OFFICE OF
MENTAL HEALTH

DIVISION OF
QUALITY ASSURANCE

TIERED CERTIFICATION

RESIDENTIAL PROGRAMS FOR ADULTS

TIER 1

TIER 2

TIER 3

NOVEMBER 5, 1996

RESIDENTIAL PROGRAMS FOR ADULTS
TIERED CERTIFICATION MANUAL
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INTRODUCTION

TIERED CERTIFICATION

OVERVIEW OF TIERED CERTIFICATION

A. BACKGROUND

The New York State Office of Mental Health has revised the process it utilizes to regulate mental health care providers. The approach is entitled "Tiered Certification". As with many governmental initiatives, there were several causative factors:

- Departmental leadership which desired to move towards a value based regulatory approach emphasizing the importance of three basic assurances for persons with mental illness. These are: (1) that regulated programs meet their mission and program intent: (2) that persons with acute or serious and persistent mental illness have access to programs and service linkages without regard to cultural, financial, or ethnic considerations, and (3) that persons served in regulated programs be protected from harm, including life safety or environmental risks, and physical or sexual abuse.

- External Criticism in the form of concerns issued by the New York State Commission on /Quality of Care for the Mentally Disabled, the Office of the State Comptroller, and members of the legislature regarding how well OMH has met its responsibility to ensure regulatory compliance for its certified programs (OMH issues licenses called "operating certificates).

- Comments from provider agencies articulated in response to a survey conducted pursuant to the Governor"s "Regulatory Mandate Relief" initiative. Regulated programs believe that the current licensing scheme takes too much time, focuses on too many specific measures, and involves excess paperwork.

- Staff who administer OMH's regulatory system have supported development of the Tiered Certification system concurring that

the existing system needed streamlined procedures, increased uniformity, and greater clarity of purposes.

Limitations of the past certification process were identified and recommendations for improvement put forth. Problems identified included:

- Failure to differentiate which standards are more important than others;
- Failure to inspect programs per Mental Hygiene Law;
- Lack of standardized on-site protocols;
- Lack of uniform scoring system;
- Absence of protocols guiding OMH responses to deficiencies;
- Too narrow a range of sanctions which are also extreme in nature;
- Reluctance to utilize the findings of other monitoring bodies, be they governmental or accreditation organizations, which has led to redundant inspections from the perspective of providers.

The recommendations for change envisioned a tiered certification process which established a hierarchy of OMH monitoring activities based upon a program's performance in meeting selected standards. The revised system would utilize a standardized set of protocols, a scoring system, and uniform procedures for follow-up actions. Likewise, it would incorporate non-certification visits/program reviews into the monitoring system, structure the process to incorporate findings from other regulatory bodies, and initiate the tiered approach by designing this new system for outpatient programs before replicating the approach with inpatient and community residential facilities.

In November 1990 the Bureau of Inspection and Certification was assigned the tiered certification project. A work group composed of the chief regional licensing staff as well as selected central office personnel was formed. This group documented OMH regulatory values, formulated value based principles for Tiered Certification, and endorsed the strategy of first developing a system to monitor outpatient programs. Central to the tiered certification principles

were differential responses to deficiencies, uniformity of protocols, identification of critical program indicators, the desirability of not reviewing all standards found in the outpatient regulations during a visit, utilization of findings from other regulatory bodies, and the intent to meet the two visits per year statutory mandate.

The Tiered Certification process for outpatient programs was officially implemented on January 1, 1993. Over the years since its inception there have been several revisions streamlining the process in response to the input of the field staff using the document and agencies being reviewed and culling out performance indicators which have proven not to provide valuable information.

At about the time the Outpatient Tiered Certification process was being put into place, a work group was formed which included representatives from OMH field and central offices, community residential provider agencies, and New York City Department of Mental Health, Mental Retardation and Substance Abuse Services, to develop a parallel tiered process for use in community residential settings. This work group developed, using the outpatient process as a model, the initial values and principles, compliance categories, and indicators of what has become the Residential Programs for Adults Tiered Certification Package. After much staff work and revisions necessitated in part by the promulgation of new regulations for residential programs, the residential tiered package is ready for its debut. While further revision and adjustment is a certainty, the process embodied in the document represents a major improvement that brings uniformity to those areas being reviewed, consistency of scoring, and a clear cut relationship between survey findings and length of operating certificate awarded.

B. COMPLIANCE MEASURES

There are three "tiers" that a program can attain during a Tiered Certification visit. Programs are placed in one of these tier levels based upon scores received on various performance indicators (PIs) within the four "Compliance Categories" identified for residential programs. These categories include Life Safety, Resident Rights,

Rehabilitation and Outcome, and Program Operations. These compliance categories are composed of "standards" and "performance indicators" which focus on issues considered to be critical in assessing whether a program is carrying out its mission, providing access and linkages, and assuring program recipients protection from harm.

- The Life Safety category includes requirements for programmatic and environmental issues which impact on the recipients' safety and treatment while participating in the program. Medication administration, incident review, physical plant review are some of the issues in this category.

- The Residents' Rights category encompasses requirements for assuring that recipients are afforded privacy, that services are offered with cultural sensitivity, that ethnically appropriate staff are employed and recipient input is solicited.

- The Rehabilitation and Outcome category addresses assessments, service planning and revision, service provision, discharge planning and utilization review.

- The Program Administration category addresses issues related to the overall operation of the program not specific to an individual's treatment. Issues include adequacy of program staff, training, and governing body oversight.

Each of the compliance categories represent the highest priority level for a programs operation under Parts 595 of NYCRR. By focusing on these areas, OMH will be able to discontinue its review of less important items, and as a result, will concurrently address the concern that important areas of performance be reviewed rather than issues that have little relationship to outcomes.

Tiered Certification standards have been developed for all compliance categories. Standards are statements that reflect OMH's values and are the bases on which performance indicators (PIs) were conceived. All standards contain PIs which are statements of

specified anticipated outcomes. PI's allow the program's compliance to be measured against given standards within the Tiered Certification system.

C. SCORING

OMH Tiered Certification has a scoring system that allows surveyors to easily score each PI with a score ranging from 0 to 3. Scoring determinations are made by the review and analysis of information obtained as described under individual PI survey guidelines. In general, to pass any given PI, a score of 2 or higher must be obtained. A detailed description of scoring can be found further on in this manual.

Once scores are assigned and the tallying of all passed Performance Indicators within compliance categories is complete, programs will be placed into one of three tiers. The number of PIs passed will be translated into the length of an operating certificate. For programs designated as Tier II or III a Notification of Deficiencies & Commendations (NODC) will be completed. Tier I program may receive an NODC, but will not be required to make a formal response to OMH.

D. FOCUSED VISITS

Focused visits, as the name implies, are surveys that review a limited range of issues. These visits will generally be used in two ways. First, they will verify improvements achieved by programs in carrying out Plans of Corrective Action. Second, once a program is assigned to Tier I, focused visits will be conducted for monitoring purposes during the term of the Operating Certificate. Approximately half of all focused visits will be unannounced, particularly when a focused visit is related to a POCA.

A menu of focused visits will be available for staff to choose from when planning visits. These include but are not limited to:

- POCA compliance reviews;

- Reviews using standards for a single compliance category;
- Investigation of an incident;
- Complaints;
- Grievances;
- Client satisfaction and outcomes

E. COORDINATION WITH OTHER VISITS

OMH routinely conducts visits which do not directly relate to certification. In particular, full and partial fiscal audits and full and focused Clinical Program Audits are ongoing. These visits will be counted as part of OMH's Tiered Certification System, assisting with the conduct of the required annual visits. More significantly, exchange of findings is planned to provide additional information and feedback to the clinical program audit, fiscal audit, and certification processes. Furthermore, each of these systems will refer programs with potential problems in a given area to the group responsible for investigating those issues. For example, a full tiered certification visit may discover fiscal issues requiring an audit or clinical issues requiring a clinical program audit.

In addition to other OMH visits, surveys conducted by local government or other accrediting bodies may, when acceptable to OMH, constitute the conduct of a visit under the Tiered system. Letters of agreement with cities/counties, which will be of most use in addressing certification, will establish protocols for this reciprocity.

F. SURVEY STAFFING

It is OMH's intention to utilize certification staff more effectively and efficiently under Tiered Certification reviews. This effectiveness and efficiency should result from the programs that attain a Tier I level and require less monitoring thus allowing staff to concentrate on programs attaining Tier III levels.

It is also OMH's goal to empower non-certification unit OMH employees and non-OMH staff to conduct discrete portions of tiered certification visits. For an example, information from recipient

surveys can be used to complete items associated with recipient's input into program operations, program services and service planning. As enhancements to the system are made, protocols will be developed for county and city staff and family members to be included as part of the Tiered Certification survey process.

G. TIERED CERTIFICATION AND THE CON PROCESS

Tiered Certification is a monitoring and license renewal system which has been designed to be congruent with residential programs operating under Part 595. Therefore, programs that have operating certificates issued pursuant with this Part will be monitored and reviewed using the Tiered Certification process. Operating Certificates are issued as a final step in the Certificate of Need process. Approximately five months after a program is issued its first operating certificate a Tiered Certification survey will occur.

H. COMMENDATIONS, ADMINISTRATIVE ACTIONS AND SANCTIONS

The Tiered Certification process will enable OMH to commend, take administrative action or impose sanctions. Protocols regarding administrative actions and sanctions are fully described elsewhere in this manual.

The following options have been identified:

- Commendations:

  Publishing notices of exemplary practices in the QA Update

  Awarding operating certificates of maximum duration

  Giving Certificate of Need priority to agencies who regularly have programs in Tier I

- **Administrative Actions:**

  Receiving mandatory technical assistance

  Continuous reporting to OMH

  Meeting with Board of Directors

  Increase in OMH oversight visits

  Delaying decisions on CON applications

- **Sanctions:**

  Levy fines

  Temporarily suspend new admissions

  Decrease service capacity (temporarily or long term)

  Suspend Operating Certificate (temporarily or long term)

  Revocation of OMH's license

TIERED CERTIFICATION
RESIDENTIAL PROGRAMS FOR ADULTS

VALUES

- Residential services should be provided in a manner designed to ensure the safety of the individuals receiving services.
- Programs and services should be accessible.
- Services should be in compliance with program mission and intent.
- Services should be appropriate and effective.
- Programs should be rehabilitative in nature, and focus on improving residents' independence, choice and level of functioning.
- Residents' choices and preferences should drive program services and define program settings.
- Residences should be integrated into the community.

