing has NOT occurred (there has been no testing or some, but not all required tests were done).
- Testing does not occur with frequency required.
- Unacceptable levels or positives have not been corrected/are not being addressed.

7-13 The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools.
633.4(a)(4)(i) No person shall be denied: a safe and sanitary environment.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA Small 8 or less
635-7.3(h)(7) Any hazardous conditions that present a threat to an individual's safety or welfare shall be repaired in a timely fashion.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
DISCUSSION As needed: • Staff about their understanding of policy and procedures for safeguarding Individuals while using pool **DOCUMENTATION REVIEW** Mandatory: • Documentation of staff training on the pool safety: general and person-specific • Agency policy and procedure on pool safeguards to prevent drowning • Incidents involving pool use **OBSERVATION** Mandatory: • As able, to observe the pool itself and any adaptive and safety equipment associated with it As needed: • Use of pool if happens to be occurring while on site For purposes of this review, pools include swimming pools, wading pools, therapeutic pools and hot tubs. Security: Access to the pool must be adequately protected.

- This is dependent on the type of pool (in-ground or above-ground) or local laws. Generally, in-ground pools require a four (4) foot high enclosure, with self-closing locked gate. For above-ground pools the barrier can be around the pool or mounted on top of the pool structure. For both types of pools, the barriers must be sturdy. Removable ladders should not be draped across a barrier (which defeats the purpose of the barrier).
- Pools constructed or substantially modified after 12/14/06 must be equipped with an approved pool alarm.
- Safety devices must be working properly (i.e., pool alarms, door alarms, etc.).
- Access to filled hot tubs is secured through locking covers or in secured room/area.

Policy/procedure and training: The program/agency have policies and procedures in place to ensure the safety of individuals using the pool. It should address (but not be limited to) the following:

- Access/security
- Staff and program participants are trained in pool safety precautions developed by the agency
- Individuals are assessed regarding their swimming capabilities/needs
- Staff are aware of each individual's needs regarding pool safety, such as limitations, need for supervision, adaptive devices, etc.
- Program participants are supported to understand pool safety, to the best of their ability

The Safeguarding Alert from OPWDD 00-01-Drowning Alert has helpful information.

Select MET if all of the following are present:

- The pool or hot tub is adequately secure/protected for unauthorized and unsupervised access.
- Adequate policy and procedure for use of water source and supervision/safeguards.
- Staff are trained and understand their responsibility per the policy and procedure.
- If in use, safe practices are observed.

OR

- The site does not have pool or has rendered it unusable and inaccessible.

Select NOT MET if a pool is onsite and accessible:

- Access to the pool or hot tub is not secure.
- The facility lacks adequate policy and procedure for safeguarding and/or use.
- Staff cannot explain of required safeguards related to the pool, regardless of if training records are evident.
- If in use, unsafe practices are observed during pool use.
- Unsafe practices identified as part of an incident investigation and have not been addressed/corrected.

7-14 The site has a land line telephone service which is in working order and functions during power outages.
635-7.4(b)(3)(iii)(a)-(d) (b) Safety and welfare requirements.(3) All family care homes and IRAs for eight or fewer persons shall comply with the following general safety and welfare requirements:(iii) The home must have and maintain active telephone service. (a) Cellular and/or landline services must be used to meet this requirement. (b) If cellular telephone service is not available at a location at all times, landline telephone service is required. (c) Landline telephone service, where provided, must consist of one or more of the following types of land based transmission: cable, microwave, fiber optic, or copper wire. (d) Landline telephone service must remain in working order and function during power outages or be backed up by immediately available cellular service.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
635-7.3(c)(6)(i)-(iv) (c) Physical plant requirements. (6)The facility must have and maintain active telephone service. (i) Cellular and/or landline services must be used to meet this requirement. (ii) If cellular telephone service is not available at a location at all times, landline telephone service is required. (iii) Landline telephone service, where provided, must consist of one or more of the following types of land based transmission: cable, microwave, fiber optic, or copper wire. (iv) Landline telephone service must remain in working order and function during power outages or be backed up by immediately available cellular service.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
DISCUSSION Mandatory: • Program direct support staff As needed: • Program management staff • Family members/advocates **DOCUMENTATION REVIEW** As needed: • Communication logs • Incident management records

OBSERVATION
Mandatory:
- To verify the presence of functioning telephone service

Standard 5-7 of this protocol reviews the effectiveness of the facility's communication system. This standard reviews the reliability of the site's telephone service.

Survey staff must ask to use the site's telephone to verify that the service is functioning at the time of the visit and interview staff to determine the ongoing reliability of the telephone service and type or types of telephone service available at the site. If cellular and landline services are used, survey staff should check the reliability of both.

Interviews with individuals and family members or advocates and a review of Incident management records and communication logs may provide information about lapses in phone service.

Determine the standard is MET if:
- The site has reliable and appropriate telephone service.

Determine the standard is NOT MET if:
- The site does not have reliable telephone service due to lack of service at the time of the site review.
- Interviews with staff or others revealed repeated lapses in telephone service.

OR
- The type of telephone service at the site is not in accordance with requirements of subpart 635-7.

7-16 The agency provided each individual residing at the site with an occupancy agreement as required by OPWDD.
636-2.4(b)(1) (b) In addition to those qualities and conditions described in paragraphs (a)(1) through (9) of this section, all the following conditions must be met in OPWDD-operated or provider owned or controlled residential settings: (1) The individual's residence must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under applicable landlord/tenant law. For a residence in which landlord/tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for the individual that provides for eviction processes and appeals comparable to those provided under applicable landlord/tenant law.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
ADM 2023-05 Occupancy Agreement Guidelines
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS HCBS: Home and Community Based Services **GUIDANCE** Review for a random sample of not less than half of the individuals residing in the residence, including all new admissions. ADM 2023-05 specifies that although there is no required format for an occupancy agreement, OPWDD does require the documentation of the following in any occupancy agreement: • The individual's rent obligations, including the timing of rent payments. Variations in an individual's income can regularly result in a change in rent. A new signed agreement is not needed every time there is a change in income. However, the individual must be given written notice of the new amount of rent owed and how it was calculated. • The individual's rights under the occupancy agreement. The agreement should identify applicable regulations and include an affirmative statement that the individual, by signing the agreement, is not waiving any applicable rights under state, federal, or local laws. • Responsibilities of the provider. The agreement must include statements advising that: o The provider will follow all applicable laws and regulations in the operation of the residence and in providing services. o The residence will meet all applicable state and local codes including health, safety and building codes and OPWDD requirements.

- The provider will give the individual a copy of the residence's written policies, responsibilities, and procedures that govern the individual's stay in the residence.
- The provider will give the individual notice of rent changes and assistance to ensure that the correct amount of rent is paid.

• Ending the occupancy agreement. The agreement must describe the process to address situations when the individual decides to leave the residence or must leave the residence.

- The agreement should note that when an individual decides to leave a residence, the agreement will end, and the individual understands that they will have to move and will work with their care manager to plan the move. The agreement should also state that the provider will continue to maintain services at the residence until the individual moves out.
- The agreement must describe the process that is followed when the provider decides to end the occupancy agreement or initiates a transfer of the individual to another residence. Examples of reasons that may cause a provider to terminate the agreement could include circumstances that jeopardize the health, welfare, or safety of the individual or others in the home or because the individual violated significant terms of the agreement. The reasons, however, must not include the violation of any "prohibited terms" identified below.
  - The agreement must include a statement noting that if an individual is asked to move out or to transfer to another residence, the procedures in 14 NYCRR § 633.12 apply and that the individual may formally object. The agreement should also advise that if the individual formally objects to being moved or discharged through the procedures in 633.12, other than in cases of emergency moves or time limited services, while the objection is still under review, the individual can only be moved or discharged with the OPWDD commissioner's approval.
  - The agreement should inform the individual that the provider will cooperate with the individual and the care manager to develop a safe discharge plan when the individual leaves the residence. The agreement should also specify that when the provider initiates the discharge or transfer, the provider is responsible to assist the individual to find a new residential opportunity.

• Term of the Agreement: The occupancy agreement should state that the agreement remains in effect for the duration of time the individual resides at the location, and that the individual must enter into a new agreement if they move to a different residence. (OPWDD does not require the individual to sign a new agreement before such a move is completed, but the individual should sign a new agreement as soon as possible after the move.)

• Appropriate Signatures: The occupancy agreement must have a signature space for the provider, the individual, and the individual's representative.

Occupancy agreements must not include any of the following prohibited terms that are inconsistent with individual rights under current laws and regulations, or conflict with HCBS standards.

• Waivers of individual rights under applicable laws, regulations, or rules. Rights modifications or restrictions are also inappropriate terms in these agreements and must separately follow applicable regulatory processes.

• Restrictions or prohibitions on visitors.

• Provisions that permit termination of the agreement and removal from the residence if an individual's needs increase, even if there were resources available to provide additional support to allow the individual to remain.
• Requirements that the individual works or participates in a provider's HCBS or other programs.
• Provisions that require an individual to vacate their rooms or residence during specified periods of time.

Failure to Sign Occupancy Agreement:
Providers may not treat a failure or inability to sign an occupancy agreement as a basis to terminate an individual's services, initiate or propose a discharge or relocation, or to ask an individual to move out of a residence. The provider must not threaten or attempt to coerce individuals into signing an occupancy agreement. If the individual is not able to sign due to incapacity to provide informed consent, or the individual or advocate has refused to sign after the provider has explained the purpose of the occupancy agreement, the provider must appropriately document the individual's (or advocate's) refusal or the individual's inability to sign. The provider must reintroduce the occupancy agreement at each of the individual's regularly scheduled Life Plan meetings to document good faith attempts to comply with regulatory requirements to obtain a signed agreement. OPWDD will accept documentation of good faith attempts to obtain a signed compliant agreement through this process as satisfying the occupancy agreement requirement. A provider representative must always sign the occupancy agreement.

Determine the standard is MET if:
• The agency/facility provided each individual residing in the facility with an occupancy agreement as required by OPWDD.

Determine the standard is NOT MET if any of the following is present:
• The agency/facility has not provided each individual residing in the facility with an occupancy agreement as required by OPWDD.
• Occupancy agreements lack required content.
• Occupancy agreements include prohibited terms.

Section 8: Fire Safety
QQ-8-Is it necessary to review fire safety requirements at this time?
8-1 The site has an acceptable fire evacuation plan.
635-7.5(e) An evacuation and safety plan specific to the certified premises shall be developed and implemented that is designed with consideration of the capabilities of the persons receiving services, the staffing of the premises, and the physical plant configuration. A description of the evacuation and safety training for individual participants and staff shall be included in the plan.
Program Class/Type: Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
686.16(b)(1) OPWDD shall verify that each individualized residential alternative has implemented a facility evacuation plan. OPWDD shall verify that staff and persons residing in the facility are trained and evaluated regarding their performance of said plan. Also reference ADM 2012-02
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ADM # 2012-02 There is a written plan specifying how the agency/facility will deal with life threatening emergencies.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS IRA: Individualized Residential Alternative LSC: Life Safety Code **DISCUSSION** As needed **DOCUMENTATION REVIEW** Mandatory: • The written evacuation plan

• Supporting documentation such as diagrams or assessments if referenced/considered part of the plan

OBSERVATION
N/A

An evacuation plan specifies emergency procedures that staff are to implement in the event of an emergency (i.e., a fire). A floor plan should be included in the evacuation plan. In the case of IRAs, the site-specific protective oversight plan should include evacuation procedures or reference the evacuation plan, which is usually a separate document.

The plan should follow generally accepted safety principles.

The site's evacuation plan should describe actions to be taken upon discovery of an emergency. Review the site's evacuation plan. It should:

- Be clearly written and understandable
- Be site-specific
- Describe actions to be taken upon:
  - actual discovery of the fire
  - smelling smoke
  - hearing the alarm
- Describe how to notify site occupants of the need to evacuate (i.e., pull alarm).
- Identify evacuation routes and exit doors.
- Describe how to safely check and enter rooms during the evacuation process.
- Describe any priorities with regard to the evacuation of specific individuals.
- Describe any priorities with regard to the use of exits.
- Clearly assign and describe individual staff responsibilities for protection, rescue, and evacuation, designated by staff role on the shift, not by name or title of staff.
- Instruct staff to call 911/Fire Department.
- Identify by name, the meeting place for head count.
- Be updated and revised and reviewed by all staff when revisions required based on individuals at the site:
  - When individuals' abilities and needs for support change
  - When individuals are new to the site (i.e., respite or new admissions), needs for support are identified and including in evacuation planning:
    - Persons newly admitted
    - Persons at the site for a temporary period

- The plan should take into account the individuals' significant fire safety needs as discussed in DISCUSSION and indicated in assessments such as the Life Plan and individual protective oversight plans. This should include the level and type of supervision and assistance needed.
- Note that defend-in-place strategies may be applicable, depending on the type of building. The plan should identify defend-in-place use and areas of refuge.
    - For structures where the defend-in-place strategy is used, the plan should include what should be done in the event that conditions become untenable in the building.
    - If defend-in-place strategies are used, the physical plant safety enhancements which allow for its use must be identified by the facility and their functionality verified by a LSC surveyor.

For Apartments: Additional considerations for inclusion in evacuation plans for sites in apartment buildings. It is critical to include a distinction between apartment building fires that originate in the certified apartment unit and those that originate elsewhere in the building.

- When the fire is in the apartment unit, the appropriate plan is to get everyone in the apartment unit out of the building.
- If fire is not in the specific apartment reviewed, the following actions are appropriate practice in all apartments regardless of location:
    - If there is a fire in a non-fireproof building it is usually safer to leave the building immediately.
    - If there is a fire in a fireproof building but not in your dwelling unit, it is usually safer to stay inside the apartment rather than entering smoke filled hallways, especially if the fire is above your apartment.
- Additional information on evacuation planning and preparedness in apartment settings is available on the New York City Fire Dept.

For certified site-based Day Habilitation and Prevocational Services [635-7.5(e)]: The Day Habilitation Program must have an evacuation plan that is specific to the premises and designed with consideration of:

- Capabilities of the persons receiving services
- Staffing of the premises
- Physical plant configuration

Refer to the OPWDD document for additional information: Essential Elements of a Fire Evacuation Plan.

Refer to ADM # 2012-02 Fire Safety | OPWDD as needed.

Determine the standard is MET if:

- The site's evacuation plan generally meets described expectations for content and clarity. Any omissions or issues will not impact on ensuring the safe and timely evacuation of the site and protection of individuals.

Determine the standard is NOT MET if:

• The site's evacuation plan does not meet described expectations for content and clarity. Omissions or concerns regarding the plan have the potential to negatively impact safe and timely evacuation of the site and protection of individuals.

8-2 All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.

ADM # 2012-02
Standardized fire drill forms are to be used by July 1, 2012.

Program Class/Type:
Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS
LSC: Life Safety Code

DISCUSSION
As needed:
- Regarding form use

DOCUMENTATION REVIEW
Mandatory:
- Completed evacuation report forms

OBSERVATION
N/A

The use of OPWDD standardized evacuation report forms is required to be used in all certified programs. The facility should document evacuation drills on the standardized form* appropriate to the program type.

Verify that the appropriate OPWDD forms are used to document evacuations/drills.

Verify that required information is documented on the form correctly.

*There are 5 different forms that encompass the multiple types of occupancy found throughout OPWDD programs: LSC Board and Care Impractical, LSC Board and Care Prompt or Slow, LSC Health Care, Residence/IRA with 3-minute Strategy (non-LSC), and Day Habilitation (expected to include certified Prevocational sites). ADM #2012-02 Fire Safety Attachments.

Determine the standard is MET if:

- The correct OPWDD Evacuation Report Forms for the site/LSC status are used and completed correctly.

Determine the standard is NOT MET if either of the following are present:

- The correct OPWDD Evacuation Report Forms for the site/LSC status are not used consistently.
- There is a pattern of incomplete documentation of drill information onto the forms.

8-3 The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
635-7.5(e) An evacuation and safety plan specific to the certified premises shall be developed and implemented that is designed with consideration of the capabilities of the persons receiving services, the staffing of the premises, and the physical plant configuration. A description of the evacuation and safety training for individual participants and staff shall be included in the plan.
Program Class/Type: Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
686.16(b)(1) OPWDD shall verify that each individualized residential alternative has implemented a facility evacuation plan. OPWDD shall verify that staff and persons residing in the facility are trained and evaluated regarding their performance of said plan.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA Small 8 or less, CR-Supervised apartment, CR/Supportive Community Residence
ADM # 2012-02 In order to provide specific direction to the field and to provide consistency, OPWDD has standardized the minimum frequencies of required evacuation and fire drills in both homes and day settings.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS: CR: Community Residence IRA: Individualized Residential Alternative LSC: Life Safety Code **DISCUSSION** As needed: • Program site staff, if fire drill report documentation fails to verify compliance with frequency required by the program setting **DOCUMENTATION REVIEW** Mandatory: • Completed evacuation report forms

OBSERVATION
As Needed:
- If drills lacking and cannot verify that individuals will be safe in fire emergency

OPWDD has standardized the minimum frequency of evacuation - fire drills in both residential and day program settings per ADM #2012-02 (ADM #2012-02 Fire Safety Attachments).

Through review of drill documentation/evacuation report forms, assess that evacuation/fire drills are minimally implemented as follows:
24-Hour Staffed Residential Settings:
- Non-LSC: One (1) full evacuation drill per shift per quarter
- LSC Board & Care Prompt or Slow: One (1) full evacuation drill per shift per quarter
- LSC Board & Care Impractical: One (1) full evacuation drill per shift per quarter
- LSC Board & Care Impractical, with individuals unable to participate:
  - One (1) drill per shift per quarter with
  - One (1) drill per shift per year being full evacuation drills if the site is designed to defend in place
- LSC Health Care Occupancy: One (1) drill per shift per quarter with one (1) drill per shift per year being full evacuation drills

Non-24 Hour Staffed Residential Settings (supportive IRAs and supportive CRs):
- Four (4) full evacuation drills per year.
- For fire resistive apartment buildings with at least one hour enclosed interior stairs, two (2) of the four (4) evacuation drills could be limited to the stair well landing.
- In situations where there is only one exit and the alternate means is a window or a porch not leading directly to grade level, four full evacuations and an additional two drills which practice use of the alternate means.

Day Programs and Article 16 Clinics:
- One (1) full evacuation drill per quarter

Day programs which are designed to defend in place:
- Four (4) drills per year/two of which include two full evacuations per year

Determine the standard is MET if:

• There is documentation evidencing evacuations drills are practiced with the required frequency and type of practice activities required for the setting.

Determine the standard is NOT MET if either of the following are present:

• Evacuation drills are not practiced with the required frequency required for the setting.

• Evacuation drills do not include the required practice activities with the frequency specified (i.e., Health Care or Board and Care using defend in place hold the correct number of drills but do not practice one full evacuation).

8-4 Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
633.4(a)(4)(i) No person shall be denied: (i) a safe and sanitary environment.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.16(b)(1-2) For individualized residential alternatives of eight or fewer beds, OPWDD shall verify that each person's individualized services plan (see glossary) contains a current evaluation of the fire evacuation capacity of the person based on actual performance. OPWDD shall verify the accuracy of the information in each person's individualized services plan relative to fire evacuation performance. OPWDD shall verify that each person has a plan for protective oversight, based on an analysis of the person's need for same, and that such need has periodically, but at least annually, been reviewed, revised as appropriate, and integrated, as appropriate, with other services received.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ADM # 2012-02 Supportive Administrative Memo.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS IRA: Individualized Residential Alternative LSC: Life Safety Code **DISCUSSION** As needed: • Program site staff: If fire drill report raises questions or fails to verify that drills are conducted appropriately as described below

DOCUMENTATION REVIEW
Mandatory:
- The written evacuation plan
- Completed evacuation report forms to verify that the actions taken during a drill meet the requirements described below

OBSERVATION
As Needed:
- If drills lacking and cannot verify that individuals will be safe in fire emergency

Review drill documentation. Drills should be conducted as follows:
- Drills should normally mirror the elements of a real fire emergency. Drills should be held at unexpected times and under varying times and conditions.
- Drills should be held with normal staffing levels; not with extra staff working.
- Individuals and staff practice what they are actually going to be expected to do in the event of a fire emergency, as designated in their evacuation plan.
- In LSC homes, the night shift drill should occur after the 1st hour of sleep and before the 3rd hour of sleep.
- Evacuation drills should be occurring as quickly and safely as possible. Evacuation times for the facility should be appropriate to the site and time frames established for it, if applicable.
    - For Small IRAs (unless meeting LSC), the time frame should be three minutes or less.
    - For Apartment buildings, evacuation needs to occur to the exterior at ground level within the three minutes to meet the three minute all out requirement, unless the apartment building is a fire resistive building with an enclosed interior stairwell. In the case of an enclosed interior stairwell, the three minute maximum would apply to time the time it took to get to that stairwell.
    - For LSC Board and Care IRAs evacuation should occur swiftly, but not to exceed the following maximums for the LSC designation for their site:
        - Prompt – 3 minutes
        - Fast/Slow - 8 minutes
        - Slow/Slow - 13 minutes

For all sites, drill times should be reviewed and any problems or concerns identified.

See also ADM #2012-02 Fire Safety Attachments FIRE DRILL REQUIREMENTS.

Determine the standard is MET if:

- There is documentation evidencing evacuations drills are practiced in accordance with appropriate expectations: varied time/conditions, normal staffing levels, per the evacuation plan strategies and per the individuals' needs and with attention to safety and timeliness.

Select NOT MET if a pattern of any of the following is evidenced:

- Evacuation drills are not practiced with normal staffing but run with increased staffing (i.e., full staff day or shift change) or participation parties that would not routinely be present (i.e., clinical or management staff).
- Evacuation drill documentation or discussion evidence that practice does not include the strategies identified in an acceptable evacuation plan.
- Documented staff evacuation activities increase potential for harm to themselves or the individuals.
- Required assistance and supervision is not provided to the individuals per their needs.
- Defend in place strategies are implemented in environments where it is not an acceptable practice.
- Any practice identified that has an effect of providing a false assessment of effectiveness of the drill or dangerous practice that has the potential for harm to individuals.

8-5 The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
ADM # 2012-02 Unannounced observation of evacuation and fire drills by administrative staff: In addition to the review of fire drill reports by administrative staff, OPWDD implemented a policy in the state operated homes that requires administrative staff above the house manager level to be present on an unannounced basis to observe fire and evacuation drills. OPWDD is requiring that this activity be conducted at each supervised home, a minimum of once per year on the overnight shift, and once per year on a shift chosen by the agency. If problems are found during these drills, the agency may need to do additional unannounced observations in order to ensure resolution of problems raised. The purpose of this activity is to confirm that the operational minimum staffing pattern for a given home and shift is sufficient to successfully implement the fire evacuation plan in the timeframes relevant to that home. This activity also serves as a way to verify that the information contained on fire drill reports is consistent with the staff and individual's observed performance.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
DISCUSSION As Needed: • Management and program site staff: If evacuation report forms do not indicate administrative monitoring **DOCUMENTATION REVIEW** Mandatory: • Evacuation report forms to verify that fire drills are monitored per the criteria staffing and actions described below **OBSERVATION** N/A Assess how management staff supervise that drills are conducted properly. There should be evidence of on-going review of the fire evacuation plan for effectiveness, correct implementation and for need for revisions. Review includes review of evacuation report forms as well as the required unannounced observation of drills.

Talk to staff, supervisors and administrators. Ask how they monitor that the evacuation plan is appropriate and how often they do so. Review for the following monitoring actions:

- Verify that for supervised residences, that unannounced, management-observed drills have been conducted (i.e., by an administrative staff member above the level of a house manager).
  - These unannounced observations must be done minimally:
    - Once per year on the overnight shift, and
    - Once per year on a shift chosen by the agency
- Verify that the observation results and any corrective actions are documented.

Reports of fire drills conducted by staff outside normal business hours (i.e., night shift) should be reviewed and verified by agency administrative staff (above the level of a house manager) within 24 hours (or next business day) to ensure that the report filed by staff is an accurate reflection of what actually occurred.

NOTE: Unannounced observed drills are required as administrative oversight of fire drills in supervised settings. In supportive settings it is the responsibility of the agency to periodically assess individuals' continued independence in evacuation, particularly in situations in which that independence is in doubt. The agency may apply whatever oversight methods are needed to provide reasonable assurances of this in the non-24 hour supervised setting.

Determine the standard is MET if:

- There is documentation of the review for adequacy and effectiveness of the drill by management and/or administrators through review of evacuation report forms.
- There is documentation of the management/administrative completion of required unannounced observations of actual drills.

Determine the standard is NOT MET if any of the following are present:

- Required unannounced observation of drills are not occurring.
- There is pattern of failure to review the adequacy and effectiveness of the drills by management and/or administrators through review of evacuation report forms.

8-6 Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.

ADM # 2012-02

Unannounced observation of evacuation and fire drills by administrative staff:

In addition to the review of fire drill reports by administrative staff, OPWDD implemented a policy in the state operated homes that requires administrative staff above the house manager level to be present on an unannounced basis to observe fire and evacuation drills. OPWDD is requiring that this activity be conducted at each supervised home, a minimum of once per year on the overnight shift, and once per year on a shift chosen by the agency. If problems are found during these drills, the agency may need to do additional unannounced observations in order to ensure resolution of problems raised. The purpose of this activity is to confirm that the operational minimum staffing pattern for a given home and shift is sufficient to successfully implement the fire evacuation plan in the timeframes relevant to that home. This activity also serves as a way to verify that the information contained on fire drill reports is consistent with the staff and individual's observed performance.

Program Class/Type:

Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS

BPC: Bureau of Program Certification
DDSO: Developmental Disabilities Service Office
DQI: Division of Quality Improvement

DISCUSSION

Mandatory:

- Management and site staff regarding drills, any problems, and actions taken to identify and address concerns

DOCUMENTATION REVIEW

Mandatory:

- Written evacuation plan
- Evacuation report form

OBSERVATION

N/A

Verify that the facility management effectively monitors evacuation drills, staff actions, and the effectiveness of the evacuation plan, through inclusion of the criteria below:

- The evacuation was completed within time/duration requirements.
- The evacuation procedures are effectively and safely implemented reviewed for safety, and provision of appropriate assistance and supervision to individuals requiring it.
- Staff actions and the need for staff training are identified and provided as needed.
- Each staff member participates in at least one drill per year.
- Staffing levels are effectively reviewed to ensure there is sufficient, capable staff on all shifts to ensure individuals with physical limitations, behavior issues, or other concerns can be evacuated safely.
- Administrative review includes review of implementation of protect-in-place strategies for appropriateness given the drill scenario.
- Plans are modified based on drill performance concerns and staff recommendations.

For UNSUCCESSFUL DRILLS: Verify that the facility/agency identifies and takes action for unsuccessful drills (i.e., those in which all program participants were not evacuated in the expected time frame and/or unsuccessful implementation of the fire plan) as per criteria above: unsuccessful drills, that identification and correction of root cause result in successful follow up drills, as described below.

- Agency administrative staff are contacted immediately, regardless of shift, if a drill was unsuccessful.
- The contacted administrative staff has decided if the situation requires immediate remediation response to preserve individuals' health and safety.
- This decision is documented on the fire drill reporting form.
- If an immediate response is not required, then action to correct occurs within 24 hours of the unsuccessful drill.
- Action is taken to identify root cause of unsuccessful drills.
- There is evidence that identified problems have been addressed.
- If a pattern of unsuccessful drills is present, the agency takes timely and systemic action to ensure safety of the individuals served.
- If such a pattern emerges, the agency must report it to the local DDSO and DQI-BPC for monitoring.

Determine the standard is MET if either of the following are present:

- There is documentation evidencing that problems with the implementation, effectiveness, or appropriateness of the evacuation drill have been identified, documented and appropriate corrective actions taken.
- 9-5 is MET in that monitoring activities are occurring appropriately, there are no concerns identified regarding the evacuation drills, and this appears to be an appropriate assessment.

Select NOT MET if any of the following are identified:

• Documentation of evacuation drills indication concerns, problems, ineffectiveness but these were not identified by the program and program administrative review.

8-7 Agency staff can describe fire safety and emergency evacuation procedures.
633.4(a)(4)(i) No person shall be denied: (i) a safe and sanitary environment.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.8(b)(1)(vii) OPWDD shall verify that employees (other than exempted administrators), volunteers or family care providers have received or will receive training within three months of initial employment on… appropriate topics relative to the safety and welfare as may have been specified by the facility.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.8(b)(2)(v) Employees, volunteers and family care providers shall receive training in the following areas on at least an annual basis: (v) the agency's safety and security procedures (including fire safety).
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS IPOP: Individualized Plan of Protective Oversight

DISCUSSION
Mandatory:
- Facility staff regarding:
  - Training received
  - Their responsibilities in emergency evacuations and the individualized needs of the individuals

DOCUMENTATION REVIEW
Mandatory:
- Written evacuation plans of the site
- Evacuation report forms

As Needed:
- Supporting documentation (i.e., Life Plan, IPOP, other documentation of safeguards)

OBSERVATION
N/A

Through discussion with staff, assess that:
- All staff (supervisory and direct care) have been trained on and know about individuals' fire safety needs, including level of physical assistance needed.
- Staff have received training on the implementation of the evacuation plan.
- Staff can describe the procedure in full, including use of all fire protection equipment to include use of alarm activation devices and central station, notification of staff and occupants, and 911.
- Staff can describe use of primary and alternate exits.

Determine the standard is MET if:
- Staff on duty can adequately explain to you actions they are required to take in the event of a fire emergency per the evacuation plan, the individuals' needs and safe practices.

Determine the standard is NOT MET if:

• Staff on duty cannot adequately explain to you actions they are required to take in the event of a fire emergency per the evacuation plan, the individuals' needs and safe practices.

8-8 The certified site provides safe exiting to a public way.
635-7.3(h)(2) Safe, continuous and unobstructed exits are maintained from the interior of a facility to the exterior at a street or to a yard, courtyard or passageway leading to an open public area. A landlocked courtyard must have unrestricted access to a location which is at least 30 feet away from the building.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.4(b)(3)(xiii) Safe, continuous and unobstructed exits shall be maintained from the interior of the home or IRA to the exterior at a street or to a yard, courtyard or passageway leading to an open public area. A landlocked courtyard must have unrestricted access to a location which is at least 30 feet away from the building.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
ACRONYMS CR: Community Residence IRA: Individualized Residential Alternative **DISCUSSION** As needed: • Management staff and program site staff regarding any questions, concerns, findings if observations point to any situations which fail to assure safe exiting to a public way **DOCUMENTATION REVIEW** N/A **OBSERVATION** Mandatory: During physical plant tour to assure compliance, as described below:

- If special locking mechanisms are disengaged by alarm system, assessment must include request for activation of the system by facility staff. In addition, emergency bypass of locking mechanism must be tested.

Through observation and physical plant walk through, verify the following:

- Doors (except in Supportive CRs, Self-Preserving CRs and small IRAs) should be provided with single-function locks. Occupants must be able to use a dual function locking arrangement if one exists at small IRAs or Supportive and Self-Preserving CRs. If any individual is unable to use a dual function lock in these settings, a single function locking mechanism must be used.
- Special locking mechanisms on doors function properly, disengaging for emergencies as required when the alarm system is activated
- Aisles/corridors are unobstructed.
- There is adequate lighting of exit ways.

EXTERIOR: This is applicable to facilities that serve individuals during hours of darkness/nighttime. During physical plant "walk through", assess whether exterior lights work. Evaluate their locations to see if they are sufficient to guide individuals from the facility to the meeting place. If possible (early mornings and evenings, winter late afternoons), note during times of darkness whether illumination is sufficient to allow safe travel to meeting areas. Also, when possible, test that lights that are activated by darkness or motion do so.

There is a clear path to a public way in good condition. It is not required that these surfaces are paved.

The facility has a reliable system for the removal of snow and ice from exterior exit ways including exterior stairs and walkways in a timely manner.

Gates along the exit way and the street, can be opened easily

Safe exiting includes the exterior of the building (i.e., to the street and/or, in New York City, a courtyard, which shall be a minimum of 30 feet unless there is an unlocked gate with access to adjacent yard or open public space).

Apartment windows provided with gates, are of the Fire Dept. approved variety only and can be opened from the inside without a key.

For Apartment Buildings

- The exit routes from the apartment unit to the public way must be properly lit and unobstructed. In cases where the apartment building has enclosed interior stairs, surveyors should check the common corridor at the certified apartment unit level and at the level of exit discharge as well as the integrity of stair doors at all intervening levels. In open stairwell construction, surveyors would need to assess all levels. In particular, check the following:
  - The door to the certified site apartment unit should self-close and latch
  - Stairwell doors (if provided) should self-close and latch
  - Trash compactor chutes or doors to trash compactor rooms should self-close and latch

- Emergency lighting units should be operational
- If egress routes pass boiler, laundry, storage, trash compactor or other utility rooms, the hardware provided on those rooms (self-closers and latches) must be operational
- Doors noted above should not be propped open

Note that while the agency may have no jurisdiction over the building, it is the agency's responsibility to ensure safe and unobstructed exit routes for the home. This would involve identifying problems, bringing them to building management, and monitoring for resolution.

Determine the standard is MET if:

• Safe and barrier free exiting is verified based on your observation, testing and the guidance for this standard.

Determine the standard is NOT MET if:

• There are observed impediments to safe and barrier free exiting as described in guidance such as: items blocking hallways, inappropriate and/or inoperable locking/unlocking mechanisms, snow/ice covered walkways, etc.

