# Georgia Department of Behavioral Health and Developmental Disabilities
## Division of Accountability and Compliance
## Office of Provider Certification and Services Integrity
### Certification Review Report

**Date of Report:** **Review Date(s):**

**Provider Name:**

**Contact Person:**

**Address:**

**Service:**

**Region:**

**Review Team:**

| AREAS REVIEWED | SCORE | OVERALL SCORE |
|---|---|---|
| Leadership and Organizational Practice | | |
| Healthcare Management | | |
| Rights and Protection | | |
| Holistic and Person Centered Approach | | |
| Environment of Care | | |
| Human Resources | | |
| Service Specific | | |

| | CRITERIA W/ SCORES BELOW 70% COMPLIANCE | SCORE |
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| Certification Review Report<br>Identifiers | |
|---|---|
| **Date of Report:** | **Review Date(s):** |
| **Provider Name:** | |

| Individuals / Clients | |
|---|---|
| #1 | |
| #2 | |
| #3 | |
| #4 | |
| #5 | |
| #6 | |
| #7 | |
| #8 | |
| #9 | |
| #10 | |

| Staff / Contractors | | |
|---|---|---|
| A | Name | Title |
| B | | |
| C | | |
| D | | |
| E | | |
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## LEADERSHIP & ORGANIZATIONAL PRACTICES

**1.01 Quality Improvement Plan** **(Eff. 4/1/17)**

Written policy, procedure and practice document a well-defined plan to assess and improve organizational quality.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 13-15

Approaches to evaluate this standard include, but are not limited to:
Review:
• Quality improvement plan
• Reviews conducted of records
Interview:
• Director regarding plan, how issues are identified and corrected
• Other staff regarding the reporting of issues

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| *There is a well-defined quality improvement plan for assessing and improving organizational quality, to include:* | | | |
| 1 | Processes for how issues are identified | | |
| 2 | What solutions are implemented | | |
| 3 | Any new or additional issues are identified and managed on an ongoing basis | | |
| 4 | The internal structures minimize risk for individuals and staff | | |
| 5 | The organization documents a review of the quality improvement plan at least annually. | | |
| *At a minimum, the following areas of risk are monitored:* | | | |
| 6 | Incidents and accidents | | |
| 7 | Health and safety | | |
| 8 | Complaints and grievances | | |

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| 9 | Review of restrictive interventions by the Rights Sub-Committee | | |
| 10 | Practices that limit freedom of choice or movement | | |
| 11 | Medication management | | |
| 12 | Infection control | | |
| 13 | Positive Behavior Support Plan tracking and monitoring, including restrictive interventions, review for efficacy of the plan and needed adjustments, recommendations and modifications made in a timely manner. | | |
| 14 | Breaches of confidentiality | | |
| 15 | Protection of health and human rights | | |

**1.02 Performance Measurement** **(Eff. 4/1/17)**

Written policy, procedure and practice document performance data to determine if organizational objectives are being met.

Reference:
DBHDD Policy 02-803
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 13-15

Approaches to evaluate this standard include, but are not limited to:
Review:
• Quality improvement plan
• Reviews conducted of records
Interview:
• Director regarding plan, how issues are identified and corrected
• Other staff regarding the reporting of issues

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| *Indicators of performance are in place for each issue, to include:* | | | |
| 1 | Method of routine data collecting and reporting | | |

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| 2 | Method of routine measurement | | |
| 3 | Method of routine evaluation | | |
| 4 | Target goals/expectations for each indicator | | |
| 5 | Outcome measurements are determined and reviewed for each indicator on a quarterly basis. | | |
| 6 | At least five percent (5%) of all HRST(s) administered by designated staff are reviewed monthly. | | |
| 7 | At least four individual records or the records of 5% of the total number of individuals served (whichever number is greater) are reviewed each quarter. The records are randomly chosen. Documentation of reviews are maintained for at least two years. | | |
| 8 | The form used for records reviews include, but is not limited to, the following: (1) the record is organized; complete, accurate and timely; (2) services are based on assessment and need; (3) individuals have choices; (4) documentation of service delivery including individuals' responses to services and progress toward ISP/IRP goals; (5) documentation of health service delivery; (6) medication management and delivery, including the use of PRN and over the counter PRN medications, and their effectiveness; (7) approaches implemented for individuals with challenging behaviors. | | |
| 9 | Appropriate utilization of human resources is assessed, including, but not limited to: competency, qualifications, numbers and type of staff, and staff to individual ratios to include enhanced staffing. | | |

**1.06 Incident Reporting and Review** **(Eff. 2/1/16)**

Written policy, procedures and practice document a safe and humane environment for individuals that is free of abuse, neglect and exploitation.