PRINCIPLES

There are certain basic principles under which the Tiered Certification process will operate:

- Standards and performance indicators, based on the Office of Mental Health regulations and industry standards, will be the criteria used to measure a program's performance.

- The survey process, protocols, acknowledgements and sanctions will be uniformly applied.

- Programs that consistently meet or exceed operating standards established by the Office of Mental Health will receive the minimal amount of monitoring allowed by law. Conversely, programs that do not meet minimal standards will receive additional monitoring, and if necessary, may be sanctioned.

- Scoring and survey guidelines will, to the extent possible, seek to address outcome over process variables.

- All programs whose operating certificates are about to expire will be evaluated under tiered certification. This will aid the Office of Mental Health in its efforts to maintain currency in the issuance of operating certificates for Residential Services Programs.

- In accordance with the Mental Hygiene Law, the minimum number of visits a program receives during a given year is one. All program visits will be documented and counted towards this requirement. The type and nature of these visits may vary, as will the staff conducting these visits.

- Findings from other review groups (e.g. Consumers, JCAHO, CQC, Counties or other Office of Mental Health personnel) will be incorporated into the tiered certification process.

COMPLIANCE CATEGORIES, STANDARDS, PERFORMANCE INDICATORS and SURVEY GUIDELINES

TIERED CERTIFICATION COMPLIANCE CATEGORIES, STANDARDS, PERFORMANCE INDICATORS & GUIDELINES for RESIDENTIAL PROGRAMS FOR ADULTS

COMPLIANCE CATEGORY 1 - RESIDENTIAL PROGRAMS FOR ADULTS SAFETY AND ENVIRONMENT

Standard 1.1: Medications are stored and monitored in accordance with OMH approved policies and procedures. 595.6(d)(7)(v), 595.12(b)(5)

CR 1.11: *
Medication storage and monitoring assures resident safety.

Survey Guidelines: Inspection of medication storage areas, both individual and communal, should verify the security of storage arrangements. Double locked storage must be provided for controlled substances. Access to communally stored medications should be effectively limited. Review of medication orders and logs, interviews with staff and comparisons to medication on hand should allow judgement as to the accuracy of record keeping and medication administration.

CR 1.12:
Residents are trained and assisted as needed in self-administration of medication.

Survey Guidelines: If possible, medication administration should be observed. Observation and staff interview should be used to ascertain the adequacy of resident medication supervision. Review of medication records, resident service plans and, if possible, resident interviews should allow a conclusion as to the consistency and quality of the self-administration of medication training being provided.

Standard 1.2: Program has an effective incident reporting, investigation and management process. 595.6(d)(8)(iii), 595.13(a)(2), Part 524

CR 1.21: *
Incidents are reported and investigated in accordance with the program's approved incident reporting plan.

Survey Guidelines: A review of the past year's, or the 10 most recent incidents, should verify that any reportable occurrences have been treated as incidents and should allow an evaluation regarding timeliness and conformity to regulation of required investigation and notifications.

CR 1.22: *
Incident reviews result in appropriate changes to policies and practices.

Survey Guidelines: Surveyors should identify recommendations in Incident Review Committee minutes and then seek indications that these recommendations are presented to the appropriate body within the agency and implemented. Where implementation does not occur there should be evidence of Incident Review Committee follow up.

Standard 1.3: The program maintains a safe environment. 595.15(a)(1),(a)(2)(i)(c),(a)(4), 595.16

CR 1.31: *
Residents meet requirements for self-preservation.

Survey Guidelines: Individual resident records should be examined for initial evaluation of self preservation ability (and yearly reevaluations in apartments) and for fire drill performance. The surveyor should check fire drill logs to verify that drills are conducted monthly (apartments excluded) and to confirm that they are conducted at varied times of the day and night. Drills should utilize various escape routes from the residence. The consistency and accuracy of the documentation should be assessed. Surveyors must keep in mind that certain residences, designated as approved for slow evacuators on the OC, need only be evacuated within 13 minutes.

CR 1.32:
The building, its equipment and fixtures are free from fire and safety hazards.

Survey Guidelines: Inspection should confirm that the premises is free from prohibited items and significant fire or safety hazards.

CR 1.33: *
Smoke detectors and fire fighting equipment are located and maintained as required by regulation.

Survey Guidelines: The surveyor should confirm the presence of required smoke detection and fire fighting equipment. Program maintenance logs and equipment tags should be examined to assess the regularity of smoke detector and fire extinguisher maintenance. Staff and resident familiarity with the use of extinguishers should be verified.

Standard 1.4: Living spaces are adequately furnished and well maintained. 595.15(b)(1)(v),(vi)

CR 1.41:
Personal living spaces meet minimum regulatory requirements for furniture and linen and are properly maintained and clean.

Survey Guidelines: Surveyors should note the amount and condition of furniture and linen and the maintenance and cleanliness of personal areas during their inspection of the premises. Since many of the judgements related to this indicator are subjective the surveyor should be generous in his/her evaluations. Because the surveyor will be viewing personal living spaces s/he must be sensitive to individual privacy and aware of acceptable individual variations in housekeeping. When a question exists regarding the degree to which the rooms observed represent the condition of the facility as a whole the surveyor should seek to view additional rooms.

CR 1.42:
Common living spaces are appropriately furnished and furniture and spaces are properly maintained and clean.

Survey Guidelines: Surveyors should note the amount and condition of furniture in common areas and the maintenance and cleanliness of these areas during their inspection of the premises. Appropriateness of furnishings (includes not only furniture but activity supplies, decorative items, etc.) should be judged based upon the use of the particular area and the number and type of residents in the program. The degree to which the environment is personalized by residents and reflects their preferences should be taken into consideration. Since many of the judgements related to this indicator are subjective the surveyor should be generous in his/her evaluations.

Standard 1.5: The program ensures that residents have access to emergency and crisis services. 595.12(b)(4), (b)(11), & (f)

CR 1.51: *
Emergency health care services are provided to residents as needed.

Survey Guidelines: Surveyors should review training records for evidence of staff (and resident) training in emergency procedures. (Resident familiarity with emergency resources and interventions is essential in settings without twenty-four hour supervision and recommended in all other settings.) Incident reports, program logs and resident records should be reviewed to evaluate staff and resident functioning in emergency situations. Staff and, if possible, resident interviews should provide insight into responses to emergencies and verify the existence of an emergency on call procedure.

CR 1.52: *
Crisis intervention services are available to residents as needed.

Survey Guidelines: Surveyors should review training records for evidence of staff training in crisis intervention techniques and accessing external intervention resources. Incident reports, program logs and resident records should be reviewed to evaluate staff and resident functioning in situations which would warrant crisis intervention. Staff interviews should provide insight into the effectiveness of responses to crises.

Standard 2.1: Program exhibits respect for individual rights, dignity, personal integrity and the various ethnic and cultural backgrounds of its residents. 595.6(d)(6), (e) & (i); 595.8(d) & 595.10

CR 2.11:
Program is sensitive to the culture and ethnicity of the residents served.

Survey Guidelines: Program efforts to incorporate the ethnic and cultural character of the residents into daily program operation and external activities should be a subject of inquiry. Observation of residence decor and program activities, and interviews with staff and, if possible, residents should assist the surveyor in assessing the degree to which culture and ethnicity influence program design and staff/resident interaction.

CR 2.12: *
Residents are informed of and aware of their rights. Resident rights are respected.

Survey Guidelines: Prior to the visit the surveyor should request and review any complaint information on the program. Resident records should be reviewed for the presence of a properly complete and signed residency agreement and notice of resident rights. If there is a question as to whether the notice is understood the resident should be queried. Review of complaints, resident records, house meeting minutes, Personal Needs Allowance documentation and incident reviews, as well as interviews with residents, if possible, should seek to determine the degree to which resident rights are respected.

Standard 2.2: Resident input is solicited and incorporated into policy decisions. 595.6(d)(5) & (d)(8)(iv); 595.10(a)(2)(vii) & (a)(5); & 595.13(e)

CR 2.21:
Resident input is incorporated into residence operation.

Survey Guidelines: The surveyor should review documentation that substantiates the existence of program mechanisms for resident input into daily operations and program evaluation activities. The surveyor should evaluate the regularity with which these mechanisms are utilized and the effectiveness of each in producing changes in program practice and policy. Documentation could include minutes of house meetings or resident council meetings, annual program evaluations or other surveys of consumer satisfaction and board of director's meeting minutes documenting deliberation of resident input. Staff and administrative interviews, and when possible resident interview, should also be used to determine the degree to which resident input is solicited and utilized in shaping program operation.

CR 2.22:
Resident grievances are reviewed and resolved in a timely manner.

Survey Guidelines: Prior to the visit the surveyor should request and review any complaint information on the program. Grievance process documentation should be reviewed for evidence of the timeliness and objectivity of the process and resident satisfaction with the results. Interviews with staff, administration and, if possible, residents should support the accessibility and effectiveness of the grievance process.

Standard 2.3: Resident information is safeguarded for confidentiality. Mental Hygiene Law Sections 33.13 595.6(d)(7)(vi)

CR 2.31:
The confidentiality of resident records is maintained.

Survey Guidelines: During the site inspection the surveyor should observe the security of resident record storage. Interviews with administration and staff should identify procedures for limiting unauthorized access to records.

CR 2.32: *
Resident consent is obtained prior to the release of identifying or clinical information regarding the resident.

Survey Guidelines: Interviews with administration and staff should identify procedures for obtaining resident consent for the release of information to others. Resident records should be reviewed for the consistency with which consent is granted for the release of information.