8-9 There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
635-7.3(e)(1) (i)-(vii) Clarifying documents: ADM (i) All required heat and smoke-detecting services shall be interconnected as necessary to ensure that activation of anyone device will sound an alarm that is audible throughout the facility. Heat-detecting devices shall be either the rate-of-rise or fixed self-restorative type. (ii) A smoke detector shall be installed in each bedroom. (iii) A smoke detector shall be installed in each corridor adjacent to sleeping rooms. In corridors or adjacent open areas such as living rooms, dining rooms or recreation rooms, smoke detectors shall be installed at a maximum of 30 feet on center and no more than 15 feet from a wall. (iv) A smoke detector shall be installed at the head of each open stairway located within the facility; or a smoke detector shall be installed within six feet of the bottom opening of a stairway that is enclosed at the top. (v) At least one smoke detector shall be installed in basements (see section 635-99.1 of this Part) and at least one heat detector installed in accessible and usable attics at a ratio of one detector for each 1,000 square feet of floor space. Additional detectors may be required for those basements and attics subdivided by partitions.(vi) A heat detector shall be installed in kitchens. (vii) A heat detector shall be installed in storage rooms and near a furnace, boiler or any heat producing equipment located within the facility.
Program Class/Type: IRA/FSR Large 9 or more, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
635-7.4(b)(3)(v)(a-c) Clarifying documents: A (a) A smoke detector shall be installed in each corridor adjacent to sleeping rooms. In corridors or adjacent open areas such as living rooms, dining rooms or recreation rooms, smoke detectors shall be installed at a maximum of 30 feet on center and no more than 15 feet from a wall. (b) A smoke detector shall be installed at the head of each open stairway located within the home or IRA; or a smoke detector shall be installed within six feet of the bottom opening of a stairway that is enclosed at the top. (c) At least one smoke detector shall be installed in basements (see section 635-99.1 of this Part). Additional detectors may be required for those basements and attics subdivided by partitions.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
635-7.5(f) Clarifying documents: ADM # 97-01; AD Unless the building is fully sprinklered, each certified site shall be equipped with interconnected, hardwired smoke detection and alarm devices to assure early notification of the certified site. At a minimum, the devices shall be installed in required exit ways from the certified space.
Program Class/Type: Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ADM # 97-01; ADM # 99-01 Supportive Administrative Memos.

Program Class/Type:
Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS
CR: Community Residence
ICF: Intermediate Care Facility
IRA: Individualized Residential Alternative

DISCUSSION
As needed

DOCUMENTATION REVIEW
Mandatory:
- Alarm and detection equipment/system check/test documentation which will indicate presence/absence of needed equipment and whether operable or defective

OBSERVATION
Mandatory:
- During physical plant tour review for installation of required devices

Verify during the physical plant walkthrough that smoke detectors and heat detectors are present in accordance with regulatory requirements. There is a separate standard that addressed heat detectors required per ADM #2012-12.

NOTE: For situations that present an immediate risk to the safety of an individual, contact your area director & require immediate correction.

SMOKE & HEAT DETECTION & ALARM:
- Surveyors should familiarize themselves with the different types of smoke and heat detectors (or combo smoke/heat detectors).

- During a physical plant walk-through, surveyors should ensure that the facility is meeting the requirements for smoke and heat detection identified.
- Some detectors can be physically tested for interconnectivity.
- Ensure that smoke detectors are installed greater than three (3) feet or less of operable ceiling fans. Smoke detectors in a room with a ceiling fan must be photoelectric vs. ionization type unless specifically listed for conditions of rapid air movement. (ADM # 99-01).

RESIDENTIAL SITES:
General smoke detection system requirements:

- Hardwired
- Powered by house electrical service
- Must sound an alarm that is audible in all parts of the facility
- The battery-operated smoke detector exception should be applied in VERY RARE instances. Battery-operated smoke detectors are allowed by exception only, and if used must be a combination photoelectric/ionization type. For guidelines for exceptions to battery-operated smoke detectors ban, see referenced memorandum (ADM #97-01).

Applies to Supervised CRs, IRAs (9+) and ICFs:

- All required heat and smoke-detecting services are interconnected to ensure that activation of any one device will sound an alarm that is audible throughout the facility.
- Heat-detecting devices are either the rate-of-rise or fixed self-restorative type. Older fixed temperature heat detectors need to be replaced according to manufacturers' instruction (usually every 10 years). Replacements should be rate-of-rise or fixed self-restorative.
- Smoke detectors are installed:
    - in each bedroom
    - in each corridor adjacent to sleeping rooms
    - in corridors or adjacent open areas such as living rooms, dining rooms or recreation rooms
    - at a maximum of 30 feet on center and no more than 15 feet from a wall
    - at the head of each open stairway located within the facility or a smoke detector is installed within six feet of the bottom opening of a stairway that is enclosed at the top.

- At least one smoke detector is installed in a basement and at least one heat detector installed in accessible and usable attics at a ratio of one detector for each 1,000 sq. ft. of floor space. Additional detectors may be required for those basements and attics subdivided by partitions.
- A heat detector is installed:
    - In each kitchen
    - In each storage room
    - Near a furnace, boiler, or any heat producing equipment located within the facility

Applies to Small IRA's (8 beds or less):

- A smoke detector is installed in each corridor adjacent to sleeping rooms.
- Smoke detectors are installed in corridors or adjacent open areas such as living rooms, dining rooms or recreation rooms at a maximum of 30 feet on center and no more than 15 feet from a wall.
- A smoke detector is installed at the head of each open stairway located within the home or IRA or a smoke detector is installed within six feet of the bottom opening of a stairway that is enclosed at the top.
- At least one smoke detector is installed in basements (see section 635-99.1). If a basement alarm is placed six feet from the bottom of the staircase, it counts as coverage for the basement (a detector at the top of the staircase does not).
- Additional detectors may be required for those basements and attics subdivided by partitions.

DAY HABILITATION SITES ONLY:

- Unless the building is fully sprinklered, each certified site shall be equipped with interconnected, hardwired smoke detection and alarm devices to assure early notification of the certified site. At a minimum, the devices shall be installed in required exit ways from the certified space.
- Smoke detectors in hallways should be spaced every 30 feet. This is under normal conditions where the hallways are of average width, height and slope.

Also refer to the grid entitled: REQUIRED FIRE PROTECTION EQUIPMENT BY FACILITY TYPE in the fire safety protocol.

Determine the standard is MET if:

- REGULATION REQUIRED: Smoke detector, heat detection and alarm devices are installed and operable per the facility type.

Determine the standard is NOT MET if ANY of the following are missing or inoperable:

- Smoke detectors as required by regulation per facility type.
- Heat detectors as required by regulation per facility type.
- Alarms devices as required by regulation per facility type.

8-10 Heat detectors are present in the residence as required by OPWDD.

ADM # 2012-02

The use of smoke detectors is not recommended in spaces that are subject to high humidity or very cold or hot temperatures, such as unheated attics, crawlspaces and roofed porches. However, fires can still occur in these locations for a variety of reasons including faults in electrical wiring or faults in HVAC or ventilation equipment installed in these locations. For this reason OPWDD is requiring that all attics, crawl spaces and roofed porches within residential sites be eventually equipped with fixed self-restorative heat detectors that are hard wired, powered by the building electrical service and are interconnected to the building's fire alarm and smoke detection system.

Program Class/Type:

IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School

DISCUSSION

As needed

DOCUMENTATION REVIEW

Mandatory:

- Alarm and detection equipment/system check/test documentation which will indicate presence/absence of needed equipment and whether operable or defective

OBSERVATION

Mandatory:

- During physical plant tour observe for installation of required heat detectors

See ADM 2012-02.

In an effort to increase the level of detection and resultant safety in residential sites, OPWDD requires that specified areas of the residences be equipped with heat detectors as indicated below. The installation of heat detection per these requirements is effective 05/01/2012 in the following circumstances:

- All new residential development projects where construction begins after 5/01/2012.
- All significant physical plant upgrades or replacement of existing fire alarm/smoke detection systems.

The heat detection requirements are:

• All attics, crawl spaces and roofed porches within residential sites will be equipped with rate-of-rise or fixed self-restorative heat detectors that are hard wired, powered by the building electrical service and are interconnected to the building's fire alarm and smoke detection system. ADM #2012-02.
  - Attics:
    - All attics need heat detectors and must be accessible for inspection. If inaccessible, attics must be made accessible and heat detectors installed.
  - Crawl Spaces:
    - Accessible crawl spaces need heat detectors.
    - Previously inaccessible crawl spaces need not be made accessible.
    - Crawl spaces that are not accessible to routine staff, have only restricted access for inspection purposes, and with no equipment installed, do not require heat detectors. (Restricted access: i.e., locked gate or access panel for which access is limited to maintenance staff or a contractor.)

• Overhangs:
  - Heat detectors are required for overhangs that extend out from the building four (4) feet or more when the overhang is at least four (4) feet wide.
  - In specific locations exposed to weather, heat detectors rated for outdoor use should be used.
  - Heat detector coverage must not exceed 1000 sq. ft. of coverage per detector.
  - Heat detectors must provide lateral coverage of thirty (30) feet on center.
  - Exception: Heat detectors are not required for buildings with overhangs having solid surfaces (non-perforated/non-ventilated), non-combustible soffits and fascias, and non-combustible exterior walls or siding.

For specific sites to which the requirements do not apply, in which the lack of heat detectors in proposed locations appears to present a particular vulnerability, based on the population served or other factors, surveyors will strongly recommend that the provider agency promptly explore the feasibility of installing heat detectors at the site.

Determine the standard is MET if either of the following are verified:

• The requirement does not apply as the residence was constructed prior to 05/01/2012 and has not implemented any physical plant upgrades or replacement of existing fire alarm/smoke detection systems since 05/01/2012.
• Required heat detectors in attics, crawl spaces and overhangs, as described in guidance (per ADM #2012-02) are installed and operable.

Determine the standard is NOT MET if either of the following are verified:

• Construction of the residence began at or after 05/01/2012 and required heat detectors in attics, crawl spaces and overhangs as described in guidance (per ADM #2012-02) are NOT installed and/or NOT operable.

• The residence has implemented physical plant upgrades and/or replacement of existing fire alarm/smoke detection systems since 05/01/2012 and required heat detectors in attics, crawl spaces and overhangs as described in guidance (per ADM #2012-02) are NOT installed and/or NOT operable.

8-11 Fire alarm and notification systems are operational and effective.
633.4(a)(4)(i) Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.3(h)(7) Any hazardous conditions that present a threat to an individual's safety or welfare shall be repaired in a timely fashion.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.4(b)(3)(xviii) Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
635-7.5(f) Unless the building is fully sprinklered, each certified site shall be equipped with interconnected, hardwired smoke detection and alarm devices to assure early notification of the certified site. At a minimum, the devices shall be installed in required exit ways from the certified space.
Program Class/Type: Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
686.16(b)(5) OPWDD shall verify, in facilities of eight beds or less that the alarms of fire detectors installed pursuant to section 635-7.4(b)(3)(v) of this Title are clearly audible in sleeping areas with intervening doors closed.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
ACRONYMS NFPA: National Fire Protection Association **DISCUSSION**

As need:
- Site and/or agency staff

DOCUMENTATION REVIEW
Mandatory:
- Documentation of the testing, inspection, and maintenance of the fire alarm/notification equipment
- Proof of repair and/or replacement of any faulty equipment

OBSERVATION
Mandatory:
- During physical plant tour request activation of alarms to assess operation and that they are audible as required

All fire alarm systems must be maintained in continuously operable condition at all times. Fire alarm and notification systems may include but are not limited to: alarms, strobes, bed and pillow shakers, and any other mechanisms installed to support notification. No one may interfere with the operation of the equipment by practices such as silencing fire alarm systems. In some sites a formal system may not be in place, however the interconnected hard wired smoke alarms must be tested and operable also.

Review the documentation of the testing, inspection, and maintenance of the fire alarm/notification equipment. The documented reports should indicate that the equipment is operational and that any problems identified have been addressed/corrected. Testing documentation must adhere to NFPA 72 requirements. See ADM 2012-02 for guidance (ADM #2012-02 Fire Safety Attachments).

During the walk-through, review the following:
- In all sites except apartment buildings, request facility staff to activate the alarm system in the most naturally occurring way possible (i.e., test/activate smoke detection, activate the pull station, etc.). If the facility is connected to the fire department or a central monitoring station, it may be helpful to remind staff to notify the parties that a test will be occurring. Verify the following:
  - The alarms activate.
  - Alarms are clearly audible in sleeping areas with intervening doors closed, and typical ambient room noise such as air conditioners or televisions running. The sound should be likely to wake the occupants.
  - Strobes flash.
  - Bed shakers activate, properly placed and are protected from tampering.
  - The alarm relays to the monitoring station or fire department, if applicable.
  - For sites that are divided into apartments, the alarm, when sounded in one apartment, must be audible in all apartments.

Determine the standard is MET if:

- Based on activation the alarm/notification system, the system and all required components are working and effective to alert according to the needs of the individuals.
- Documentation of alarm system and component testing indicates the system has been maintained as operable and any needed repairs/replacements occur timely.

Determine the standard is NOT MET if any of the following are present:

- Based on activation the alarm/notification system, the system and/or any required component is NOT working and/or not effective to alert according to the needs of the individuals.
- Documentation of alarm system and component testing indicates identified needed repair and/or replacement of any portion of the system has not occurred or has not occurred timely.

8-12 Other fire protection equipment is operational.
633.4(a)(4)(i) No person shall be denied: (i) a safe and sanitary environment.
Program Class/Type: Diagnostic and Evaluative Clinic, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.3(h)(9) Door stops, wedges or other nonautomatic releasing hold-open devices are not used on openings in fire walls, fire separations and smoke barriers.
Program Class/Type: IRA/FSR Large 9 or more, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
635-7.4(b)(3)(xviii) Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
DISCUSSION As needed: • Site and/or agency staff **DOCUMENTATION REVIEW** Mandatory: • Documentation of testing, monitoring of other fire protection equipment • Proof of repair and/or replacement of any faulty equipment **OBSERVATION** Mandatory: • During physical plant tour to assure working and effective fire protection equipment, other than that specified in other standards in this protocol. All fire safety equipment must be maintained in continuously operable condition at all times. Other fire protection equipment may include self-closing and auto-closing doors*, special locking devices, emergency lighting units, smoke dampers, auto-disengagement of locked exit doors, and any other mechanisms installed to support fire and smoke protection and evacuation.

Through review of maintenance reports and during the walk-through, verify that the equipment works as intended. Some items are best verified at the time of alarm activation. Review may include but is not limited to the following:

- Locked exit doors automatically disengage.
- Auto-closing doors close and latch. There should be nothing that interferes with the action of doors that are required to be equipped with self-closing devices. These doors are so equipped to provide fire and smoke partitions, separation of potentially hazardous areas, separation of stories and separation of egress routes from common living areas. Using tie backs, door stops etc. defeats the function of the self-closing device.
- Emergency lighting illuminates when tested.

Determine the standard is MET if:

- Based on activation of other fire protection equipment it is working properly (if activation applicable).
- Observable equipment is in working order without damage.
- There is no documentation to indicate that the equipment has not been maintained.
- The site does not have, nor is required to have “other” fire protection equipment.

Determine the standard is NOT MET if ANY of the following are present:

- Based on activation of other fire protection equipment it is NOT working properly (if activation is applicable).
- Observable equipment is damaged.
- There is documentation to indicate that the equipment has not been maintained, repaired, replaced as needed and in a timely manner.

8-13 Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
635-7.3(i)(1) There is documentation that all heat and smoke-detecting alarm devices have been tested quarterly.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.4(b)(3)(xviii) Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
ACRONYMS NFPA: National Fire Protection Association **DISCUSSION** As needed: • Site and/or agency staff **DOCUMENTATION REVIEW** Mandatory: • Records which document fire alarm, smoke detection, and sprinkler system inspections **OBSERVATION** N/A Through documentation review and discussion, verify that this equipment was tested, inspected and maintained in accordance with the manufacturer’s recommendations.

Quarterly inspection is required unless documentation is provided by the agency evidencing contrary inspection instruction by the manufacturer, or alternate instruction is on the Maintenance Inspection Schedule.

Documentation of inspection/testing maintenance is dependent on the equipment and the party responsible for the task. For example, sites with hard wired smoke detectors that may be tested by agency staff will likely be documented on an agency form for that purpose, while inspection of complex alarm and detection systems by contracted professionals will be indicated on documents meeting NFPA standards. Some testing may be indicated right on the device, such as tags on fire extinguishers where notations of required inspections may be noted.

Refer to MAINTENANCE INSPECTION SCHEDULE for specific requirements for maintenance frequency per equipment/system type.

Determine the standard is MET if:

- The facility has documentation that verifies testing/inspection at required frequencies.

Determine the standard is NOT MET if either of the following are present:

- There is no documentation of inspection.
- Documented inspection indicates a pattern of missed testing and inspections/inspections do not occur with required frequency.

8-14 Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.

ADM # 2012-02

To ensure consistency and code compliance across the state, contract templates for sprinkler system testing and maintenance and fire alarm and smoke detection system testing and maintenance, that include information related to fire alarm system central station monitoring requirements, are available. Agencies that are negotiating or renewing contracts for these services must utilize these templates to ensure that contracts are sufficiently clear and comprehensive with regard to the responsibilities of the vendor.

Program Class/Type:

Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS

NFPA: National Fire Protection Association

DISCUSSION

As needed:

- Site and/or agency staff

DOCUMENTATION REVIEW

Mandatory:

- Records which document fire alarm and smoke detection inspections

OBSERVATION

N/A

While completing the site reviews, verify that there are testing and maintenance reports for Alarm and Detection Systems that provide a full record of all testing (including results) and maintenance actions taken in regard to the equipment and/or system. The inspections/testing should be documented on NFPA forms “Inspection and Testing Form”, as appropriate for the inspection and testing work being performed. A similar maintenance, inspection and testing form may be substituted and must include at a minimum all of the information required by NFPA 72.

It is acceptable for hard-wired line voltage interconnected smoke detectors without a panel system to be inspected by non-certified agency personnel, including, but not limited to maintenance personnel.

Per ADM #2012-02 the following is Inspection and Testing expected for Fire Alarm Systems. This list does not apply to the systems described immediately above.

FIRE ALARM SYSTEM INSPECTION and TESTING GENERAL REQUIREMENTS:

- The contractor or in some situations an agency's own appropriately trained staff must complete testing and maintenance for system components as applicable.
- Initial visual examinations of fire alarm system components for proper operation, position and condition as appropriate.

Fire Alarm System Testing General Requirements:

- QUARTERLY (four times per year): Initiating devices, central station operation, emergency voice/alarm communications equipment.
- SEMI-ANNUAL (two times per year): Batteries, sprinkler alarming services
- ANNUALLY (Once per year): Control equipment building systems – Functions, fuses, interfaced equipment, lamps and LEDs, primary power supply, transponders, batteries (other), fiber optic wiring, control unit trouble signals, heating, ventilating, and air conditioning (HVAC) system, remote annunciators, main panel, supervising station equipment receivers (Central Station)
- EVERY TWO YEARS: Sensitivity testing on initiating devices and in accordance with NFPA 72

NOTE: Assurance that the contracts for inspection and testing include detail of all required activities and by competent parties will be reviewed during the Agency review.

Determine the standard is MET if:

- The facility has documentation that verifies that required maintenance, testing and inspection of the smoke alarms (where applicable) or alarm and detection system (where applicable) is occurring with appropriate components included.

Determine the standard is NOT MET if either of the following are present:

- There is no documentation of required maintenance, inspection and testing of the smoke alarms (where applicable) or the alarm and detection system (where applicable).
- Documented maintenance/inspection/testing of the alarm and detection system indicates a pattern of incompleteness of the expected activities per timelines.

8-15 Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.

ADM # 2012-02

To ensure consistency and code compliance across the state, contract templates for sprinkler system testing and maintenance and fire alarm and smoke detection system testing and maintenance, that include information related to fire alarm system central station monitoring requirements, are available. Agencies that are negotiating or renewing contracts for these services must utilize these templates to ensure that contracts are sufficiently clear and comprehensive with regard to the responsibilities of the vendor.

Program Class/Type:

Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS

NFPA: National Fire Protection Association

DISCUSSION:

As needed:

- Site and/or agency staff

DOCUMENTATION REVIEW:

Mandatory:

- Records which document fire alarm and smoke detection inspections

OBSERVATION:

N/A

While completing the site reviews, verify that there are testing and maintenance reports for sprinkler systems that provide a full record of all testing (including results) and maintenance actions taken in regard to the sprinkler system. The inspections/testing should be documented on NFPA forms “Inspection, Testing and Maintenance of Fire Sprinkler Systems” or equivalent as deemed acceptable by OWPDD as appropriate for the inspection and testing work being performed.

The contractor or in some situations an agency's own appropriately trained staff must complete testing and maintenance. The facility /agency should have documentation noting the sprinkler system type and that evidences the water supply is sufficient. The requirements for specific inspection and testing of sprinkler systems per ADM #2012-02 are as follows (see ADM for more details as needed):

- QUARTERLY (four times per year): Visual examinations of all sprinkler system components for proper operation, position and condition as appropriate, and sprinkler system inspection and testing.
- ANNUAL sprinkler system inspection and testing:
  - Wet pipe sprinkler system: Test the freezing point of anti-freeze solutions if used.
  - Dry pipe sprinkler system: Trip test the dry pipe valve, preferably in the spring.
  - Cold weather valve, if used, should be closed before freezing weather and piping drained. Valve should be opened in spring.
  - Low point drains should be drained thoroughly before cold weather and after any system trip.
  - Fire pump test.
- Every 3 YEARS: Trip test the dry pipe valve – FULL FLOW TEST
- 5 YEAR INSPECTION: Test representative sample of sprinklers with temperature classification of extra high (325 degrees F) or greater.
- BLOCKAGE INVESTIGATION (Every five years minimum or more often as needed): Ensure that the sprinkler system piping be maintained free of obstructions.

- At any interval, identified problems and needed repairs must be addressed and evidenced/documented.

NOTE: Assurance that the contracts for inspection and testing include detail of all required activities and by competent parties will be reviewed during the Agency review.

Determine the standard is MET if:

- The facility has documentation that verifies that required maintenance, testing and inspection of the sprinkler system is occurring with appropriate components included.

Select NOT MET if any of the following are present:

- There is no documentation of required maintenance, inspection and testing of the sprinkler system.
- Documented maintenance/inspection/testing of the sprinkler system indicates a pattern of incompleteness of the expected activities per timelines.

Select N/A if:

- No sprinkler system is installed at the site.

8-16 At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
635-7.3(h)(4) At least one fire extinguisher equal to Class-1-A-5BC, 2.5 pound unit, approved and labeled by the Underwriters Laboratories, is located in an accessible place on each floor. Extinguishers are tested and recharged in accordance with the recommendations of the manufacturer and the NFPA.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.4(b)(3)(vi) Fire extinguishers shall be portable and in accordance with the requirements of NFPA 10, and approved and labeled by the Underwriters Laboratories.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
635-7.4(b)(3)(xvii) Other fire protection equipment is maintained in accordance with the recommendations of the manufacturer.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
ACRONYMS IRA: Individualized Residential Alternative NFPA: National Fire Protection Association **DISCUSSION** As needed: • Site and/or agency staff **DOCUMENTATION REVIEW** Mandatory: • Documentation of monitoring of extinguisher function and effectiveness **OBSERVATION** Mandatory:

• During physical plant tour observe for location, readiness (i.e., charge level), and condition as described below

Verify:

• Fire extinguishers must be equal to Class-1-A-5BC, 2.5-pound unit, approved and labeled by the underwriter's laboratories.
• Fire extinguishers are located on each floor of the facility. Small IRAs required extinguishers near kitchen areas.
• Extinguishers are mounted so that their location is fixed so they can be accessed easily.
• Function is reviewed through verification that testing and recharges occur per manufacturer and the NFPA recommendations. Minimally, extinguishers should be inspected monthly to ensure that:
  - There is no obstruction to access.
  - The pressure gauge is in the operable range.
• Inspections/testing should be documented to include date and inspector's initials.

Determine the standard is MET if:

• Operable fire extinguishers of the appropriate type and are on each floor and accessible per requirements.

Determine the standard is NOT MET if any of the following are present:

• Fire extinguishers are lacking in any applicable floor or area.
• Fire extinguishers are present but not easily accessible.
• Any fire extinguisher is inoperable, damaged, not charged.

8-17 In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.

633.4(a)(4)(i)
No person shall be denied: (i) a safe and sanitary environment

Program Class/Type:
IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supervised Group Home, Private School/Private School

686.16(b)(5)
OPWDD shall verify, in facilities of eight beds or less that the alarms of fire detectors installed pursuant to section 635-7.4(b)(3)(v) of this Title are clearly audible in sleeping areas with intervening doors closed.

Program Class/Type:
IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less

DISCUSSION
As needed:

- Site staff regarding how/if they are aware of emergencies in individual apartments
- Individuals if needed to assess staff notification and responsiveness

DOCUMENTATION REVIEW
N/A

OBSERVATION
Mandatory:

- Request demonstration of notification mechanism used on site with activation of the alarm to alert of needs in a particular apartment
- Assess likelihood that staff may respond appropriate on site within 1 minute.

In such supervised apartment living situations, the following must be assured:

- Staff on duty will be automatically notified of a fire alarm activation in the service recipient's home/apartment.
- Staff must be able to get to the individual within 1 minute of notification of fire or other emergency.
- The service recipient must have a way to notify the staff of his/her need for assistance when the staff is not in the individual's home.
- All direct support staff must have a key or other means of immediate access to the Individual's home.

Determine the standard is MET if:

• Review activities verify that there is an effective mechanism which assures automatic notification to staff AND 1 minute response AND immediate staff access to the individual's apartment.

Determine the standard is MET if either of the following are present:

• Review activities verify that there is no mechanism to ensure that staff can be summoned to an individual's apartments in an emergency in a supervised apt setting.

• There is a mechanism however in does not assure all three elements: assurance of automatic notification of staff AND 1 minute response AND immediate staff access to the individual's apartment.

Select N/A only if:

• The site is NOT a setting of individual apartments certified as a supervised residence.

8-18 A carbon monoxide alarm is appropriately located in all new and existing residences on sleeping levels, per requirements.
633.4(a)(4)(i) No person shall be denied: (i) a safe and sanitary environment
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
635-7.3(h)(8) When required by other State agencies, the facility shall keep records that document compliance with the sanitation, health and environmental safety codes of New York State or the City of New York.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
ACRONYMS CO: Carbon monoxide **DISCUSSION** As needed: • Site and/or agency staff **DOCUMENTATION REVIEW** As needed: • Regarding maintenance of equipment if concerns are identified **OBSERVATION** Mandatory: • During physical plant tour to assure condition and placement on site as noted in guidance Facilities should meet ALL the requirements of Amanda's law requirement for carbon monoxide installations Amanda's Law, in particular, those listed below: • CO detectors shall be provided in the following locations: o On any story of a building that contains a carbon monoxide source (a fuel-burning appliance). o On any story, below the floor (or mezzanine) with a carbon monoxide source, where an interconnecting stair is open to both floors (or not otherwise protected with a smoke barrier), and the space on the lower level is considered habitable. This is a specific clarification to Amanda’s Law- location of CO devices in townhomes and similar conditions, like split level homes.

- Within each dwelling unit, with a carbon monoxide source, on each level containing a sleeping area, within 15 feet of each sleeping area.
- More than one carbon monoxide detector shall be provided, where necessary, to assure that no sleeping area on any level is more than 15 feet away from a carbon monoxide detector.
- Health Care Occupancies are required to have a CO detector located within each sleeping area.
- All new CO detectors shall be hardwired and interconnected with the smoke and heat detection system.
- A hardwired interconnected CO detector(s) shall be installed if not otherwise appropriately located, when a new fuel burning appliance is installed.
- A CO detector is recommended to be placed in all vehicular garages which are attached to a home with a common interconnecting door.
- CO detectors should be maintained as operable.

Carbon monoxide detectors are not required in homes where no carbon monoxide source is located within or attached to the building.

Determine the standard is MET if:

• Review activities verify carbon monoxide alarms are installed in locations in the home as required and operable.

Determine the standard is NOT MET if:

• Review activities verify that carbon monoxide alarms are NOT installed in locations in the home as required and operable.

Select N/A only if:

• The home does not have a carbon monoxide source (i.e., room and water heating are electric only).

8-19 The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
635-7.3(h)(7) Any hazardous conditions that present a threat to an individual's safety or welfare shall be repaired in a timely fashion.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/9 or more conversion (from ICF), IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
635-7.4(b)(3)(xv) Any hazardous conditions that present a threat to an individual's safety or welfare are repaired in a timely manner.
Program Class/Type: IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA Small 8 or less
DISCUSSION Mandatory: • Facility and agency staff and individuals for any questions or concerns they may have regarding the safety of the site **DOCUMENTATION REVIEW** As needed: • Any documentation which co-evidences any other existing hazard which is not addressed in another protocol standard **OBSERVATION** Mandatory: • During physical plant tour to observe for any other hazards, not specifically addressed in other protocol standards During the survey and during the physical plant walk through, surveyors must be vigilant in the assessment of facilities for potential fire hazards. Possible examples of fire hazards are, but not limited to, as follows: GENERAL FIRE SAFETY ISSUES may include: • Overloaded electrical outlets including "piggy-backed" power strips. • Fixtures or appliances with damaged electrical wiring. • Wiring that is placed so that it is routinely run over such as by bed wheels and may become damaged.

- Use of narrow-gauge extension cords.
- Extension cords draped over doors or under carpets.
- Complaints of tripping circuit breakers when certain appliances are turned on.
- Smells of gas or the smell of the products of combustion.
- Noisy or dust clogged exhaust fans in bathrooms, kitchens etc.
- Improperly stored combustibles in the home (i.e., propane tanks, gasoline for mowers etc., oil-based paints, charcoal lighter fluid etc.). Typically flammable materials are not permitted indoors. If they are kept on premises, quantities must be strictly limited and kept either in an exterior shed or a vented metal cabinet within a properly enclosed hazardous area.
- Items such as outdoor grills, backup generators etc. too close to exterior siding such as vinyl or wood. Less than 3 feet clearance around grills. Grills placed under a roof.
- Combustibles such as paper towel or dish towels hung close to or over the stove.
- Significant grease accumulations on stove tops or in ovens.
- Halogen lights should be avoided in lamps that can tip over such as torch lamps.
- Use of toaster ovens on flammable surfaces such as wooden cutting boards or their observed unattended.
- Unattended lit candles.

CLOTHES DRYERS:

- The use of a plastic or flexible foil vent duct to vent clothes dryers is NOT PERMITTED. Clothes dryer vent conduit must be constructed of rigid or flexible solid metal.
- Torn lint filter (this leads to extensive lint build up in dryer vent conduits).
- Extensive kinking in dryer vent conduit.
- Extensive lint accumulation on the lint filter in the dryer and/or at the terminus of the dryer vent arrangement (indicative of infrequent cleaning).
- An accumulation of clothes or debris behind the dryer.

Determine the standard is MET if:

- No other fire safety hazards as described above are identified.

Determine the standard is NOT MET if:

- Other fire safety hazards as describe above are identified and not addressed by the agency prior to identification by DQI staff.

For situations that present an immediate risk to the safety of an individual, contact your Area Director & require immediate correction.

Section 9: Site Specific Requirements
9-1 The site/program has a written Quality Assurance Plan that has been implemented.
679.4(m)(1)-(3) OPWDD shall verify that the written plan for the facility's quality assurance program describes the program's objectives, organization, responsibilities of all staff members, scope of the program and procedures for overseeing the effectiveness of monitoring, assessment and problem-solving activities and that the plan has been implemented. The quality assurance process shall define methods for the identification and selection of clinical and administrative problems to be reviewed, and include: (1) the establishment of review criteria developed in accordance with current standards of professional practice for monitoring and assessing the appropriateness of treatment and clinical performance; (2) regularly scheduled reviews of clinical records, complaints, suggestions from persons served and their collaterals, reported incidents or allegations of abuse, and other documents pertinent to problem identification; (3) documentation of all quality assurance activities, including but not limited to the findings, recommendations, and actions taken to resolve identified problems.
Program Class/Type: Diagnostic and Evaluative Clinic, Outpatient/Clinic Treatment
690.6(n)(1)-(3) OPWDD shall verify that the facility's quality assurance process defines methods for the identification and selection of clinical and administrative problems to be reviewed, and includes: (1) the establishment of review criteria developed for monitoring and assessing the appropriateness of treatment and clinical performance; (2) regularly scheduled reviews of clinical records, complaints, suggestions from persons served, their correspondents and/or advocates, reported incidents or allegations of abuse, and other documents pertinent to problem identification; (3) documentation of all quality assurance activities, including but not limited to the findings, recommendations, and actions taken to resolve identified problems.
Program Class/Type: Outpatient/Day Treatment
ACRONYMS QA: Quality Assurance **DISCUSSION** If present, talk with staff with who can explain an overview of the plan, plan activities, and how they use the findings for quality improvement **DOCUMENTATION REVIEW** • Review the program's current written QA plan

- Verify that required components/activities are identified in the written plan
- Request and review documentation that demonstrates implementation of components of the plan in the past year
- Review the past year's documentation that summarizes findings and recommended actions to address issues

OBSERVATION
N/A

The written plan for and implementation of the program's Quality Assurance Plan includes:

- The objectives of the Quality Assurance plan/activities.
- The responsibilities of staff members and assignment of implementation.
- Selection of clinical and administrative criteria/ issues/requirements to be reviewed.
- Procedures for overseeing the effectiveness of the Quality Assurance program.
- Review criteria for monitoring and assessing the appropriateness of treatment and clinical performance.
- Regularly scheduled reviews of individual's records, complaints, suggestions from persons served (and their family/advocates as needed), reported incidents or allegations of abuse; and other documents and standards determined by the program to be pertinent to quality and problem identification.
- Methods for selecting the records to be reviewed.
- The standards against which reviewed areas will be judged.
- There is documentation of all Quality Assurance activities including findings and problems.
- The summary includes for recommendations for actions to resolve identified problems.