Reference:
DBHDD Policy 04-106

Approaches to evaluate this standard include, but are not limited to:
Review:
• Internal incident reports
• Incident reports in ROCI
• QI/PI process for a review of incidents
Interview:
• Staff regarding the process for reporting incidents

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses, at the minimum, the following: incident reporting, review, data entry (as applicable), investigation, and corrective action. | | |
| 2 | Critical incidents are reported to the DBHDD Office of Incident Management and Investigation within the time frames outlined in DBHDD policy. | | |
| 3 | The organization has an internal process for the handling of non-reportable incidents and accidents that includes documentation, investigation and appropriate action. | | |
| 4 | The provider immediately notifies the individual's guardian/next of kin, support coordinator, and law enforcement (as applicable). | | |
| 5 | The administrator performs a managerial review of all Critical Incident Reports that includes reading the report, statements, and other items associated with the incident, completing any incomplete or missing documentation, and signing the attestation on the form. | | |

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| 6 | For all Category II incidents, the provider assigns an investigator within the timeframes outlined in DBHDD policy. The investigation includes interviews, reviews of documentation, collaborations with outside agencies (as applicable), and submission of the Investigative Report to DBHDD within 30 days of the date of the incident or discovery of the incident. | | |

**1.08 Budget** **(Rev. 4/1/17)**

Written policy, procedure and practice document a budget that serves as a plan for managing resources.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 11

Approaches to evaluate this standard include, but are not limited to:
Review:
• Budget
Interview:
• Administrator or designee to determine their understanding of the budget

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a written budget that includes expenses and revenue and serves as a plan for managing resources. | | |
| 2 | Utilization of fiscal resources if assessed in the quality improvement processes and/or by the advisory board. | | |

**1.09 Provider Enrollment** **(Rev. 4/1/17)**

The organization ensures that DBHDD is provided accurate information regarding the service location.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 12, ,36-37

Approaches to evaluate this standard include, but are not limited to:
Review:
• Provider enrollment information
• DBHDD certificate

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 2 | The organization has documentation of current general liability insurance in the amount of $1 million per occurrence and $3 million aggregate. DBHDD is listed as the certificate holder. | | |

## HEALTHCARE MANAGEMENT

**2.01 Health Oversight** **(Rev. 4/1/17)**

The organization provides comprehensive oversight of the holistic healthcare needs of the individual.

Reference:
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP), Part II, Chapter 600, Section 706.2
DCH Policies and Procedures for New Options Waiver Program (NOW), Part III, Section 1702
Georgia Crisis Manual, page 1
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 55

Approaches to evaluate this standard include, but are not limited to:
Review:
- Annual physical exam
- Named primary physician
- Specialist appointments as applicable
- Lab testing
- DMA-6 or DMA-7
- Allergies and precautions noted on front of records and MARs
- Medical history
- Assessments –psychosocial, psychiatric, physical health, nursing
- Risk assessments and protocols when applicable
- Assessment by LCSW or LPC
- HRST updates
- Physician orders
- Referrals are implemented

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | Each individual receives a physical examination at least annually. | | |

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| 2 | The organization documents the implementation of healthcare recommendations (e.g., lab testing, specialist appointments, etc.). The organization documents the provision of or referral for needed specialized healthcare such as ROM, physical, occupational and speech therapies, specialized medical equipment or supplies, dental care, smoking or tobacco cessation, substance abuse, mental health, etc. | | |
| 3 | There is documentation in the individual's record of all medical care received, including office visits, procedures, laboratory testing, etc. | | |
| 4 | The individual's past medical history is documented in the record. | | |

**2.02 Medication Management** **(Rev. 4/1/17)**

Written policy, procedure and practice document safe medication management.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 14-18
Rules and Regulations for Personal Care Homes, Subject 111-8-62-.20

Approaches to evaluate this standard include, but are not limited to:
Review:
• Pharmacy/ Pharmacist license
• MARs (stat medication times, medication availability)
• Packaging and dispensing of medications
• Storage of medication including controlled substances
• Refrigerated medications and temp logs
• Accountability of controlled medications
• Disposal of medication
• Medication transport security and conditions
• Informed consent and medication education to individuals/guardians, etc.
• Lab testing for medications requiring monitoring and AIMS testing for psychotropic medications
• Polypharmacy review by pharmacist, physician, etc.
• Medication errors and variances
• Accountability of sample medications by physician
• Biennial assessment
• CLIA waiver
Interview:
• Pharmacist as needed
• Agency nurse as needed
Observe:
• Medication pass