Standard 3.1: The service planning process identifies resident needs, goals and objectives. The service plan identifies services and interventions designed to address these needs and attain resident objectives. The plan is based upon resident input and reflects the priorities of the resident. 593.6, 595.1 & 595.11
The surveyor should review a representative sample of resident records, including some for residents present at the time of the survey, if possible. If problems are detected the sample may be enlarged to assure an accurate picture of program operation.

CR 3.11:
Assessments identify resident needs.

Survey Guidelines: This indicator seeks to assure that the psychiatric rehabilitative assessment process picks up all significant resident needs. The surveyor should evaluate the assessment in the context of the picture presented by referral information, physical exams, intake notes, progress notes, or other material relevant to assessing resident needs; to determine if the assessment has been conducted in a comprehensive fashion. Potential areas of need may include health and dental needs, symptom management, medication management, substance abuse problems, educational deficits, vocational deficits and deficits in: daily living skills, social interaction skills, community integration skills, and self advocacy skills.

The psychiatric rehabilitative aspect of an assessment is characterized by resident involvement, identification of an overall rehabilitation goal, and the identification of needed skills and supports in the context of the environment of choice. Interviews with the involved staff and, when possible, residents should be used to assist the surveyor in determining the degree of resident involvement.

CR 3.12: *
Service plans identify specific, measurable goals and objectives and discharge criteria. Methods and time frames for attaining objectives are explicit.

Survey Guidelines: Residents should participate in the formulation of goals and objectives that reflect their own needs and environments of choice. Interventions should be chosen cooperatively with the resident. Goals and objectives should be specific enough to allow the evaluation of progress or lack thereof and should show a clear relation to identified needs and discharge criteria. Time frames for goal attainment should be present as should clearly expressed interventions to be utilized in the attainment of stated goals. Staff and, when possible, resident interviews should be used to shed light on the degree to which the plan is resident generated.

CR 3.13:
With resident consent, families (when clinically appropriate) and/or collaterals are part of the service planning/review process.

Survey Guidelines: Participation of the family (when clinically appropriate) and collateral service providers may be ascertained from signatures, progress notes or resident interview.

CR 3.14: *
Service plans are periodically reviewed and revised as needed.

Survey Guidelines: The indicator not only seeks to assure regular quarterly review and revision of the service plan but also highlights modification of the plan as part of the ongoing effort to reach the goals of the resident. Both goals and objectives and implementation strategies should be reviewed longitudinally to allow the surveyor to assess the degree to which they are modified in response to changing resident needs and the success or failure of various intervention approaches. Progress notes should be reviewed to identify evidence of changing needs which could warrant revisions to planned objectives or interventions. Staff and, when possible, resident interviews may be utilized to ascertain whether service planning is responsive to changing resident need and flexible in its choice of approaches to problems.

CR 3.15:
Progress notes are timely and reflect residents' progress toward attaining agreed upon objectives.

Survey Guidelines: Progress notes should be reviewed for relevance to stated goals and objectives and for compliance to regulatory standards for frequency.

CR 3.16: *
Agreed upon services are available and provided as stated in the service plan.

Survey Guidelines: Progress notes should reflect the delivery of agreed upon services. Services provided by collateral service providers should be documented and evidence of joint planning and review should be present.

Standard 3.2: Program ensures that there are systematic, independent, ongoing reviews of appropriateness of services for each resident. 595.13(a)(1)

The surveyor should review a representative sample of resident records, including some for residents present at the time of the survey, if possible. If problems are detected the sample may be enlarged to assure an accurate picture of program operation.

CR 3.21: *
Residents shall be appropriately admitted and retained.

Survey Guidelines: The surveyor must keep in mind that, while the central function of utilization review is the evaluation of need for programming; licensed housing, because of its role as both program and resident's home, imposes a requirement upon the program to weigh the desires of the resident in the making of continued stay decisions. The surveyor should review utilization review documentation in resident records to ascertain frequency of review. Documentation of admission and continued stay decisions should be reviewed in the context of admission criteria, service plans and the resident's preferences for services and housing. The presence of a feedback loop from the U.R. process to discharge planning should be evident from documentation.

CR 3.22:

The utilization review process is carried out by staff who do not have primary responsibility for the resident under review.

Survey Guidelines: The surveyor must verify that the U.R. authority does not regularly deliver services to the resident.

Standard 3.3: The discharge planning process ensures that residents are discharged to appropriate settings. 595.9

The surveyor should review a representative sample of resident records, both open and closed, including some for residents present at the time of the survey, if possible. If problems are detected the sample may be enlarged to assure an accurate picture of program operation.

The standard seeks to assure "good" placements which, where possible, are based upon resident desires and which in all cases safeguard the rights of all residents and the community into which the individual is moving.

CR 3.31:

Discharge planning shall be based upon resident preferences and shall include input from relevant staff, community service providers and, where clinically appropriate, family members.

Survey Guidelines: The surveyor should seek to determine, through a review of service plan participants and through staff and, when possible, resident interviews whether discharge planning is an integrated process which throughout involves resident, staff, community service providers and appropriate collaterals in a dialog based upon resident goals and preferences.

CR 3.32:

Discharges of residents who are not discharge ready adequately safeguard the rights of all residents of the program and the community.

Survey Guidelines: Discharges of residents who are not discharge ready should be evaluated in terms of providing due process to the individual being discharged, while simultaneously protecting other residents and the community from harm. Discharge decisions must be made in a timely manner to assure the safety of all. The settings into which residents are placed must be appropriate to the resident's level of function. Staff interviews, reviews of notes and discharge summaries in closed records, and, where relevant, correlation with incident reports should be used by the surveyor to make these determinations.

CR 3.33: *

Connections to necessary community support services are, with the resident's consent, made prior to discharge.

Survey Guidelines: Discharge summaries, service plans, referral forms or other relevant documentation should be reviewed to ascertain whether needed community supports are in place at the time of discharge.

COMPLIANCE CATEGORY 4 - RESIDENTIAL PROGRAMS FOR ADULTS
PROGRAM ADMINISTRATION

Standard 4.1: The program's administration ensures that staffing is sufficient to carry out the mission of the program and to assure that quality services are provided. 595.6(d)(3), 595.7(a)(8), 595.12

CR 4.11: *

Staffing is adequate to provide the program's stated services.

Survey Guidelines: Review of service plans should confirm that identified services are being provided. Review of resident council minutes, staff day books, incidents, grievances, or other documentation should not raise the concern that inadequate staff coverage or qualifications adversely effects program operation. If problems are identified the surveyor should verify that the actual staffing conforms to the approved level. (The approved level is based upon the "New Model" requirements or the presence of an approved staffing waiver.)

CR 4.12:

Training is regularly provided to all program staff to enhance their ability to effectively provide program services.

Survey Guidelines: Training may be provided by the sponsoring agency itself or any other qualified provider of such services. Personnel files should be reviewed longitudinally to ascertain regularity of training. Staff and administrative interviews should be used to confirm the delivery, relevance, and impact of training. (Relevance could be related to: the needs of the particular population served, i.e. MICA, MI/MR, homeless, etc.; problems identified through the program's own internal monitoring or; response to weaknesses identified by external monitoring entities. Training impact could be reflected in self reports by staff of improved skills, knowledge, or competency; or by resident statements regarding improvements in program function; or by performance as reflected in such indicators as incident reviews.)

Standard 4.2: The governing body effectively oversees the operation of the program. 595.6(d), 595.7(a)(6), 595.13(a)(3)

CR 4.21: *

Program operation is regularly monitored against the goals and objectives established by the program and approved by OMH.

Survey Guidelines: Program goals and objectives are part of the functional program and should be reviewed prior to the recertification visit. The surveyor should ascertain from administrative interview or from review of the policy and procedure manual the presence of procedures designed to insure monitoring of program goal attainment and adjust procedures in response to the results of the monitoring. Review of the minutes of governing body meetings should allow the surveyor to evaluate the degree to which the governing body is informed of goal attainment and their level of oversight.

SECTION III

PROTOCOLS AND PROCESSES

TIERED SCORING SYSTEM

CORING RULES:

1) Each Performance Indicator (PI) must receive a score between 0 and 3, with 0 being the worst and 3 being the best. PIs that are Not Applicable (NA) are scored with a 2.
2) In order for a PI to be considered as passing it must receive a score of 2 or 3.
3) After all PIs within the categories are scored, the number of PIs passed and the number of critical indicators (*) failed are tallied by category and noted on the Tiered Certification Scoring Tabulation Sheet on the last page of the checklist.
4) The determination of Tier levels will be based on the total number of PI's passed and the total number of critical indicators failed.
5) Programs which have the highest number of passed PI's and the lowest number of failed critical indicators will receive operating certificates of the longest duration.
6) The completed checklist should be used to formulate the Notification of Deficiencies and Commendations (NODC). The "Comments" column is designed for brief statements. Additional pages should be used for lengthy comments, especially when deficiencies or commendations are to be noted.

REMINDER: Work sheets and Interview sheets should be used to assist the reviewer in completing the scoring of Performance Indicators on the Program Scoring Checklist.

SCORING: The following descriptions are to be used when determining performance indicator scores:

0 is given when there is little or no evidence that the program is meeting the intended outcome.

*Example: CR 1.22 * requires that the results of special review committee reviews be appropriate changes to policy and practice. However, the program did not have a special review committee. Therefore, the program could not meet the intended outcome of the PI.*

1 is given when there is evidence that the program is attempting to attain the intended outcome, but is not consistently meeting the requirements specified or is missing a required element.

Example: CR 1.11 requires that medications be stored so as to ensure resident safety. Reviewers noted that the medication box was locked, however the key to the medication box was stored on a hook in an unlocked closet near the box. Therefore, while the program had made an attempt to meet the outcome, they had not "effectively limited access" as indicated in the survey guidelines and had no met the intended outcome.

2 is given when there is evidence that the program consistently attains the intended outcome and required elements are present.