Determine the standard is MET if:

- The program has a QA plan (by whatever name they give it).
- The QA plan includes most of the components included in the bullets above. If there is a missing component to the written plan, it does not negatively impact the identification of issues impacting the quality of care or safety of individuals.
- There is adequate documentation to demonstrate implementation of the QA Plan.
- Findings from QA activities are summarized/documented.
- Recommendations for corrective actions are identified for any problems identified.

Determine the standard is MET if ANY of the following are identified:

- The program does not have a QA plan.
- The program has a QA plan, but it was not implemented per the plan as follows:
  - The plan was not implemented with the frequency stated.

- The plan was implemented but significant activities stated in the plan were omitted, incomplete or poorly implemented. Use judgement to determine the extent of missed activities and impact to identification of significant issues and quality care (e.g., some slight variation in samples size completion or erroneously missing only one occasion of implementation when multiples of that same activity were also implemented with no negative findings, may still result in surveyor determining that plan was conscientiously implemented).
- Findings of QA activities are not documented/summarized.
- Negative findings do not result in recommendations for remediation.

9-2 Corrective actions identified per the QA Plan Activities are implemented.
679.4(m)(4) OPWDD shall verify that the written plan for the facility's quality assurance program describes the program's objectives, organization, responsibilities of all staff members, scope of the program and procedures for overseeing the effectiveness of monitoring, assessment and problem-solving activities and that the plan has been implemented. The quality assurance process shall define methods for the identification and selection of clinical and administrative problems to be reviewed, and include: (4) the timely implementation of corrective actions and periodic assessments of the results of such actions with adjustments, as appropriate.
Program Class/Type: Diagnostic and Evaluative Clinic, Outpatient/Clinic Treatment
690.6(n)(4) OPWDD shall verify that the facility's quality assurance process defines methods for the identification and selection of clinical and administrative problems to be reviewed, and includes: (4) the timely implementation of corrective actions and periodic assessments of the results of such actions with adjustments, as appropriate.
Program Class/Type: Outpatient/Day Treatment
ACRONYMS QA: Quality Assurance **DISCUSSION** Mandatory: • With those responsible for oversight and implementation of the QA plan, how they verify implementation of corrective actions • With those responsible to implement a corrective action: actions taken • With those who may have been part of corrective action implementation, verify that it occurred (i.e., did they receive training specified, are they using a revised form or procedure, etc.). **DOCUMENTATION REVIEW** Mandatory • Review document that indicates the recommendations to address issues • Review any documentation that verifies implementation of a sample of corrective actions. This may include two actions: o Documentation of QA activities that records actions taken to correct (i.e., what was done, by whom, when) o Documentation that supports/verifies that corrective actions were taken (i.e., training rosters, revised policy, updated treatment plan) • Surveyor judgment should be used to determine whether ALL corrective actions must be verified.

OBSERVATION
Any necessary verification of corrective action that requires visual confirmation (i.e., equipment change, physical plant repairs, organization of space)

See DISCUSSION, DOCUMENTATION AND OBSERVATION GUIDANCE ABOVE:
Verify:

- The agency/program ensured timely implementation of corrective actions.
- The agency/program actions are effective results of such action.
- Corrective actions should be appropriate to the problems identified.

Determine the standard is MET if:

- The agency/facility implements the corrective actions described.
- The agency/facility has a system to ensure that corrective actions are implemented and effective.
- There were no problems noted during QA activities requiring corrective actions.

Determine the standard is NOT MET if:

- The corrective actions are not implemented.
- Corrective actions are implemented but QA findings demonstrate repeats of same issues without effective corrections or corrective plans.

Section 10a: Risk Area – Skin Breakdown
QQ-10a- Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1 There is a written plan to provide care for wounds and prevent future skin breakdown.
633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.16 (b)(3) OPWDD shall verify that each person has a plan for protective oversight, based on an analysis of the person's need for same, and that such need has periodically, but at least annually, been reviewed, revised as appropriate, and integrated, as appropriate, with other services received.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
680.7(b)(2)(ii)(a)(1) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD.
Program Class/Type: Specialty Hospital/Inpatient
690.5(b)(2)(v)

The administrator of the facility shall be responsible for: ensuring that the services meet the physical, social and developmental needs of all persons attending the facility, that there is adequate protection of each person's health, safety, comfort, well-being, and civil, human and legal rights and that selection takes account of the person's preferences.

Program Class/Type:
Outpatient/Day Treatment

ADM#2003-01
The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and

Program Class/Type:
IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home

ACRONYMS
AFO: Ankle-foot Orthosis
DSP: Direct Support Professional
IPOP: Individualized Plan of Protective Oversight
MAR: Medication Administration Record
NCP: Nursing Care Plan
PONS: Plan of Nursing Service
RN: Registered Nurse

DISCUSSION
Mandatory:
- DSP
- RN if concerns with plan or DSP implementation of plan the care

As needed:
- Individual
- Family and/or advocate
- Site supervisor

DOCUMENTATION REVIEW
Mandatory:

Documents that provide instruction to address a person's health care needs, in this case, skin integrity. Some examples:

- PONS or NCP
- IPOP
- Life Plan
- Safeguards identified in waiver or site-specific individualized program plan
- MAR

OBSERVATION
N/A

A comprehensive, current, written plan which clearly tells staff what to do to provide care to treat skin integrity issues in someone who either has an active skin breakdown problem or is at risk for it, must exist. The risk may be due to a history of skin breakdown or the existence of other health issues which put them in jeopardy of developing a wound or decubitus ulcer. It may be a stand-alone care plan such as a PONS OR NCP or may be integrated into the person's service plan appropriate to the site, such as an IPOP or individualized program plan. The plan should be the source for staff to know who is at risk for or is experiencing, skin breakdown, and the specific supports to provide in order to prevent, care for and monitor skin integrity or wound care issues in a person who has a risk.

Verify that there is a written plan that describes care, monitoring and reporting necessary to address skin integrity for individuals who requires nursing care for skin integrity. Such plans must be updated for the person's current skin care needs and, at a minimum, updated annually if person is stable for ongoing preventive care. Skin integrity can change rapidly, as wounds can start in the deeper unseen layers of the skin and then appear on the surface, almost suddenly, as an advanced wound, seemingly overnight. Skin care plans may need frequent updating as the wound changes, and subsequent staff training and re-training (see standard below.)

An individualized plan should not be a 'cookie-cutter' set of instructions for general use with anyone. It must specifically address the unique care needs of the person for whom it is written. For example, it may contain attention to other chronic conditions and related health care needs of the Individual, as they relate to skin integrity so that, for example, a person who is incontinent may need more frequent assistance with care, or a person who eats poorly may also receive nutritional supplements to assist with skin integrity.

Plans to address skin integrity/care must contain specific directions regarding:

- What staff are to do for the care to affected areas and wounds (i.e., use a specific cleanser when bathing around the wound or bandage, leave open to air, take body temperature daily, remove AFO's at specific intervals while at rest, etc.)
- Clear description of positioning requirements if risk is pressure related (i.e., in what position the person's body or parts of his/her body are to be in and with what frequency these are to change while not in bed, provide reminders to reposition in wheelchair every 30 minutes and

assist as needed). Pictures of positioning requirements or options are helpful to facilitate alternate positioning, though pictures are not specifically required.
• Instruction of monitoring (i.e., what parts of body to visually inspect and what signs/symptoms to watch for regarding skin condition).
• The frequency and duration care is to be given (i.e., once per day; at every bathroom break, per the MAR, etc.).
• What to document and where (i.e., redness, color and size of wound, drainage, drainage color, person's reported pain level 1-10, or degree of warmth to touch, etc.).
• What to report to the RN (i.e., a visual increase in wound size beyond the size of a golf ball, hot red skin around the wound, drainage that is opaque and/or foul-smelling, body temperature above 99.3 F) and how soon after observing these things to contact the RN.
• The plan may contain additional elements to be successful, based on an Individual's specific skin integrity issue, mobility, and diagnoses. These may include medical or nutritional interventions (i.e., prescribed topical treatments or oral medications, protein powder mixed in food).

Determine the standard is MET if:

• Individualized written plan/instruction for care, support and treatment related to improving or maintaining health skin integrity is present.
• The plan includes strategies necessary to provide adequate care per the individuals' needs.

Determine the standard is NOT MET if any of the following are present:

• There is not a written plan/instruction for care, support and treatment related to improving or maintain healthy skin integrity for individuals with the need.
• The plan lacks sufficient clarity to ensure adequate care, and the person is not getting adequate care.
• The plan for skin integrity is not individualized to a person's specific needs.

10a-2 The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.16 (b)(4)(i-iii) The individual program plan shall be developed and implemented by an interdisciplinary team (see section 680.13 of this Part) including the providers of medical treatment and active programming and direct care staff. One member of this team who is a qualified mental retardation professional (see section 680.13) shall serve as client coordinator (see section 680.13) with primary responsibility for implementation of the individual program plan, coordination of its components and for arranging movement of the client to a less restrictive environment as soon as the client's handicapping conditions permit.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
680.6(d) The individual program plan shall be developed and implemented by an interdisciplinary team (see section 680.13 of this Part) including the providers of medical treatment and active programming and direct care staff. One member of this team who is a qualified mental retardation professional (see section 680.13) shall serve as client coordinator (see section 680.13) with primary responsibility for implementation of the individual program plan, coordination of its components and for arranging movement of the client to a less restrictive environment as soon as the client's handicapping conditions permit.
Program Class/Type: Specialty Hospital/Inpatient

690.5(b)(2)(v)
The administrator of the facility shall be responsible for: ensuring that the services meet the physical, social and developmental needs of all persons attending the facility, that there is adequate protection of each person's health, safety, comfort, well-being, and civil, human and legal rights and that selection takes account of the person's preferences

Program Class/Type:
Outpatient/Day Treatment

ACRONYMS
AFO: Ankle-foot Orthosis
DSP: Direct Support Professional
IPOP: Individualized Plan of Protective Oversight
MAR: Medication Administration Record
NCP: Nursing Care Plan
PONS: Plan of Nursing Service
PRN: *Pro re nata* (as needed)
RN: Registered Nurse

DISCUSSION
Mandatory:
- DSP if interventions not occurring during observation or direct observation cannot occur due to respect for individual's privacy
- RN if concerns with plan or DSP implementation of plan the care

As needed:
- Individual
- family and/or advocate
- Site supervisor

DOCUMENTATION REVIEW
Mandatory:
Documents that provide instruction to address a person's skin integrity needs, and documentation of supports and treatments required. Some examples:
- PONS or NCP
- IPOP
- Life Plan

- Safeguards identified in waiver or site-specific individualized program plan
- MAR
- Physician's orders
- Diet orders

Documentation/notes on provision of care, i.e. PRN notes, daily progress notes, health care notes, nursing progress notes.

OBSERVATION

Mandatory:

- During observation periods, be attentive for implementation of required actions, as applicable. Survey staff should not violate privacy of the individual
- Appropriate positioning and repositioning per individualized plans and within required time frames
- Removal of AFOs or adaptive braces when indicated
- Provision of equipment related to skin integrity such as special cushions
- Nutritional supports per the plan as applicable

Verify by discussion that staff understand what actions they take, and via observation as able, that individuals are provided specified care, based on his/her written plan.

If staff are unable to adequately describe, and/or are not providing support and care for skin integrity per the plan, request/review documentation of staff training on the plan and individualized interventions for each person's skin integrity.

Ask Individuals what they know about, and experience, related to performing the requirements of the current written plan for skin integrity issues. For example, if they are aware that they have skin breakdown, who takes care of it for/with them, if they are satisfied with the care, if the care is helping them get better, etc.

Documentation of care and monitoring will vary depending on the interventions in the care plan. Some may require documentation, while other required interventions may not. Review the individual's record and documentation to verify that supports that must be documented per the plan are indicated in documentation. This may include, for example, wound care treatments, monitoring notes re: skin condition, position changes if the plan requires this. Documentation may be part of the MAR or other documentation sources per the written plan and site procedures.

Diet orders may be part of a care plan addressing skin integrity, and individuals' diets should be followed accordingly. This however may not be included in routine documentation and will need to be verified through discussion and when possible, observation.

Determine the standard is MET if:

- Based on observation, DISCUSSION and documentation review, the individual(s) is receiving care required to improve/maintain skin integrity.

Determine the standard is NOT MET if:

- Based on observation, DISCUSSION and documentation review, any individual is not receiving/not consistently receiving skin integrity care per their written plan and per their needs

Section 10b: Risk Area – Discharge From Hospital
QQ-10b-Has anyone been discharged from the hospital in the past 3 months?
10b-1 Clear written instructions were provided to staff regarding care and monitoring required by the person discharged.
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS DSP: Direct Support Professional MAR: Medication Administration Record MD: Doctor of Medicine NP: Nurse Practitioner PA: Physician's Assistant PRN: *Pro re nata* (as needed) RN: Registered Nurse

DISCUSSION
Mandatory:
- DSP
- RN if concerns with plan or DSP implementation of plan of care

As needed:
- Individual
- Family and/or advocate
- Site supervisor

DOCUMENTATION REVIEW
- Prescriber orders
- Discharge instruction form; instructions for follow-up appointment
- MAR for meds and treatments
- Documentation/notes on health status
- Documentation/notes of provision of care, e.g. PRN notes, daily progress notes, health care notes, nursing progress notes
- Any written plans of care for health needs such as a nursing care plan, plan of nursing service, guidelines for dining, swallowing, ambulation, seizures, etc. as appropriate to the health status and reason for hospitalization or hospital visit

OBSERVATION
N/A

Upon discharge from a hospital, skilled nursing facility, emergency department or rehabilitation center, discharge instructions (usually written by the facility staff) will accompany a person from the hospital or facility.

The RN is responsible to translate the discharge instructions into the written plan of care/instruction staff will follow to provide any required care, monitoring of condition, notifications, and f/u visits to health care providers. The RN is responsible to train applicable staff on any required services to effectively support the newly discharged person and prevent unnecessary institution readmission. The plan of care should be related to the hospitalization, for instance care after surgery will be different that care after a psychiatric admission. This may include:
- Medications and treatments the person is prescribed to include all the required information for any prescribed medicine
- Vital signs monitoring
- Revised or new therapies such as physical, speech or respiratory therapy

- Changes in level of supervision or supports, mobility support, behavioral supports, ambulation guidelines, etc. as applicable
- Revised or new diet order, swallowing guidelines, tube feeding instructions, bowel management regimen, etc.
- Revised or new dressing changes, oral care, seizure precautions, etc.
- Signs and symptoms of disease or health related concerns (i.e., blood pressure, blood sugar, mental status, fatigue level, breathing difficulties, seizure activity, etc.) of which staff are to be aware and/or respond to
- Description of what symptoms are to be reported to the RN, RN on call, medical prescriber, etc., and within what time frame the report is to be made
- Time/duration of care and monitoring, i.e. for 10 days following discharge, until further notice, etc.

Note: For specialty hospital reviews, this applies to discharges from hospitals/medical facilities that are not the specialty hospital.

Determine the standard is MET if:

• Clear individualized instruction was developed and provided to staff regarding care, monitoring, services and supports required by a person(s) following hospitalization. Individualized instruction means appropriate to the person's specific condition, diagnoses, needs, and abilities.
• The written instruction/plan of care was developed by a qualified medical professional who is an employee/or contractor with the agency (RN, NP, PA, MD).
• The instruction is consistent with the instructions provided by the facility that discharged the person.
• Strategies in the plan, if implemented appear sufficient to address the needs of the individual.

Determine the standard is NOT MET if any of the following are present:

• Individualized instruction was not provided regarding care and support of an individuals after discharge from a medical facility.
• Instruction was provided verbally but not in a written plan.
• Instruction was not individualized and appropriate to the person's specific condition, diagnoses, needs, and abilities.
• Individualized instruction was provided, but not by a qualified medical professional who is an employee/or contractor with the agency (RN, NP, PA, MD).
• Strategies in the plan are not sufficient to address the needs of the individual as evidenced by preventable health concerns.

10b-2 Clear written instructions were provided to staff regarding documentation of care and monitoring required by the person discharged. Nursing instructions specified how and what staff must document regarding the care and monitoring provided following a hospital discharge.
633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
ADM 2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS DSP: Direct Support Professional RN: Registered Nurse **DISCUSSION** As needed: • DSP if questions/concerns with documentation • RN if questions/concerns with plan or DSP documentation • Site supervisors re: training and oversight

DOCUMENTATION REVIEW

- Written plans of care for health needs such as a nursing care plan, plan of nursing services
- Documentation of care and monitoring

OBSERVATION

N/A – See standard on implementation below

It is imperative that there is an ongoing record of the care and support provided to individuals in the site regarding health care. Documentation may be entered on paper forms/hard copy or through electronic record keeping, daily notes or other agency specified recording methods. What, when and where to document care and monitoring required after discharge should be clearly specified in the care plan.

Consider the following care and monitoring that may be included in the written plan as requiring documentation after a hospitalization, rehabilitation or nursing facility, or emergency department stay.

Documentation of the provision of, and the Individual's response to therapies such as required physical exercises, supported range of motion, respiratory exercise, etc.

Documentation of the provision of, and the Individual's response to revised or new diet order or feeding methodologies.

The provision of, and the Individual's response to revised or new treatments, for example, dressing changes, use of a vagal nerve stimulator, etc.

Documentation of any observed signs and symptoms of disease or health related concerns (i.e., temperature, blood pressure, blood glucose level, skin turgor, mental status, fatigue level, breathing difficulties, seizure activity, and status relative to what is "normal" for the individual, etc.) per the written plan.

Documentation of what staff did in response to any of the observed signs and symptoms, if they were outside of the written plan's recommended limits or if the person was observed to be in distress or acting abnormally (i.e., if blood sugar level as measured by finger stick monitor was above an identified level of 250, if a person was still wheezing after the administration of a nebulizer treatment, if a person who is normally oriented to person, place and time was suddenly no longer so oriented.)

Documentation of the Individual's response to what the staff performed.

Documentation of the actual communication made, of any concerns about symptoms and/or level of distress related to symptoms, to the RN, RN on call, medical prescriber, etc.

Documentation of what the staff was directed to do by the health care professional.

Documentation of what staff did in response to the communication made to the RN, etc.

Documentation of the person's response to what the staff performed.

Documentation of any follow-up actions or communications.

While new medications and medications orders may occur following discharge from a medical, hospital or rehab facility, evidence of medication administration per orders should be reviewed in Section 3.

Note: For Specialty Hospital reviews, this applies to discharges from hospitals/medical facilities that are not the specialty hospital.

Determine the standard is MET if:

- The plan instructs on the required/expected documentation of care provided and/or status of the individual based on monitoring of the person's condition (what, where, when).
- The instruction is consistent with the instructions provided by the facility that discharged the person, if applicable.

Determine the standard is NOT MET if either of the following are present:

- The plan lacks instruction/does not require documentation of care and monitoring provided following discharge from medical/hospital facility.
- While the plan directs that staff document care and monitoring, it lacks sufficient clarity resulting in insufficient evidence of continuity of care following discharge.

10b-3 There was evidence that the staff implemented required care and monitoring following discharge.
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
680.6 (j)(1)(iv-vi) The specialty hospital shall maintain the following system of records: Client record. The specialty hospital shall maintain a comprehensive record for each client. Each record shall be organized in the manner and contain the information prescribed by OPWDD. Each client's record shall contain the following types of information:(iv) copies of assessments, reassessments, progress notes and previous individual program plans;(v) service plans, description of treatments provided and medications administered;(vi) reports of illness or injury including the date and time of occurrence and action taken regarding each occurrence.
Program Class/Type: Specialty Hospital/Inpatient
ACRONYMS DSP: Direct Support Professional MAR: Medication Administration Record NCP: Nursing Care Plan PONS: Plan of Nursing Service RN: Registered Nurse **DISCUSSION** Mandatory: • DSP if interventions not occurring during observation or direct observation cannot occur due to respect for individual's privacy • RN if concerns with plan or RN or DSP implementation of plan the care

As needed:
- Individual
- Family and/or advocate
- Site supervisor

DOCUMENTATION REVIEW

Documents that provide instruction to address an Individual's needs, supports, and treatments required. For example:
- PONS or NCP
- MAR
- Physician's orders
- Diet orders
- Documentation/notes on provision of care (i.e., prn notes, daily progress notes, health care notes, nursing progress notes)

OBSERVATION
- Mandatory as possible. Attend to what you expect to see occurring based on the post discharge written instructions. Survey staff should not violate privacy of the individual

Consider the following when trying to validate that staff are effectively delivering individuals' needed care and monitoring as best evidenced by its impact on the Individual and effective response to changing health.

Verify by discussion that staff understand what care to provide and that they provide it. If concerned regarding the staff's competence, seek information about training provided regarding discharge care.

Observe as able, depending on when care and monitoring is provided, that the person receives care and monitoring per the written plan.

Documentation of care and monitoring will vary depending on the interventions in the care plan. Some may require documentation, while other required interventions may not. Review the individual's record and documentation to verify that supports that must be documented per the plan are indicated in documentation. Documentation may be part of the MAR or other documentation sources per the written plan and site procedures.

Ask Individuals (and/or family, advocate) what they know about their stay at the facility (i.e., why they had to be there, if they are better or healthier now and if so, what is helping them to feel better, how the staff takes helps them to get well and if they are satisfied with this care).

Ask staff what they know about the person's health care needs after a stay in the hospital/facility and how they provide this care. If staff cannot report the care needs adequately, ask them where they would access the needed information. Ask staff if they know what signs and symptoms they are to monitor and/or report after the return home, and to whom they are to report these. If a repeat hospitalization, emergency department trip, or another unexpected illness or relapse occurs soon after the discharge, within the 3-month period, evaluate if a lapse in care may have contributed to it.

Note: For specialty hospital reviews, this applies to discharges from hospitals/medical facilities that are not the specialty hospital.

Determine the standard is MET if:

- Based on observation, discussion, and documentation review, the individual(s) is receiving care necessary to facilitate and monitor their health status and recovery.
- Individuals health returns to normal/baseline for them or any relapse/subsequent illness cannot be attributed to inadequate care.

Determine the standard is NOT MET if:

- Based on observation, discussion, and documentation review, any individual is not receiving/not consistently receiving necessary care to facilitate and monitor their health status and recovery.
- Individuals relapse in health can be attributed to inadequate implementation of an adequate written care plan following discharge from a health care facility.

Section 10c: Risk Area – Current Illness
QQ-10c-Is any person in the site currently showing signs/symptoms of illness?
10c-1 RN or other medical professional has been informed of the signs/symptoms.
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
680.6(j)(1)(vi) The specialty hospital shall maintain the following system of records: Client record. The specialty hospital shall maintain a comprehensive record for each client. Each record shall be organized in the manner and contain the information prescribed by OPWDD. Each client's record shall contain the following types of information (vi) reports of illness or injury including the date and time of occurrence and action taken regarding each occurrence.
Program Class/Type: Specialty Hospital/Inpatient
ACRONYMS DSP: Direct Support Plan ER: Emergency Room MAR: Medication Administration Record LPN: Licensed Practical Nurse RN: Registered Nurse S/S: Signs and symptoms **DISCUSSION** Mandatory: • DSP

- Individuals

As needed:
- Family and/or advocate if necessary
- RN if concerns with communication
- Others, as appropriate: LPN, residential management staff

DOCUMENTATION REVIEW

Mandatory:
- Daily progress notes and/or daily health care or medical book progress notes

As Needed:
- MAR
- Training records to evaluate what staff have been trained on regarding signs/symptoms of health concerns

OBSERVATION

Mandatory:
- Routine observations and conversation occurring may evidence current or emerging changes in any individual's health

By observation take note of whether staff are aware of individuals and any signs/symptoms (s/s) of illness which one or more Individuals are exhibiting. At times symptoms may present, at other is may be just an awareness that they are "not themselves", change in appetite, change in behavior, change in activity level, change in ambulation, etc. Staff may also converse with individuals about how they are feeling.

By discussion, staff can tell surveyor when, in what manner, they reported the s/s of illness to the RN or other medical professional.

Individuals may report to staff that they are not feeling well or mentions specific symptoms (i.e., head hurts, stomach aches). Individuals may tell surveyor that they are not feeling well and who, if anyone, they have told this to (i.e., staff, RN, or other medical professional). Survey should f/u with staff to determine if they know and what has been done to report and address.

By document review, review that there is documentation in Individual's record (i.e., medical or other daily notes per agency system) that the communication was made to RN or other medical professional, what they were told to do by the RN.

For the purpose of this standard, notification of health care professional may also include calling 911 or taking to walk-in or ER.

There should be evidence through documentation of:

- The actual communication made, of any concerns about symptoms and/or level of distress related to symptoms, to the RN/RN on call/ physician, etc. This should include what the staff reported, and questions asked by the medical professional to gather more information to provide guidance.
- During “business hours” this communication may occur when an RN is on site, at other times this may occur by telephone (telephone triage).
- What the staff was directed to do by the health care professional.

Determine the standard is MET if:

- RN or other health care professional was informed of individual’s signs/symptoms and/or change in their usual status/baseline.

Determine the standard is NOT MET if either are present:

- Staff did not recognize presenting signs that individuals may be ill or that their status had changed.
- Staff did not contact RN or other medical professional despite recognition of change in status and/or sign of illness.

10c-2 Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition, including notifications when needed.
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS BRAT Diet: Bananas, Rice, Applesauce and Toast Diet DSP: Direct Support Professional HCP: Healthcare Professional LPN: Licensed Practical Nurse MAR: Medication Administration Record MD: Doctor of Medicine NCP: Nursing Care Plan NP: Nurse Practitioner PA: Physician's Assistant PONS: Plan of Nursing Service

PRN: *Pro re nata* (as needed)
PT: Physical Therapy
RN: Registered Nurse
S/S: Signs and symptoms

DISCUSSION
Mandatory:
- DSP
- RN if concerns with plan instructions or DSP implementation of plan

As needed:
- Others as appropriate: LPN, residential management staff, Individual, family and/or advocate if necessary

DOCUMENTATION REVIEW
Mandatory:
- Written plans of care for health needs such as a PONS or NCP
- MAR for meds and treatments
- Daily progress notes and/or daily health care or medical book, nursing progress notes
- Training records to evaluate what staff have been trained on regarding routine and/or seasonal health outbreaks

OBSERVATION
N/A

The RN (or HCP designated by agency) is responsible to provide instructions to staff to effectively support individuals who are ill or may be ill, monitor their changing status, provide care to ameliorate illness and/or its symptoms, and prevent transmission of the illness to others. Training may be necessary.

While initially the instruction may be conveyed verbally (especially during off hours over telephone). Staff should be instructed to document the direction given by the HCP and asked to repeat what they have written back to the HCP to verify accuracy. The RN should then f/u to a ensure the person has a clear and individualized plan of care.

Care, monitoring, and support to be provided may include:

- Administer prescribed PRN medication
- Revisions to routines or scheduled activities if warranted for increased rest (i.e., stay home from work, cancel PT session if too strenuous, or reschedule recreational plans)
- Revise diet orders, swallowing guidelines, tube feeding instructions, due to illness (i.e., hold tube feeding for nausea, vomiting or high residual checks, clear or BRAT diet for nausea, vomiting, etc.)
- Interval measure of vital signs (i.e., temperature, blood pressure, pulse, respiratory rate)
- More frequent measure of blood glucose level
- Every shift reporting of other observations (i.e., appetite, activity level, mental status, fatigue level, breathing difficulties, seizure activity, etc.)
- Revised supervision levels or mobility support
- Description of S/S to be reported to the RN, RN on call, medical prescriber, etc., and within what time frame the report is to be made

Determine the standard is MET if:

• Clear individualized instruction was developed and provided to staff regarding care, monitoring, supports and notifications required by a person(s). Individualized instruction means appropriate to the person's specific condition, diagnoses, needs, and abilities.
• The instruction/plan of care was provided by a qualified medical professional who is an employee/or contractor with the agency (RN, NP, PA, MD).
• Strategies in the plan, if implemented appear sufficient to address the needs of the individual towards health.

Determine the standard is NOT MET if any of the following are present:

• Individualized instruction was not provided regarding care and support of individuals showing signs of illness or known to be ill.
• Instruction was provided verbally but not documented.
• Instruction was not individualized and appropriate to the person's specific condition, diagnoses, needs, and abilities.
• Individualized instruction was provided, but not by a qualified medical professional who is an employee/or contractor with the agency (RN, NP, PA, MD).
• Strategies in the plan are not sufficient to address the needs of the individual as evidenced by preventable exacerbation of condition.

10c-3 The instruction included how and what to document regarding required care and monitoring for the individual's identified health concern.
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS DSP: Direct Support Professional RN: Registered Nurse **DISCUSSION** As Needed: • DSP if questions/concerns with documentation • RN if questions/concerns with plan or DSP documentation • Site supervisors re: training and oversight

DOCUMENTATION REVIEW

- Written plans of care for health needs such as a nursing care plan, plan of nursing services
- Documentation of care and monitoring per instruction and agency mechanism

OBSERVATION

N/A

It is imperative that there is an ongoing record of the care and support provided to individuals in the site regarding health care. Documentation may be entered on paper forms/hard copy or through electronic record keeping, daily notes or other agency specified recording methods. What, when and where to document care and monitoring required after discharge should be clearly specified in the care plan.

Consider the following care and monitoring that may be included in the instruction/plan of care that should be documented:

- Documentation of any observed signs and symptoms or changing conditions to observe and per the written plan. This may be specific measures such as vital signs or staff observations of the individual signs that are different from their individualized “normal”.
- Documentation of what staff did in response to any of the observed signs and symptoms, if they were outside of the written plan’s recommended limits or if the person was observed to be in distress or acting abnormally.
- Documentation of the Individual’s response to what the staff performed.
- Documentation of the actual communication made, of any concerns about symptoms and/or level of distress related to symptoms, to the RN, RN on call, medical prescriber, etc.
- Documentation of what the staff was directed to do by the health care professional.
- Documentation of what staff did in response to the communication made to the RN, etc.
- Documentation of the person’s response to what the staff performed.
- Documentation of any follow-up actions or communications.
- Documentation of the Individual’s response to prn medications or dietary changes made to help the illness or symptoms of illness.
- Documentation of any observed worsening or improving of signs and symptoms of health concerns.

Determine the standard is MET if:

- The plan instructs on the required/expected documentation of care provided and/or status of the individual based on monitoring of the person’s condition (what, where, when).

Determine the standard is MET if either of the following are present:

• The plan lacks instruction/does not require documentation of care and monitoring and individual condition and response. • While the plan directs that staff document care and monitoring, it lacks sufficient clarity resulting in insufficient evidence of continuity of care.

10c-4 There is evidence that the staff implement required care and monitoring.
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
680.6(j)(1)(v)-(vi) The specialty hospital shall maintain the following system of records: (v) service plans, description of treatments provided and medications administered; (vi) reports of illness or injury including the date and time of occurrence and action taken regarding each occurrence.
Program Class/Type: Specialty Hospital/Inpatient
680.7(b)(2)(ii)(a)(2) The objectives of nursing services shall be to evaluate each client's need for nursing care on a continuing basis, and to provide such care directly by or under the supervision of a registered nurse (see section 680.13 of this Part). Such services shall include: participation in preventive, habilitative and rehabilitative services to eliminate, limit or reduce the client's health related problem.
Program Class/Type: Specialty Hospital/Inpatient
ACRONYMS DSP: Direct Support Professional MAR: Medication Administration Record NCP: Nursing Care Plan PONS: Plan of Nursing Service PRN: *Pro re nata* (as needed) RN: Registered Nurse S/S: Signs and symptoms

DISCUSSION

Mandatory:

- DSP if interventions not occurring during observation or direct observation cannot occur due to respect for individual's privacy
- RN if concerns with plan or RN or DSP implementation of plan the care

As needed:

- Individual
- Family and/or advocate
- Site supervisor

DOCUMENTATION REVIEW

Documents that provide instruction to address a person's acute health needs, supports, and treatments required. For example:

- PONS or NCP
- MAR
- Physician's orders
- Diet orders
- Documentation/notes on provision of care (i.e., PRN notes, daily progress notes, health care notes, nursing progress notes)

OBSERVATION

Mandatory:

- During observation periods, give attention to what you expect to see occurring based on the written instructions to staff regarding the period of acute illness for one or more persons. Survey staff should not violate privacy of the individual.

Consider the following, when trying to validate that staff are effectively delivering individuals' needed care and monitoring as best evidenced by its impact on the Individual and effective response to changing health:

- Verify by discussion and via observation as able, that staff understand what care and monitoring to provide and that they provide it. For example, if the following supports are to be provided, are they providing offers of additional fluids every hour, inquiring as to pain level least 4x/day, providing a temporarily modified consistency diet, taking body temperature every 4 hours while awake, etc.
- Ask staff what they know about the person's health care needs and how they provide this care.
- Ask staff if they know what signs and symptoms they are to monitor and/or during the illness period, and to whom they are to report these in what time frame.

• Ask staff how they would know if signs and symptoms (s/s) of illness were worsening for the Individuals affected and what they would do if and when they saw the situation deteriorating.
• If staff cannot report the care needs adequately, ask them where they would access the needed information.
• If concerned regarding the staff's competence, seek information about training provided regarding care.
• Observe as able, depending on when care and monitoring is provided, that the person receives care and monitoring per the written plan.
• There should be documentation of care and monitoring provided. Documentation of care and monitoring will vary depending on the interventions in the care plan. Some may require documentation, while other required interventions may not. Review the individual's record and documentation to verify that supports that must be documented per the plan are indicated in documentation. Documentation may be part of the MAR or other documentation sources per the written plan and site procedures.
• Ask Individuals what they know about their illness (e.g. how they are feeling, how they think they became ill, what is helping them to feel better, how the staff takes care of them and if they are satisfied with this care, if they know who to talk to if they don't believe that the care they're receiving is satisfactory, etc.)