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses, at the minimum, the following: (1) medication procurement/dispensing/pharmacy services; (2) medication labeling, storage, and security; (3) protocols regarding medication errors, reactions, problems, refusals, and variances that include notifying the prescriber; (4) safeguards utilized for medications known to have substantial risk or undesirable effects; (5) transportation and disposal of discontinued and expired medication; and, (6) protocols for the handling of drugs brought into the service setting; (7) Administration/supervision based on acceptable standards of practice that meet the individual safety needs, the nature of the prescribed medication and its specific clinical use; and, (8) Protocols for educating staff in the specific individualized medication information from the individual's primary physician, a prescribing practitioner or pharmacy for the importance of timeliness of medication administration/supervision of medications. | | |
| 2 | A pharmacist or independent RN not attached to the organization conducts an assessment of the medication management practices at least every two years. The organization has documentation of the assessment that includes the a report of findings, a photocopy of the license of the reviewer, and an attestation that any deficiencies identified are corrected. | | |
| 3 | In residential placements, initial medication orders and refills are obtained within 24 hours of receipt of the order or 24 hours before the refill is exhausted. | | |
| 4 | All PRN medications are accessible onsite for each individual as ordered. | | |

NOTE: This Compliance Review Report provides explanations of only the deficient practices identified during this review. The criteria deemed “not applicable” or “not evaluated” are not identified and not included in the scoring.

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| 5 | Medications are not repackaged or dispensed except by a physician, pharmacist or by the individual prescribed the medication who is capable of independent self administration. | | |
| 6 | Medications are stored under lock at all times in a clean and secure location, including when transporting to another service setting. | | |
| 7 | Refrigerated medications are locked and stored separately from food, including when transporting to another service setting. (A separate refrigerator for medications is not required.) The refrigerator temperature is recorded daily. | | |
| 8 | Controlled substances are double locked, including when transporting to another service setting. Refrigerated controlled substances are double locked. (A separate refrigerator for medications is not required.) | | |
| 9 | A daily inventory of all controlled medications is maintained. Each individual dose is signed out and recorded on the controlled count sheet by the staff administering the medication. | | |
| 10 | At least two staff account for the accuracy of the controlled substances inventory when there is a change of the staff responsible for the controlled substances. | | |
| 11 | Medication is disposed of via a method that is environmentally friendly or by a pharmacy or law enforcement. | | |
| 12 | There is documented evidence that medication education has been provided to individuals and/or their families in a way that is understandable. | | |
| 13 | AIMS testing is documented as indicated by the physician for all individuals who receive psychotropic medications or medications known to have risks (e.g., Reglan). | | |

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| 14 | Notifications of medication errors, variances, problems, reactions, refusals and omissions are made to the prescriber. (The organization may have policies in place for additional internal notifications.) | | |

**2.03 Medication Orders and Informed Consent** **(Rev. 4/1/17)**

Written policy, procedure and practice document orders by a healthcare professional duly licensed to order medications. The healthcare professional documents informed consent for all psychotropic medications.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 14-18
DCH Comprehensive Supports Wavier Program Part II, Section 1100

Approaches to evaluate this standard include, but are not limited to:
Review:
- Current physician orders
- Psychiatric medications prescribed by psychiatrist or psychiatric nurse practitioner
- Standing orders for psychotropic medications
- Medications utilized in combination for chemical restraint
- Verbal order authentication by physician
- Informed consent

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses, at the minimum, the following: (1) a current copy of the physician's order or current prescription dated and signed for the past year is placed in the individual's record for every prescription and over-the-counter (OTC) medication; (2) discontinuation orders, as applicable; (3) prescribing practices; (4) authentication of orders & timeframe; and, (5) informed consent. | | |
| 2 | Medications are ordered by an appropriately licensed professional (MD, PA, NP). | | |

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| 3 | Each medication (PRN, controlled substance, OTC, etc.) being administered has an active, current order on file that is dated and signed within the past 12 months. | | |
| 4 | Anti-psychotic medication is prescribed by a psychiatrist or psychiatric Nurse Practitioner unless the medication is prescribed for epilepsy or dementia. | | |
| 5 | There are no orders for psychotropic PRN medications. | | |
| 6 | Authentication by the physician/designee signature of all verbal medication orders is completed. | | |
| 7 | The organization maintains documentation of the individual's informed consent for all psychotropic medications including antipsychotic, anti-manic, antidepressant, anti-anxiety, and anti-obsessive drugs as well as other medications employed as treatment of psychiatric disorders. | | |