*Example: CR 3.14 * requires service plans to be periodically reviewed and revised as needed. A program holds quarterly service planning meetings which include the resident, collateral service providers and program staff. Progress toward objectives is reviewed and objectives adjusted to reflec progress. When progress toward a particular objective is slow or non-existent the group considers wh should be changed to improve chances for progress. Decisions regarding these changes are then*

written into the plan. The program is reviewing and revising the plan as required and incorporating the resident (CR 3.12) and collaterals (CR 3.13) into the process. Therefor a score of 2 is given.

3 is given when there is evidence that the program exceeds the intended outcome noted in the PI.

Example: CR 2.21 requires programs to incorporate resident input into program operation. A program collected consumer input through regular written surveys of consumer satisfaction. Additionally the program held weekly issues groups that encouraged resident identification of operational issues within the residence. Input from the issues group was routinely used in program planning and review activities. A score of three is warranted because the program went further than required to both actively involve residents in evaluation of their residence and making improvements in it.

Professional judgement and discretion remain fundamental to the Tiered Certification process. Reviewers have the discretion to lower scores when poor quality material is presented and/or when interviews with administration, staff and recipients do not verify written documentation. The reason for the lowering of a score should be noted on the scoring sheet in the comments section and be included on the Notification of Deficiencies and Commendations.

TIER DETERMINATION

Once scores are assigned to all performance indicators, the PIs with a score of 2 or 3 should be counted to obtain the total number of PI's passed. All critical indicators (*) with a score 0 or 1 should be counted to obtain the total number of critical indicators failed. The number of PI's passed and the number of critical indicators failed will determine the Tier level attained and the duration of the operating certificate.

Tier Levels - The three tier levels are described as follows:

Tier I is attained when the program passes 27 or more of a possible 31 performance indicators and does not fail any critical indicators (*). The program will receive a 36 month operating certificate with or without a Notification of Deficiencies and Commendations (NODC). Tier I programs are not required to respond the NODC.

Tier II is attained when a program passes between 19 and 26 out of a possible 31 performance indicators and/or a maximum of 4 out of a possible 16 critical indicators are failed. The duration of an operating certificate under Tier II can range from 12 to 30 months.

30 mths = 25-26 PIs are passed and 1 or less critical indicators are failed
24 mths = 23-24 PIs are passed and/or 2 or less critical indicators are failed
18 mths = 21-22 PIs are passed and/or 3 or less critical indicators are failed
12 mths = 19-20 PIs are passed and/or 4 or less critical indicators are failed

A NODC which describes all failed PIs will be included with the operating certificate. The program will be responsible to return an acceptable Plan of Corrective Action (POCA) to the BIC field unit within 30 days of receipt of the NODC. Programs will receive a follow-up visit from the BIC field unit between 6 months to a year after the original recertification visit to determine progress on the POCA.

If noted deficiencies appear to be of a nature that administrative actions and/or sanctions are warranted the regional office should proceed following the protocols noted in this manual.

Tier III is attained when 18 or fewer out of a possible 31 PI's are passed or 5 or more out of a possible 16 critical indicators are failed.

A NODC will be issued to the program by the BIC field unit within 10 working days of the visit. The program will have 15 days to respond to the BIC field unit with its POCA. The BIC field unit will determine if the POCA is acceptable and notify the agency that a follow-up visit will occur prior to the issuance of an operating certificate. If the follow-up visit is successful an operating certificate with a maximum duration of 9 months should be issued. In some cases, the approved POCA will be sufficient to issue an operating certificate prior to the BIC field unit conducting a follow-up visit. This will be determined on a case-by-case basis.

If noted deficiencies appear to be of a nature that administrative actions and/or sanctions are warranted the protocols included in this manual should be followed.

In order for BIC field units to avoid unbalanced certification workloads they will have the option to decrease the duration of operating certificates by a maximum of three months.

VISIT PROTOCOL
TIERED CERTIFICATION
RESIDENTIAL PROGRAMS FOR ADULTS

A. RECERTIFICATION VISITS

The guidelines for conducting a tiered recertification visit are presented below.

- Approximately three months prior to expiration of the program's license, a renewal application and letter should be sent to the executive director and/or the program director requesting completion of th renewal application and scheduling the visit, unless it is to be unannounced. The visit should be scheduled at least one month prior to the expiration of the license. This should ensure that the program will be issued an operating certificate prior to the expiration date on the existing license. The letter wi cover the following:

    - the purpose of the visit
    - the date and time
    - the administrative and program staff that should be available
    - the documents that will be reviewed
    - the need for a private work area
    - the need to notify residents in advance of the date, time and purpose of the visit and that OMH staff will be available to talk with them.

- Staff from the Local Government Unit or other interested parties should be notified at the same time and, as appropriate, be invited to participate in the recertification visit.

- Two months prior to expiration, the agency should submit the renewal application. The application w be reviewed by the Field Unit and if incomplete, the applicant should be notified to submit the missing documents or to have them available at the beginning of the on site visit.

- One month prior to the visit a listing of complaints should be requested from Customer Relations.

- Staff conducting the visit should review the agency's file to familiarize themselves with the certificatic history of the agency/program(s) prior to the visit. Special attention should be given to the addendum from the last visit, the goals and objectives of the program, any complaints or incidents filed since th last visit and any other reports that might be available eg. financial audits, UR audits, recipient surveys.

- Visits must be conducted when staff are present and, ideally, when residents are available for interviewing.

- The number of surveyors conducting a review is left to the discretion of each field unit.

- Upon arrival at the site:

    - surveyors should be fully prepared, on time and present proper identification (if a team is being used, one surveyor should be introduced as the team leader and serve as the spokesperson);

- the survey should begin with a statement of the purpose of the survey and a description of how the day will be structured;

- inform the administrative staff when and how long they will be needed, as well as which program staff members will need to be available;

- indicate what information will be reviewed (the checklist can be used as an easy reference) and request that it be brought to the reviewer's work place, as appropriate. Specific items would usually include:

  * program goals and objectives (there may have been revisions from those available in the CON or conversion application);
  * a specific number of closed records (usually chosen at random);
  * a specific number of open records (selected by reviewers);
  * incidents and minutes of the special review committee's meetings;
  * medication records;
  * personnel records which include credentials and inservice training;
  * program daybooks;
  * fire drill and safety equipment maintenance logs;
  * minutes of house/resident meetings;
  * Personal Needs Allowance documentation;
  * annual program evaluation or consumer surveys;
  * minutes of board of directors' meetings;
  * grievance documentation;
  * UR documentation;

o At some point during the visit, surveyors must inspect the congregate site or a sample of apartment sites. Inspections should include:

- All common spaces;

- Attic and basement spaces;

- Medication storage including a sample of arrangements for individual storage of medications if appropriate;

- Record storage and security;

- A sample of personal spaces randomly chosen and distributed on the various floors of the building (25% of the rooms should be adequate unless a pattern of problems is detected);

- Approximately a 25% sample of apartment sites for apartment programs unless a pattern of problems is detected. Choice of apartments may be based on previously reported problems, or lack of previous visitation, or may be at random.

o Interviews with direct care staff, administrative staff and, if possible, program residents, should be conducted using the survey questionnaires as guidelines. A single form may be used to aggregate the results of several individual interviews in a category (administrative, direct care or resident) providing a

composite of the responses obtained.

- Tiered Certification questionnaires and scoring sheets should be completed as much as possible during the on site review. Instructions for completing survey instruments are included in the review packet.

- An exit conference should be conducted to clarify any issues about which surveyors have questions and to notify agency administration of any high risk findings that require immediate program attention. Reviewers are not required to present each deficiency noted or indicate the tier level attained. The exit conference is to be used as an overview of recertification activities.

- Certification personnel will verify and total the scores after the visit is completed. Scores will be utilized to make a recertification decision (Tier I, II or III).

- An operating certificate will be issued for Tier I and Tier II with an addendum listing commendations, recommendations(Tier I) and/or a NODC (Tier II).

- POCAs will be required in response to NODCs (Tier II and III), with specific time limits for response keyed to Tier.

- If the results of a recertification visit culminate in placement of the program in Tier III, the operating certificate will NOT be renewed until, at minimum, the program submits an acceptable POCA to the field unit.

  Within 10 working days of the survey, the field unit will issue a Notice of Deficiencies and Commendations (NODC) to the program and its Board of Directors. The program will have 15 working days from receipt of the NODC to submit a POCA. A follow-up visit will be conducted within 6 weeks of the original survey. At the time of the 6 week visit a determination will be made whether sufficient progress has been made to issue an operating certificate. If progress has been substantial, an OC may be issued for a longer duration than the 3-9 months allowed under the Tier III schedule. If the POCA or progress on corrections is unsatisfactory, a letter will be sent outlining the remaining problems needing correction. If non-compliance is serious enough The Bureau of Inspection and Certification should proceed with administrative actions and/or sanctions. Further sanctions (see next section) ma occur if the results of meetings with the program administration/board of directors or progress on the POCA continues to be unsatisfactory.

- If a program believes that the survey was improperly conducted and/or resulted in an incorrect tier level they have recourse to the Director of the Bureau of Inspection and Certification. Concerns of this type should accompany submission of the POCA. However, the POCA must be submitted in all cases regardless of agency concerns about the accuracy of the survey process. Comments regarding the survey will be taken under advisement by the Director of the Bureau of Inspection and Certification. If there is clear evidence that the survey process was not properly conducted the program will be notified by the field unit regarding a course of remediation.

B. FOCUSED VISITS

Focused visits will be used to:

- o Verify progress or completion of POCA's submitted as a result of Tier II or III NOD's.

- o Monitor overall consistency of compliance.

- o Review compliance with specific performance indicators either identified by the certification process or through such other channels as listed below. Depending on the compliance measure being reviewed, they can be conducted by a variety of staff or consultants. This type of focused visit may be triggered by:

    - review of a Medicaid billing practice;
    - incidents;
    - complaints.

    Due to the variety of focused visits, the protocol is designed to meet the general needs of each visit allowing for flexibility in its application.