Determine the standard is MET if:

• Based on observation, discussion, and documentation review, the individual(s) is receiving care necessary to facilitate and monitor their health status and recovery.
• Individuals health returns to normal/baseline for them or any relapse/worsening illness cannot be attributed to inadequate care.

Determine the standard is NOT MET if:

• Based on observation, discussion, and documentation review, any individual is not receiving/not consistently receiving necessary care to facilitate and monitor their health status and recovery from illness.
• Individuals' worsening health can be attributed to inadequate implementation of an adequate written care plan.

Section 10d: Risk Area – Diabetes
QQ-10d- Is any person diagnosed with diabetes?
10d-1 Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required for the individual.
633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
680.6(a) Each client of a specialty hospital shall have an individual program plan which describes for the client his or her medical treatment for health-related problems and active programming for developmental disability(ies).
Program Class/Type: Specialty Hospital/Inpatient
680.6(g) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD…
Program Class/Type: Specialty Hospital/Inpatient
680.6(g)(2) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: service plans for each mandatory and selective service which combine into an integrated program of individually designed activities, experiences and programs necessary to achieve the individual client's objectives. These plans shall contain, as appropriate, specific individual medical prescriptions or written direction from the interdisciplinary team for all necessary services.

Program Class/Type: Specialty Hospital/Inpatient
680.7(b)(2)(ii)(a)(1) The objectives of nursing services shall be to evaluate each client's need for nursing care on a continuing basis, and to provide such care directly by or under the supervision of a registered nurse (see section 680.13 of this Part). Such services shall include: participation in preventive, habilitative and rehabilitative services to eliminate, limit or reduce the client's health related problem.
Program Class/Type: Specialty Hospital/Inpatient
686.16 (b)(4)(i)-(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following:(i) any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid;(ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS DSP: Direct Support Professional IPOP: Individualized Plan of Protective Oversight LPN: Licensed Nurse Practitioner MAR: Medication Administration Record MD: Doctor of Medicine NCP: Nursing Care Plan NP: Nurse Practitioner PA: Physician's Assistant PONS: Plan of Nursing Service

PRN: *Pro re nata* (as needed)
RN: Registered Nurse

DISCUSSION
Mandatory:
- DSP
- RN if concerns regarding the written instruction

As needed:
- LPN
- Residential management

DOCUMENTATION REVIEW
Mandatory as appropriate to facility systems:
- Healthcare records which may include notes and orders from physicians and health care professionals involved in the individuals' diabetic care and oversight
- Written plans of care to address diabetes such as a NCP, PONS, specific portion of IPOP
- MAR for meds and treatments
- Diet order
- Life Plan
- Routine documentation (i.e., PRN notes, progress notes and/or daily health care or medical book, nursing progress notes)

OBSERVATION
N/A

The RN is responsible to provide written instructions which trained staff are to use, to effectively support persons with diabetes and to minimize its complications. These written instructions may appear in different documents (e.g., MAR, diet order, NCP, IPOP) and should all provide consistent information so that staff have current, non-contradictory information from all guidance sources to use to provide care. The plan may need to include:
- Prescribed medications to administer to persons with diabetes (oral, injection, insulin pump) which includes all the required information to accurately administer.

• Blood sugar checks with a finger stick glycemic monitor (glucometer) with a specific frequency to be included in the plan (i.e., before meals and bedtime). This monitoring is very important and sometimes determines the dosage of insulin a person is to receive at any given administration (i.e., 'sliding scale' insulin injections).
• The plan must identify individual-specific symptoms of both hyper- and hypo-glycemia and what staff must do in response to either condition.
• The person's dietary needs/ modification must be identified per the individual's needs.
• Strategies to minimize diabetic complications may be necessary such as: exercise, diabetic foot care, diabetic eye care, etc.
• Signs and symptoms of health-related concerns (i.e., blood pressure, blood sugar, mental status, fatigue level, breathing difficulties, seizure activity, acute illness, etc.) of which staff are to be aware and/or may need to respond to differently for a person who has diabetes (i.e., erratic behavior or fatigue may be a symptom of hyper- or hypo-glycemia and an immediate blood sugar check may be needed with follow-up actions to call RN or medical provider).
• Description of symptoms of diabetes and/or level of distress related to symptoms are to be reported to the RN, RN on call, medical prescriber, etc., and within what time frame the report is to be made.

Determine the standard is MET if:

• Clear individualized instruction was developed and provided to staff regarding care, monitoring, services and supports required by a person(s) related to the diabetes diagnosis.
• The written instruction/plan of care was developed by a qualified medical professional who is an employee/or contractor with the agency (RN, NP, PA, MD).
• Strategies in the plan, if implemented appear sufficient to address the needs of the individual.

Determine the standard is MET if any of the following are present:

• Individualized instruction was not provided regarding diabetic care and support of individuals with diabetes.
• Instruction was provided verbally but not in a written plan.
• Instruction was not individualized and appropriate to the person's specific condition, needs and abilities.
• Individualized instruction was provided, but not by a qualified medical professional who is an employee/or contractor with the agency (RN, NP, PA, MD).
• Strategies in the plan are not sufficient to address the needs of the individual as evidenced by preventable health concerns.

10d-2 The written instruction includes how and what to document regarding the required care and monitoring for identified diabetic needs.
633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
680.6(j)(1)(iv)-(v) The specialty hospital shall maintain the following system of records: The specialty hospital shall maintain a comprehensive record for each client. Each record shall be organized in the manner and contain the information prescribed by OPWDD. Each client's record shall contain the following types of information: copies of assessments, reassessments, progress notes and previous individual program plans; service plans, description of treatments provided and medications administered.
Program Class/Type: Specialty Hospital/Inpatient
ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS DSP: Direct Support Professional IPOP: Individualized Plan of Protective Oversight LPN: Licensed Nurse Practitioner

MAR: Medication Administration Record
NCP: Nursing Care Plan
PONS: Plan of Nursing Service
RN: Registered Nurse

DISCUSSION
Mandatory:
- DSP
- RN if concerns regarding the written instruction

As needed:
- LPN
- Residential management

DOCUMENTATION REVIEW
Mandatory:
- Written plans of care for health needs such as a PONS or NCP
- MAR for meds and treatments
- Diet order
- IPOP
- Life Plan
- Daily progress notes and/or daily health care or medical book, nursing progress notes
- Training records to evaluate what staff have been trained on documentation of their care and monitoring of the person's diabetes

OBSERVATION
N/A

When verifying this standard, the documentation may take place on hard copy or electronic tracking forms, clinical progress notes or other agency specified communication methods but whatever the specified format is, it should be clear in the written plan what, when and where to document it.

Consider the following kinds of things that would have to be documented regarding care and monitoring, per the written instructions from the RN, for those diagnosed with diabetes, for one or more Individuals:

- Documentation of administration of diabetic medications and treatments the person is prescribed to include all the required information for any prescribed medicine.
- Documentation of the provision of, and the Individual's response to, therapies such as new or prn medications, diet therapy, skin care to prevent diabetic ulcers in the extremities (usually lower limbs), etc.
- Documentation of any observed worsening of signs and symptoms of disease or related health concerns (i.e., blood sugar and pressure, body temperature checks, mental status, fatigue level, unable to easily rouse from a nap, breathing difficulties, seizure activity, cardiac symptoms such as chest pain or shortness of breath, etc.)
- Documentation of what staff did in response to any of the observed signs and symptoms, if they were outside of the written plan's recommended limits or if the person was observed to be in unexpected distress or acting abnormally, during the acute illness period (i.e., if pre-meal blood sugar level as measured by finger stick monitor was above an identified upper level of, for example, 250, if a person was still wheezing after the administration of a nebulizer treatment, if a person who is normally oriented to person, place and time was suddenly no longer so oriented).
- Documentation of the Individual's response to what the staff performed to treat the symptoms.
- Documentation of the actual communication made, of any concerns about symptoms and/or level of distress related to symptoms, to the RN, RN on call, medical prescriber, etc.
- Documentation of what the staff was directed to do by the health care professional.
- Documentation of what staff did in response to the communication made to the RN, etc.
- Documentation of the person's response to what the staff performed.
- Documentation of any follow events which occurred after this process.

10d-3 There is evidence the agency staff implement required diabetic care and monitoring.
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
680.6(d) The individual program plan shall be developed and implemented by an interdisciplinary team (see section 680.13 of this Part) including the providers of medical treatment and active programming and direct care staff. One member of this team who is a qualified mental retardation professional (see section 680.13) shall serve as client coordinator (see section 680.13) with primary responsibility for implementation of the individual program plan, coordination of its components and for arranging movement of the client to a less restrictive environment as soon as the client's handicapping conditions permit.
Program Class/Type: Specialty Hospital/Inpatient
680.6(j)(1)(iv)-(v) The specialty hospital shall maintain the following system of records: The specialty hospital shall maintain a comprehensive record for each client. Each record shall be organized in the manner and contain the information prescribed by OPWDD. Each client's record shall contain the following types of information: copies of assessments, reassessments, progress notes and previous individual program plans; service plans, description of treatments provided and medications administered.
Program Class/Type: Specialty Hospital/Inpatient
680.7(b)(2)(ii)(a)(2) The objectives of nursing services shall be to evaluate each client's need for nursing care on a continuing basis, and to provide such care directly by or under the supervision of a registered nurse (see section 680.13 of this Part). Such services shall include: participation in preventive, habilitative and rehabilitative services to eliminate, limit or reduce the client's health related problem.
Program Class/Type: Specialty Hospital/Inpatient

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

Program Class/Type:
IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home

ACRONYMS
DSP: Direct Support Professional
LPN: Licensed Practical Nurse
MAR: Medication Administration Record
NCP: Nursing Care Plan
PONS: Plan of Nursing Service
RN: Registered Nurse
S/S: Signs and symptoms

DISCUSSION
Mandatory:
- DSP
- Individual
- RN if concerns with plan or DSP implementation of plan

As needed:
- LPN
- Residential management staff
- Family and/or advocate

DOCUMENTATION REVIEW
Mandatory:
- MAR for diabetic meds and treatments
- Daily progress notes and/or daily health care or medical book, nursing progress notes
- Training records

• Written plans of care for health needs such as a PONS or NCP

OBSERVATION

Mandatory:

• During observation periods, give attention to what you expect to see occurring based on the written instructions to staff regarding the care and support of a person with diabetes, as described below.

Consider the following when trying to validate that staff are effectively delivering the care and monitoring its impact on the Individual:

• Verify by discussion that staff understand what actions they take, and via observation as able, to provide specified care and monitoring, based on the written instructions.

• Ask staff what they know about the person with diabetes' health care needs such as described above, and how they provide this care. If staff cannot report the care needs adequately, ask them where they would access the needed information.

• Ask staff if they know what signs and symptoms (s/s) they are to monitor routinely for a person with diabetes and/or during a period of their acute illness, and how they are to report these.

• Ask staff how they would know if s/s of diabetes were worsening for an Individual with diabetes and what they would do if and when they saw the situation deteriorating.

If staff are unable to adequately describe, and/or are not providing, what they are responsible to provide for care person(s) with diabetes, per the plan, review the documentation of staff training written by the RN. It should include that all direct care staff responsible for the care have been educated on the current plan. If the training was provided and the trained staff is still not providing, pursue why.

Ask Individuals (and/or family, advocate) what they know about their diabetes (i.e., how they are feeling, how they experience low and high blood sugars, what they are doing to take care of themselves, such as exercise, diet, stress reduction techniques, if they keep their medical appointments, how the staff supports them to keep their diabetes under control and if they are satisfied with this support, if they know who to talk to if they don't believe that the care they're receiving is satisfactory, etc.).

Section 10e: Risk Area – Fluid Intake
QQ-10e-Does any individual require a specific daily level of fluid intake?
10e-1 The amount of fluid to be consumed is clearly identified in the individual's plan of care.
633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
680.6(a) Each client of a specialty hospital shall have an individual program plan which describes for the client his or her medical treatment for health-related problems and active programming for developmental disability(ies).
Program Class/Type: Specialty Hospital/Inpatient
680.6(g) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD…
Program Class/Type: Specialty Hospital/Inpatient
680.6(g)(2) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format

prescribed by OPWDD and shall contain the following components: service plans for each mandatory and selective service which combine into an integrated program of individually designed activities, experiences and programs necessary to achieve the individual client's objectives. These plans shall contain, as appropriate, specific individual medical prescriptions or written direction from the interdisciplinary team for all necessary services.
Program Class/Type: Specialty Hospital/Inpatient
680.7(b)(2)(ii)(a)(1) The objectives of nursing services shall be to evaluate each client's need for nursing care on a continuing basis, and to provide such care directly by or under the supervision of a registered nurse (see section 680.13 of this Part). Such services shall include: development of a written nursing services plan for each client as part of the individual program plan.
Program Class/Type: Specialty Hospital/Inpatient
686.16 (b)(4)(i)-(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following:(i) any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid;(ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS DSP: Direct Support Professional LPN: Licensed Practical Nurse NCP: Nursing Care Plan PONS: Plan of Nursing Service RN: Registered Nurse

DISCUSSION
As needed:
- DSP
- RN if concerns with plan or DSP implementation of plan
- Others as appropriate: LPN, residential management staff

DOCUMENTATION REVIEW
Mandatory:
- Prescriber orders
- Diet order
- The written plans of care, across all service settings, for health needs such as a PONS, NCP, guidelines for dining, swallowing, etc.

OBSERVATION
N/A

When an Individual is prescribed a daily fluid intake, compliance requires that a plan, or plans, exist(s) (i.e., PONS, diet order, etc.) which are consistent and clear in their instruction to staff regarding how much fluid the person is to receive. Examples:
- Prescriber orders to push fluid intake to at least 2 quarts/day. In this case, the person is to be offered and encouraged to consume over 2 quarts per day (i.e., to prevent dehydration and/or constipation.) The NCP to hydrate this person adequately may refer to the diet order and medication administration record for staff to provide a specific amount of fluid at each time (i.e., 8 oz of water or juice with each med pass, 3x day and 8 oz of fluid with each meal and 6 oz fluid with snacks at mid-morning, after arriving home in afternoon and after dinner or before bed. This results in 66 oz/day, just over 2 quarts.)
- If the above example is instead a fluid restriction to 2 quarts/day (i.e., to treat congestive heart failure or edema), the same concept of specific times and volumes applies, but the staff are to ensure that the person doesn't consume more than what is prescribed.
- Look for written plans with consistent information that all staff who work with the Individual can use to implement the fluid prescription correctly.

Determine the standard MET if the following are present:
- The amount of fluid an individual is to receive daily or other intervals for fluid consumption are identified in the written plan.

- The written plan is consistent with directives provided by the health care professional.

Determine the standard is NOT MET if any of the following are present:

- The amount of fluid an individual is to receive daily or other intervals for fluid consumption are not identified in the written plan.
- The written plan is not consistent with directives provided by the health care professional.

10e-2 The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
680.6 (j)(1)(v) The specialty hospital shall maintain the following system of records: The specialty hospital shall maintain a comprehensive record for each client. Each client's record shall contain the following types of information: copies of assessments, reassessments, progress notes and previous individual program plans; service plans, description of treatments provided and medications administered.
Program Class/Type: Specialty Hospital/Inpatient
680.6(g)(3) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: progress notes describing the client's response to programs and services
Program Class/Type: Specialty Hospital/Inpatient
ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and

related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].

Program Class/Type:
IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home

ACRONYMS
DSP: Direct Support Professional
H.S.: *Hora somni* (at bedtime)
IRA: Individualized Residential Alternative
LPN: Licensed Practical Nurse
MAR: Medication Administration Record
NCP: Nursing Care Plan
PONS: Plan of Nursing Service
RD: Registered Dietician
RN: Registered Nurse

DISCUSSION
As needed:
- DSP
- RN if concerns with plan or DSP implementation of plan
- Others as appropriate: LPN, residential management staff

DOCUMENTATION REVIEW
Mandatory:
- Prescriber orders
- Diet order, including prescribed fluid intake
- The written plans of care, across all service settings, for health needs such as a PONS or NCP, guidelines for dining, swallowing, related to the fluid prescription, etc.
- Training records on written plans of care for fluid prescription

OBSERVATION
Mandatory:

- During dining and snacking, verify that the fluid prescription is being implemented correctly

When an Individual is prescribed a daily fluid intake, compliance requires that staff, who support the person across all of his/her service settings throughout the day coordinate with each other, and with the person supported regarding his/her fluid intake.

The RN (and at times, in coordination with a RD) is responsible to translate the fluids prescription into the written format staff can use, and train staff, to effectively support the person to comply throughout the day. This includes instructions on how to provide the 24-hour fluid prescription throughout the day. It includes:

- how much fluid the person is to consume during administration of medications (i.e., 120ccs per medication session at 6a, 3p, and H.S.)
- how the rest of his/her fluid intake is to be provided throughout the day. For example, it may be divided into amounts per shift (i.e., 600cc's/shift), and/or per meal (i.e., 240ccs meal and 120ccs at H.S. snack), per service setting (i.e., 480ccs at day hab M-F), etc.

However the fluid prescription is divided, it is imperative that each service setting staff are aware of their responsibility to provide and monitor fluid intake and communicate issues to staff in other settings, as necessary to maintain compliance.

Diet order, swallowing guidelines, tube feeding instructions, should reflect consistency with the prescribed fluid intake, i.e. regular diet with fluid restriction of 1800ccs per day (from which the division of the 1800ccs is directed by the RN and w/ consultation w/ RD as needed.)

What staff are to do if the person doesn't consume the prescribed amount of fluids (i.e., if they consume too few fluids) when the prescription is to 'push' fluids (i.e., to prevent dehydration) or if they consume more than a prescribed fluid restriction (i.e., to prevent total body fluid overload, edema, water intoxication, etc.)

Signs and symptoms of body fluid status concerns, either over-hydration or under-hydration, of which staff are to be aware and/or respond to (i.e., changes in consciousness or seizures related to over-hydration, skin tone, constipation or low blood pressure, with dehydration.)

Description of what symptoms and/or level of distress related to symptoms are to be reported to the RN, RN on call, medical prescriber, etc., and within what time frame the report is to be made.

How, what and where to document on the above information (i.e., write on the MAR amount of fluid consumed with medications, write on a tracking sheet what fluid is consumed at meals and snacks, to include what was consumed at a day setting.

Coordination between service settings (i.e., IRA and day hab) and shifts (days, eve, night) is critical to compliance for the person's best health.

Documentation and communication tools need to be in effect and used consistently for the best outcome (i.e., different volumes may be traded between shifts and settings as long as they communicate and keep the 24-hour total as the prescriber directs.)

Ask staff what they know about the person's health care needs when the person is prescribed a certain fluid intake per day and how they've been trained on this knowledge.

Ask staff if they know what signs and symptoms they are to monitor and/or report and respond to, for a person on a prescribed fluid intake. If staff cannot report the care needs adequately, ask them where they would access the needed information.

Determine the standard is MET if the following are present:

- Clear written individualized instruction was provided to staff regarding implementation of fluid restriction/requirement.
- Instructions in the plan, if implemented, appear sufficient to address the individual's needs.

Determine the standard is NOT MET if any of the following are present:

- Clear written individualized instruction was not provided to staff regarding implementation of fluid restriction/requirement.
- Instructions in the plan were not sufficient to address the individual's needs.

10e-3 There is documentation to track the individual's fluid consumption as specified in the plan.
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
680.6(j)(1)(v) The specialty hospital shall maintain the following system of records: The specialty hospital shall maintain a comprehensive record for each client. Each client's record shall contain the following types of information: copies of assessments, reassessments, progress notes and previous individual program plans; service plans, description of treatments provided and medications administered.
Program Class/Type: Specialty Hospital/Inpatient
ACRONYMS DSP: Direct Support Professional I/O: Intake/Output LPN: Licensed Practical Nurse MAR: Medication Administration Record RN: Registered Nurse **DISCUSSION** As needed: • DSP

- RN – if concerns with plan or DSP documentation or implementation of plan
- Others as appropriate: LPN, residential management staff

DOCUMENTATION REVIEW

Mandatory:

- Prescriber orders
- MAR for fluid intake with med administration
- Daily I/O sheet, daily health care or 'medical book', nursing progress notes to record fluid consumption
- Food/fluid intake record at mealtimes

OBSERVATION

As needed

After observations of persons on fluid prescription occur, check documentation to see if tracking of fluid intake is done.

When verifying this standard, note that the documentation may take place on hard copy or electronic tracking forms, clinical progress notes or other agency specified communication methods but whatever the specified format is, it should be clear in the written plan who, what, when and where to document it. Consider the following kinds of things that would have to be documented regarding care and monitoring, per the written instructions from the RN, for those on prescribed fluid intake levels:

- Documentation of fluid intake when fluids are given with medications and treatments, to include all the required information for any prescribed medicine.
- Documentation of fluid intake when fluids are provided with meals and/or snacks. For example, the staff may be required to complete an I/O form kept in the person's med book.
- Documentation of the provision of, and the Individual's response to, guidance and support staff offer when an Individual has questions, comments or concerns about his/her prescribed fluid level.
- Documentation of any observed worsening of signs and symptoms of health concerns related to body fluid intake (i.e., blood pressure, body temperature checks, mental status, fatigue level, unable to easily rouse from a nap, breathing difficulties, skin tone or turgor, dry mouth, seizure activity, cardiac symptoms such as chest pain or shortness of breath, etc.)
- Documentation of what staff did in response to any of the observed signs and symptoms of either fluid depletion or fluid overload, such as if the person was observed to be in unexpected distress or acting abnormally (i.e., if a person was short of breath, unusually tired, unusual seizure activity, unusually constipated, if a person who is normally oriented to person, place and time was suddenly no longer so oriented).
- Documentation of the Individual's response to what the staff performed to treat the symptoms.

- Documentation of the actual communication made, of any concerns about symptoms and/or level of distress related to symptoms, to the RN, RN on call, medical prescriber, etc.
- Documentation of what the staff was directed to do by the health care professional.
- Documentation of what staff did in response to the communication made to the RN, etc.
- Documentation of the person's response to what the staff performed.
- Documentation of any follow events which occurred after this process.

Determine the standard is MET if the following is present:

- Documentation/tracking of all fluid intake is completed and totaled in accordance with the plan.

Determine the standard is NOT MET if the following present:

- Documentation/tracking of all fluid intake is not completed and totaled in accordance with the plan.

10e-4 There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
680.6(d) The individual program plan shall be developed and implemented by an interdisciplinary team (see section 680.13 of this Part) including the providers of medical treatment and active programming and direct care staff. One member of this team who is a qualified mental retardation professional (see section 680.13) shall serve as client coordinator (see section 680.13) with primary responsibility for implementation of the individual program plan, coordination of its components and for arranging movement of the client to a less restrictive environment as soon as the client's handicapping conditions permit.
Program Class/Type: Specialty Hospital/Inpatient
686.16 (b)(4)(i)-(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid; any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ADM#2003-01

Adequate nursing supervision is the provision of guidance by an RN for the accomplishment of a nursing procedure, including: initial training of the task or activity; and periodic inspection of the actual act of accomplishing the task or activity.

Program Class/Type:
IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home

ACRONYMS
DSP: Direct Support Professional
LPN: Licensed Practical Nurse
MAR: Medication Admin
NCP: Nursing Care Plan
PONS: Plan of Nursing Service
RN: Registered Nurse

DISCUSSION
Mandatory:
- DSP
- Individual
- RN if concerns with plan or DSP implementation of fluid prescription

As needed:
- LPN
- Residential management staff
- Family and/or advocate

DOCUMENTATION REVIEW
Mandatory:
- MAR for meds and treatments for fluids consumed with meds
- Daily progress notes and/or daily health care or medical book, nursing progress notes
- Training records
- Written plans of care for health needs such as a PONS or NCP

OBSERVATION

Mandatory: During observation periods, give attention to what you expect to see occurring, based on the written instructions to staff, regarding the fluid consumption of persons who have a prescription for fluid intake

Consider the following when trying to validate that staff are effectively delivering the fluid intake support and monitoring its impact on the Individual. In this standard, since persons commonly drink fluid throughout the day and even during the overnight hours, ensure that staff communicate, between shifts and service settings, to achieve the prescribed fluid intake for 24 hours.

- Verify by discussion that staff understand what actions they take, and via observation, to provide specified amount of fluids and monitoring the person's signs and symptoms body fluid balance, based on the written instructions (i.e., if he is to receive 4oz of juice or milk and 6oz of coffee at breakfast) that this is being provided. If not, verify what is done to correct the fluid intake balance for the rest of the day.
- Verify that staff communicate so that the correct total of daily fluid will be consumed.
- Verify that staff know what constitutes a fluid (i.e., anything fluid at body temperature is a fluid including gelatin, ice-cream, sherbet, and popsicles).

If staff are unable to adequately describe, and/or are not providing, what they are responsible to provide for support of person(s) with a prescribed fluid intake, review the documentation of staff training written by the RN or other responsible clinician. It should include that all direct support staff responsible for the care have been educated on the current fluid prescription plan. If the training was provided and the trained staff is still not providing, this is not met.

Ask Individuals (and/or family, advocate) what they know about their prescribed fluid intake level (i.e., how they are feeling, how they experience either dehydration or fluid overload symptoms, what they are doing to take care of themselves, such as compliance with prescribed fluids, diet, if they keep their medical appointments, how the staff support them to keep their fluid balance under control and if they are satisfied with this support, if they know who to talk to if they don't believe that the support they're receiving is satisfactory, etc.).

Determine the standard is MET if the following are present:

- Based on observation, discussion and documentation review, the individual(s) is consistently receiving the support and monitoring they require for fluid intake management.
- Individuals are maintaining health/stability related to their need for fluid intake monitoring and any problems with the condition are not attributed to errors in fluid intake.

Determine the standard is NOT MET if the following is present:

- Based on observation, discussion and documentation review, any individual is not receiving/not consistently receiving the support and monitoring they require for fluid intake management.

• The individual's condition that requires fluid intake plan is not well stabilized as indicated by physician's reports, lab values, signs and symptoms linked to fluid intake issues per documentation.

Section 10f: Risk Area – Oxygen Use
QQ-10f-Does any individual have an order for Oxygen use?
10f-1 Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
680.6(g) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD…
Program Class/Type: Specialty Hospital/Inpatient
ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].
Program Class/Type:

IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home

ACRONYMS

DSP: Direct Support Professional
IPOP: Individualized Plan of Protective Oversight
LPN: Licensed Practical Nurse
MAR: Medication Administration Record
NCP: Nursing Care Plan
PONS: Plan of Nursing Service
PRN: *Pro re nata* (as needed)
O2: Oxygen
RN: Registered Nurse

DISCUSSION

Mandatory:

- DSP
- RN

As needed

- LPN
- Residential management staff

DOCUMENTATION REVIEW

Mandatory:

- Health care records which may include notes and orders from both a primary care practice and a pulmonologist
- The written plans of care for health needs such as a PONS or NCP, guidelines for oxygen use during dining, ambulation, etc.
- MAR for meds and treatments
- IPOP
- Life Plan
- Daily progress notes and/or daily health care or medical book, nursing progress notes
- Training records to evaluate what staff have been trained on regarding management of the person’s oxygen use

OBSERVATION
N/A

When verifying this standard, consider the following:

- Upon the initiation of O2 use, either PRN or for routine use, the prescriber will write orders for the oxygen, its proper concentration, how many liters, by what method it will be administered (i.e., nasal cannula or face mask) and any precautions around its use (i.e., no open flames, etc.)

The RN is responsible to translate the prescribed instructions into the written format staff can use, and train staff on the O2 use, to effectively support the person on O2. This may include:

- The O2 prescription to include all the required information for any prescribed medicine.
- Revised or new changes to the O2 therapy such as how it is to be used during physical or respiratory therapy, behavioral needs, level of supervision or support, ambulation guidelines, etc.
- Signs and symptoms of respiratory or O2 health related concerns (i.e., blood pressure, blood O2 saturation levels, mental status, fatigue level, breathing difficulties, etc.) of which staff are to be aware and/or respond to.
- Description of what symptoms and/or level of distress related to symptoms are to be reported to the RN, RN on call, medical prescriber, etc., and within what time frame the report is to be made.

Ask staff what they know about the person's O2 care needs and how they provide this care. If staff cannot report the care needs adequately, ask them where they would access the needed information. Ask staff if they know what signs and symptoms they are to monitor and/or report after the return home, and to whom they are to report these.

Determine the standard is MET if the following are present:

- Clear individualized instruction was developed and provided to staff regarding care, monitoring, services and supports required by a person for oxygen use/administration.
- The written instruction/plan of care was developed by a qualified medical professional.
- The instruction is consistent with the physician's order.
- Strategies in the plan, if implemented appear sufficient to address the needs of the individual.

Determine the standard NOT MET if the following are present:

- Individualized instruction was not provided regarding oxygen use/administration.
- Instruction was not individualized and consistent with the physician's order.
- Individualized instruction was provided, but not by a qualified medical professional/RN.

10f-2 The written instruction includes how and what to document regarding required oxygen administration and monitoring.
633. 4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
680.6(g) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD…
Program Class/Type: Specialty Hospital/Inpatient
ADM#2003-01 The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition. The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care. The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR section 633.17(a)(17)(iii) [See Attachment].
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS DSP: Direct Support Professional

LPN: Licensed Practical Nurse
NCP: Nursing Care Plan
PONS: Plan of Nursing Service
O2: Oxygen
RN: Registered Nurse

DISCUSSION
As needed:

- DSP
- RN if concerns with plan or DSP implementation of plan
- LPN
- Residential management staff

DOCUMENTATION REVIEW
Mandatory:

- Prescriber orders
- The written plans of care, across all service settings, for health needs such as a nursing care plan, plan of nursing service for how to document and monitor O2 use
- Respiratory therapy notes, if person receives it
- Training records on how to document and monitor O2 use

OBSERVATION
N/A

When verifying this standard, the documentation may take place on hard copy or electronic tracking forms, clinical progress notes or other agency specified communication methods but whatever the specified format is, it should be clear in the written plan what, when and where to document it.

Consider the presence of the following kinds of things that would have to be documented regarding care and monitoring, per the written instructions from the RN, for those persons prescribed O2:

- Documentation of O2 administration, to include all the required information for any prescribed medicine.

- Documentation of O2 tolerance. For example, the staff may be required to note how the person is tolerating the O2 by noting the color around their lips, fingernail beds, dry skin around nose, etc.
- Documentation of the provision of, and the Individual's response to, guidance and support staff offer when an Individual has questions, comments or concerns about his/her O2 therapy.
- Documentation of any observed worsening of signs and symptoms of health concerns related to O2 administration (i.e., shortness of breath, pale or bluish lips, nail beds, skin tone, mental status, fatigue level, unable to easily rouse from a nap, dry mouth or skin around the nose).
- Documentation of what staff did in response to any of the observed worsening of signs and symptoms of health concerns related to O2 therapy, such as if the person was observed to be in unexpected distress or acting abnormally (i.e., if a person was short of breath, unusually tired, unusual seizure activity, if a person who is normally oriented to person, place and time was suddenly no longer so oriented).
- Documentation of the Individual's response to what the staff performed to treat the symptoms.
- Documentation of the actual communication made, of any concerns about symptoms and/or level of distress related to symptoms, to the RN, RN on call, medical prescriber, etc.
- Documentation of what the staff was directed to do by the health care professional.
- Documentation of what staff did in response to the communication made to the RN, etc.
- Documentation of the person's response to what the staff performed.
- Documentation of any follow events which occurred after this process.

Determine the standard is MET if the following are present:

- The individual's plan of care instructs on the required/expected documentation of oxygen administration.
- The individual's plan clearly instructs on required/expected documentation of other associate care provided and/or the status of the individual.
- Documentation required meets service standard for evidence of continuity of care.

Determine the standard is NOT MET if the following are present:

- The individual's plan of care lacks instruction/does not require documentation of oxygen administration.
- The plan lacks instruction on other types of information to document related to oxygen administration and/or the condition addressed by oxygen administration.
- While the plan directs that staff document care and monitoring, it lacks sufficient clarity resulting in insufficient evidence of continuity of care.

10f-3 The equipment needed, per the medical order for oxygen, is readily available.
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.10(a)(6) Facilities which have emergency medical equipment on hand shall ensure that such equipment is maintained in accordance with a written agency/facility plan. Such a plan shall incorporate maintenance requirements that are in accordance with manufacturer recommendations and which includes provisions for inspection/replenishment subsequent to each use. Facilities with such equipment shall ensure that there are staff appropriately qualified to use it.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS DSP: Direct Support Professional LPN: Licensed Practical Nurse MAR: Medication Administration Record O2: Oxygen RN: Registered Nurse

DISCUSSION
Mandatory:
- RN

As needed:
- DSP to ascertain routine availability of necessary and properly working equipment
- Individual to ascertain routine availability of necessary and properly working equipment
- LPN
- Residential management staff

DOCUMENTATION REVIEW
Mandatory:
- Health care records, such as prescriber orders
- MAR for O2 prescription and administration
- Daily health care or 'medical book' progress, nursing notes to record O2 equipment including tanks and tubing are available on site
- Respiratory therapy notes, if person receives it
- Training records and written plans of care for health needs which would specify the acquisition of equipment needed

OBSERVATION
Mandatory: To verify if adequate amount of tanks of O2 are available in the site, within date, of the correct concentration, properly stored and in good working order. Other equipment to observe may be clean and usable O2 delivery tubing, cannula tubing, face masks, etc.

Verify by reviewing the documents which describe what O2 equipment is needed and by observing its presence in the site. Verify that it is in good working order. Discussion based on any questions regarding documentation and/or observation.