**2.04 Rights of Medication Administration/Assistance** **(Rev. 4/1/17)**

Written policy, procedure and practice document the safe administration/assistance of medications by licensed and non-licensed staff.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 14-18

Approaches to evaluate this standard include, but are not limited to:
Review:
• Licenses/Proxy Designation for staff administering medications
• MARs – administration, exceptions, legend
Interview:
• Staff administering/assisting with medications
Observe:
• Medication pass for 8 rights of medication administration

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses in detail, as applicable, medication administration by licensed personnel, self-administration, and proxy caregiver medication assistance using the eight rights of medication administration. | | |
| 2 | Right Person: The organization utilizes 2 identifiers to identify individuals. Staff check the name on the order and match it to the individual. | | |
| 3 | Right Medication: Each time the medication is administered, the label on the medication is compared to the physician's order and the Medication Administration Record. Each medication has a label affixed by a licensed pharmacist, dentist, or physician. | | |
| 4 | Right Time: Medications are administered at the correct time and in accordance with the medication's special instructions. | | |
| 5 | Right Dose: Each time the medication is administered, the dosage on the medication label, order and MAR are compared to ensure they are identical. | | |
| 6 | Right Route: Medications are administered via the route indicated by the physician's order. The route is documented for each medication on the MAR. | | |
| 7 | Right Position: The individual is in the correct anatomical position for the medication route, including for tube feedings. | | |
| 8 | Right to Refuse: Any medication refusal by the individual is documented and reported timely according to agency policy. | | |

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| 9 | Right Documentation: All aspects of the medication administration are documented on the MAR immediately after each medication is administered. | | |
| 10 | For medication administration, only licensed personnel administer medications. | | |
| 11 | Unlicensed staff assist with self-administration of medications as needed to include reminding the individual to take the medication, reading the container label to the individual, checking the dosage according to the label and order, providing water and assisting physically using the hand over hand technique. Unlicensed staff are not allowed to pour medications, remove the medication from the bubble pack, place the medication in the individual's mouth, etc. *(does not apply to DD Crisis Homes)* | | |

**2.05 Medication Administration Records (MAR)** **(Eff. 4/1/17)**

Written policy, procedure and practice document the safe administration of medications by licensed personnel.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 14-18

Approaches to evaluate this standard include, but are not limited to:
Review:
• MARs – administration, exceptions, legend
Interview:
• Staff administering medications
Observe:
• Medication pass for medication documentation

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses in detail the documentation of medication administration using a Medication Administration Record (MAR). | | |

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| 2 | An MAR is in place for each calendar month that an individual takes or receives medication. Each MAR is for a full calendar month. | | |
| 3 | A listing of all medication (standing and PRN) is documented on the MAR in full replication of the physician's order to include name of medication, dose as ordered, route as ordered, time of day as ordered, and special instructions if needed. | | |
| 4 | If a medication is taken more than once daily, each time of the day has a separate entry. | | |
| 5 | When medication is added or discontinued, a single line is marked through dates and times not ordered by the physician. When discontinued, "d/c" and the date is clearly documented. | | |
| 6 | PRN medications are documented in a separate portion of the MAR from standing medications. The date and time the medication is taken or received is documented for each use. | | |
| 7 | When PRN medication is used, the effectiveness is clearly documented on the MAR. | | |
| 8 | The MAR includes a legend that clarifies the identity of staff using a full signature and title. | | |
| 9 | Each MAR has a legend that clarifies medications not given or otherwise not received by the individual. | | |

**2.06 Proxy Caregiver Health Maintenance Activities *(does not apply to DD Crisis Homes)*** **(Eff. 2/1/16)**

In DD facilities licensed by Healthcare Facilities Regulations (HFR), written policy, procedure and practice document medication assistance by a proxy caregiver.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 20, 46-47
DCH Comprehensive Support Waivers Program Part II Section 1100
HFR Rule 111-8-100, Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities

Approaches to evaluate this standard include, but are not limited to:
Review:
• Competency based training of non-licensed staff on proxy caregiving
• Informed consent for proxy caregiver
• TOFHLA score
• MARs content and documentation
• Legend and use
Interview:
• Agency proxy caregivers as needed
• Agency professional providing proxy oversight as needed
Observe:
• Medication pass for 8 rights of medication administration