    Focused visits may be announced by letter or phone call or be unannounced. One visit a year, focused or full recertification, must be unannounced. **All focused visits will result in a written report of the site visit findings with recommendations.** Focused visits may be conducted by staff other than certification staff.

1. POCA focused visit

The most common type of focused visit is a follow-up on addenda items (NODC) from a recertification visit. Visits will typically occur sometime after the POCA is submitted but prior to the next recertification visit and consist of verification that the POCA has been fully implemented. In addition to the POCA, tiered certification survey guidelines and scoring checklists and guidelines should be used to assist in determining compliance with each of the performance indicators which were originally failed. If other areas are suspect based on occurrences during the visit, they should also be reviewed. The results of the focused visit/POCA review will be documented in a letter with findings. The outcome of the POCA review could effect movement of the program from one tier level to another, either up or down.

2. Consistency of Compliance Focused Visits

Focused visits of Tier I and II programs might consist of a drop-in visit just to see how things are going or how approved construction or renovations looks or a random selection of a few performance indicators or issues which may be of concern.

3. Compliance with Specific Issues

Individual incidents or complaints may trigger focused visits as may an analysis of trends in these areas. Such visits may be initiated by Central Office or OMH field unit staff and performed by Central Office and/or field unit staff. Results of these visits will generate site visit reports to the agency. Subsequent monitoring will follow the pattern of any other focused visit report, with follow-up on repeated offenses through the sanction process.

Medicaid Billing Audits will be initiated based on billing data from the MMIS system or by random selection. The report of audit findings will be forwarded to the BDIM. The final report will be sent to the OMH field

staff and BIC for follow-up monitoring.

Financial audits will follow protocols developed by the Finance Group of the Bureau of Investigation and Audit. Written reports of audit findings will be forwarded to the respective regional office and BIC for inclusion in certification decisions.

ADMINISTRATIVE ACTION AND SANCTION PROTOCOLS
RESIDENTIAL PROGRAMS FOR ADULTS
TIERED CERTIFICATION

A. PURPOSE OF ADMINISTRATIVE ACTIONS AND SANCTIONS

The Office of Mental Health will take administrative action and, when necessary, employ sanctions to motivate programs to efficiently and effectively take all necessary actions to correct serious deficiencies. Administrative actions will be taken and/or sanctions will be imposed for programs that have exhibited egregious non-compliance including; serious health and safety violations on one or more performance indicators, repeated non-compliance on the same performance indicator(s) and/or lack of progress correcting cited deficiencies. See definitions below.

B. GENERAL RULES

1. OMH will attempt to assist programs in correcting deficiencies. Generally, technical assistance by appropriate OMH field unit staff will be available to programs prior to the implementation of other administrative actions or sanctions.

2. OMH may take multiple administrative actions and/or impose multiple sanctions depending on the number and/or the severity of cited deficiencies. For example: OMH might require continuous reporting and prohibit new admissions.

3. OMH will generally begin by using the least severe actions and/or sanctions available for the cited non-compliance. However, if non-compliance warrants the imposition of stringent sanctions, they will be utilized.

4. All programs will receive written notice of administrative actions or sanctioning. The notice will identify the area(s) of non-compliance and what action is being taken or what sanction is being imposed and the duration of said action or sanction, if applicable.

    a) The taking of an administrative action does not afford a program a right to hearing. The Bureau of Inspection and Certification (BIC) will internally review any protest made by a program. Once the protest is reviewed, BIC has discretion to remove or sustain the action against the program. The program will be notified of BIC's decision.

    b) Where sanctions have been proposed, the program has a right to request an

administrative or evidentiary hearing, depending on the sanction to be imposed. Formal notices must be sent which describe the applicable hearing process and the date that the identified sanction will be imposed. Prior to mailing, all notices regarding sanctions should be sent to Counsel's Office for review and sign-off. The hearing process will be handled through Counsel's Office.

5. OMH, as described under Part 593, will notify the Department of Social Services when it appears that there is material non-compliance with applicable sections of Parts 593 or 595.
6. Certification staff may decide to refer programs for additional specialized reviews such as fiscal audits, and/or utilization review audits, as appropriate.

C. DEFINITIONS OF NON-COMPLIANCE

1. Egregious non-compliance: Profound disregard for performance requirements that are by themselves serious in nature, e.g. failure to report and evaluate incidents; failure to maintain the program site in a safe condition; failure to provide adequate staff for the number of residents served.

2. Failure to make corrections: A program is cited for non-compliance on a performance indicator, has an approved plan of corrective action but makes no or minimal progress toward correction as provided in the plan.

3. Repeated non-compliance: A program is cited for non-compliance on a performance indicator and makes acceptable corrections; then is re-cited under the same performance indicator during a subsequent review.

D. DEFINITION OF ADMINISTRATIVE ACTIONS AND THEIR APPLICABILITY

The administrative actions noted below are listed by order of severity. In some instances severity is considered relatively equal. The agency will be notified in writing of an administrative action (Letter A). Rights to a hearing are not applicable to administrative actions.

1. Mandatory technical assistance: The Office of Mental Health will assign appropriate OMH staff to assist the agency in correcting areas of non-compliance. This action would primarily be taken when a program has substantially complied with the requirements under Tiered Certification in the past. It would not generally be used for egregious or repeated non-compliance.

2. Continuous reporting to OMH: The Bureau of Inspection and Certification can request that the program submit specific items relating to non-compliance such as staffing lists, UR reports, building inspections, etc. on a designated schedule. Depending on the performance indicator cited, this action primarily would be taken for failure to correct and/or repeated non-compliance.

3. Meet with Board of Directors: The OMH can initiate formal meetings with the Board of Directors to ensure that the program is receiving adequate attention from the Board with regards to overall program operation.

4. Increase number of oversight visits: The Bureau of Inspection and Certification may wish to increase the frequency of visits to a program. Most of these visits should be unannounced with the purpose of verifying that compliance is being maintained on previously noted deficiencies or that progress is continuing on the approved plan of corrective action.

5. Delay decision on any outstanding CON applications: The Bureau of Inspection and Certification may decide to delay any decision on any active CON applications until adequate corrective action has been taken by the program. This particular action may be combined with other administrative actions or sanctions.

E. DEFINITION OF SANCTIONS AND THEIR APPLICABILITY

The sanctions noted below are listed by order of severity. In some instances severity is considered relatively equal. Rights to a hearing are applicable to all sanctions. Imposition of sanctions will be coordinated through OMH's Counsel's Office.

1. Levy fines: The Bureau of Inspection and Certification may determine that non-compliance is significant enough to warrant a fine be levied against an agency. This sanction may be used when deficient performance indicators fall into the categories of egregious non-compliance, lack of adequate correction and/or repeated non-compliance. Fines cannot exceed the maximum allowed by law. Prior to implementation, agencies will be notified of the right to an **administrative** hearing.

2. Temporarily suspend new admissions: The OMH can decide that non-compliance is serious enough to warrant a temporary suspension of new admissions if the program is non-compliant in areas such that the continued acceptance of new persons would exacerbate non-compliance and potentially jeopardize the health, safety, or welfare of recipients already receiving services. The temporary suspension of new admissions should not exceed 60 days. Agency will be notified of the right to an **evidentiary** hearing.

   If it appears that the suspension of new admissions will go beyond 60 days the agency must be notified of its right to an **administrative** hearing.

3. Temporarily decrease licensed capacity: The Bureau of Inspection and Certification may determine that non-compliance is significant enough to decrease the licensed capacity of a program. This sanction may be used when items noted as deficient fall into the categories of egregious non-compliance, lack of adequate correction and/or repeated non-compliance. It would primarily be used when programs are repeatedly below approved staffing levels, required services are not readily available, the physical plant is inadequate (condition or space) and/or recipients' safety is in jeopardy. A temporary decrease in certified service capacity should not exceed 60 days. Agency will be notified of the right to an **evidentiary** hearing.

   If it appears that the decrease in certified capacity will go beyond 60 days the agency must be notified of its right to an **administrative** hearing.

4. Temporarily suspend operating certificate: The Bureau of Inspection and Certification in

conjunction with OMH Counsel's Office may determine that recipients' safety and/or well being are in jeopardy and the temporary suspension of the OC would be the best recourse until outstanding issues have been resolved between the program and OMH. This sanction can be used when the facility is deemed to be unsafe or if treatment methods are adverse and contrary to standard practices for example: treatment which violates patient's rights, treatment that is dehumanizing or physically harmful. Temporary suspensions of OC's should not exceed 60 days. Agency will be notified of their rights regarding an **evidentiary** hearing.

If it appears that the suspension will go beyond 60 days the agency will be notified of its right to an **administrative** hearing.

5. Revocation of OMH license: The Bureau of Inspection and Certification with the support of the OMH Counsel's Office may decide that the program continues to have serious issues which jeopardize the health, safety and welfare of the recipients such as to warrant a revocation of the operating certificate. Prior to the implementation of this sanction, the agency must be notified of the right to an **administrative** hearing.

F: HEARING PROCESS

Anytime OMH determines to sanction a program, the agency has a right to a hearing. There are two different types of hearings: evidentiary and administrative.

1. Evidentiary Hearing: The purpose of an evidentiary hearing is to allow the agency to contest the validity of the imposition of a temporary sanction. Evidentiary hearings are limited to a determination, based upon a preponderance of the evidence, of whether a recipient's health or safety is in imminent danger or there exists any condition or practice or a continuing pattern of conditions or practices which poses imminent danger to the health or safety of any recipient.

Overview of Process:

a) Program will receive notice of sanctioning via certified mail (Letter C).
b) Within 10 days of receipt of notification, the agency may request an evidentiary hearing.
c) The hearing will commence within 10 days of the filing of the hearing request. Agency will be notified by OMH of the hearing date.
d) Agency will be notified in a timely manner of the Commissioner's ruling.

2. Administrative Hearing: The purpose of an administrative hearing is to allow an agency to contest the validity and severity of a permanent sanction, prior to its imposition. The Commissioner's final determination shall be based upon a preponderance of the evidence and shall contain conclusions concerning the alleged violations of the terms of the operating certificate or the alleged violation of applicable statute, rule or regulation.