Determine the standard MET if the following is present:
- Evidence supports that equipment to administer oxygen to the individual(s) per their order is routinely available and operational.

Determine the standard is NOT MET if any of the following are present:
- Documentation, discussion and/or observation indicate that equipment necessary to deliver oxygen to the individual(s) is not available at time of survey, resulting in inability to administer.

• Documentation and/or interview indicate that there have been occasions when individual(s) did not receive needed oxygen due to lack of supply/equipment or malfunctioning equipment.

10f-4 There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
633.10(a)(1) Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.4(a)(4)(x) No person shall be denied: appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
680.6(g)(3) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: (3) progress notes describing the client's response to programs and services
Program Class/Type: Specialty Hospital/Inpatient
ACRONYMS DSP: Direct Support Professional LPN: Licensed Practical Nurse MAR: Medication Administration Record NCP: Nursing Care Plan O2: Oxygen PONS: Plan of Nursing Service RN: Registered Nurse **DISCUSSION**

Mandatory:
- RN

As needed:
- DSP to confirm their understanding of what they are to document regarding a person's O2 therapy
- Individual to confirm administration of O2
- LPN
- Residential management staff

DOCUMENTATION REVIEW
Mandatory:
- NCP or PONS containing guidelines for respiratory status symptoms, etc. on O2 administration
- Prescription for O2
- MAR for O2
- Training records on O2 therapy
- Daily health care or 'medical book' progress, nursing notes

OBSERVATION
N/A

When verifying this standard, review the documentation requirements of the standard above.

"The written instruction includes how and what to document regarding required oxygen administration and required monitoring."

When verifying this standard, the documentation may take place on hard copy or electronic tracking forms, clinical progress notes or other agency specified communication methods but whatever the specified format is, it should be clear in the written plan what, when and where to document it. Review the document sources noted in the second column of this standard, to validate that staff are correctly documenting O2 administration per orders and nursing care plan or nursing service plan, as they have been trained to do. If there are any questions regarding the documentation of O2 administration, perform discussions as above.

Determine the standard MET if the following are present:

• Based on observation, interview and documentation review, the individual(s) is consistently receiving O2 as prescribed and the related support and monitoring they require.
• Individuals are maintaining health/stability related to their need for oxygen use and any problems with the condition are not attributed to errors/omission in oxygen administration.

Determine the standard NOT MET if any of the following are present:

• Based on observation, interview and documentation review, any individual is not receiving/not consistently receiving O2 as prescribed and the related support and monitoring they require.
• The individual's condition that requires O2 is not well stabilized as indicated by physician's reports, oxygen saturation values, signs and symptoms linked to errors/omissions in O2 administration per documentation.

Section 10g: Risk Area – Supervision
QQ-10g-Enhanced supervision levels are required by one or more person supported by this site?
10g-1 There are sufficient staff on duty to maintain the supervision levels required by the Individuals.
633.4(a)(ix) No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
Program Class/Type: Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.16(a)(6)(i) The assessment of each person's need for the amount and type of supervision necessary including both staff and/or technology as appropriate to the person and circumstance.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
686.9(a)(2) There shall be a staffing plan based upon such considerations as the number of clients and their levels of functioning and need, support staff requirements, and physical plant demands.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional IPOP: Individualized Plan of Protective Oversight LPN: Licensed Practical Nurse LOS: Level of Supervision RN: Registered Nurse **DISCUSSION** Mandatory: • DSP and program management staff to ascertain their perception of staffing adequacy to maintain supervision requirements

• Individuals to understand their perception of personal security, as either a person with specialized supervision levels or as a peer of another who does

As needed:
• RN
• LPN
• Psychologist/BIS
• Family members and/or advocates
• Care Managers to understand their perception of security for Individuals, as either persons with specialized supervision levels or as peers of another who does

DOCUMENTATION REVIEW
Mandatory:

- Staffing minimum requirement documents such as Program Protective Oversight Plan
- Staff schedules for last 6-12 months
- Individual safeguarding documents (i.e., IPOP which contains the LOS needed)
- BSPs for anyone requiring restrictive interventions, per entrance conference
- Life Plan and habilitation plans for person supported

OBSERVATION
Mandatory:

- To verify if staffing supports are adequate for the person with specialized needs and for those he/she lives with. Extra attention to times of transition, such as early morning before leaving for daily activities and coming home afterwards, mealtimes, and medication administration times

When verifying this standard, consider the levels of supervision documented in persons' safeguarding documents including behavioral support plans and staff schedule documents. Verify the following:

- That the number of correctly trained staff to support individuals of specialized supervision level is met during periods of observation.
- That the staff on duty during survey visit and observations is typical of actual staffing volume and pattern, not supplemented for purposes of survey visit.
- That Individuals who will be out in the community during the observation periods desire to be out as opposed to a planned absence to make the observation go more smoothly with a more favorable staffing ratio.

• Via discussions and observation, that staff feel supported both by training, teamwork, and management to competently provide the specialized supervision levels with the number of staff on duty. • That they know the staffing minimum requirements and how the increased levels are to be met in periods of high need (i.e., what to do if an Individual needs restrictive intervention which will take some staff out of the support milieu). • Via discussions and observation that Individuals, both those with and those without the need for the higher supervision levels, feel supported and safe in their program site and/or home with the number of staff on duty. Validate this with family members and/or advocates.

10g-2 Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
633.4(a)(ix) No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
Program Class/Type: Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
686.16 (b)(4)(i)-(iii) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid; any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional IPOP: Individualized Plan of Protective Oversight IRMA: Incident Reporting & Management Application LPN: Licensed Practical Nurse LOS: Level of Supervision RN: Registered Nurse **DISCUSSION** Mandatory: • DSP and program management staff to ascertain their perception of staffing adequacy to maintain supervision requirements • Individuals to understand their perception of personal security, as either a person with specialized supervision levels or as a peer of another who does As needed: • RN • LPN

- Psychologist/BIS
- Family members and/or advocates
- Care Managers to understand their perception of security for Individuals, as either persons with specialized supervision levels or as peers of another who does

DOCUMENTATION REVIEW

Mandatory:

- IRMA review prior to visit to identify any incidents in which a lapse of LOS contributed to an incident
- Staffing minimum requirement documents such as Program Protective Oversight Plan
- Staff schedules for last 6-12 months
- Individual safeguarding documents (i.e., IPOP which contains the needed LOS)
- BSPs for anyone requiring restrictive interventions, per entrance conference
- Life Plan and habilitation plans for person supported

OBSERVATION

Mandatory:

- To verify if staffing supports are adequate for the person with specialized needs and for those he/she lives with. Extra attention to times of transition, such as early morning before leaving for daily activities and coming home afterwards, mealtimes, and medication administration times

When verifying this standard, consider the levels of supervision documented in persons' safeguarding documents including behavioral support plans and staff schedule documents. Verify the following:

- That investigation reports for incident review in IRMA have not pointed to trends of inadequate staffing as contributing to negative outcomes for persons served (i.e., if there are multiple serious or even minor notable injuries in IRMA whose investigations cite inadequate maintenance of LOS due to decreased number of staff as contributing to injuries, that certain shifts are represented more often during times of incident occurrence, etc.).
- That the number of correctly trained staff (per their report and their training records) to support Individuals of specialized supervision level is met during your period of observation and by review of past staff schedules.
- That the number of correctly trained staff to support individuals of specialized supervision level is routinely met by analysis of 6 -12 months of staff schedules. Look for any trends of staff minimum levels not being maintained historically.
- That the staff on duty during survey visit and observations is typical of actual staffing volume and pattern, not supplemented for purposes of survey visit.

• That Individuals who will be out in the community during the observation periods desire to be out as opposed to a planned absence to make the observation go more smoothly with a more favorable staffing ratio.
• Via discussion and observation, that staff feel supported both by training, teamwork, and management to competently provide the specialized supervision levels with the number of staff on duty. That they know the staffing minimum requirements and how the increased levels are to be met in periods of high need (i.e., what to do if an Individual needs restrictive intervention which will take some staff out of the support milieu).
• Via discussion and observation that Individuals, both those with and those without the need for the higher supervision levels, feel supported and safe in their program site and/or home with the number of staff on duty. Validate this with family members and/or advocates.
• Via discussion and observation, the individualized habilitation plans of Individuals are met in regard to the frequency with which supports are to be provided to assist persons to achieve their personal goals (i.e., determine if person's desires to attend certain community activities, per their plan and spontaneously, are frequently unmet due to insufficient staffing.) Note: If persons who desire to go into the community on an individual basis with staff often have to settle for going with a group because the number of staff is inadequate to meet their preference and supervision level needs.

Section 10h: Risk Area – All Rights Limitation/Restrictions
QQ-10h-Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1 Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
633.16(c)(5) & (8-9) OPWDD discourages the use of restrictive/intrusive interventions. General and specific requirements regarding the use of restrictive/intrusive interventions are imposed in order to limit the use of these interventions to those situations when necessary. Unless there is a clear risk to the health or safety of the person or others, or a violation of others' basic personal rights, any restrictive/intrusive intervention or limitation on a person's rights as specified in a behavior support plan shall be employed only after less intrusive or more positive interventions have been tried and have not been sufficiently successful. Additional requirements apply to the use of "restrictive/intrusive interventions." These interventions include the following: any intermediate and/or restrictive physical intervention techniques (see paragraph [j][1] of this section);the use of time-out (exclusionary and non-exclusionary) (see paragraph [j] [3] of this section);the use of any mechanical restraining device with the intent to modify or control challenging behavior (see paragraph [j][4] of this section);the use of medication solely to prevent, modify, or control challenging behavior (see paragraph [j][5] of this section); and other professionally accepted methods to modify or control behavior which are determined by agency/facility policy to be restrictive/intrusive interventions because they impose a risk to a person's protection or encroach unduly on a person's normal activities (e.g., response cost, overcorrection, negative practice, and satiation).Additional requirements apply to behavioral interventions which impose a limitation on a person's rights as specified in section 633.4 of this Part, including behavioral consequences negatively impacting the person's dignity (see paragraph [j][2] of this section).
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS: BSP: Behavior Support Plan DSP: Direct Support Professional F/U (f/u): Follow up **DISCUSSION** As needed: • DSP • Individual • Site supervisor

- Clinician/psychologist

DOCUMENTATION REVIEW

- BSP

OBSERVATION

- Take note of any observed limitations or restrictions so you may f/u with discussion and documentation review to ensure requirements are met

Review for 1 person. If concerns are raised that limitations/restrictions occur without a written plan, consider sample expansion. Upon discovery that any individual is subject to restrictions or limitations to their rights due to behaviors that they exhibit that need to be addressed, verify that there is a written BSP in place and implemented that identifies the restrictions as strategies.

A written plan is the means to provide instruction in how to support the person to function most effectively and/or minimize challenging behaviors and/or symptoms. A BSP outlines specific interventions designed to support, develop or increase replacement or alternative behaviors and/or modify or control a person's challenging behavior. Agencies may use other equivalent unique and agency specific terms for such plans. The intent, content, strategies and characteristics of the plans determine whether it is a BSP, not the moniker.

NOTE: This is not a comprehensive review of 633.16 requirements regarding an individual's behavior plan and behavior supports. That review occurs via the Person-Centered Review and may be used if necessary.

Determine the standard is MET if:

- A written BSP is in place for the individuals subject to a rights limitation or restriction due to behaviors.

Determine the standard is NOT MET if:

- An individual is subject to a rights limitation or restrictions due to behaviors, but a written BSP is not in place.

10h-2 The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.

633.16(e)(2)(i-ix)
All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan; be developed on the basis of a functional behavioral assessment of the target behavior(s);include a concrete, specific description of the challenging behavior(s) targeted for intervention; include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports; include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success; include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others; provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated; and include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.

Program Class/Type:
IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS
BSP: Behavior Support Plan
DSP: Direct Support Professional
IRMA: Incident Reporting and Management Application
RIA: Restrictive Intervention Application

DISCUSSION
As needed:

- DSP to determine if staff understand documentation requirements
- Clinician/psychologist on documentation expectations, especially if you have questions/concerns regarding documentation available for review

DOCUMENTATION REVIEW

Mandatory:
- BSP
- RIA for restrictive physical interventions and/or Time Out use
- Review IRMA for any incidents which have occurred for persons in relation to documented or undocumented rights restrictions
- Documentation of behavior and behavioral interventions

OBSERVATION
- If implementation is observed or discussed, this may lead to decisions regarding discussions to have and documentation review

Review for 1 person minimum.

Guideline: This applies to BSPs with restrictive, intrusive, or right limiting interventions.

The BSP should clearly describe what needs to be documented for each intervention and limitation, the format for this documentation, the frequency of the documentation, and the expected content/details to be documented (i.e., exhibited behavior, strategies attempted prior to restrictive/intrusive/limiting intervention, the specific intervention, durations as applicable, individual's response). The documentation may be hard copy or electronic.

The BSP must also include description of requirements for mandated reporting of physical interventions and time out use in RIA.

Determine the standard is MET if:
- The BSP provides clear instruction on documentation necessary when staff implement a restriction, limitation, or intrusive intervention to address an individual's behavior.

Determine the standard is NOT MET if either of the following are evident:
- The BSP does not provides instruction on documentation necessary when staff must implement a restriction, limitation or intrusive strategy to address an individual's behavior.
- Instruction in the BSP is incomplete, inadequate or unclear regarding documentation required when staff implement a restriction, limitation or intrusive intervention to address an individual's behavior.

Select N/A if:
- A BSP is not in place.

10h-3 Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
633.16(e)(4)(ii) Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BSP: Behavior Support Plan DSP: Direct Support Professional WIC: Written Informed Consent **DISCUSSION** As needed: • Individual and/or DSP to determine if rights limitations may be in place • Individuals to understand their perception of written informed consent to rights restrictions in their BSP • Clinician/psychologist if you have questions/concerns about WIC **DOCUMENTATION REVIEW** Mandatory: • BSP • Document evidencing WIC **OBSERVATION** N/A Review for 1 person. If limitations/restrictions occur without a WIC, consider sample expansion.

There should be documentation that written informed consent was obtained prior to implementing a restrictive plan. Written informed consent must be documented with the consenting party's signature and their relationship to the person and a date. Guidance regarding parties who may provide informed consent is found in regulatory references below, but when appropriate should first be sought from the individual.

- 633.16(g)(6) - Hierarchy of parties appropriate to provide consent
- 633.16(g)(7) – Determination of an individual's capacity to give informed consent
- 633.16(g)(8) – Informed Consent Committee

Time Limited Verbal Consent: Per 633.16(f)(5)(ii), If written informed consent cannot be obtained within a reasonable period of time prior to the initiation or continuance of a plan, verbal consent may be accepted only for the period of time before written informed consent can be reasonably obtained. Verbal consent must be witnessed by two members of the staff and documented in the person's record. This verbal consent is valid for a period of up to 45 days and may not be renewed.

The specific requirements that must be followed to obtain appropriate written informed consent can be found in section 633.16(g), including involved parties that can provide the consent, starting with the individual receiving supports, when appropriate.

Determine the standard is MET if any of the following is present:

- Written Informed Consent to the BSP and its strategies is evident from the individual or other appropriate consenting party prior to plan implementation.
- Written Informed Consent is current (within 12 months of previous consent).
- If strategy/plan is new or recently amended to meet a need, verbal consent is documented as described above, but not exceeding the 45-day period.

Determine the standard is NOT MET if any of the following are present:

- Written Informed Consent to the BSP and its strategies is not evident.
- Written Informed Consent is not current.
- Verbal consent has been received but has met its time limit and the site has not taken adequate action to receive WIC.

Select N/A if:

- A BSP is not in place.

10h-4 Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
633.16(e)(4)(i) Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.16(f)(3) Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.16(f)(5)(1-11) The committee chairperson must verify that :(i) the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person; and(ii) written informed consent is obtained prior to the implementation of the approved behavior support plan. If written informed consent cannot be obtained within a reasonable period of time prior to the initiation or continuance of a plan, verbal consent may be accepted only for the period of time before written informed consent can be reasonably obtained. Verbal consent must be witnessed by two members of the staff, and documented in the person’s record. This verbal consent is valid for a period of up to 45 days and may not be renewed.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BSP: Behavior Support Plan HRC: Human Rights Committee WIC: Written Informed Consent

DISCUSSION
As needed:
- Individual
- Family
- Clinician/psychologist

DOCUMENTATION REVIEW
Mandatory:
- BSP
- Documents evidencing HRC review and approval

OBSERVATION:
N/A

Review for 1 person. If limitations/restrictions occur without a WIC, consider sample expansion.

There should be documentation that written informed consent was obtained prior to implementing a restrictive plan. Written informed consent must be documented with the consenting party's signature and their relationship to the person and a date. Guidance regarding parties who may provide informed consent is found in regulatory references below, but when appropriate should first be sought from the individual.
- 633.16(g)(6) - Hierarchy of parties appropriate to provide consent
- 633.16(g)(7) – Determination of an individual's capacity to give informed consent
- 633.16(g)(8) – Informed Consent Committee

Time Limited Verbal Consent: Per 633.16(f)(5)(ii), If written informed consent cannot be obtained within a reasonable period of time prior to the initiation or continuance of a plan, verbal consent may be accepted only for the period of time before written informed consent can be reasonably obtained. Verbal consent must be witnessed by two members of the staff and documented in the person’s record. This verbal consent is valid for a period of up to 45 days and may not be renewed.

The specific requirements that must be followed to obtain appropriate written informed consent can be found in section 633.16(g), including involved parties that can provide the consent, starting with the individual receiving supports, when appropriate.

Determine the standard is MET if any of the following is present:

- Written Informed Consent to the BSP and its strategies is evident from the individual or other appropriate consenting party prior to plan implementation.
- Written Informed Consent is current (within 12 months of previous consent).
- If strategy/plan is new or recently amended to meet a need, verbal consent is documented as described above, but not exceeding the 45-day period.

Select NOT MET if any of the following are present:

- Written Informed Consent to the BSP and its strategies is not evident.
- Written Informed Consent is not current.
- Verbal consent has been received but has met its time limit and the site has not taken adequate action to receive WIC.

Select N/A if:

- A BSP is not in place.

10h-5 Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.

633.4(b)(6)
For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect.

Program Class/Type:
IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

636-1.4 (c)(1)-(8)
The service coordinator must ensure documentation of the following in the individual's person-centered service plan: a specific and individualized assessed need underlying the reason for the modification; the positive interventions and supports used prior to any modifications; less intrusive methods of meeting the need that were tried but did not work; a clear description of the condition that is directly proportionate to the specific assessed need; a regular collection and review of data to measure the ongoing effectiveness of the modification; established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; an assurance that interventions and supports will cause no harm to the individual; and the informed consent of the individual.

Program Class/Type:
IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab

ACRONYMS
BSP: Behavior Support Plan
CMS: Centers for Medicaid & Medicare Services
F/U (f/u): Follow up
HCBS: Home and Community Based Services
IPOP: Individualized Plan of Protective Oversight

DISCUSSION
As needed:
- Individual
- Family
- Clinician

DOCUMENTATION REVIEW
Mandatory:
- Written protective oversight, habilitation, treatment or service plans
- Life Plan as applicable
- Documents evidencing required consents

OBSERVATION
- Take note of any observed limitations or restrictions so you may f/u with discussion and documentation review to ensure HCBS requirements are met

Review for 1 person if rights as limited/restricted but addressed in a plan other than BSP. If concerns are raised, consider size of sample expansion.

This standard applies to limitations/restrictions in place for reasons other than behavior, for example health and safety.

A person's rights include:
- Civil rights as a US citizen
- Rights guaranteed under NYCRR Part 633.4
- Rights that apply to provider-owned or controlled Settings, as stated in the HCBS Settings regulations issued by CMS – 441.301(C)(4)(vi)(B)-(F)

When assessing this standard, consider all routine aspects of a person's life, access, and opportunities. Rights restrictions and rights modifications include alterations to any personal rights identified above, including rights limitations, restrictions, and intrusive interventions as defined in NYCRR Part 633.16.

Rights restrictions and modifications may or may not require an individualized behavior support plan.

This standard addresses those that are not addressed via a BSP. Any modification of rights must be supported by a specific assessed need and justified in the person-centered service plan. CMS Regulations identify standards related to any modification or restriction of rights in HCBS settings.

The following requirements must be documented in the person-centered service plan (or BSP). For further guidance of the following requirements, refer to the HCBS Assessment Guidance Document using the crosswalk to find specific pages:

1. Identification of a specific and individualized assessed need
2. Documentation of the positive interventions and supports used prior to any modifications to the person-centered service plan
3. Documentation of less intrusive methods of meeting the need that have been tried but did not work
4. Includes a clear description of the condition that is directly proportionate to the specific assessed need
5. Includes a regular collection and review of data to measure the ongoing effectiveness of the modification
6. Includes established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
7. Includes the informed consent of the individual
8. Includes an assurance that interventions and supports will cause no harm to the individual

For rights restrictions and limitations due to health or safety concerns:
In the event that any of the person's rights are limited or modified for a person because of health or safety concerns (such as using a bed rail or helmet because of epilepsy), it may not be necessary or appropriate to develop a behavior support plan. However, requirements #1-8 listed above still apply and need to be documented. In those instances, the information regarding limitation/restriction may fit appropriately into an IPOP, habilitation plan, or safeguard section of the Life Plan.

Note: If the IPOP is selected by the provider as the document source for required information, ensure that the information is documented in a manner or location that does not confuse staff's ability to identify current strategies to be implemented. (This note is made as requirements #2 and #3 above may provide historic strategies no longer used and determined not to currently be effective.

Exceptions due to emergency situations involving an immediate, serious, and credible threat to health and safety:
The only exception to meeting the rights modifications requirements #1-8, above, is if there is an emergency situation where the person places themselves or others around them in serious jeopardy (i.e., there is an immediate, serious, and credible threat). In this case, the provider/staff must take immediate and appropriate action necessary to address the crisis situation, regardless of documentation present. Once the immediate crisis is over, the provider/staff is expected to reassess the person’s preferences and needs using a person-centered planning process, determine strategies to address health and safety threats determined to be recurring/likely to recur, and update the person’s habilitation/service plan accordingly[1].

Determine the standard is MET if:

- All eight (8) requirements for rights limitations noted above are met.
- For documentation of positive and less-intrusive approaches:
  - The service plan documents the description of positive and less intrusive approaches that were tried but were not successful, prior to inclusion of the current restrictions or intrusive interventions.

- For documentation of a specific, individualized assessed need:
  - The person's service plan includes the individualized description of each behavior or need requiring/justifying each restrictions or intrusive interventions.
  - The use of the restrictive strategies in relation to the behavior/need appears justified.
- For documentation of written informed consent:
  - Written informed consent is evidenced through signature of consenting party for all limitations, restrictions, modifications. This may be through consent to the person's BSP (when required) or another component of their service plan that identifies the limitations; OR
  - Verbal consent is documented for a restriction implemented fewer than 45 days; AND
  - There is no indication that the process used to obtain consent was insufficient per 483 guidance noted above.
- For documentation of periodic review for effectiveness:
  - Documentation regarding implementation of strategies and resultant effect is collected as described in the plan, AND
  - This information is reviewed to determine effectiveness of strategies, AND
  - The review of implementation and effectiveness is conducted regularly per the time period identified in the plan, AND
  - Decisions regarding the continuation of a limitation, restriction, intrusion appear appropriate based on the documentation provided.

Determine the standard is NOT MET if any of the following are evident:

- For documentation of positive, less-intrusive approaches:
  - The person's service plan does not include the required information.
  - There is no evidence that positive and less intrusive measures have been implemented and tested.
- For documentation of a specific, individualized assessed need:
  - The person's service plan does not include the required information; AND/OR
  - The use of the restrictive strategies in relation to the behavior/need does not appear justified and/or proportionate.
- For documentation of written informed consent:
  - Written informed consent is not present.
  - Written informed consent is incomplete.
  - Consent is evident for some but not all limitations, restrictions, modifications.
  - There is evidence that the process used to obtain consent was insufficient per 483 guidance noted above.
- For documentation of periodic review for effectiveness:
  - Any of the three components above (data collection, data review, or time period for review) is absent either in planning or implementation; AND/OR
  - The implementation of any component is inconsistent, incomplete or untimely; AND/OR
  - Decisions regarding the continuation of a limitation, restriction, intrusion are not justified based on the documentation provided.

10h-6 When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
633.4(b)(4) OPWDD shall verify that staff are aware of the rights of persons in the facility.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
636-1.4 (d) In the event that a rights modification affects another individual receiving services in the setting who does not require a rights modification, the service coordinator must ensure documentation of the following in such individual's person-centered service plan: the impact that the rights modification has on the individual; the efforts taken to lessen the impact on the individual; and the informed consent of the individual.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ACRONYMS IPOP: Individualized Plan of Protective Oversight **DISCUSSION** Mandatory: • Individuals receiving services • Program staff • Clinical staff • Site supervisors As needed: • Families and/or advocates **DOCUMENTATION REVIEW** As needed: • Service plans addressing specific environmental limitations

- IPOP
- Life Plan

OBSERVATION

Mandatory:

- Observe for any environmental limitations and use to guide discussions and documentation review

In the event that a rights modification affects another person in the setting who does not require a rights modification, documentation of the following is required in the individual's person-centered service plan (or attachments):

1. The impact that the rights modification has on the person not requiring the modification
2. The efforts taken to lessen the impact on the person, and:
3. The written informed consent of the person

Example:
When one person requires a locked refrigerator for clinical reasons, this can impact the access and right of everyone in the residence to having food at any time. Steps must be taken to allow others in the facility access to the fridge, such as having their own key, or an alternate location to access the food.

Determine the standard is MET if:

- If there are justified rights modifications are the residence implements active measures to ensure that others' rights are accommodated; AND
- Individuals not requiring the rights modification are not negatively impacted by modifications required by their peers; AND
- Written informed consent has been provided.

Determine the standard is NOT MET if any of the following are present:

- Rights modifications in place for a peer restrict individuals who do not require the modification.
- Written informed consent has not been received from affected individuals.

Section 10i: Risk Area – Behavior Supports - General
QQ-10i-Is a behavior support plan or medication monitoring plan required/in place for any Individual ?
10i-1 The individual's behavior supports needs are implemented per the written plan.
633.16(b)(28) A written plan that outlines specific interventions designed to support, develop or increase replacement or alternative behaviors and/or modify or control a person's challenging behavior. The plan is a component of a person's overall plan of services. Agencies may use other equivalent terms for such plans. (See subdivision [e] of this section.)
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional IPOP: Individualized Plan of Protective Oversight IRMA: Incident Reporting and Management Application LCSW: Licensed Clinical Social Worker MMP: Medication Monitoring Plan RIA: Restrictive Intervention Application
DISCUSSION Mandatory: • DSP and program management staff to determine their knowledge of the written BSP • Individuals to understand their perception of the BSP written to support their unique behavioral needs and to which they, or their agent, has given consent As needed: • Licensed psychologist, or LCSW and BIS • Family members and/or advocates
DOCUMENTATION REVIEW

Mandatory:

- Review IRMA for any incidents which may have occurred related to a person BSP or MMP
- RIA review to gather information about implemented physical and time out interventions
- BSP
- MMP
- IPOP, as needed
- Daily notes, progress notes
- Clinical notes as needed
- BSP implementation documentation
- Behavioral data tracking

OBSERVATION

Mandatory:

- To verify if staff are providing the supports outlined in the BSP
- Documenting on behavior as directed in the BSP and/or MMP

See below for additional considerations during observations.

Review for 1 person minimum. If concerns with implementation, consider whether sample expansion is warranted.

Consider the following, when verifying that staff are effectively delivering both the proactive and reactive behavioral supports outlined in the BSP and monitoring the person's response to these supports or to those in the MMP.

Observation, discussion and documentation review should indicate that the positive, instructive, and supportive interventions described in the plan are routinely provided.

Observation, discussion and documentation review should indicate that restrictive, intrusive interventions and/or rights limitations are only implemented as indicated for circumstances identified in the plan and per the described methodology (hierarchy used, time limitations, safeguards and monitoring provided during and after the implementation.

Review the daily progress notes and behavioral tracking data to see if staff are implementing and documenting strategies as defined by the plan, both positive and supportive strategies as well as reactive interventions. Documentation of both positive and untoward behaviors which will enable

the clinicians to evaluate the effectiveness of the plan. If progress notes reflect behavioral information and it is not reflected in the behavioral tracking records, investigate why.

IRMA review may reveal that inadequate implementation of the BSP may have played a role the occurrence of untoward incident(s). If so, evaluate if resultant recommendations were generated and if these were implemented and effective to prevent further incidents.

Through discussion with staff, verify that all who support the Individual with a BSP or a MMP can describe their responsibilities to implement it, record on it and report it. Ask staff to describe what is working well in the plan, if they believe that their input to clinicians is valued and what ideas they have for maximum success for the plan to the Individual.

As needed, ask the person supported, family member/advocate their impression of the BSP or MMP. Verify if they believe that the plan is helping to make his/her life better and how satisfied they are with the implementation of the plan.

Determine the standard is MET if:

- Observations, discussions and documentation review result in no concerns with appropriate plan implementation.
- Implementation occurs as described in the plan.
- There is evidence of implementation of positive strategies designed to guide person to alternative behaviors and/or to prevent behaviors from occurring.
- Staff understand the behavior plan(s) and their role in implementation.

Determine the standard is NOT MET if:

- Observations, discussions and documentation review result in examples of inappropriate plan implementation.
- Implementation is inconsistent with strategies described in the plan.
- Implementation of positive strategies designed to guide person to alternative behaviors and/or to prevent behaviors from occurring is inconsistent or not occurring.
- Staff are unable to explain the behavior plan(s) and their role in implementation.

10i-2 The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
633.16(e)(2)(ix) All behavior support plans must: include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional LCSW: Licensed Clinical Social Worker MMP: Medication Monitoring Plan **DISCUSSION** As needed: • DSPs regarding the plan's effectiveness in addressing the person's behavior • Licensed psychologist, or LCSW and BIS, on how they review the effectiveness of the strategies in the plan (when not evident in summary of review) **DOCUMENTATION REVIEW** Mandatory, as applicable: • BSP • MMP • Daily progress notes • Documentation by licensed psychologist, or LCSW and BIS, of their (minimum every six months) thorough and thoughtful review of the behavioral tracking • Behavioral data tracking records to include staff-generated data on behaviors, antecedents, fading plan requirements and proactive supports being implemented

OBSERVATION
N/A

Review for 1 person minimum. If concerns with implementation, consider whether sample expansion is warranted.

Verify that appropriate clinicians (licensed psychologist or LCSW and the BIS) are effectively reviewing, minimally every six months, documentation regarding the person's target behaviors and the delivery of both the proactive and reactive behavioral supports outlined in the BSP. The review should include:

- Review of the notes and behavioral tracking data documented by staff implementing the plan.
- Evaluation of the effectiveness of the strategies in the plan to reduce/maintain unwanted behaviors and improve appropriate adaptive behaviors.
- Evaluation if any restrictive interventions can be faded, liberalized or eliminated, based on behavioral data if BSP. (Restrictive techniques).
- If a person receives more than one service, review includes review for consistent implementation and effectiveness across his/her service environments.
- Discussion with support staff and the individual regarding effectiveness of the plan.
- The plan's effectiveness in helping the person live successfully in their home and community, socially and functionally should be part of the review.

Determine the standard is MET if:

- There is documentation of review of the plan by the clinician.
- The review thoroughly addresses effectiveness of the BSP/MMP plan and its strategies to assist the person to live more successfully.
- The review occurs at least every six months.

Determine the standard is NOT MET if any of the following are present:

- There is not documentation evidencing review.
- The plan's effectiveness is reviewed but duration between reviews significantly exceeds every six months.
- Review of the plan is not thorough/components of the review are not evident. For example:
  - Does not include review of documentation/data of behaviors; and
  - Circumstances regarding the behavior (i.e., antecedents, environment)
  - Does not include review of strategies implemented, correct use of hierarchy
  - Does not include person's response to strategies

10i-3 The Behavior Support Plans are revised based on the individual's needs.
633.16(e)(2)(ix) All behavior support plans must: include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional LCSW: Licensed Clinical Social Worker LPN: Licensed Practical Nurse MMP: Medication Monitoring Plan RN: Registered Nurse **DISCUSSION** Mandatory: • If concerns, licensed psychologist or LCSW and BIS to learn how they review the recorded tracking data to make decisions about the effectiveness of the plan which result in revision of the plan supports, as appropriate As needed: • Individuals to learn what they think and feel about the plan's effectiveness and if and how the plan is revised over time • RN, LPN if any health concerns arise as a result of behavioral support needs as these may change over time with plan review and revisions • Family members and/or advocates • Care Managers to learn what they think and feel about its effectiveness and revision over time **DOCUMENTATION REVIEW** Mandatory:

- BSP
- MMP
- Daily progress notes
- Behavioral data tracking records to include data on fading plan requirements and proactive supports being implemented, in addition to untoward behaviors
- Documentation by licensed psychologist, or LCSW and (BIS), of their (minimum every six months) review of the behavioral tracking data which demonstrates thoughtful assessment and subsequent plan revisions, if necessary

OBSERVATION
N/A

Verify that clinicians responsible for the plan are reviewing documentation related to BSP, to determine whether a revision of the plan, is necessary.

Verify that the responsible clinician(s) is/are reviewing the totality of the information recorded to get a holistic picture of how the BSP or MMP is effectively meeting the Individual's behavioral support needs throughout his day. This includes monitoring whether both the proactive and reactive behavioral supports are effective.

Evaluate if the clinician uses information to identify elements which can be revised to maximize the effectiveness of the plan (i.e., retaining strategies that are effective but removing strategies proven to be ineffective or including a new intervention for implementation in the evening after discovery that the strategy is highly effective during the daytime, but ineffective when the person is more tired in the evening).