Overview of Process:

a) Program will receive notice of sanctioning via certified mail (Letter B).
b) Within 10 days of receipt of notification, the agency may request an administrative

hearing.

c) If the request for hearing is received in a timely manner by OMH, the execution of th described sanction will be stayed pending the outcome of the hearing.

d) Within 30 days of receipt of request for hearing, a written notice of hearing shall be sent by Counsel's Office to the agency. Details of the hearing process will be includ in this communication.

e) Evidence is taken by the hearing officer, who then recommends a decision to the Commissioner.

f) The hearing officer will make his report available to all parties. Any party may submit objections to the hearing officer's report by filing a written response within 20 days after service of hearing report.

g) The Commissioner makes his/her final determination based on the record of the hearing, hearing officer's report and any responses and replies.

h) The Commissioner sends his/her final decision to the agency.

Should an agency wish to appeal a Commissioner's final decision, whether after an administrative hearir or after an evidentiary hearing, they must do so in court, through an "Article 78" petition.

Letter A

ADMINISTRATIVE ACTION LETTER

RE: Program:
OC#:

Dear **AGENCY DIRECTOR**:

This is to inform you that based on the results of the Tiered Certification review conducted on **DATE** by **NAME OF REVIEWERS** the Office of Mental Health is taking the following action(s):

(Description of Action)

Example: *The Bureau of Inspection and Certification's field staff will be conducting several unannounced visits to the program to ensure that medications are being properly stored.*

The reason(s) for this action is (are) as follows:

(Reason for Action)

Example: *It was noted that you have previously been cited for non-compliance on Performance Indicator 1.11 which requires the agency to ensure controlled access to medications stored on premises. During the tour of the physical plant, the door to the nurse's office was unlocked and the room was unattended. The cabinet storing medications was also not locked.*

This action will remain in effect for a **LENGTH OF TIME** period. If during that period continued compliance can be verified, OMH will cease this action.

Administrative actions do not afford the program an opportunity for requesting a hearing. If you would like to discuss this decision with certification staff you may contact **NAME** (Field Unit Director) at **PHONE NUMBER**.

Sincerely,

Larry Chase, Director
Bureau of Inspection and Certification

cc: President of Board of Directors
Counsel's Office
Field Unit Director
Certification Staff at Field Unit

Letter B

HEARING SANCTION LETTER
ONLY FOR IMPOSITION OF FINES
AND REVOCATIONS

RE: Program:
OC#:

Dear **AGENCY DIRECTOR**:

This is to inform you that based on the results of the Tiered Certification review conducted on **DATE** by **NAME OF REVIEWERS** the Office of Mental Health has determined to take the following action against the agency:

(Description of Sanction)

Example: *The program will be fined five hundred dollars ($500) for the lack of non-compliance as described.*

The reason(s) for this action is(are) as follows:

(Reason for Sanctioning)

Example: *It was noted that the program was non-compliant with Performance Indicator 1.21. Even though the agency had been previously instructed by the Bureau of Inspection and Certification's field staff on the required reporting and investigation procedures, the program did not properly report or investigate several incidents that were of a serious nature.*

It is the expectation of the Office of Mental Health that the agency will make all necessary corrections as noted in their Plan of Corrective Action(POCA) associated with the above visit. The Bureau of Inspection and Certification's field staff will be making unannounced visits to assure compliance is being maintained.

The imposition of this fine (revocation) will take effect on **DATE (12 days after the date this letter is mailed)**. Pursuant to 14 NYCRR Parts 503.4 & 503.5 you have a right to request an administrative hearing to contest this decision. If the Office of Mental Health does not receive a written request for a hearing prio to the date listed above, the above referenced action will become final.

Please send hearing requests via registered mail (fax transmissions will not be accepted, unless prior arrangements are made) to my attention at:

Bureau of Inspection and Certification
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

If you would like to discuss this action you may contact **NAME** (Field Unit Director) at **TELEPHONE NUMBER**. However, contact with the field unit will not assure that your right to a hearing is retained. You must still send a written request for a hearing.

Sincerely,

Larry Chase, Director
Bureau of Inspection and Certification

cc: President of Board of Directors
OMH Deputy Commissioner - QA
Counsel's Office
Field Unit Director
Certification Staff at Field Unit

*** Counsel's Office must approve and sign-off on this letter prior to distribution.**

Letter C

HEARING SANCTION LETTER
ONLY FOR TEMPORARILY DECREASING LICENSED CAPACITY, TEMPORARILY STOPPING NEW ADMISSIONS or TEMPORARILY SUSPENDING OPERATING CERTIFICATE

RE: Program:
OC#:

Dear **AGENCY DIRECTOR**:

This is to inform you that based on the results of the Tiered Certification review conducted on **DATE** by **NAME OF REVIEWERS** the Office of Mental Health is taking the following action against the program.

(Description of Action)

Example: *The program will have its Operating Certificate temporarily suspended for the lack of compliance as described.*

The reason(s) for this action is(are) as follows:

(Reason for Sanctioning)

Example: *It was noted that the program was non-compliant with Performance Indicator 1.32. During the physical plant tour it was noted that program areas were considerably cold. Program recipients noted that water had frozen in the bathrooms on several occasions during the Winter. This is the second time that the program has been cited for this serious situation.*

This action will be in effect until appropriate corrections are completed to OMH's satisfaction, but for no longer than 60 days. It is the expectation of the Office of Mental Health that the agency will immediately make all necessary corrections. Once corrections are completed and sanctions are lifted, the Bureau of Inspection and Certification will be making unannounced visits to assure compliance is being maintained

Chose paragraph A,B or C:

A. The imposition of this sanction will take effect on **DATE (12 days after the date this letter is mailed)**. Pursuant to Title 14 NYCRR Parts 503.4 & 503.6 you have a right to request an evidentiary hearing to contest this decision. If a request for a hearing is received, the OMH will stay the imposition of the action until a decision is made by the Commissioner. If the OMH does not receive a request for a hearing prior to the date listed above, the proposed action will become final.

B. The imposition of this sanction will take effect on **DATE (12 days after the date this letter is mailed)**. Pursuant to Title 14 NYCRR Parts 503.4 & 503.6 you have a right to request an evidentiary hearing to contest this decision. If the Commissioner's decision supports the agency, sanctions will be withdrawn immediately. If the OMH does not receive a request for a hearing prior to the date listed above, the proposed action will become final.

C. Due to the seriousness of non-compliance the imposition of this sanction will take effect immediately. An OMH staff member has already or will be contacting you directly to assist program recipients in finding alternative services or explaining their options during sanctioning. Pursuant to Title 14 NYCRR Parts 503.4 & 503.6 you have a right to an evidentiary hearing. If the OMH does not receive a request for a hearing within 10 days of receipt of this letter, the proposed action will become final.

If it appears that the above action will remain in effect for over 60 days you will have the right to request an administrative hearing pursuant to Title 14 NYCRR Part 503.5.

Please send hearing requests via registered mail (fax transmissions will not be accepted, unless prior arrangements are made) to my attention at:

Bureau of Inspection and Certification
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

If you would like to discuss this action you may contact my office at **TELEPHONE NUMBER**. However, telephone contact will not assure that your right to a hearing is retained. You must still send a written request for a hearing.

Sincerely,

Larry Chase, Director
Bureau of Inspection and Certification

cc: President of Board of Directors
OMH Deputy Commissioner - QA
Counsel's Office
Field Unit Director
Certification Staff at Field Unit

*** Counsel's Office must approve and sign-off on this letter prior to distribution.**

APPENDICES

A.

Scoring Checklist
Scoring Tabulation Sheet

B.

Worksheet Instructions
Physical Plant Inspection
Resident Records Review Work Sheet
Resident Records Tabulation Sheet
Resident Records Review Work Sheet - Closed Records

C.

Interview Instructions
Administration
Staff
Resident

APPENDIX A

TIERED CERTIFICATION

RESIDENTIAL PROGRAMS FOR ADULTS SCORING CHECKLIST

PROGRAM INFORMATION: Site Type: CONGREGATE APARTMENT

Program Type: TREATMENT SUPPORT

Agency Name:_____

OC #_____

Program Name:_____

Program Address:_____

_____

Director's Name:_____

Telephone Number:_____

Certified Capacity:_____ Current Census:_____ Crisis/Respite Capacity _____

Population Descriptors: Age Range: _____ Male_____ Female_____

Ethnic or cultural makeup ___%

REVIEW INFORMATION: Review Date(s): ___/___/___ ___/___/___

Reviewers' Names: 1)_____ 2)_____

3)_____ 4)_____

Names & Titles of Staff at Exit : 1)_____

2)_____

3)_____

4)_____

No. of Open Records Reviewed:_____ No. of Closed Records:_____

No. of Staff Interviewed: _____ Governing Body Information Obtained: Yes No

No. of Residents Interviewed:____ Tier Level Obtained: I II III

No. of Apartments Visited: ____

TIERED CERTIFICATION for RESIDENTIAL PROGRAMS FOR ADULTS
SCORING CHECKLIST

CATEGORY 1 - SAFETY & ENVIRONMENT		COMMENTS	SCORE
CR 1.11: *	Medication storage and monitoring assures resident safety.		DFCNCY COMM
CR 1.12:	Residents are trained and assisted as needed in self-administration of medication.		DFCNCY COMM
CR 1.21: *	Incidents are reported and investigated in accordance with the program's approved incident reporting plan.		DFCNCY COMM
CR 1.22: *	Incident reviews result in appropriate changes to policies and practices.		DFCNCY COMM
CR 1.31: *	Residents meet requirements for self-preservation.		DFCNCY COMM
CR 1.32:	The building, its equipment and fixtures are free from fire and safety hazards.		DFCNCY COMM
CR 1.33: *	Smoke detectors and fire fighting equipment are located and maintained as required by regulation.		DFCNCY COMM
CR 1.41:	Personal living spaces meet minimum regulatory requirements for furniture and linen and are properly maintained and clean.		DFCNCY COMM
CR 1.42:	Common living spaces are appropriately furnished and furniture and spaces are properly maintained and clean.		DFCNCY COMM
CR 1.51: *	Emergency health care services are provided to residents as needed.		DFCNCY COMM
CR 1.52: *	Crisis intervention services are available to residents as needed.		DFCNCY COMM

Category # 1 - Scoring Block	No. of PIs Passed	No of * PIs Failed
Total of 11 PIs including 7 * PIs	____ of 11	____ of 7

CATEGORY 2 - RESIDENT RIGHTS		COMMENTS	SCORE
CR 2.11:	Program is sensitive to the culture and ethnicity of the residents served.		DFCNCY COMM
CR 2.12: *	Residents are informed of and aware of their rights. Resident rights are respected.		DFCNCY COMM
CR 2.21:	Resident input is incorporated into residence operation.		DFCNCY COMM
CR 2.22:	Resident grievances are reviewed and resolved in a timely manner.		DFCNCY COMM
CR 2.31:	The confidentiality of resident records is maintained.		DFCNCY COMM
CR 2.32: *	Resident consent is obtained prior to the release of identifying or clinical information regarding the resident.		DFCNCY COMM

Category # 2 - Scoring Block	No. of PIs Passed	No. of * PIs Failed
Total of 6 PIs including 2 * PIs	____ of 6	____ of 2

CATEGORY 3 - REHABILITATION AND OUTCOME		COMMENTS	SCORE
CR 3.11:	Assessments identify resident needs.		DFCNCY COMM
CR 3.12: *	Service plans identify specific, measurable goals and objectives based on assessments and discharge criteria. Methods and time frames for attaining objectives are explicit.		DFCNCY COMM
CR 3.13:	With resident consent, families (when clinically appropriate) and/or collaterals are part of the service planning/review process.		DFCNCY COMM
CR 3.14: *	Service plans are periodically reviewed and revised as needed.		DFCNCY COMM
CR 3.15:	Progress notes are timely and reflect residents' progress toward attaining agreed upon objectives.		DFCNCY COMM
CR 3.16: *	Agreed upon services are available and provided as stated in the service plan.		DFCNCY COMM
CR 3.21: *	Residents shall be appropriately admitted and retained.		DFCNCY COMM
CR 3.22:	The utilization review process is carried out by staff who do not have primary responsibility for the resident under review.		DFCNCY COMM
CR 3.31:	Discharge planning shall be based upon resident preferences and shall include input from relevant staff, community service providers and, where clinically appropriate, family members.		DFCNCY COMM
CR 3.32:	Discharges of residents who are not discharge ready adequately safeguard the rights of all residents of the program and the community.		DFCNCY COMM
CR 3.33: *	Connections to necessary community support services are, with the resident's consent, made prior to discharge.		DFCNCY COMM

Category # 3 - Scoring Block	No. of PIs Passed	NO. of * PIs Failed
Total of 11 PIs including 5 * PIs	____ of 11	____ of 5

CATEGORY 4 - PROGRAM ADMINISTRATION	COMMENTS	SCORE

CR 4.11: *	Staffing is adequate to provide the program's stated services.		DFCNCY COMM
CR 4.12:	Training is regularly provided to all program staff to enhance their ability to effectively provide program services.		DFCNCY COMM
CR 4.21: *	Program operation is regularly monitored against the goals and objectives established by the program and approved by OMH.		DFCNCY COMM

Category # 4 - Scoring Block	No. of PIs Passed	NO. of * PIs Failed
Total of 3 PIs including 2 * PIs	____ of 3	____ of 2

TIERED CERTIFICATION
RESIDENTIAL PROGRAMS FOR ADULTS

SCORING TABULATION SHEET

TABLE ONE

INSTRUCTIONS

1) Transpose the number of PIs passed from the end of each of the four categories to Column A on the right.

2) Transpose the number of critical indicators failed from the end of each category to Column B on the right.

3) Enter the totals where indicated for Columns A and B.

4) Proceed to Table Two.

CATEGORY	# of PIs Passed	# of Critical Indicators(*) failed
	COLUMN A	**COLUMN B**
1) SAFETY AND ENVIRONMENT		
2) RESIDENT RIGHTS		
3) REHABILITATION AND OUTCOME		
4) PROGRAM ADMINISTRATION		
TOTAL		

TABLE TWO

INSTRUCTIONS

1) Note the number under totals in Column A from **Table One** and circle the corresponding number in Column A on **Table Two**. Repeat the same for Column B.

2) Of the two numbers circled, find the one that is closer to the bottom of **Table Two**.

3) On this row and to the left will be the Tier level and the length of the Operating Certificate.

Examples:

1) The total number of PIs passed was 26 and the total number of critical indicators failed was 0. Because the 26 in Column A is on the row closer to the bottom, the final Tier level would be Tier II with a 30 month OC.

2) The total number of PIs passed was 23 and the total number of critical indicators failed was 4. Because the 4 in Column B is on the row closer to the bottom, the final Tier level would be Tier II with a 12 month OC.

TIER LEVEL & OC DURATION		COLUMN A # of PIs Passed	COLUMN B # of Critical Indicators failed (*)
TIER LEVEL	**OC LENGTH**		
TIER I	36 Months	27 or MORE	0
TIER II	30 Months	25 26	1
TIER II	24 Months	23 24	2
TIER II	18 Months	21 22	3
TIER II	12 Months	19 20	4
TIER III	9 Months or LESS	18 or LESS	5 or MORE

BOTTOM OF TABLE TWO

APPENDIX B

PHYSICAL PLANT INSPECTION	Date of Review:
Program Name and Address:	Reviewer(s):
Apartment Address (if appropriate):	

INSTRUCTIONS: Score each of the items under the indicated PI for compliance. Enter relevant comments.

PERFORMANCE INDICATOR		ITEM	Y	N	COMMENTS
CR 1.11 *	Medication storage and monitoring assures resident safety.	Communally held medication is in locked storage.			
		Controlled substances are under double lock.			
		Keys to medication storage are properly safeguarded.			
		Medication kept by individual residents is securely stored.			
CR 1.32	The building, its equipment and fixtures are free from fire and safety hazards.	The residence is free from items prohibited under Part 595.15(a)(4)(iii).			
		Items restricted by 595.15(a)(4)(iv) have been approved by OMH and required maintenance procedures are followed.			
		Building exits are unobstructed by accumulated material, furniture or by locking devices which could inhibit emergency egress.			
		The building is free from unsafe accumulations of combustible materials.			
		Flammable materials are safely stored.			
		Electrical circuits are free from overload.			
CR 1.33 *	Smoke detectors and fire fighting equipment are located and maintained as required by regulation.	Smoke detectors are placed as required by regulation. *			
		Hardwired detectors are tested not less than once/month and battery operated detectors at least weekly.			
		Battery operated detectors are capable of issuing a trouble signal prior to battery failure.			
		At least one fire extinguisher is accessible on each floor.			
		All extinguisher have been tested and recharged as required.			
		The building emergency evacuation plan is posted.			

PERFORMANCE INDICATOR		ITEM	Y	N	COMMENTS
CR 1.41	Personal living spaces meet minimum regulatory requirements for furniture and linen and are properly maintained and clean.	Adequate cleanliness is maintained.			
		Bathroom fixtures are in good repair and free from leakage.			
		Walls, ceilings and floors are free from prominent holes or signs of leakage.			
		The condition of paint or wall coverings in the space is satisfactory.			
		Each resident is provided with a bed, chair, desk or table, dresser and closet or wardrobe.			
		Furniture is in satisfactory condition.			
		Each resident is provided with at least two sets of sheets, a blanket, two towels and a washcloth.			
		Linens are kept clean and in satisfactory condition.			
		Each bedroom has window coverings that are clean and in acceptable repair.			
CR 1.42	Common living spaces are appropriately furnished and furniture and spaces are properly maintained and clean.	Adequate cleanliness is maintained.			
		Bathroom fixtures are in good repair and free from leakage.			
		Walls, ceilings and floors are free from prominent holes or signs of leakage.			
		The condition of paint or wall coverings in the space is satisfactory.			
		Common areas are furnished appropriately to the function of the space, and the population.(Includes decorative items, activity supplies, recreational equipment, etc.)			
		Furniture and other room furnishings are in satisfactory condition.			
CR 2.31	The confidentiality of resident records is maintained.	Resident specific materials are securely maintained, including written materials, computer disks, and hard drives.			

RESIDENT RECORD REVIEW WORKSHEET		Program:	
		Reviewer:	
Date:	DOA:	Diagnosis:	Resident Identification:

INSTRUCTIONS: Use this sheet to score record related PIs and then transfer PI scores from each individual record to tabulation sheet to obtain overall score for each performance indicator.

	PERFORMANCE INDICATOR	COMMENTS	SCORE
CR 1.12	Residents are trained and assisted as needed in self-administration of medication.		
CR 1.31 *	Residents meet requirements for self-preservation.		
CR 2.12 *	Residents are informed of and aware of their rights. Resident rights are respected.		
CR 2.32 *	Resident consent is obtained prior to the release of identifying or clinical information regarding the resident.		
CR 3.11	Assessments identify resident needs.		
CR 3.12 *	Service plans identify specific, measurable goals and objectives based on assessments and discharge criteria. Methods and time frames for attaining objectives are explicit.		
CR 3.13	With resident consent, families (when clinically appropriate) and/or collaterals are part of the service planning/review process.		
CR 3.14 *	Service plans are periodically reviewed and revised as needed.		
CR 3.15	Progress notes are timely and reflect residents' progress toward attaining agreed upon objectives.		
CR 3.16 *	Agreed upon services are available and provided as stated in the service plan.		
CR 3.21 *	Residents shall be appropriately admitted and retained.		
CR 3.22:	The utilization review process is carried out by staff who do not have primary responsibility for the resident under review.		
CR 3.31	Discharge planning shall be based upon resident preferences and shall include input from relevant staff, community service providers and, where clinically appropriate, family members.		