Review the daily notes and behavioral tracking data to see that strategies staff are using and report as effective become part of the plan if not already included. This will assist in identifying the most effective strategies, including strategies that may not be in the plan, but staff are finding effective (i.e., if staff discover that a certain activity presented calmly has a positive effect in redirecting an individual's agitation, this should be considered as a strategy in the plan.)

If recorded behavioral data demonstrates a successful trend in behavior, determine if it has resulted in the fading or modification of restricting/intrusive/limiting restrictive interventions. If not, verify that it is based on a reasoned decision.

New behaviors or changes in behavior that negatively impact the individual's quality of life are noted.

Determine the standard is MET if:

- The plan is revised when there is evidence of:

- Sustained improvement in behavior; or
- Sustained increase in behaviors that negatively impact the person's life; or
- New strategies not included in the plan are discovered to be effective; or
- New behaviors are occurring/sustained.

• The plan is not revised when the above conditions are noted, but the failure to revise is based on a reasoned appropriate decision.

Determine the standard is NOT MET if:

• The plan is not revised even though there is evidence of:

- Improved behavior allowing for reductions of restrictions, intrusions, or limitations
- Ineffective strategies and/or increase in undesirable behaviors; or
- Input from others regarding effective and ineffective strategies is not considered; or
- Behaviors that negatively impact the person's quality of life.

Section 10j: Risk Area – Mechanical Restraints
QQ-10j- Are Mechanical Restraints used for any individual?
10j-1 Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
633.16(j)(4)(ii)(e) Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: (1) the facts justifying the use of the device; (2) staff or family care provider action required when the device is used; (3) criteria for application and removal and the maximum time period for which it may be continuously employed, see clause (i) of this subparagraph; (4) the maximum period of time for monitoring the person's needs, comfort, and safety, see clause (j) of this subparagraph; and (5) a description of how the use of the device is expected to be reduced and eventually eliminated.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS ASAP: As Soon As Possible BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional IRMA: Incident Reporting and Management Application LCSW: Licensed Clinical Social Worker RIA: Restrictive Intervention Application RN: Registered Nurse **DISCUSSION** As needed, with any questions about the plan's implementation of mechanical restraints: • DSP and other site staff re: application, removal and use duration of mechanical restraints as part of a BSP • Psychologist, or LCSW and BIS, to verify their understanding of content requirements of the BSP and the application, removal, and duration of mechanical restraints in the BSP, and staff understanding/implementation of the plan • Individual re: their experience of mechanical restraints

- RN if any questions regarding mechanical restraint use and impact to health, skin integrity, etc.
- Family members and/or advocates

DOCUMENTATION REVIEW

Mandatory:

- Review IRMA for any incidents which have occurred for persons in relation to use of mechanical restraints
- Prior to the visit a review of RIA will provide the surveyor information about mechanical interventions that have been implemented
- BSP
- Documentation that tracks/records the application, removal and duration of use of mechanical restraints

OBSERVATION

N/A

Review for 1 person minimum.

The BSP must clearly describe why use of mechanical restraints is necessary. A mechanical restraining device is any physical apparatus or equipment used to limit or control challenging behavior. The apparatus or equipment cannot be easily removed by the person and may restrict the free movement, or normal functioning, or normal access to a portion or portions of a person's body or may totally immobilize a person.

The BSP should include clear criteria and instruction for use of mechanical restraints as follows:

- All alternative strategies or actions to be implemented by staff prior to using the device
- A description of the individual's behavior and/or behavior progression that indicates the need to use the mechanical restraining device
- Clear criteria and the conditions for application of device
- Clear instruction for monitoring of the person's condition during use
- Clear individualized behavioral criteria for when device should be removed
- Other conditions for removal of the mechanical restraint/device (i.e., hours of sleep, mealtimes, personal hygiene, or certain durations of use)
- Instruction regarding maximum duration of device application
- Circumstances for reapplication
- Documentation required related to use and monitoring of person's well-being

Note: Regarding maximum duration of device application: Per 633.16(j)(4)(ii)(i) In the absence of a physician's order for a shorter time period for release, the individual must be released from the device at least once every hour and fifty minutes for not less than ten (10) minutes. They must be provided opportunities for movement, eating, drinking and toileting. In the absence of a physician's order specifying otherwise, this is not applicable if the person is asleep, however the opportunities describe above must be offered immediately upon waking. If an individual requests release for movement or toileting prior to specified time period per plan, the opportunity should be provided ASAP.

The following types of mechanical restraining devices may be used without specific OPWDD approval:

(1) Mittens, helmets, face masks, goggles, sleeve boards (by whatever name known), clothing (i.e., jumpsuit, leotard, or custom-designed clothing such as tear-proof/nonshreddable heavyweight cloth shirts or pants), bolsters, and mats used to safely contain a person.

(2) Lap trays, seatbelts, and harnesses; only when used to maintain an ambulatory person in a fixed location for the purpose of enhancing services.

(3) The use of a seatbelt, harness, or mechanical brake to maintain a non-ambulatory person in a fixed location for the purpose of preventing risk to health or safety resulting from challenging behavior.

Other mechanical devices or modifications of the above require specific review and approval by OPWDD. Verify this has been received by the agency. If approved, the provider agency will have documentation via email or letter from OPWDD Statewide Services Division. For state operated services, the Area Director will verify through the Statewide Services Division.

NOTE: Mechanical restraining devices used as a support to achieve proper body position, balance, or alignment, as part of a medical or dental procedure or as a medical or dental safeguard are not subject to the requirements of this section.

The use of devices to limit movement for the safe transport of the individual in vehicles, wheelchairs, etc., is not considered to be the use of a mechanical restraining device and is not subject to the requirements of this section.

Determine the standard is MET if:

- The BSP provides clear instruction on the individual’s behaviors necessitating application of mechanical restraints and the interventions that must be provided prior to application if applicable.
- The BSP provides clear instruction for appropriate application of mechanical restraints.
- The BSP provides clear criteria and instruction for removal of mechanical restraints.
- The BSP provides clear instruction of the supervision and monitoring that staff must provide while mechanical restraints are worn by an individual.

Determine the standard is NOT MET if either of the following are evident:

- Mechanical restraints not meeting the exceptions above, are used with an individual but not included as strategy in a behavior support plan.
- The BSP does not provide clear instruction for one or more of the following:
  - Behaviors that must be exhibited for mechanical restraint application.
  - How to apply.
  - Criteria for removal.
  - Required supervision and monitoring of the individuals while mechanical restraints are used.

10j-2 Restraints are only applied per the criteria described in the Behavioral Support Plan.
633.16(j)(4)(i)(b) Mechanical restraining devices shall only be used in a manner consistent with the provisions of this section. Any other use shall be reported as a reportable incident in conformance with Part 624 of this Title.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.16(j)(4)(ii)(g) Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional IRMA: Incident Reporting and Management Application LCSW: Licensed Clinical Social Worker RIA: Restrictive Intervention Application RN: Registered Nurse
DISCUSSION Mandatory: • DSP to determine their understanding and competency in implementation of use of mechanical restraints As needed:

- Responsible clinician: psychologist, BIS, LCSW re: their monitoring for appropriate implementation of mechanical restraint intervention
- Site supervisors re: appropriate implementation
- RN if concerns about negative health impact because of use of mechanical restraints
- Family members and/or advocates

DOCUMENTATION REVIEW

Mandatory:

- IRMA for any incidents which have occurred in relation to use of mechanical restraints
- RIA to identify implementation of mechanical restraints noted in the online application
- Other documentation regarding restraint use and monitoring
- BSP

As Needed:

- Staff training records is concerns regarding mechanical restraint implementation and staff competency

OBSERVATION:

Mandatory if opportunity arises to verify use of any mechanical restraint/device is compliant with application criteria

Observe and converse with relevant parties. Review BSP, documents, and reports of behaviors and interventions to determine:

- Required preliminary interventions were provided by staff prior to use of mechanical restraints in the hierarchy of interventions in the plan (i.e., when an individual exhibits eye poking, the plan states to interrupt the behavior through touch control, calming prompts and redirection to a preferred supervised activity, but when the person persists after 5 minutes of the behavior and is not responsive to redirection, a helmet with face guard should be applied).
- Target behaviors were exhibited by the individuals precipitating use of mechanical restraints (i.e., the plan allows for use of helmet for eye poking, it cannot be used for hand mouthing).

NOTE: The use of mechanical restraining devices in an emergency is not permitted.

Determine the standard is MET if:

- Documentation and discussion evidence that mechanical restraints/devices are applied to the individual only in accordance with the strategies and hierarchy in the BSP.

Determine the standard is NOT MET if any of the following are evident:

- Mechanical restraints/devices are applied without following the hierarchy of interventions in the plan.
- Mechanical restraints/devices are applied for reasons other than the target behavior(s) for which they are necessary.
- Documentation regarding use of mechanical restraints/devices is lacking.
- Mechanical restraints are not identified as a strategy in the BSP.

10j-3 Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
633.16(j)(4)(i)(b) Mechanical restraining devices shall only be used in a manner consistent with the provisions of this section. Any other use shall be reported as a reportable incident in conformance with Part 624 of this Title.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS ASAP: As Soon As Possible BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional IRMA: Incident Reporting & Management Application LCSW: Licensed Clinical Social Worker RIA: Restrictive Intervention Application RN: Registered Nurse **DISCUSSION** Mandatory: • DSP to determine their understanding and competency in implementation of use of mechanical restraints As needed: • Responsible clinician: psychologist, BIS, LCSW re: their monitoring for appropriate implementation of mechanical restraint intervention • Site supervisors re: appropriate implementation • RN if concerns about negative health impact because of use of mechanical restraints • Family members and/or advocates **DOCUMENTATION REVIEW** Mandatory: • IRMA for any incidents which have occurred in relation to use of mechanical restraints. • RIA to identify use and removal of mechanical restraints noted in the online application

- Other documentation regarding restraint use and monitoring
- BSP

As Needed:

- Staff training records is concerns regarding mechanical restraint use and staff competency

OBSERVATION

Mandatory if opportunity arises to verify use of any mechanical restraint/device is compliant with removal criteria and duration

Observe, converse, and review the BSP, documents, and reports of behaviors and interventions to determine whether mechanical restraining devices were used in accordance with BSP instruction and criteria for removal of devices.

Documentation must evidence that when mechanical restraints are used, they are worn by the individual for the minimum time required per the plan's criteria for removal and the person's exhibited behavior at the time. That is, the devices are removed as soon as the individual meets behavioral criteria per the BSP (i.e., if the plan states that the helmet is removed after 10 minutes of calm as defined as no screaming, agitation and attempts to poke eyes, the helmet is removed).

The duration mechanical restraints are worn does not exceed the maximum duration written in the plan. The plan must not allow a person to wear restraint devices longer than 1 hour and 50 minutes.

Note: Regarding maximum duration of device application: Per 633.16(j)(4)(ii)(i), in the absence of a physician's order for a shorter time period for release, the individual must be released from the device at least once every hour and fifty minutes for not less than ten (10) minutes. They must be provided opportunities for movement, eating, drinking and toileting. In the absence of a physician's order specifying otherwise, this is not applicable if the person is asleep, however the opportunities describe above must be offered immediately upon waking. If an individual requests release for movement or toileting prior to specify time period per plan, the opportunity should be provided ASAP.

Determine the standard is MET if:

- Documentation and discussion evidence that mechanical restraints are removed in accordance with the criteria described in the BSP for removal.

Determine the standard is NOT MET if any of the following are evident:

- Mechanical restraints/devices are NOT removed when criteria for removal is met per the BSP.

- Mechanical restraints/devices are worn by the individual longer than described in the BSP.
- Documentation regarding use of mechanical restraints/devices is lacking.
- Mechanical restraints are not identified as a strategy in the BSP.

10j-4 There is a current physician's order for the mechanical restraint device use.
633.16(j)(4)(ii)(g)(1-3) A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan LCSW: Licensed Clinical Social Worker RN: Registered Nurse **DISCUSSION** As needed: • RN • Psychologist • BIS • LCSW **DOCUMENTATION REVIEW** Mandatory: • Physician or prescriber's orders • BSP **OBSERVATION** Mandatory if opportunity arises to verify use of any mechanical restraint/device is compliant with the physician's order

The BSP instruction/guidance for use of the mechanical restraint/device should be consistent with the physician's order. The order must be in the person's clinical record.

The physician's order must specify:

- The type of device to be used
- An expiration date for the order
- Any special considerations related to the use of the device based on the person's medical condition, including the monitoring which is required during and after use of the device. This must incorporate specific components such as checking of vital signs and circulation if needed

The order must be renewed with the frequency specified in the plan but no less frequently than every 6 months.

Note: If the device is used solely to maintain an ambulatory person in a fixed location or position for the purpose of enhancing the delivery of care or services (i.e., medical interventions), a physician's order is not required. This use must conform to all other requirements regarding use of mechanical restraints.

Determine the standard is MET if:

- The BSP includes use of a mechanical restrain/device and there is a current physician's order for use of the device. Current means within 6 months or more frequently if required by the BSP or physician.

Determine the standard is NOT MET if either of the following are present:

- The BSP includes use of a mechanical restrain/device and there is NOT a current physician's order for use of a mechanical restraint/device. Current means within 6 months or more frequently if required by the BSP or physician.

10j-5 There is documentation that is "full record" of the mechanical restraint device use.
633.16(j)(4)(ii)(g)(4) A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: be retained in a person's clinical record with a full record of the use of the device.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional IRMA: Incident Reporting and Management Application LPN: Licensed Practical Nurse RIA: Restrictive Intervention Application RN: Registered Nurse **DISCUSSION** As needed: • DSP • RN • LPN • Psychologist • BIS **DOCUMENTATION REVIEW** Mandatory: • IRMA for any incidents which have occurred in relation to use of mechanical restraints • RIA to identify use and removal of mechanical restraints noted in the online application • Other documentation regarding restraint use and monitoring • BSP

OBSERVATION:
Mandatory if opportunity arises in which the mechanical restraint is implemented during the visit to verify the documentation of its full record of use

Review documentation to verify that there is a "full record" documented for each use of a mechanical restraint. A "full record" means:

- A description of the event that caused the device to be applied (precipitation events, behavior exhibited by the person and other strategies attempted)
- The time it was applied
- The times when monitoring occurred
- The findings of monitoring activities and any actions taken
- The time of release
- Any other information required by the BSP

Determine the standard is MET if:

- There is a "full record" documenting the implementation of the mechanical restraint strategy as described in the six (6) bullets above.

Determine the standard is NOT MET if:

- There is not a "full record" documenting the implementation of the mechanical restraint strategy: as described in the six (6) bullets above. Any one of the items is lacking.
- Mechanical restraints are not included in the BSP as a strategy.

Section 10k: Risk Area – Time Out
QQ-10k-Is 'Time-out' used for any Individuals?
10k-1 Time-out is used only in accordance with the Behavior Support Plan.
633.16(j)(3)(iv)(a)(1) The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional IRMA: Incident Reporting and Management Application LCSW: Licensed Clinical Social Worker RIA: Restrictive Intervention Application
DISCUSSION As needed: • DSP staff to ascertain their knowledge of the criteria needed to implement time-out as part of a BSP • Licensed psychologist or LCSW and BIS to verify their understanding of the functional need for and how staff implement time-out in the plan • Individuals to understand their perception of the use of time-out • Family members and/or advocates
DOCUMENTATION REVIEW Mandatory: • Review IRMA for any incidents which have occurred for persons in relation to use of time-out • RIA for documentation of time out interventions that have been implemented with individuals • Other documentation and notes that describe use of time-out

- BSP

As Needed:

- Staff training records if concerns regarding their competence on the use of time-out

OBSERVATION

Mandatory if opportunity arises in which the use of time-out occurs during the visit, to verify its use is based on the criteria which the plan specifies.

Review for 1 person minimum.

Based on observation, discussion and review of documents and reports, determine whether use of the Time Out strategy was implemented safely and in accordance with the BSP criteria and instruction. An account of time out use will also be documented in RIA.

Documentation should evidence that the plan is followed regarding circumstance for initiation of Time Out per the BSP.

Documentation should also evidence adherence to the BSP criteria and time frames for release from Time Out.

NOTE: Time Out cannot be used in an emergency in the absence of a written plan. It cannot be used as a form of punishment or retribution or for the convenience of staff.

NOTE: Time Away, when a person is redirected to a quieter or less stimulating area of the program and where staff do not actively prevent egress from that area, is not considered a form of time-out.

Determine the standard is MET if:

- Documentation and discussion evidence that Time Out interventions are implemented in accordance with the criteria described in the BSP for initiation and release.

Determine the standard is NOT MET if any of the following are present:

- Time Out interventions are implemented when unwarranted, for behaviors other than describe in the BSP.
- Time Out interventions are implemented prior to implementation of previous strategies in the hierarchy per the BSP.
- The individual is required to remain in Time Out longer than required per the BSP.
- Documentation regarding use of Time Out is lacking.

- Time Out is not identified as a strategy in the BSP.

10k-2 The use of a time out room is reported electronically to OPWDD.
633.16(j)(3)(iv)(d) Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan LCSW: Licensed Clinical Social Worker RIA: Restrictive Intervention Application **DISCUSSION** As needed: • Agency staff • Site supervisor • Licensed Psychologist or LCSW band BIS to ascertain their knowledge and oversight of the need to electronically report time-out as part of a BSP **DOCUMENTATION REVIEW** Mandatory: • Review IRMA for any incidents which have occurred for persons in relation to use of time-out • RIA for documentation of time out interventions that have been implemented with individuals • Other documentation and notes that describe use of time-out • BSP As Needed: • Staff training records if concerns regarding their competence on the use of Time Out **OBSERVATION**

N/A

The use of Time Out is to be reported in RIA. Review RIA to verify that each use of Time Out was reported, and all required information was entered into RIA and is consistent with other information available regarding the use of Time Out, as available in behavior tracking and documentation in the person's record.

Determine the standard is MET if:

- All required Time Out use is entered into RIA with required fields completed.

Determine the standard s NOT if any of the following are present:

- All events of Time Out use is not entered into RIA.
- Many events of time out use are not entered into RIA.
- Information entered into RIA is inaccurate based on discussion with staff and/or documentation of Time Out use elsewhere.

10k-3 Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
633.16(j)(3)(iv)(a)(2) The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional IRMA: Incident Reporting and Management Application LCSW: Licensed Clinical Social Worker RIA: Restrictive Intervention Application
DISCUSSION As needed: • DSPs to ascertain their knowledge of the monitoring required when implementing Time Out as part of a BSP • Licensed psychologist or LCSW and BIS to verify their understanding of how staff implement Time Out in the plan • Individuals to understand their perception of the use of Time Out • Family members and/or advocates
DOCUMENTATION REVIEW Mandatory: • Review IRMA for any incidents which have occurred for persons in relation to use of Time Out • RIA for documentation of time out interventions that have been implemented with individuals • Other documentation and notes that describe use of Time Out • BSP

As Needed:

- Staff training records if concerns regarding their competence on the use of Time Out

OBSERVATION

Mandatory if any Time Out is used during the review to verify if there is constant auditory and visual contact

Constant auditory and visual contact is mandated to ensure that if the Individual engages in behavior that poses a risk to their health or safety, staff intervenes to prevent injury. Guidance to provide this monitoring should be clearly indicated in the BSP. Documentation for implementation of time out should indicate that visual and auditory supervision is provided. Review documentation in onsite notes and RIA to verify that it is provided and appropriate.

Determine the standard is MET if:

- There is documentation to support the provision of visual and auditory supervision during Time Out.
- Discussion evidences that appropriate monitoring occurs.
- There is no evidence to raise doubt that appropriate auditory and visual monitoring is maintained during Time Out.
- The Time Out room/location physical characteristics allow for the proper provision auditory and visual monitoring during Time Out.

Determine the standard is NOT MET if any of the following are present:

- There is no documentation to support that visual and auditory supervision is maintained during Time Out.
- Discussion with staff or individuals or family reveal that appropriate supervision is not maintained during Time Out interventions.
- Incident reports or other information indicate that required supervision is not maintained during Time Out interventions.
- The Time Out room/location does not allow for proper maintenance of auditory and visual monitoring during time out interventions based on physical characteristics.

Section 10I: Risk Area – Physical Interventions
QQ-10I-Are physical Interventions used for any Individuals?
10I-1 Physical interventions are used only in accordance with the Behavior Support Plan.
633.16(j)(1)(i)(a-d) The use of any physical intervention technique shall be in conformance with the following standards: the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; the technique must be applied in a safe manner; the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional IRMA: Incident Reporting and Management Application LCSW: Licensed Clinical Social Worker RIA: Restrictive Intervention Application
DISCUSSION As needed: • DSP staff to ascertain their knowledge of the criteria needed to implement physical interventions as part of a BSP • Licensed psychologist or LCSW and BIS and site supervisor to verify their understanding of how staff implement physical interventions per the plan • Individuals to understand to understand their perception of the use of physical interventions • Family members and/or advocates
DOCUMENTATION REVIEW Mandatory: • Review IRMA for any incidents which have occurred for persons in relation to use of physical interventions

- RIA for documentation of physical interventions that have been implemented with individuals
- Other documentation and notes that describe use of physical interventions
- BSP

As Needed:

- Staff training records if concerns regarding their competence on the use of physical interventions

OBSERVATION

Mandatory if opportunity arises to verify its use is based on the criteria which the plan specifies

Review for 1 person minimum.

Based on observation if opportunity presents, discussion with relevant parties, and review of documents and reports of behaviors and interventions, determine whether:

- Physical interventions were used safely and in accordance with OPWDD approved interventions. The technique must be applied safely, with the minimal amount of force necessary to safely interrupt the challenging behavior.
- Physical interventions were implemented only in accordance with behavioral criteria for use in the BSP and in accordance with BSP guidelines. Physical Interventions used must be the same interventions listed in the BSP and used in the same hierarchy as put forth in the plan (least restrictive used first).

Determine the standard is MET if:

- Documentation and DISCUSSION indicate that physical interventions are used appropriately and only per the written BSP.
- Observation (if possible) indicates that physical interventions are implemented only when necessary and per the plan.
- Physical interventions implemented are OPWDD approved.

Determine the standard is NOT MET if:

- Documentation and discussion indicate that physical interventions are NOT used appropriately and and/or are not implemented per the written BSP.
- Observation (if possible) indicates that physical interventions are implemented for behaviors or circumstances different that those identified as justifiable in the written plan.
- Interventions implemented are not OPWDD-approved.
- The BSP does not include physical interventions as a strategy.

10I-2 The use of restrictive physical interventions is reported electronically to OPWDD.
633.16(j)(1)(vii) Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.16(j)(3)(iv)(d) Requirements for the use of time-out rooms. Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
Program Class/Type: IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR-Supervised apartment, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Outpatient/Day Training(sheltered workshop), Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS BIS: Behavioral Intervention Specialist BSP: Behavior Support Plan DSP: Direct Support Professional IRMA: Incident Reporting and Management Application LCSW: Licensed Clinical Social Worker RIA: Restrictive Intervention Application
DISCUSSION As needed: • DSP • Site supervisor • Licensed psychologist or LCSW and BIS to ascertain their knowledge and oversight of the need to electronically report time-out as part of a BSP

DOCUMENTATION REVIEW
Mandatory:

- Review IRMA for any incidents which have occurred for persons in relation to use of time-out
- RIA for documentation of time out interventions that have been implemented with individuals
- Other documentation and notes that describe use of time-out
- BSP

As Needed:

- Staff training records if concerns regarding their competence on the use of time-out

OBSERVATION
N/A

The report of the use of physical interventions with individuals should be available in RIA with all appropriate fields completed. Through documentation review, verify:

- That the information entered in RIA is accurate for each physical intervention.
- For services provided in non-certified sites, documentation may occur via paper documentation. RIA entry is not required.

The use of physical interventions to assist a person to more effectively cope must be reported in RIA. Review RIA and documentation available on site to verify that each use of interventions was reported, and all required information was entered into RIA and is consistent with other information such as behavior tracking and documentation in the person's record.

Determine the standard is MET if:

- All required physical intervention use is entered into RIA with required fields completed.

Determine the standard is NOT if any of the following are evident:

- All events of physical intervention use are not entered into RIA.
- Many events of physical interventions use are not entered into RIA.
- Information entered into RIA is inaccurate based on discussion with staff and/or documentation of physical interventions elsewhere.

Section 11: Risk Area – Background Checks
11-7 A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
633.24(b)(2-5) (b) Check of the register of substantiated category one cases of abuse or neglect, also known as the Staff Exclusion List (SEL). (2) Agencies (including agencies) shall comply with the requirements in section 495 of the Social Services Law and procedures established by the Justice Center for the Protection of People with Special Needs (Justice Center) for checking the SEL. (3) If the name of subject party has been submitted for a check of the SEL, the agency shall not allow the party to have regular and substantial contact with a person receiving services until the agency has the results of the check. (4) If a party is listed on the SEL, the agency or sponsoring agency shall not hire or otherwise allow such party to have regular and substantial contact with an individual receiving services. (5) The agency or sponsoring agency shall comply with all requirements of the Justice Center regarding confidentiality and actions to be taken concerning the results of the SEL check.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS CBC: Criminal Background Checks JC: Justice Center SEL: Staff Exclusion List **DISCUSSION** Discussion based on surveyor discretion, i.e. interview relevant staff (personnel manager/administrator, and/or the designated authorized party) regarding the agency's policy and procedures to complete the SEL checks and discuss any questions or concerns regarding the SEL checks, the results/findings of the check and the determined clearance status. In addition, discuss and resolve any missing/discrepant information with the designated authorized party. **DOCUMENTATION REVIEW** Mandatory: • Request a list of all new employees and volunteers that were hired or selected to volunteer, since the completion date of the last full site survey who are still employed by the agency.

- Compare the list of names of the employees and volunteers with the SEL determinations that were issued by the JC. The designated authorized party should make these determinations available to surveyors during the review.
- If concerns/questions arise, request and review the agency's policy and procedures.

SEL requirements are applicable to applicants/employees/volunteers/contractors hired on or after June 30, 2013.

SEL checks are requested by the agency first, before the other background checks (CBC, MHL 16.34, SCR).

SEL checks are required for all prospective employees and volunteers working in sites certified by OPWDD, who are required to have CBCs, and the SEL checks must be submitted before the applicant/employee or volunteer is hired or selected to volunteer.

Following submission for an SEL check, the agency must not allow the party to have any regular and substantial contact with an Individual receiving services until the agency has the results of the check and the JC determination.

If a party is listed on the SEL, the agency shall not hire or otherwise allow the party to have regular and substantial contact with an Individual receiving services.

Surveyors must immediately contact a Bureau of Program Certification Area Director when it is determined that a subject party had regular and substantial contact with an Individual/Individuals receiving services and was not subject to a SEL check, as required. An immediate plan of correction will be required to ensure that people receiving services are provided appropriate protections.

In addition, should a surveyor identify concerns with the agency's background checks during the full site review, contact a Bureau of Program Certification Area Director to further discuss and determine if additional survey activities may be necessary (i.e., expanding the scope of the survey, opening a partial Agency Review etc.).

The background check section is required to be completed for all full reviews. However, the section may be completed at any time if there is a concern related to background checks that needs to be investigated.

Staff should review records for all staff hired since the date of the last full review who are still employed by the agency.

Determine the standard is MET if:

- SEL checks were submitted/completed for all new employees and volunteers, who are subject to a criminal background check.
- Following submission for an SEL check, the agency did not allow the subject party to have any regular and substantial contact with an individual receiving services until the agency had the results of the check and the JCs determination.

• If it was determined by the JC that the party is listed on the SEL, the agency did not hire the staff or utilize the volunteer or allow the party to have any substantial contact with an individual receiving services.

Determine the standard is NOT MET if any of the following are present:

• SEL checks were not submitted/completed for all new prospective employees and volunteers, who are subject to a criminal background check.
• Following submission for an SEL check, the agency allowed the party to have regular and substantial contact with an individual receiving services prior to receiving the JCs determination.
• If it was determined by the JC that the party is listed on the SEL, the agency hired or allowed the party to have substantial contact with an individual receiving services.

Select N/A if:

• No new employees or volunteers were hired or utilized to volunteer, since the completion date of the last full site survey.

11-8 Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
633.22(d)(2)(i,iii,iv) (d) Determination of when a criminal history record check is required. (2) Criminal history record checks are required for the following parties: (i) prospective employees and operators who will have regular and substantial unsupervised or unrestricted physical contact with people receiving services, according to the criteria established by policies and procedures. Unless the agency or provider of services has documented the grounds for determining that the party does not have such contact, the following employees and operators are presumed to have regular and substantial unsupervised or unrestricted physical contact: (a) a party providing direct care services to people in facilities and non-certified settings authorized, funded, or approved by OPWDD, including but not limited to: (1) residential facilities (ICFs, CRs and IRAs); (2) home and community-based waiver habilitation services (including residential habilitation, day habilitation, community habilitation, pathway to employment, supported employment, and pre-vocational services); (3) day treatment facilities; (4) day training facilities; (5) sheltered workshops; (6) respite services; (7) recreational services; (8) authorized demonstration programs (e.g., NYS-Options for People Through Services [NYS-OPTS]); and (9) any service similar to those specified in subclauses (1)-(8) of this clause; (b) a party providing line or onsite supervision of direct care staff; (c) a party providing transportation services, whether driving or accompanying people while they are being transported; (d) a job coach (or equivalent) providing supported employment services; (e) a clinician providing clinical services to people receiving services; (f) in a clinic treatment facility (article 16 clinic), a clinic treatment coordinator, a medical director and an authorized party (see section 679.99 of this Title) providing services; (g) a care manager and a supervisor of a care manager ; and (h) a party whose work assignment location is at a certified site at least some of the time that persons are receiving services; (iii) prospective volunteers who will have regular and substantial unsupervised or unrestricted physical contact with persons receiving services, as determined by the agency or provider of services according to criteria established by policies and procedures; (iv) employees, volunteers and operators who currently have a position or volunteer opportunity which does not involve regular and substantial unsupervised or unrestricted physical contact with persons receiving services, who will be assuming a position or volunteer opportunity which does involve such contact;
Program Class/Type:

Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS

BPC: Bureau of Program Certification
CBC: Criminal Background Checks
DSP: Direct Support Professional
JC: Justice Center
SEL: Staff Exclusion List

DISCUSSION

Discussion based on surveyor discretion i.e. interview relevant staff (personnel manager/administrator, and/or the designated authorized party) regarding the agency's policy and procedures to complete the CBC and discuss any questions or concerns regarding the CBCs, the results/findings of the check and the determined clearance status. In addition, discuss and resolve any missing/discrepant information with the designated authorized party.

DOCUMENTATION REVIEW

Mandatory:

- Request a list of all new employees and volunteers that were hired or selected to volunteer, who will have regular and substantial unsupervised or unrestricted physical contact with an individual receiving services, since the completion date of the last full site survey who are still employed by the agency.
- Compare the list of names with the CBC information and results found on the JC website via the portal. Do not rely on agency documentation that may include dates and results of background checks; verify background check completion and results through the portal.
- Review the CBCs completed by the agency and determine whether all staff and volunteers have had a background check submitted/completed and clearance was determined prior to a subject party having regular and substantial unsupervised or unrestricted physical contact with an individual receiving services.
- If concerns/questions arise, request and review the agency's policy and procedures.

Important Note: CBCs are required for prospective contractors, registered providers, family care providers, and others; however, these parties are not included and reviewed during the completion of a Site Protocol. The specific regulatory requirements applicable to these other providers and subject parties are reviewed during the completion of an Agency Review.

Prior to requesting a CBC, the provider should first request the Justice Center to check its register of substantiated category one cases of abuse or neglect, also known as the SEL. If the check of the SEL list does not preclude the provider from hiring or utilizing the subject party, then the agency should proceed with requesting a CBC.

Note: A staff member may be temporarily approved to work pending CBC results, in accordance with 633.22(f)(1)(i)-(ix), but not before the background check is submitted. In this case, surveyors must verify through interview and documentation review, that the employee or volunteer, did not have regular and substantial unsupervised or unrestricted physical contact with an individual receiving services.

If it is discovered that an employee or volunteer, who is required to have a CBC, has not been subject to the criminal background check, verify the employee's current title/assignments/responsibilities and verify that the employee did not have regular and substantial contact with an individual receiving services.

If the site is utilizing staff from a temp agency such as DSPs, clinicians, nurses etc., the temp agency completes the background checks. Please verify that the temp agency is on OPWDD's registered provider list. This can be verified on OPWDD's website and if necessary, by contacting the Incident Management Unit. Contact a Bureau of Program Certification Area Director immediately if the agency is utilizing a temp agency that is not a registered provider. An immediate plan of correction will be required. Additional requirements specific to registered providers are located in the Agency Review.

Surveyors must immediately contact a BPC Area Director when it is determined that a subject party has had regular and substantial contact with an individual receiving services and was not subject to a CBC check, as required. An immediate plan of correction will be required to ensure that people receiving services are provided appropriate protections. *In addition, should a surveyor identify concerns with the agency's background checks during the full site review, contact a BPC Area Director to further discuss and determine if additional survey activities may be necessary (i.e. expanding the scope of the survey, opening a partial Agency Review etc.).

The background check section is required to be completed for all full reviews. However, the section may be completed at any time if there is a concern related to background checks that needs to be investigated.

Staff should review records for all staff hired since the date of the last full review who are still employed by the agency.

Determine the standard is MET if:

• CBCs were submitted/completed for all new prospective employees and volunteers, who will have regular and substantial unsupervised or unrestricted physical contact with an individual receiving services.
• Following submission of the CBC, and while the CBC results were pending, the agency did not allow the subject party to have regular and substantial unsupervised or unrestricted physical contact with people receiving services.