RESIDENT RECORD TABULATION SHEET	PROGRAM: REVIEWER:

	SCORES FOR EACH PERFORMANCE INDICATOR												
Record	1.12	1.31*	2.12	2.32*	3.11	3.12*	3.13	3.14*	3.15	3.16*	3.21*	3.22	3.31
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
10.													
TOTAL													
PI SCORE													

INSTRUCTIONS: For each record reviewed enter the scores for each PI from the Resident Record Review Worksheet. Scores for each separate record should be entered on a separate row. The total score for each PI should be calculated by summing the column and should be entered under total for that PI. The PI score for all records reviewed is obtained by dividing the total for each PI by the number of records entered. PI scores should be rounded to the nearest whole digit. If a PI is failed (an average rounded score of 1 or 0) three additional records should be reviewed for that PI only. The column should be retotaled and an average obtained and rounded to the nearest whole digit.

RESIDENT RECORD REVIEW WORKSHEET CLOSED RECORD	PROGRAM:	
	REVIEWER:	DATE:

INSTRUCTIONS: **Review up to five closed records and score each of the items for each record reviewed with a YES or a NO. Scores for each of the two PIs should be assigned based on the 0-3 scale utilized throughout the tiered package. Scores for each PI are to be transferred to the Scoring Checklist.**

INDIVIDUAL CLOSED RECORDS		PI 3.32 Discharges of residents who are not discharge ready adequately safeguard the rights of all residents of the program and the community.						PI 3.33: * Connections to necessary community support services are, with the resident's consent, made prior to discharge.			
RESIDENT IDENTIFICATION	Date of discharge	Discharge planning activities have been followed to the extent practicable.		There is documentation that the resident met one of the criteria for being discharged when not discharge ready.		When required, a clinical assessment was conducted by qualified staff.		Referrals to appropriate support and residential services were completed.		Arrangements for appointments with appropriate support and residential services were made.	
		Y	N	Y	N	Y	N	Y	N	Y	N
1.											
2.											
3.											
4.											
5.											
						SCORE 3.32				SCORE 3.33	

COMMENTS:

APPENDIX C

GENERAL INSTRUCTIONS FOR COMPLETING INTERVIEW FORMS

Interview sheets are designed to assist the surveyor in scoring various performance indicators. The use of these interview sheets is not mandatory; however, their use is encouraged because the questions are intended to obtain information that is needed to score

given performance indicators. The intent is to help the surveyor verify that programs are providing needed services and are following program policy and procedures. The written questions are not intended to be asked verbatim but as suggestions to assist th surveyor. Additional questions may follow in response to given answers.

All interview sheets are to be used to obtain a cross section of information from various people. In most cases, it is anticipated tha one form per survey should suffice. When a performance indicator will be failed the results of interviews was central to the decision the comment section should be completed detailing the problems identified. The number of staff or recipients interviewed will var depending on the program size and their availability.

Instructions to surveyors for resident protocol: The resident interview protocol is intended to provide the surveyor with an instrument that provides some structure to the interview situation while allowing the surveyor to create an atmosphere informa enough that unforeseen information can surface. The form allows the inclusion of data from up to five interviews on a number of performance indicators for which resident input is preferred to score the PI. The information obtained from resident interviews i intended to be combined by the surveyor into a single interview based measure for each of the listed PIs. This aggregated residen perception of program function is then to be integrated with information derived from document reviews, other interviews and observation into a score for the PI in question.

Residents may be selected at random, from volunteers, or based upon issues which surface during record reviews. Individuals should not be selected by the program. Interviews may be conducted with a group of residents or individually and should be conducted in a private setting. Time limits should be set from the start to conserve surveyor time. Every effort should be made to put the residents at ease and assure them of the confidentiality of the information they provide. The general purpose of the recertification visit should be explained and any questions the residents express answered. The surveyor should stress that s/he is interested in the residents' own experiences in the program, both positive and negative.

The form is divided into columns: the first indicating the PI, the second, "area of inquiry", presents a question to be answered to help score the PI. This question is followed by a number of **suggested** questions denoted by letters. These are neither mandated no meant to be all inclusive. It is up to the surveyor to alter and select from these as the situation warrants. The first row of boxes unde "resident identification" is to be used for the initials of the person(s) interviewed, up to five. The boxes directly below the spaces for initials are to be used to enter the overall thrust of the individual's response about the PI. The protocol is structured to allow a "yes" "no", or "N/A" determination to be made **by the surveyor**. In the column labeled "aggregated comments" the surveyor is expected to arrive at an overall determination reflecting the input of the residents interviewed regarding the PI and may also include furthe detail to assist in final scoring.

RESIDENTIAL ADMINISTRATIVE INTERVIEW	Program:
Administrator:	Title:
Date of Review:	Reviewer:

INSTRUCTIONS: The following questions are designed to assist the surveyor in scoring various Performance Indicators (PI) and to verify the knowledge of the administrator about specific program operations related to performance outcomes.

CR/PI	Question	Reviewer Comments
2.21	Resident input into daily operation: • How is resident input solicited? • What mechanisms are used to incorporate this input into daily program operation? • Examples?	
2.22	Grievance process: • Describe the process. • How is objectivity assured? • Time frames?	
2.31	Confidentiality: • How do you assure that only authorized personnel have access records?	
2.32*	Consent for release of information: • How do you go about obtaining consent? • What if resident refuses?	
4.12	Staff training: • What training provided? • By whom? • How frequently? • How is need for training ascertained? • What kind of results?	
4.21*	Goals and Objectives: • How do you go about monitoring attainment of program goals? • What is the mechanism for adjusting objectives?	

RESIDENTIAL STAFF INTERVIEW	Program:
Staff name(s):	Staff title(s):
Date of Review:	Reviewer:

INSTRUCTIONS: The following questions are designed to assist the surveyor in scoring various Performance Indicators (PI) ar to verify the knowledge of direct care staff about specific program operations related to performance outcomes.

CR/PI	Question	Reviewer Comments
1.12	Self administration of meds: • What are your responsibilities regarding assisting residents receive medication? • What are your responsibilities regarding training residents to self medicate?	
1.51*	Emergency health care: • Have you been trained in CPR and first aid? • Have you ever had to use these skills? • How would you get help in an emergency?	
1.52	Crisis intervention: • Have you been trained in crisis intervention techniques? • Have you ever had to use these skills? • How would you get help in an emergency?	
2.11	Cultural sensitivity: • How are the ethnic and cultural identities of residents incorporated into program operation?	
2.21	Resident input into daily operation: • How can residents bring about changes in program operation? • Examples?	
2.22	Grievance process: • Describe the process. • How is objectivity assured? • Time frames?	

CR/PI	Question	Reviewer Comments
2.31	Confidentiality: • How do you assure that unauthorized personnel cannot access records?	
2.32*	Consent for release of information: • How do you go about obtaining consent? • What if a resident refuses?	
3.12*	Goals and objectives resident generated: • Who participates in service planning? • How do you go about setting service plan goals and objectives?	
3.14*	Revision of service plans: • Is it regular practice to modify service plan objectives or methods? • What circumstances call for such changes?	
3.31	Discharge planning: • How is a setting for a discharge arrived at? • When does this planning begin? • Who participates?	
3.32	Unplanned discharges: • Have you been involved in the discharge of residents who were not ready for less restrictive settings? • What were the reasons? • Can you describe the process?	
4.12	Staff training: • What training have you received? • From whom? • How frequently? • How was the need for training ascertained? • What kind of results?	

RESIDENT INTERVIEW PROTOCOL

PROGRAM:	SURVEYOR(S):

PI	AREA OF INQUIRY	RESIDENT IDENTIFICATION					AGGREGATED COMMENTS
1.12	**Does the program provide consistent, high quality training in self medication?**						
a) Do you take medication? b) Do you receive training in self medicating? c) Describe the training or assistance you receive. d) Are you satisfied with the level of help you get? e) What meds do you take on what schedule?							
1.51	**Are residents aware of how to access emergency health services?**						
a) What would you do if you became seriously ill? b) What would you do if you became seriously ill and no staff were present?							
2.11	**Does the residence employ staff who are sensitive to resident's ethnic and cultural individuality?**						
a) Do staff speak your language? b) Are there staff who share your cultural background? c) Do you ever feel that the program ignores your holidays? special foods? peoples' way of doing things? religious observances? d) Does the program feel like home?							

PI	AREA OF INQUIRY	RESIDENT IDENTIFICATION					AGGREGATED COMMENTS
2.12	**Are resident rights respected?**						
a) Do you understand the rules of the program? b) Do you know the program fee you pay? What it pays for? c) Do you know your rights as a resident? d) Do you feel that your rights are respected?							
2.21	Is resident input part of determining how the house runs?						
a) Is there a resident council? b) Does it meet regularly? c) Does it have a say in house rules and how things operate? d) Are changes likely to follow if the council raises an issue?							
2.22	**Does the grievance process work?**						
a) What would you do if you felt the program had treated you unfairly? b) Has this ever happened to you or another resident you know? c) Was the complaint dealt with quickly? d) Were you satisfied with the result?							
3.11	**Do assessments take resident priorities into account?**						
a) Were you involved in deciding on a list of your needs? b) What did you and your counselor do to decide what areas you needed help in?							

PI	AREA OF INQUIRY	RESIDENT IDENTIFICATION					AGGREGATED COMMENTS
3.12 *	**Are resident service plan goals and objectives resident generated?**						
a) Were you involved in deciding on the goals in your service plan? b) Do the goals in your plan reflect your reasons for being in the program, the things you want to accomplish? c) How were the goals and objectives in your service plan arrived at?							
3.14	**Does the process for revising service plans take into account changing resident priorities?**						
a) Do you take part in service plan reviews? b) Have you requested changes in the goals your working toward or the things you and staff are doing to get there? c) Has staff paid attention to your requests?							
3.31	**Is the resident regularly involved in discharge planning?**						
a) When you sit down with staff to discuss your service plan is your future housing discussed? b) Is this a regular part of your service plan review?							