Determine the standard is NOT MET if any of the following are present:

• CBCs were not submitted/completed for all new prospective employees and volunteers, who will have regular and substantial unsupervised or unrestricted physical contact with an individual receiving services.
• Following submission of the CBC, and while the CBC results were pending, the agency allowed the party to have regular and substantial unsupervised or unrestricted physical contact with people receiving services.

Select N/A if:

• No new employees or volunteers were hired or utilized to volunteer, since the completion date of the last full survey.

11-9 A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.

633.24(d)(1-6)
(d) MHL 16.34 check.
(1) Agencies shall submit a request for an MHL 16.34 check to OPWDD in accordance with section 16.34 of the Mental Hygiene Law, to the extent permitted by section 16.34 of the Mental Hygiene Law.
(2) Agencies shall submit the request for an MHL 16.34 check in the form and format specified by OPWDD, including information from the applicant as specified by OPWDD.
(3) The MHL 16.34 check shall be submitted to OPWDD after the agency obtains the results of the SEL check and shall only be requested if the agency does not deny the application based on the results of the SEL check.
(4) If the name of a subject party has been submitted for an MHL 16.34 check, the agency shall not allow the party to have unsupervised contact with individuals receiving services until the agency has the results of the check.
(5) The agency shall comply with the requirements of section 496 of the Social Services Law and other applicable laws and regulations concerning confidentiality.
(6) Registered providers (see section 633.22[n] of this Part) shall request an MHL 16.34 check for subject parties if the registered provider was required to request a criminal history record check for that party. Agencies with which the registered provider contracts are not required to request an MHL 16.34 check concerning subject parties of a registered provider with which it contracts.

Program Class/Type:
Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS
CBC: Criminal Background Checks
MHL: Mental Hygiene Law
SEL: Staff Exclusion List

DISCUSSION
Discussion based on surveyor discretion, i.e. interview relevant staff (personnel manager/administrator, and/or the designated authorized party) regarding the agency's policy and procedures to complete the MHL 16.34 (Abuse/Neglect History) checks, address any questions, concerns or discrepancies regarding the prospective party's check completion, the results/findings of the check and the determined status.

DOCUMENTATION REVIEW

Mandatory:

- Request a list of all employees and volunteers required to have criminal background checks (CBCs), since the completion date of the last full site survey who are still employed by the agency.
- Staff can access the MHL database to look up the determinations electronically. The database is stored in enterprise solutions and is named MHL_PRODSQL.
- Compare the names of the employees and volunteers with the MHL 16.34 information and determinations.
- If concerns/questions arise, request and review the agency's policy and procedures.

MHL 16.34 requirements in 633.24(d) are applicable to applicants for employment/volunteer opportunities hired on or after June 30, 2013.

The MHL 16.34 check should be submitted to OPWDD after the agency obtains the results of the SEL check and the MHL check should only be requested if the agency does not deny the applicant based on the results of the SEL checks.

Note: A staff member may be temporarily approved to work pending MHL results, but not before the MHL check is submitted. In this case, surveyors must verify through interview and documentation review, that the employee or volunteer, did not have regular and substantial unsupervised or unrestricted physical contact with an individual receiving services.

If the name of the subject party has been submitted for an MHL 16.34 check, the agency should not allow the party to have unsupervised contact with individuals receiving services, until the agency has the results from the check. The Justice Center defines "regular and substantial contact" as the potential for frequent and significant interaction with a person receiving services.

Surveyors must immediately contact a Bureau of Program Certification Area Director when a surveyor determines that a subject party, who has regular and substantial unsupervised or unrestricted physical contact with individuals receiving services, has not been subject to a MHL 16.34 check, as required. An immediate plan of correction will be required to ensure that people receiving services are provided with appropriate protections. *In addition, should a surveyor identify concerns with the agency's background checks during the full site review, contact a BPC Area Director to further discuss and determine if additional survey activities may be necessary (i.e., expanding the scope of the survey, opening a partial Agency Review etc.).

Determine the standard is MET if:

- The MHL 16.34 checks were submitted/completed for all employees and volunteers, who were required to have MHL 16.34 checks.
- Following submission of the MHL, and while the MHL results were pending, the agency did not allow a subject party to have unsupervised contact with people receiving services.

Determine the standard is NOT MET if any of the following are present:

- The MHL 16.34 checks were not submitted/completed for employees and volunteers, who are subject to a criminal background check.
- Following submission of the MHL, and while the MHL results were pending, the agency allowed a subject party to have unsupervised contact with people receiving services.

Select N/A if:

- No new employees or volunteers were hired or utilized to volunteer, since the completion date of the last full site review.

11-10 The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.

633.24(e)(1-3)

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

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

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

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

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

(3) Any information provided shall be subject to the confidentiality provisions of section 845-b (7) of the Executive Law and section 496 of the Social Services Law.

Program Class/Type:

Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS

MHL: Mental Hygiene Law

SEL: Staff Exclusion List

DISCUSSION

Discussion based on surveyor discretion, i.e. interview relevant staff (personnel manager/administrator, and/or the designated authorized party) regarding the agency's policy and procedures for SEL and MHL 16.34 checks and reviewing results. Interview the agency's designated authorized party about the agency's process for hiring employees with a past incident of substantiated neglect or abuse. If a subject party has a history of abuse or neglect and was hired or utilized, discuss any questions or concerns regarding the agency's documented decision and rationale.

DOCUMENTATION REVIEW

Mandatory:

- Request a list of new employees and volunteers, who were hired or selected to volunteer, since the completion date of the last full site survey and are still employed at the agency.

- Review the SEL and MHL 16.34 checks/records and identify if the Justice Center or OPWDD provided information about a subject party's conduct and/or a substantiated abuse or neglect incident (classified as a category two). If it is identified that a subject party has such a history, request documentation that includes the agency's decision and rationale to hire the employee or utilize the volunteer and allow the party to have regular and substantial contact with people receiving services. Survey staff should access the MHL results electronically.
- If concerns/questions arise, request and review the agency's policy and procedures.

The agency's designated authorized party may receive information about substantiated reports of abuse or neglect concerning a subject party as a result of a background check. This information may either be:

- provided by the Justice Center about category two conduct
- provided by OPWDD about substantiated reports of abuse or neglect occurring before June 30, 2013.

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

Employees and volunteers cannot be hired or utilized if they have a category one substantiated abuse or neglect incident in their history.

Surveyors must immediately contact a Bureau of Program Certification Area Director if the agency has not complied with this regulatory standard. An immediate plan of correction will be required to ensure that people receiving services are provided with appropriate protections.

The background check section is required to be completed for all full reviews; however, the section may be completed at any time if there is a concern related to background checks that needs to be investigated.

Staff should review records for all staff hired since the date of the last full review who are still employed by the agency.

Determine the standard is MET if:

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

Determine the standard is NOT MET if any of the following are present:

- The agency has not reviewed conduct and substantiated reports of abuse or neglect concerning a subject party that are received.

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

Select N/A if:

• No new employees or volunteers were hired or utilized to volunteer, since the completion date of the last full site survey.
• There were no substantiated reports received for any of the new hires during the time period reviewed.

11-11 A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.

633.24(c)(1-5)

(c) Statewide Central Register of Child Abuse and Maltreatment (SCR).

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

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

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

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

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

Program Class/Type:

Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School

ACRONYMS

SCR: Statewide Central Register of Child Abuse and Maltreatment

DISCUSSION

Discussion based on surveyor discretion, i.e. interview relevant staff (personnel manager/administrator, and/or the Agency Designated Authorized Party) to determine the agency's process for obtaining the SCR checks and discuss any missing/discrepant information. Address any questions or concerns regarding the subject party's check completion and results. If applicable, discuss the agency's documented decision and rationale, if a subject party with an "indicated" report was hired or utilized.

DOCUMENTATION REVIEW

Mandatory:

- Request a list of all new employees and volunteers, who were hired or selected to volunteer, since the completion date of the last full site survey who are still employed by the agency.
- Request access and review the SCR determinations issued by the Office of Children and Family Services, that were sent to the agency's designated authorized party.
- Compare the list of new employees and volunteers to the SCR determinations.
- If a subject party has an "indicated" report of child abuse or maltreatment, request and review documentation on the agency's decision and rationale to hire the employee or utilize the volunteer who has an "indicated" report of child abuse or maltreatment.
- If concerns/questions arise; request and review the agency's policy and procedures.

SCR requirements in 633.24(c) are applicable to applicants/employees hired on or after June 30, 2013. (Before June 30, 2013, SCR checks were only required for applicants/employees who worked with children under the age of 18 years.)

SCR checks are required for all employees and volunteers, who are required to have Criminal Background Checks. SCR check results must be obtained and reviewed by the agency before the employee or volunteer is allowed any unsupervised contact with people receiving services.

Surveyors must immediately contact a Bureau of Program Certification Area Director when a surveyor determines that a subject party has had unsupervised contact with an individual receiving services and has not had the required SCR check completed. An immediate plan of correction will be required to ensure that people receiving services are provided with appropriate protections.

The background check section is required to be completed for all full reviews. However, the section may be completed at any time if there is a concern related to background checks that needs to be investigated.

Staff should review records for all staff hired since the date of the last full review who are still employed by the agency.

Determine the standard is MET if:

- The SCR checks were submitted/completed for new employees and volunteers, who are subject to a criminal background check.
- Following submission of the SCR, and while the SCR results were pending, the agency did not allow a subject party to have unsupervised contact with people receiving services.

Determine the standard is NOT MET if any of the following are present:

- The SCR checks were not submitted/completed for new employees and volunteers, who are subject to a criminal background check.

• Following submission of the SCR, and while the SCR results were pending, the agency allowed a subject party to have unsupervised contact with people receiving services.

Select N/A if:

• No new employees or volunteers were hired or utilized to volunteer, since the completion date of the last full site survey.

11-12 The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
633.7(c)(1)(i) (c) Requirements concerning the code of conduct adopted by the Justice Center for People with Special Needs (Justice Center). (1) Applicability. The requirements of this subdivision are applicable to facilities and programs certified or operated by OPWDD. (i) The agency operating the facility or program is responsible for assuring compliance with the requirements of this subdivision.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.7(c)(3)(i-ii) (c) Requirements concerning the code of conduct adopted by the Justice Center for People with Special Needs (Justice Center). (3) For the purposes of this section only, the definition of custodian is: A party that meets one of the following criteria: (i) a director, operator, employee or volunteer of a facility or program which is certified or operated by OPWDD; or (ii) a consultant or an employee or volunteer of a corporation, partnership, organization or governmental entity which provides goods or services to such facility or program pursuant to contract or other arrangement that permits such party to have regular and substantial contact with individuals receiving services from the facility or program;
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.7(c)(4-5) (c) Requirements concerning the code of conduct adopted by the Justice Center for People with Special Needs (Justice Center). (4) New custodians of the facility or program with regular and direct contact must read and sign the code of conduct at the time of employment or affiliation. (5) All custodians with regular and direct contact must read and sign the code of conduct adopted by the Justice Center on at least an annual basis.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
DISCUSSION

Discussion based on surveyor discretion, i.e. interview relevant staff (facility management, direct care staff, administrators and/or the program's designated authorized party) regarding the program's policy and procedures for ensuring that custodians, employees and volunteers have read and signed the Justice Center Code of Conduct upon hire and annually thereafter. If necessary, discuss how the program tracks compliance with this requirement and resolves any missed or overdue acknowledgments.

DOCUMENTATION REVIEW

- Request a list of all custodians, employees and volunteers hired, onboarded, or otherwise affiliated with the program since the completion date of the last full site survey and still employed or active.
- Review training records, tracking systems, and personnel files to confirm that each custodian, employee and volunteer read and signed the Justice Center Code of Conduct at the time of hire/affiliation.
- For those affiliated with the program for longer than one year, confirm that the Code of Conduct was also signed annually (i.e., within 12 months of the previous signature).
- If necessary, request and review the program's policy and procedures, and training curriculum if needed, regarding implementation of this requirement.

1. Per 14 NYCRR 633.7(c)(3)(i-ii), the term "custodian" includes:
(i) Employees, directors, operators, or volunteers of OPWDD-certified or operated programs
(ii) Consultants or third-party providers with regular and substantial contact with Individuals

2.
- The Code of Conduct must be signed at the time of hire or affiliation, and annually thereafter.
- The date of signature must accompany each signed document.
- Applicable custodians must not be allowed to work or provide services unless they have signed the Code of Conduct as required.
- Signature tracking may be maintained electronically or in paper format but must be accessible for verification.

Determine the standard is MET if:

- All applicable program custodians, employees and volunteers reviewed and signed the Justice Center Code of Conduct upon hire or affiliation.
- Custodians, employees and volunteers who have been affiliated for more than one year have also signed the Code of Conduct annually (i.e., within 12 months of the previous signature).
- All signatures are accompanied by the date signed and are verifiable through training records or personnel files.

Determine the standard is NOT MET if:

- The Justice Center Code of Conduct was not signed by custodians, employees and volunteers at the time of hire/affiliation.
- An annual signature was not obtained for custodians, employees and volunteers affiliated for more than one year.
- Dates of signature are missing or cannot be verified.
- The program does not maintain adequate documentation for tracking annual completion.

Section 12a: Infection Control
12a-1 The certified site is implementing their daily Infection Control practices as described in the Plan.
633.4(a)(4)(i,ix) (a) Principles of compliance. (4) No person shall be denied: (i) a safe and sanitary environment; (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS MAR: Medication Administration Record MMR: Measles-mumps-rubella MRSA: Methicillin-resistant staphylococcus aureus NYS DOH: New York State Department of Health PONS: Plan of Nursing Service PPE: Personal Protective Equipment RSV: Respiratory syncytial virus TB: Tuberculosis **DISCUSSION** Discussion based on surveyor discretion, i.e. agency staff including management, nursing staff, clinical staff, and individuals receiving services **DOCUMENTATION REVIEW** Mandatory: • Review policy and procedures. Additional documentation review based on surveyor discretion, i.e. medical record(s) and/or supporting documentation, PONS, MAR.

OBSERVATION
Mandatory:
To discern if the certified site is implementing infection control measures to meet the needs of the people living in the home.

Consider and verify the following:

- Verify that the site(s) has an infection control plan that is based off their infection control policy.
- Verify if an individual is currently diagnosed with an infectious disease.
- Verify staff are implementing the infection control measures identified in the Infection Control Plan. For example: donning and doffing personal protective equipment (PPE) when needed, cleaning surfaces that are possibly contaminated, etc.

Review for the following:
The certified site has an Infection Control Plan.

This plan addresses actions to be taken to proactively and/or reactively address the following:

- Response to an outbreak (respiratory, contact, etc.)
- Monitoring, tracking, and trending when an issue arises
- Notifications to anyone exposed, to families, to physicians (as needed), to OPWDD and other government agencies (such as local and/or NYS DOH), as required at the time of the outbreak
- Proper hand washing
- How and where to obtain PPE
- Donning and doffing PPE
- How to monitor the current PPE supply
- Educate on how these infections are transmitted and how to prevent spreading
- Isolation practices, such as an isolation room, transferring to another facility, etc.
- Proper practices of handling potentially infectious materials (soiled linens, etc.)
- How staff and individual infections will be handled such as testing, treatment and test of cure
- The plan provides information on how to operationalize/address frequently common infections such as: COVID-19, influenza, MRSA, RSV, scabies, etc.
- The plan includes information on how to ensure standard immunization records are up to date, specifically TB, MMR, and varicella (chickenpox)
- The plan is reviewed annually and revised as needed

If an individual is currently diagnosed with an infectious disease the following are addressed:

• The individual has a personalized plan that addresses the precautions necessary to mitigate transfer of infection to others, including the use of PPE.
• Training documentation provided reflects how the plan is implemented, including necessary precautions.
• Interview with staff on training to ensure plan is being implemented as documented.
• Review of medical documentation indicates the infection was addressed by a medical provider.
• Review of the plan reflects recommendations that were given by the provider, if any.
• Review of the MAR ensures all medications/treatments recommended were administered, if any.

Determine the standard is MET if:

• Discussion and documentation review indicate there is an effective infection control plan in place that addresses how the certified site(s) will operationalize and educate staff on infection control measures.
• Discussion and documentation review indicate there is an effective, individualized, control plan in place for any individual(s) currently diagnosed with an infectious disease.

Determine the standard is NOT MET if:

• Discussion and documentation review indicate that there is no plan, or the plan does not sufficiently outline how the certified site(s) will operationalize and educate staff on infection control measures.
• Discussion and documentation review indicate there is no plan, or the plan does not sufficiently outline how to effectively care for any individual(s) currently diagnosed with an infectious disease.

12a-2 The certified site staff have been trained on Infection Control measures.
633.8(a)(1)(vii-x) (a) Principles of compliance. (1) It is the responsibility of the agency or the sponsoring agency to heighten the awareness of its employees, volunteers, and family care providers to those factors which affect and/or contribute to situations that can be potentially abusive or harmful. To this end, there shall be training (see section 633.99 of this Part) of employees, volunteers and family care providers to meet the needs of staff, volunteers and persons who receives services in the following topics: (vii) the agency's safety and security procedures (including fire safety); (viii) the prevention of circumstances that would result in exposure to body substances which could put persons or others at significant risk (see glossary) for HIV infection (see glossary); (ix) the program for managing anyone exposed to significant risk of body substances during circumstances which meet the criteria for significant risk contact; and (x) other appropriate topics relative to safety and welfare, especially those that may be related to the functions of the employee, volunteer or family care provider.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
633.8(b)(3)(i-ii) (b) Standards of certification. (3) There is a mechanism for monitoring the type, frequency and amount of training employees, volunteers or family care providers need and received, and that: (i) the records are current; and (ii) employees, volunteers or family care providers, through interview, concur that they have received the specified training.
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
ACRONYMS PPE: Personal Protective Equipment **DISCUSSION**

- Program staff.
- Nursing staff.
- Management and clinical staff.
- Individuals receiving services

Discussion based on surveyor discretion.

DOCUMENTATION REVIEW

Mandatory:

- Certified Site's Infection Control Plan
- Staff training records
- Individual's medical binder and/or medical documentation
- Plan of Nursing Service (PONS)

OBSERVATION

Mandatory

To discern if the site is training staff and educating individuals on infection control precautions per infection control standards and/or as indicated in their plan.

- Verify that staff are trained on the Infection Control plan.
- Verify that staff are trained on the infection control methods per individual's plan. For example: staff have been trained on what PPE (gowns, masks, gloves, etc.) is appropriate to utilize based on individual's diagnosis.
- Verify that staff are trained on how to use infection control supplies such as spill kits, biohazard bags, disinfectants, sharps containers, etc.
- Verify that staff are actively encouraging individuals to practice good infection control habits such as washing hands, covering mouths when coughing, covering open wounds, etc., to the best of the individual's ability.

- The certified site has an Infection Control plan and there are training records that indicate that staff have been trained on the plan.
- Training documentation on infection control standards related to individual's diagnoses if currently diagnosed with infectious disease.
- Observation indicates that individual's practice good infection control habits. If not, determine if staff make efforts to educate and encourage individuals.
- Interview with staff based on their Infection Control plan indicates that staff can articulate training.

- Have staff been trained on the agency's infection prevention policies and procedures before they are allowed to complete their duties and at least annually as a refresher?

Determine the standard is MET if:

- Discussion, documentation review, and observation indicate that staff have been trained on the Infection Control plan in a way that addresses the criteria above.
- Interview indicates that staff can articulate training in a way that addresses the criteria above.

Determine the standard is NOT MET if:

- Discussion, documentation review, and observation do not indicate that staff have been trained on the Infection Control Plan or there is an individual currently diagnosed with an infectious disease and staff have not been trained on how to provide necessary care while adhering to infection control

12a-3 The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
635-9.1(a)(1)(vi,ix) (a) Principles of compliance. (1) Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DDs), community residences including Individualized Residential Alternatives (IRAs), private schools, and specialty hospitals shall assume the cost of: (vi) The purchase, operation, and maintenance of all equipment and furniture necessary to operate the facility in accordance with regulations of the applicable facility class, and any other applicable regulations. (vii) Special equipment necessary to meet the developmental needs of persons at the facility. (viii) Items required to meet the special, clinically determined, individual needs of persons where such items are costly and/or are used on an ongoing basis (e.g., adult diapers) and are not covered by Medicaid, Medicare, or other health insurance. (ix) Environmental adaptions made to the facility to meet the needs of persons at the facility.
Program Class/Type: IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Specialty Hospital/Inpatient, Private School/Private School
635-9.2(a)(1)(v) (a) Principles of compliance. (1) Nonresidential facilities shall assume the cost of: (v) The purchase, operation and/or maintenance of all equipment, furniture, or supplies necessary to operate the facility in accordance with the regulations for the class of facility or any other applicable regulations.
Program Class/Type: Diagnostic and Evaluative Clinic, Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab
ACRONYMS PPE: Personal Protective Equipment **DISCUSSION** Mandatory: • Agency staff to determine if they know where and how to obtain supplies for infection control issues Additional discussion based on surveyor discretion.

DOCUMENTATION REVIEW
Documentation review based on surveyor discretion, i.e. policy and procedures.

OBSERVATION
Mandatory

Verify the agency has sufficient supplies to perform hand hygiene, i.e. soap, paper towels, alcohol-based hand rubs.

Verify the agency has sufficient disinfectants that have microbiocidal activity against the pathogens most likely to contaminate the patient-care environment.

Verify the agency has sufficient personal protective equipment (PPE), i.e. gloves, gowns, face masks/KN-95 masks, goggles, and face shields.

Verify the agency has sufficient waste and biohazard bags to ensure adherence to infection control standards, i.e. bags to be used for soiled linens and any items containing bodily fluids.

Verify the agency has sufficient spill kits or a system to address how they would handle blood, urine, or waste spillage.

Determine the standard is MET if:

- Discussion and observation review indicates there are adequate supplies in the agency and staff are aware of how to obtain supplies if needed.

Determine the standard is NOT MET if:

- Discussion and observation review indicates that there are not sufficient supplies readily available, and staff are not aware of where to obtain the supplies for infection control issues.

Section 12b: Infection Control: Active Concern
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1 The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.
633.4(a)(4)(i,ix) (a) Principles of compliance. (4) No person shall be denied: (i) a safe and sanitary environment; (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
Program Class/Type: Diagnostic and Evaluative Clinic, IRA/FSR Large 9 or more, IRA/FSR Small 8 or less, IRA/8 or less conversion (from ICF), IRA/9 or more conversion (from ICF), IRA Small 8 or less, IRA Large 9 or more, CR/Supportive Community Residence, CR/Supervised Group Home, Outpatient/Clinic Treatment , Outpatient/Day Treatment, Outpatient/Day Training, Outpatient/Client Education, Site Based Pre voc/managed Care Pre-enrolled and enrolled, Site Based Day Hab, Specialty Hospital/Inpatient, Private School/Private School
DISCUSSION: Discuss with staff at the certified site to see if there is an active communicable concern, infection control concern, or active pandemic at the time of the review. If there is, refer to the infection control plan reviewed as required. **DOCUMENTATION REVIEW:** If there is an active concern, refer to the infection control plan to identify what precautions are needed based on the live concern. **OBSERVATION:** Observe staff and individuals to ensure the necessary safety precautions are occurring based on the live concern and the direction identified in the plan. **Determine the standard is MET if:** • The staff are implementing the necessary precautions as directed in the infection control plan based on the live concern at the time of review. **Determine the standard is NOT MET if:**

• The staff are not implementing the necessary precautions as directed in the infection control plan based on the live concern at the time of review.

Truncated Standards	
4-1	Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2	The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-3	The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-4	The site has a mechanism to assess living arrangement choice and satisfaction, including satisfaction with the residential site, characteristics of the home environment, selection of bedrooms, and roommate assignments.
4-6	The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-7	The agency has an effective mechanism to offer individuals keys to enter the home or other means to enter the home independently.
4-8	The agency has an effective mechanism to offer individuals keys to their bedrooms or other means to secure their bedrooms with independence or increased autonomy.
4-10	Individuals' schedules and routines are personally determined in accordance with their needs, interests and preferences rather than by staff or agency operations. Schedules are driven by wants/needs and preferences of individuals and not directed by the needs or convenience of the staff or agency.
4-12	Individuals are encouraged and supported to participate in the routine of their homes (e.g., cooking, menu planning, routine chores, etc.)
4-13	Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14	Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15	Individuals are supported by the site to exercise control and choice in their own lives.
5-5	Individuals receive appropriate support and supervision based on other observed needs for support.
5-6	There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
6-1	Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2	The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3	Individuals are supported to engage in activities in accordance with their interests and preferences.

6-4	Individuals have full access to all areas without restrictions or barriers.
6-5	Individuals' health and other protected information is kept private/protected.
6-6	Individuals have privacy in their home and service environments as appropriate to the situation.
6-7	Individuals have access to food at any time.
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10	Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11	Immediate care and treatment was provided to the individual involved in the incident.
6-12	Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14	Measures identified to prevent future similar events were developed and implemented.
6-15	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16	The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-1	The residence appears "home-like", rather than institutional.
7-2	Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3	There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4	The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5	All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6	There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7	Bathrooms provide personal privacy.
7-8	The site is clean.
7-9	The site is well maintained for the safety and comfort of the individuals receiving services.
7-10	The site operates in accordance with OPWDD smoking requirements.
7-11	The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12	Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13	The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14	The site has a land line telephone service which is in working order and functions during power outages.
7-16	The agency provided each individual residing at the site with an occupancy agreement as required by OPWDD.

8-1	The site has an acceptable fire evacuation plan.
8-2	All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3	The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4	Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5	The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6	Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7	Agency staff can describe fire safety and emergency evacuation procedures.
8-8	The certified site provides safe exiting to a public way.
8-9	There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-10	Heat detectors are present in the residence as required by OPWDD.
8-11	Fire alarm and notification systems are operational and effective.
8-12	Other fire protection equipment is operational.
8-13	Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14	Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15	Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16	At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-17	In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.
8-18	A carbon monoxide alarm is appropriately located in all new and existing residences on sleeping levels, per requirements
8-19	The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
10b-1	Clear written instructions were provided to staff regarding care and monitoring required by the person discharged.
10b-2	Clear written instructions were provided to staff regarding documentation of care and monitoring required by the person discharged. Nursing instructions specified how and what staff must document regarding the care and monitoring provided following a hospital discharge.
10b-3	There was evidence that the staff implemented required care and monitoring following discharge.
10h-5	Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6	When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.

Remote Standards	
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10	Events and situations as defined in Part 625 that are required to be reported have been reported to OPWDD.
6-11	Immediate care and treatment identified was provided to the individual involved in the incident.
6-12	Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14	Measures identified to prevent future similar events were planned and implemented.
6-15	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16	Part 625 events and actions reported in IRMA regarding recommendations, were implemented as reported.
8-1	The site has an acceptable fire evacuation plan
8-2	All fire and evacuation drills or events MUST be documented on the standardized drill report form developed by OPWDD.
8-3	The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4	Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5	The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6	Evaluation of drills results in identifying concerns (when demonstrated) and implementation of needed corrective actions (if applicable).
8-13	Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14	Maintenance and inspection of Fire Alarm and Detection systems are performed by competent parties and according to OPWDD standards.
8-15	Maintenance and inspection of Sprinkler Systems is performed by competent parties and according to OPWDD standards.

Standards Separated by Type of Program Site	
Diagnostic and Evaluative Clinic	Outpatient/Clinic Treatment
IRA/FSR Large 9 or more	Outpatient/Day Treatment
IRA/FSR Small 8 or less	Outpatient/Day Training
IRA/8 or less conversion (from ICF)	Outpatient/Client Education
IRA/9 or more conversion (from ICF)	Outpatient/Day Training (sheltered workshop)
IRA Small 8 or less	Site Based Pre voc/managed Care Pre-enrolled and enrolled
IRA Large 9 or more	Site Based Day Hab
CR-Supervised apartment	Specialty Hospital/Inpatient
CR/Supportive Community Residence	Private School/Private School
CR/Supervised Group Home	

Diagnostic and Evaluative Clinic
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.

6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.

8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
9-1: The site/program has a written Quality Assurance Plan that has been implemented.
9-2: Corrective actions identified per the QA Plan Activities are implemented.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

IRA/FSR Large 9 or more
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-1: There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
2a-11: The site ensures that in-home routine support/care necessary for individuals' health needs is provided in accordance with their service plans.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-4: The site has a mechanism to assess living arrangement choice and satisfaction, including satisfaction with the residential site, characteristics of the home environment, selection of bedrooms, and roommate assignments.
4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.

5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.

7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10e: Does any individual require a specific daily level of fluid intake?

10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

IRA/FSR Small 8 or less
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-1: There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
2a-11: The site ensures that in-home routine support/care necessary for individuals' health needs is provided in accordance with their service plans.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-4: The site has a mechanism to assess living arrangement choice and satisfaction, including satisfaction with the residential site, characteristics of the home environment, selection of bedrooms, and roommate assignments.
4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.

5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.

7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-17: In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.
8-18: A carbon monoxide alarm is appropriately located in all new and existing residences on sleeping levels, per requirements
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?

10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?

12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review

IRA/8 or less conversion (from ICF)
QQ-1: Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?
1-7: The site is in a building that is separate from a publicly or privately-operated facility that provides inpatient institutional treatment.
1-8: The site is not in a location that is on or immediately adjacent to a public institution property.
1-9: The site's design, appearance, and location are not institutional and do not isolate people from the broader community.
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-1: There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
2a-10: The site ensures that individuals access professional health care services in accordance with their needs, physicians' recommendations, and informed choice.
2a-11: The site ensures that in-home routine support/care necessary for individuals' health needs is provided in accordance with their service plans.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-1: An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + $20.
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.

3a-3: There are ledgers for the accounting of individuals' personal allowance.
3a-4: The ledgers clearly document receipt of funds on site.
3a-5: The ledgers clearly document disbursement of funds including their purpose for the individual .
3a-6: Ledgers accurately reflect the total amount of funds available to the individual on site.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.
3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-4: The site has a mechanism to assess living arrangement choice and satisfaction, including satisfaction with the residential site, characteristics of the home environment, selection of bedrooms, and roommate assignments.
4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-7: The agency has an effective mechanism to offer individuals keys to enter the home or other means to enter the home independently.
4-8: The agency has an effective mechanism to offer individuals keys to their bedrooms or other means to secure their bedrooms with independence or increased autonomy.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-12: Individuals are encouraged and supported to participate in the routine of their homes (e.g., cooking, menu planning, routine chores, etc.)
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.

6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-7: Individuals have access to food at any time.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-1: The residence appears "home-like", rather than institutional.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.

7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.
7-16: The agency provided each individual residing at the site with an occupancy agreement as required by OPWDD.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-10: Heat detectors are present in the residence as required by OPWDD.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-17: In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.
8-18: A carbon monoxide alarm is appropriately located in all new and existing residences on sleeping levels, per requirements
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10b: Has anyone been discharged from the hospital in the past 3 months?
10b-1: Clear written instructions were provided to staff regarding care and monitoring required by the person discharged.

10b-2: Clear written instructions were provided to staff regarding documentation of care and monitoring required by the person discharged. Nursing instructions specified how and what staff must document regarding the care and monitoring provided following a hospital discharge.
10b-3: There was evidence that the staff implemented required care and monitoring following discharge.
QQ-10c: Is any person in the site currently showing signs/symptoms of illness?
10c-1: RN or other medical professional has been informed of the signs/symptoms.
10c-2: Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition, including notifications when needed.
10c-3: The instruction included how and what to document regarding required care and monitoring for the individual's identified health concern.
10c-4: There is evidence that the staff implement required care and monitoring.
QQ-10d: Is any person diagnosed with diabetes?
10d-1: Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required for the individual.
10d-2: The written instruction includes how and what to document regarding the required care and monitoring for identified diabetic needs.
10d-3: There is evidence the agency staff implement required diabetic care and monitoring.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual’s plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual’s fluid intake requirements are met.
10e-3: There is documentation to track the individual’s fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people’s individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples’ rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.

10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.

11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

IRA/9 or more conversion (from ICF)
QQ-1: Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?
1-7: The site is in a building that is separate from a publicly or privately-operated facility that provides inpatient institutional treatment.
1-8: The site is not in a location that is on or immediately adjacent to a public institution property.
1-9: The site's design, appearance, and location are not institutional and do not isolate people from the broader community.
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-1: There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
2a-10: The site ensures that individuals access professional health care services in accordance with their needs, physicians' recommendations, and informed choice.
2a-11: The site ensures that in-home routine support/care necessary for individuals' health needs is provided in accordance with their service plans.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-1: An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + $20.
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
3a-3: There are ledgers for the accounting of individuals' personal allowance.

3a-4: The ledgers clearly document receipt of funds on site.
3a-5: The ledgers clearly document disbursement of funds including their purpose for the individual .
3a-6: Ledgers accurately reflect the total amount of funds available to the individual on site.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.
3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-4: The site has a mechanism to assess living arrangement choice and satisfaction, including satisfaction with the residential site, characteristics of the home environment, selection of bedrooms, and roommate assignments.
4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-7: The agency has an effective mechanism to offer individuals keys to enter the home or other means to enter the home independently.
4-8: The agency has an effective mechanism to offer individuals keys to their bedrooms or other means to secure their bedrooms with independence or increased autonomy.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-12: Individuals are encouraged and supported to participate in the routine of their homes (e.g., cooking, menu planning, routine chores, etc.)
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.

6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-7: Individuals have access to food at any time.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-1: The residence appears "home-like", rather than institutional.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools

7-14: The site has a land line telephone service which is in working order and functions during power outages.
7-16: The agency provided each individual residing at the site with an occupancy agreement as required by OPWDD.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-10: Heat detectors are present in the residence as required by OPWDD.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-17: In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10b: Has anyone been discharged from the hospital in the past 3 months?
10b-1: Clear written instructions were provided to staff regarding care and monitoring required by the person discharged.
10b-2: Clear written instructions were provided to staff regarding documentation of care and monitoring required by the person discharged. Nursing instructions specified how and what staff must document regarding the care and monitoring provided following a hospital discharge.

10b-3: There was evidence that the staff implemented required care and monitoring following discharge.
QQ-10c: Is any person in the site currently showing signs/symptoms of illness?
10c-1: RN or other medical professional has been informed of the signs/symptoms.
10c-2: Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition, including notifications when needed.
10c-3: The instruction included how and what to document regarding required care and monitoring for the individual's identified health concern.
10c-4: There is evidence that the staff implement required care and monitoring.
QQ-10d: Is any person diagnosed with diabetes?
10d-1: Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required for the individual.
10d-2: The written instruction includes how and what to document regarding the required care and monitoring for identified diabetic needs.
10d-3: There is evidence the agency staff implement required diabetic care and monitoring.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.

10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.

11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

IRA Small 8 or less
QQ-1: Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?
1-7: The site is in a building that is separate from a publicly or privately-operated facility that provides inpatient institutional treatment.
1-8: The site is not in a location that is on or immediately adjacent to a public institution property.
1-9: The site's design, appearance, and location are not institutional and do not isolate people from the broader community.
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-1: There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
2a-10: The site ensures that individuals access professional health care services in accordance with their needs, physicians' recommendations, and informed choice.
2a-11: The site ensures that in-home routine support/care necessary for individuals' health needs is provided in accordance with their service plans.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-1: An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + $20.
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
3a-3: There are ledgers for the accounting of individuals' personal allowance.

3a-4: The ledgers clearly document receipt of funds on site.
3a-5: The ledgers clearly document disbursement of funds including their purpose for the individual .
3a-6: Ledgers accurately reflect the total amount of funds available to the individual on site.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.
3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-4: The site has a mechanism to assess living arrangement choice and satisfaction, including satisfaction with the residential site, characteristics of the home environment, selection of bedrooms, and roommate assignments.
4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-7: The agency has an effective mechanism to offer individuals keys to enter the home or other means to enter the home independently.
4-8: The agency has an effective mechanism to offer individuals keys to their bedrooms or other means to secure their bedrooms with independence or increased autonomy.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-12: Individuals are encouraged and supported to participate in the routine of their homes (e.g., cooking, menu planning, routine chores, etc.)
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.

6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-7: Individuals have access to food at any time.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-1: The residence appears "home-like", rather than institutional.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools

7-14: The site has a land line telephone service which is in working order and functions during power outages.
7-16: The agency provided each individual residing at the site with an occupancy agreement as required by OPWDD.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-10: Heat detectors are present in the residence as required by OPWDD.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-17: In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.
8-18: A carbon monoxide alarm is appropriately located in all new and existing residences on sleeping levels, per requirements
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10b: Has anyone been discharged from the hospital in the past 3 months?
10b-1: Clear written instructions were provided to staff regarding care and monitoring required by the person discharged.

10b-2: Clear written instructions were provided to staff regarding documentation of care and monitoring required by the person discharged. Nursing instructions specified how and what staff must document regarding the care and monitoring provided following a hospital discharge.
10b-3: There was evidence that the staff implemented required care and monitoring following discharge.
QQ-10c: Is any person in the site currently showing signs/symptoms of illness?
10c-1: RN or other medical professional has been informed of the signs/symptoms.
10c-2: Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition, including notifications when needed.
10c-3: The instruction included how and what to document regarding required care and monitoring for the individual's identified health concern.
10c-4: There is evidence that the staff implement required care and monitoring.
QQ-10d: Is any person diagnosed with diabetes?
10d-1: Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required for the individual.
10d-2: The written instruction includes how and what to document regarding the required care and monitoring for identified diabetic needs.
10d-3: There is evidence the agency staff implement required diabetic care and monitoring.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual’s plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual’s fluid intake requirements are met.
10e-3: There is documentation to track the individual’s fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people’s individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples’ rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.

10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.

11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

IRA Large 9 or more
QQ-1: Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?
1-7: The site is in a building that is separate from a publicly or privately-operated facility that provides inpatient institutional treatment.
1-8: The site is not in a location that is on or immediately adjacent to a public institution property.
1-9: The site's design, appearance, and location are not institutional and do not isolate people from the broader community.
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-1: There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
2a-10: The site ensures that individuals access professional health care services in accordance with their needs, physicians' recommendations, and informed choice.
2a-11: The site ensures that in-home routine support/care necessary for individuals' health needs is provided in accordance with their service plans.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-1: An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + $20.
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
3a-3: There are ledgers for the accounting of individuals' personal allowance.
3a-4: The ledgers clearly document receipt of funds on site.

3a-5: The ledgers clearly document disbursement of funds including their purpose for the individual .
3a-6: Ledgers accurately reflect the total amount of funds available to the individual on site.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.
3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-4: The site has a mechanism to assess living arrangement choice and satisfaction, including satisfaction with the residential site, characteristics of the home environment, selection of bedrooms, and roommate assignments.
4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-7: The agency has an effective mechanism to offer individuals keys to enter the home or other means to enter the home independently.
4-8: The agency has an effective mechanism to offer individuals keys to their bedrooms or other means to secure their bedrooms with independence or increased autonomy.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-12: Individuals are encouraged and supported to participate in the routine of their homes (e.g., cooking, menu planning, routine chores, etc.)
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.

6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-7: Individuals have access to food at any time.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-1: The residence appears "home-like", rather than institutional.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.

7-16: The agency provided each individual residing at the site with an occupancy agreement as required by OPWDD.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-10: Heat detectors are present in the residence as required by OPWDD.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-17: In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10b: Has anyone been discharged from the hospital in the past 3 months?
10b-1: Clear written instructions were provided to staff regarding care and monitoring required by the person discharged.
10b-2: Clear written instructions were provided to staff regarding documentation of care and monitoring required by the person discharged. Nursing instructions specified how and what staff must document regarding the care and monitoring provided following a hospital discharge.
10b-3: There was evidence that the staff implemented required care and monitoring following discharge.

QQ-10c: Is any person in the site currently showing signs/symptoms of illness?
10c-1: RN or other medical professional has been informed of the signs/symptoms.
10c-2: Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition, including notifications when needed.
10c-3: The instruction included how and what to document regarding required care and monitoring for the individual's identified health concern.
10c-4: There is evidence that the staff implement required care and monitoring.
QQ-10d: Is any person diagnosed with diabetes?
10d-1: Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required for the individual.
10d-2: The written instruction includes how and what to document regarding the required care and monitoring for identified diabetic needs.
10d-3: There is evidence the agency staff implement required diabetic care and monitoring.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.

10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.

11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

CR-Supervised apartment
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-10: Heat detectors are present in the residence as required by OPWDD.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.

8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-17: In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10b: Has anyone been discharged from the hospital in the past 3 months?
10b-1: Clear written instructions were provided to staff regarding care and monitoring required by the person discharged.
10b-2: Clear written instructions were provided to staff regarding documentation of care and monitoring required by the person discharged. Nursing instructions specified how and what staff must document regarding the care and monitoring provided following a hospital discharge.
10b-3: There was evidence that the staff implemented required care and monitoring following discharge.
QQ-10c: Is any person in the site currently showing signs/symptoms of illness?
10c-1: RN or other medical professional has been informed of the signs/symptoms.
10c-2: Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition, including notifications when needed.
10c-3: The instruction included how and what to document regarding required care and monitoring for the individual's identified health concern.
10c-4: There is evidence that the staff implement required care and monitoring.
QQ-10d: Is any person diagnosed with diabetes?
10d-1: Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required for the individual.
10d-2: The written instruction includes how and what to document regarding the required care and monitoring for identified diabetic needs.
10d-3: There is evidence the agency staff implement required diabetic care and monitoring.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual’s plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual’s fluid intake requirements are met.
10e-3: There is documentation to track the individual’s fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.

10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.

10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.

CR/Supportive Community Residence
QQ-1: Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?
1-7: The site is in a building that is separate from a publicly or privately-operated facility that provides inpatient institutional treatment.
1-8: The site is not in a location that is on or immediately adjacent to a public institution property.
1-9: The site's design, appearance, and location are not institutional and do not isolate people from the broader community.
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-1: There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
2a-10: The site ensures that individuals access professional health care services in accordance with their needs, physicians' recommendations, and informed choice.
2a-11: The site ensures that in-home routine support/care necessary for individuals' health needs is provided in accordance with their service plans.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-1: An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + $20.
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
3a-3: There are ledgers for the accounting of individuals' personal allowance.
3a-4: The ledgers clearly document receipt of funds on site.

3a-5: The ledgers clearly document disbursement of funds including their purpose for the individual .
3a-6: Ledgers accurately reflect the total amount of funds available to the individual on site.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.
3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-4: The site has a mechanism to assess living arrangement choice and satisfaction, including satisfaction with the residential site, characteristics of the home environment, selection of bedrooms, and roommate assignments.
4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-7: The agency has an effective mechanism to offer individuals keys to enter the home or other means to enter the home independently.
4-8: The agency has an effective mechanism to offer individuals keys to their bedrooms or other means to secure their bedrooms with independence or increased autonomy.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-12: Individuals are encouraged and supported to participate in the routine of their homes (e.g., cooking, menu planning, routine chores, etc.)
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.

6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-7: Individuals have access to food at any time.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-1: The residence appears "home-like", rather than institutional.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.

7-16: The agency provided each individual residing at the site with an occupancy agreement as required by OPWDD.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
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8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
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8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10b: Has anyone been discharged from the hospital in the past 3 months?
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10b-2: Clear written instructions were provided to staff regarding documentation of care and monitoring required by the person discharged. Nursing instructions specified how and what staff must document regarding the care and monitoring provided following a hospital discharge.
10b-3: There was evidence that the staff implemented required care and monitoring following discharge.
QQ-10c: Is any person in the site currently showing signs/symptoms of illness?
10c-1: RN or other medical professional has been informed of the signs/symptoms.

10c-2: Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition, including notifications when needed.
10c-3: The instruction included how and what to document regarding required care and monitoring for the individual's identified health concern.
10c-4: There is evidence that the staff implement required care and monitoring.
QQ-10d: Is any person diagnosed with diabetes?
10d-1: Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required for the individual.
10d-2: The written instruction includes how and what to document regarding the required care and monitoring for identified diabetic needs.
10d-3: There is evidence the agency staff implement required diabetic care and monitoring.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
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10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.

10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.

11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

CR/Supervised Group Home
QQ-1: Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?
1-7: The site is in a building that is separate from a publicly or privately-operated facility that provides inpatient institutional treatment.
1-8: The site is not in a location that is on or immediately adjacent to a public institution property.
1-9: The site's design, appearance, and location are not institutional and do not isolate people from the broader community.
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-1: There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
2a-10: The site ensures that individuals access professional health care services in accordance with their needs, physicians' recommendations, and informed choice.
2a-11: The site ensures that in-home routine support/care necessary for individuals' health needs is provided in accordance with their service plans.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-1: An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + $20.
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
3a-3: There are ledgers for the accounting of individuals' personal allowance.
3a-4: The ledgers clearly document receipt of funds on site.

3a-5: The ledgers clearly document disbursement of funds including their purpose for the individual .
3a-6: Ledgers accurately reflect the total amount of funds available to the individual on site.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.
3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-4: The site has a mechanism to assess living arrangement choice and satisfaction, including satisfaction with the residential site, characteristics of the home environment, selection of bedrooms, and roommate assignments.
4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-7: The agency has an effective mechanism to offer individuals keys to enter the home or other means to enter the home independently.
4-8: The agency has an effective mechanism to offer individuals keys to their bedrooms or other means to secure their bedrooms with independence or increased autonomy.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-12: Individuals are encouraged and supported to participate in the routine of their homes (e.g., cooking, menu planning, routine chores, etc.)
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.

6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-7: Individuals have access to food at any time.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-1: The residence appears "home-like", rather than institutional.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.

7-16: The agency provided each individual residing at the site with an occupancy agreement as required by OPWDD.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-10: Heat detectors are present in the residence as required by OPWDD.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-17: In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10b: Has anyone been discharged from the hospital in the past 3 months?
10b-1: Clear written instructions were provided to staff regarding care and monitoring required by the person discharged.
10b-2: Clear written instructions were provided to staff regarding documentation of care and monitoring required by the person discharged. Nursing instructions specified how and what staff must document regarding the care and monitoring provided following a hospital discharge.
10b-3: There was evidence that the staff implemented required care and monitoring following discharge.

QQ-10c: Is any person in the site currently showing signs/symptoms of illness?
10c-1: RN or other medical professional has been informed of the signs/symptoms.
10c-2: Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition, including notifications when needed.
10c-3: The instruction included how and what to document regarding required care and monitoring for the individual's identified health concern.
10c-4: There is evidence that the staff implement required care and monitoring.
QQ-10d: Is any person diagnosed with diabetes?
10d-1: Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required for the individual.
10d-2: The written instruction includes how and what to document regarding the required care and monitoring for identified diabetic needs.
10d-3: There is evidence the agency staff implement required diabetic care and monitoring.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.

10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.

11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

Outpatient/Clinic Treatment
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.

7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.

8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
9-1: The site/program has a written Quality Assurance Plan that has been implemented.
9-2: Corrective actions identified per the QA Plan Activities are implemented.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

Outpatient/Day Treatment
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.
3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.

5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.

7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
9-1: The site/program has a written Quality Assurance Plan that has been implemented.
9-2: Corrective actions identified per the QA Plan Activities are implemented.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.

10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?

10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

Outpatient/Day Training
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.
3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.

5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.

7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10e: Does any individual require a specific daily level of fluid intake?

10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.

10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

Outpatient/Client Education
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.

8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.

10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

Outpatient/Day Training(sheltered workshop)
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.

8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
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10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
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10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?

10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician’s order for the mechanical restraint device use.
10j-5: There is documentation that is “full record” of the mechanical restraint device use.
QQ-10k: Is ‘Time-out’ used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.

Site Based Pre voc/managed Care Pre-enrolled and enrolled
QQ-1: Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?
1-7: The site is in a building that is separate from a publicly or privately-operated facility that provides inpatient institutional treatment.
1-8: The site is not in a location that is on or immediately adjacent to a public institution property.
1-9: The site's design, appearance, and location are not institutional and do not isolate people from the broader community.
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.
3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-3: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.

4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-7: Individuals have access to food at any time.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.

6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.

8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.

10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.

12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

Site Based Day Hab
QQ-1: Has there been change in condition or location of the program requiring reassessment of Heightened Scrutiny?
1-7: The site is in a building that is separate from a publicly or privately-operated facility that provides inpatient institutional treatment.
1-8: The site is not in a location that is on or immediately adjacent to a public institution property.
1-9: The site's design, appearance, and location are not institutional and do not isolate people from the broader community.
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.
3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-3: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.

4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-7: Individuals have access to food at any time.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.

6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.

8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.

10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.

12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

Specialty Hospital/Inpatient
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-1: There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
2a-10: The site ensures that individuals access professional health care services in accordance with their needs, physicians' recommendations, and informed choice.
2a-11: The site ensures that in-home routine support/care necessary for individuals' health needs is provided in accordance with their service plans.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-1: An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + $20.
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
3a-3: There are ledgers for the accounting of individuals' personal allowance.
3a-4: The ledgers clearly document receipt of funds on site.
3a-5: The ledgers clearly document disbursement of funds including their purpose for the individual .
3a-6: Ledgers accurately reflect the total amount of funds available to the individual on site.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.

3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-12: Individuals are encouraged and supported to participate in the routine of their homes (e.g., cooking, menu planning, routine chores, etc.)
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-7: Individuals have access to food at any time.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.
6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.

6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site's physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.
8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.

8-10: Heat detectors are present in the residence as required by OPWDD.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10b: Has anyone been discharged from the hospital in the past 3 months?
10b-1: Clear written instructions were provided to staff regarding care and monitoring required by the person discharged.
10b-2: Clear written instructions were provided to staff regarding documentation of care and monitoring required by the person discharged. Nursing instructions specified how and what staff must document regarding the care and monitoring provided following a hospital discharge.
10b-3: There was evidence that the staff implemented required care and monitoring following discharge.
QQ-10c: Is any person in the site currently showing signs/symptoms of illness?
10c-1: RN or other medical professional has been informed of the signs/symptoms.
10c-2: Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition, including notifications when needed.
10c-3: The instruction included how and what to document regarding required care and monitoring for the individual's identified health concern.
10c-4: There is evidence that the staff implement required care and monitoring.
QQ-10d: Is any person diagnosed with diabetes?
10d-1: Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required for the individual.
10d-2: The written instruction includes how and what to document regarding the required care and monitoring for identified diabetic needs.
10d-3: There is evidence the agency staff implement required diabetic care and monitoring.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual’s plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual’s fluid intake requirements are met.

10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?
10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.

10j-5: There is documentation that is “full record” of the mechanical restraint device use.
QQ-10k: Is ‘Time-out’ used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

Private School/Private School
2-1: There is a written plan for how the site will respond to life-threatening emergencies.
2-2: The staff know actions to take in the event of a medical emergency.
QQ-2a: The Day Service site provides nursing and/or delegated nursing services such as medication administration.
2a-1: There is a Registered Nurse on site or immediately available to staff rendering professional nursing services.
2a-2: The staff know how to contact the RN using the process established by the agency.
2a-3: Only an AMAP-certified direct support staff, LPN, RN, NP, PA, or MD administers medications and/or prescribed treatments to individuals.
2a-4: The individual's medications and treatments have been correctly administered in accordance with physicians' orders and the individual's needs.
2a-5: Medication Administration Records (MARs) are legible, correctly identify the current physicians' orders/prescriptions and include required documentation of administration.
2a-6: Information regarding each medication and prescribed treatment the individuals receive is available and accessible to staff in a form/format acceptable to OPWDD.
2a-7: Medications and treatments are stored securely as required, including the security of keys or codes to access medications, where applicable.
2a-8: Medication that is discontinued or outdated is not retained at the site.
2a-9: Used needles and syringes are disposed of in puncture resistant containers.
2a-10: The site ensures that individuals access professional health care services in accordance with their needs, physicians' recommendations, and informed choice.
2a-11: The site ensures that in-home routine support/care necessary for individuals' health needs is provided in accordance with their service plans.
3-1: Personal Allowance money is consistently available to individuals for routine expenditures and activities of their choice.
QQ-3a: Is any portion of the individuals personal funds held or managed by the site?
3a-1: An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + $20.
3a-2: Individual's personal funds held by the site are secured and safeguarded and accessible only to authorized agency staff.
3a-3: There are ledgers for the accounting of individuals' personal allowance.
3a-4: The ledgers clearly document receipt of funds on site.
3a-5: The ledgers clearly document disbursement of funds including their purpose for the individual .
3a-6: Ledgers accurately reflect the total amount of funds available to the individual on site.
3a-7: Personal allowance funds are not used for items or expenses the agency is responsible to pay for.
3a-8: Receipts required (by regulation) for items or services purchased reconcile with ledger entries.

3a-9: Individuals are reimbursed for any loss of money managed by the agency.
4-1: Sufficient transportation is available and facilitates/support individuals personal choices of activities and preferred schedules.
4-2: The general operations and staffing availability are sufficient and responsive to support each individual's participation in individualized and personally meaningful community activities.
4-6: The agency takes timely action to address individuals' dissatisfaction with the living and/or service environment.
4-10: The HCBS service site participates in the person-centered planning process and individuals are satisfied with activities, supports, and services provided at the site.
4-12: Individuals are encouraged and supported to participate in the routine of their homes (e.g., cooking, menu planning, routine chores, etc.)
4-13: Individuals are encouraged and supported to have full access and be participating members within the broader community.
4-14: Individuals' cultural, religious, and lifestyle backgrounds and choices are supported by the site.
4-15: Individuals are supported by the site to exercise control and choice in their own lives.
5-1: Staff can describe the individuals' supervision needs.
5-2: Individuals receive their food in the form and consistency required by their plans in accordance with their assessed needs and in conformance with OPWDD Choking Prevention Initiative (CPI) specifications.
5-3: Individuals receive support while eating in accordance with their assessed and observed needs.
5-4: Individuals receive support for mobility in accordance with observed needs.
5-5: Individuals receive appropriate support and supervision based on other observed needs for support.
5-6: There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
5-7: The site has a communication system which ensures staff are aware of policies for prompt contacting of on-duty agency personnel and the prompt contacting of responsible agency personnel in emergencies.
6-1: Observed and reported interactions and communications with individuals, both verbal and nonverbal, are respectful.
6-2: The site is absent of generally applied rules, policies, or procedures that limit people's rights, independence, choice and autonomy.
6-3: Individuals are supported to engage in activities in accordance with their interests and preferences.
6-4: Individuals have full access to all areas without restrictions or barriers.
6-5: Individuals' health and other protected information is kept private/protected.
6-6: Individuals have privacy in their home and service environments as appropriate to the situation.
6-7: Individuals have access to food at any time.
6-9: Events that meet the definition of reportable incident or notable occurrence have been reported.
6-10: Events and situations defined in Part 625 have been reported to OPWDD, as required.
6-11: Immediate care and treatment was provided to the individual involved in the incident.

6-12: Measures to protect individuals receiving services from harm and abuse, were implemented immediately.
6-13: Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.
6-14: Measures identified to prevent future similar events were developed and implemented.
6-15: Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.
6-16: The agency responded to any recommendations made by OPWDD to address Part 625 events and situations as required.
7-1: The residence appears “home-like”, rather than institutional.
7-2: Surveillance cameras are not present in the site, except as allowed by OPWDD.
7-3: There is evidence that individuals are allowed to have visitors of their choosing at any time.
7-4: The site’s physical characteristics support and promote the independence, comfort, preference and needs of the individuals.
7-5: All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical challenges, are in an operable/usable condition.
7-6: There are adequate supplies in the site to meet the needs of individuals per the service(s) provided.
7-7: Bathrooms provide personal privacy.
7-8: The site is clean.
7-9: The site is well maintained for the safety and comfort of the individuals receiving services.
7-10: The site operates in accordance with OPWDD smoking requirements.
7-11: The temperature of the hot water is appropriate to the abilities of people served at the site.
7-12: Sites with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.
7-13: The site implements procedures to safeguard individuals from drowning in recreational/therapeutic pools
7-14: The site has a land line telephone service which is in working order and functions during power outages.
QQ-8: Is it necessary to review fire safety requirements at this time?
8-1: The site has an acceptable fire evacuation plan.
8-2: All fire and evacuation drills or events MUST be documented on the standardized drill report form/electronic form developed by OPWDD.
8-3: The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.
8-4: Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.
8-5: The effectiveness of the fire evacuation plan is monitored by agency personnel per OPWDD requirements.
8-6: Evaluation of drills results in identifying concerns, when demonstrated and implementation of needed corrective actions.
8-7: Agency staff can describe fire safety and emergency evacuation procedures.

8-8: The certified site provides safe exiting to a public way.
8-9: There is fire alarm and detection equipment in the site as required by regulation, ADM, and LSC, where applicable.
8-10: Heat detectors are present in the residence as required by OPWDD.
8-11: Fire alarm and notification systems are operational and effective.
8-12: Other fire protection equipment is operational.
8-13: Fire alarm, smoke detection and sprinkler systems are inspected and maintained at the frequency required for each specific system.
8-14: Maintenance and inspection of fire alarm and detection systems are performed according to OPWDD standards.
8-15: Maintenance and inspection of sprinkler systems are performed according to OPWDD standards.
8-16: At least one functional Class-1-A-5BC, 2.5 pound fire extinguisher is located in an accessible place on each floor.
8-17: In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms to ensure that staff can be summoned to individual apartments in an emergency.
8-19: The site, at the time of the inspection, was free from other observed fire safety hazards not otherwise indicated in another standard.
QQ-10a: Does anyone currently have skin breakdown or a history of skin breakdown?
10a-1: There is a written plan to provide care for wounds and prevent future skin breakdown.
10a-2: The written plans to care for and prevent skin breakdown are implemented as required by agency staff.
QQ-10b: Has anyone been discharged from the hospital in the past 3 months?
10b-1: Clear written instructions were provided to staff regarding care and monitoring required by the person discharged.
10b-2: Clear written instructions were provided to staff regarding documentation of care and monitoring required by the person discharged. Nursing instructions specified how and what staff must document regarding the care and monitoring provided following a hospital discharge.
10b-3: There was evidence that the staff implemented required care and monitoring following discharge.
QQ-10c: Is any person in the site currently showing signs/symptoms of illness?
10c-1: RN or other medical professional has been informed of the signs/symptoms.
10c-2: Clear written instruction was provided to staff regarding the specific actions to take to provide care and monitoring of the condition, including notifications when needed.
10c-3: The instruction included how and what to document regarding required care and monitoring for the individual's identified health concern.
10c-4: There is evidence that the staff implement required care and monitoring.
QQ-10d: Is any person diagnosed with diabetes?
10d-1: Clear written instruction is provided to staff regarding the specific actions to provide care and monitoring of diabetes as required for the individual.
10d-2: The written instruction includes how and what to document regarding the required care and monitoring for identified diabetic needs.

10d-3: There is evidence the agency staff implement required diabetic care and monitoring.
QQ-10e: Does any individual require a specific daily level of fluid intake?
10e-1: The amount of fluid to be consumed is clearly identified in the individual's plan of care.
10e-2: The plan is sufficiently detailed to ensure that the individual's fluid intake requirements are met.
10e-3: There is documentation to track the individual's fluid consumption as specified in the plan.
10e-4: There is evidence the fluid consumption plan is implemented correctly and monitored for effectiveness.
QQ-10f: Does any individual have an order for Oxygen use?
10f-1: Clear written instruction is provided to guide staff in when and how to implement the order for oxygen.
10f-2: The written instruction includes how and what to document regarding required oxygen administration and monitoring.
10f-3: The equipment needed, per the medical order for oxygen, is readily available.
10f-4: There is evidence the ordered administration of oxygen plan is implemented correctly and monitored per their condition.
QQ-10g: Enhanced supervision levels are required by one or more person supported by this site?
10g-1: There are sufficient staff on duty to maintain the supervision levels required by the Individuals
10g-2: Required enhanced supervision and staffing ratios are maintained per people's individualized plans.
QQ-10h: Are there any observed, reported, or documented limitations to peoples' rights (HCBS, Part 633, Civil and Legal Rights, use of restricting interventions)?
10h-1: Any limitation or restriction of rights due to behaviors occur only as part of a written Behavior Support Plan.
10h-2: The individual's Behavior Support Plan describes how the use of each restrictive/intrusive intervention and/or rights limitation is to be documented.
10h-3: Rights limitations/restrictions occur only when written informed consent was obtained from an appropriate consent giver.
10h-4: Rights limitations/restrictions occur only when approved by the Human Rights Committee prior to implementation and approval is current.
10h-5: Rights limitations that are not part of a Behavior Support Plan, comply with applicable requirements for justification and documentation of rights limitation.
10h-6: When environmental protections, due to an individual's needs, restricts other individuals in the site, appropriate action is taken to ensure that they are not negatively affected.
QQ-10i: Is a behavior support plan or medication monitoring plan required/in place for any Individual?
10i-1: The individual's behavior supports needs are implemented per the written plan.
10i-2: The Behavior Support Plans are reviewed for effectiveness by the clinical staff responsible for the plan.
10i-3: The Behavior Support Plans are revised based on the individual's needs.
QQ-10j: Are Mechanical Restraints used for any individual?

10j-1: Criteria for the application, removal and duration of mechanical restraint device use, is clearly described in the Behavior Support Plan.
10j-2: Restraints are only applied per the criteria described in the Behavioral Support Plan.
10j-3: Restraints are removed per the criteria and duration described in the Behavioral Support Plan.
10j-4: There is a current physician's order for the mechanical restraint device use.
10j-5: There is documentation that is "full record" of the mechanical restraint device use.
QQ-10k: Is 'Time-out' used for any Individuals?
10k-1: Time-out is used only in accordance with the Behavior Support Plan.
10k-2: The use of a time out room is reported electronically to OPWDD.
10k-3: Constant auditory and visual contact is maintained during time-outs to monitor the Individual's safety.
QQ-10l: Are physical Interventions used for any Individuals?
10l-1: Physical interventions are used only in accordance with the Behavior Support Plan
10l-2: The use of restrictive physical interventions is reported electronically to OPWDD.
11-7: A check of the Staff Exclusion List (SEL) is completed for every subject party, before hiring or allowing that party to have any regular and substantial contact with a person receiving services.
11-8: Criminal background checks are completed for every subject party, before hiring or allowing that party to have regular and substantial unsupervised or unrestricted physical contact with a person receiving services.
11-9: A Mental Hygiene Law 16.34 check is completed for every subject party, before that party has unsupervised contact with a person receiving services.
11-10: The agency reviews any information received about substantiated reports of abuse or neglect concerning a subject party and documents its rationale and decision to hire or allow the party to have regular and substantial contact with people receiving services.
11-11: A check of the Statewide Central Register of Child Abuse and Maltreatment is completed as required for every subject party, before that party is allowed any unsupervised contact with a person receiving services.
11-12: The facility ensures that every custodian, employee, and volunteer reads and signs the Justice Center Code of Conduct upon hire and annually thereafter.
12a-1: The certified site is implementing their daily Infection Control practices as described in the Plan.
12a-2: The certified site staff have been trained on Infection Control measures.
12a-3: The certified site has adequate Infection Control supplies and Personal Protective Equipment (PPE) readily available for use when needed.
QQ-12b: Is there an active contagious concern, infection control issue, or active pandemic at the time of the review?
12b-1: The certified site is implementing Infection Control practices as required specific to the identified live concern at the time of review.

Partial Review Choices:

Dropdown Options	Dropdown Purpose
1) Complaint Review	Staff utilize this drop-down option when a complaint is received, and they visit a site due to such complaint
2) HCBS Validation	Staff utilize this drop down when assessing a programs compliance with HCBS regulations. This is done 30 days after a new site opens or after an ICF converts to an IRA.
3) Monitoring Review	Staff utilize this drip down when returning to a site to monitor their implementation of a POCA.
4) OFPC Physical Plant/LSC Review	Staff utilize this drop down when conducting a LSC review. Primarily done by OFPC.
5) OFPC Validation Review	Staff utilize this drop down when returning to a site to validate corrections from a LSC review.
6) Remote	Staff utilize this drop down when conducting the RSO Remote review.
7) Supplemental Review	Staff utilize this drop down when conducting a supplemental review.
8) Truncated	Staff utilize this drop down when conducting the RSO Truncated review
9) Validation Review	Staff utilize this drop down when returning to a site that was previously issued a 45 day letter to validate the implementation of the POCA.

Acronym Glossary

A
AFO: Ankle-foot Orthosis
AMAP: Approved Medication Administration Personnel
ANSUL: Anhydrous Sulfur Dioxide
ASAP: As Soon As Possible
ATM: Automated Teller Machine

B
BGL: Blood glucose level
BIS: Behavioral Intervention Specialist
BM: Bowel movement
B/P: Blood pressure
BPC: Bureau of Program Certification
BRAT Diet: Bananas, Rice, Applesauce and Toast Diet
BSP: Behavior Support Plan

C
CAP: Corrective Action Plan
CBC: Criminal Background Checks
CMS: Centers for Medicaid and Medicare Services
CO: Carbon monoxide
CPR: Cardiopulmonary resuscitation
CPI: Choking Prevention Initiative
CR: Community Residence

D
DDSO: Developmental Disabilities State Office
DSP: Direct Support Professional
DQI: Division of Quality Improvement

E
ER: Emergency Room

F
FSR: Free Standing Respite
F/U (f/u): Follow up

G
GFI: Ground Fault Interrupters

H
HCBS: Home and Community Based Services
HCP: Healthcare Professional
HRC: Human Rights Committee
H.S.: *Hora somni* (at bedtime)

I
ICF(/DD): Intermediate Care Facility (for the Developmentally Disabled)
ID/DD: Intellectual Disability/Developmental Disability
I/O: Intake/Output
IPOP: Individualized Plan of Protective Oversight
IRA: Individualized Residential Alternative
IRC: Incident Review Committee
IRMA: Incident Reporting and Management Application

J
JC: Justice Center

L
LCSW: Licensed Clinical Social Worker
LGBTQ: Lesbian, Gay, Bi, Transgender & Queer/Questioning
LOS: Level of Supervision
LPN: Licensed Practical Nurse
LSC: Life Safety Code

M
MAR: Medication Administration Record
MD: Doctor of Medicine
MHL: Mental Hygiene Law
MMA: Money Management Assessment
MMP: Medication Monitoring Plan
MMR: Measles-mumps-rubella
MNO: Minor Notable Occurrence
MRSA: Methicillin-resistant staphylococcus aureus

N
NCP: Nursing Care Plan
NFPA: National Fire Protection Association
NP: Nurse Practitioner
NYS DOH: New York State Department of Health

O
O2: Oxygen
OIIA: Office of Investigations and Internal Affairs
OMH: Office of Mental Health
OT: Occupational therapy
OTC: Over-the-counter

P
PA: Personal Allowance
PA: Physician’s Assistant
PEP: Personal Expenditure Plan
PIN: Personal Identification Number
P.O.: Per os (by mouth)
PONS: Plan of Nursing Service

T
TB: Tuberculosis

PPE: Personal Protective Equipment
PRN: Pro re nata (as needed)
PT: Physical therapy

Q
QA: Quality Assurance

R
RI: Reportable Incident
RIA: Restrictive Intervention Application
RN: Registered Nurse
RSV: Respiratory syncytial virus

S
SAM: Self-Administration of Medication Assessment
SAP: Staff Action Plan
SEL: Staff Exclusion List
SCR: Statewide Central Register of Child Abuse and Maltreatment
S/S (s/s): Signs and symptoms
SSI: Social Security Income
ST: Speech therapy

V
VA: Veterans Affairs

W
WIC: Written Informed Consent