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses in detail, at a minimum, the following: (1) assistance with prescribed medications, OTC medications and controlled substances using the eight rights of medication administration by a proxy caregiver; (2) written informed consent; (3) written orders for health maintenance activities; (4) written plan of care; and (5) proxy caregiver competency. | | |
| 2 | There is a written informed consent in the individual's record that designates the selected proxy caregiver(s) authorized to provided the healthcare activities outlined in the physician's written order. | | |

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| 3 | There are current written orders for the health maintenance activity by the attending physician, advance practice registered nurse or physician assistant. (A plan of care signed by the prescriber may substitute for a separate written order.) | | |
| 4 | A licensed healthcare professional documents a competency-based skills checklist for the proxy caregiver that reflects the proxy caregiver has demonstrated the necessary knowledge and skill to satisfactorily perform the necessary health maintenance activities. | | |
| 5 | Skill competency checklists for proxy caregivers assisting with medications must be updated by a licensed healthcare professional annually and whenever new medications are added that staff have not been previously trained. | | |
| 6 | A licensed healthcare professional develops a written plan of care in accordance with the written orders that specifies the health maintenance activities to be performed, the frequency of training and evaluation requirements for the proxy caregiver and when additional training will be required. The plan of care is signed by the licensed healthcare professional providing oversight. The plan of care is renewed at least annually. The proxy caregiver is not trained or permitted to provide services outside their scope of practice. | | |
| 7 | The proxy caregiver(s) scores at least a 75 on the long version of the Test of Functional Health Literacy for Adults (TOFHLA). | | |
| 8 | The organization has a properly indexed medication information notebook or folder which contains information (descriptions of medication, dosing, side effects, adverse reactions, contraindications etc.) about only the medications for which the proxy caregiver is providing assistance. | | |

**2.07 Adaptive Supportive and Medical Protection Devices (Rev. 4/1/17)**

The individual has access to adaptive supportive, and medical protection devices to assist the individual with medical treatment or corrective supportive needs.

Reference:
DBHDD Policy 02-409
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 48-51

Approaches to evaluate this standard include, but are not limited to:
Review:
• Current physician's order for all adaptive equipment
• Documentation that adaptive equipment is being utilized for medical rather than behavior reasons
• ISP or addendum authorized the use of any adaptive equipment
• Evidence of equipment safety, maintenance and cleanliness is timely
• Documentation of staff training on the use and application of any adaptive equipment
Interview:
• Agency staff on adaptive equipment as needed
Observe:
• All adaptive equipment is the personal property of the individual and is not shared
• Adaptive equipment is utilized according to the manufacturer's instructions
• Adaptive equipment is being utilized for medical rather than behavior reasons
• All adaptive equipment is with the individual for immediate use
• Evidence of equipment safety, maintenance and cleanliness is timely

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that defines the adaptive supportive, and medical protection devices and the restrictive interventions that are implemented or prohibited by the organization and licensure requirements. | | |
| 2 | A current physician's order is documented for all devices utilized by an individual. The physician's order is renewed at least every 6 months. | | |

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| 3 | The written physician's order includes the rationale and instructions for the use of the device. The adaptive equipment is used for medical reasons and/or physical support and not for treatment of challenging behaviors. | | |

**2.08 Protocols for Specialized Healthcare Needs** **(Rev. 4/1/17)**

Written policy, procedure and practice document protocols for preventive health maintenance or the management of specialized needs.

Reference:
DBHDD Policy 02-801 and 02-802
DBHDD Provider Manual for Community Developmental Disabilities, page 20

Approaches to evaluate this standard include, but are not limited to:
Review:
• Protocols
• Staff training on protocols
Interview:
• Staff regarding their understanding of specific protocols for individuals

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced which describes the process for developing healthcare protocols, monitoring, reporting, and, if applicable, preventative healthcare maintenance. | | |
| 2 | The organization has protocols for preventative healthcare maintenance for the following healthcare needs, at a minimum: (1) bowel elimination; (2) hypertension; (3) weight management; (4) skin care; (5) seizures; (6) fluid intake; (7) aspiration; (8) falls; and, (9) diabetes. | | |
| 3 | The organization has a protocol for an unconscious choking victim. All staff have received choking training and know how to access the protocol. | | |

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| 4 | All individuals who are at risk for choking, based on an individualized assessment by an appropriate licensed health care practitioner, has individualized protocols. The protocols include: type of diet, food size and portion, who should be called if a choking incident occurs, what emergency techniques should be implemented, and emergency contact numbers. | | |
| 5 | Residential providers utilize their established bowel elimination protocols for monitoring bowel function for individuals with a history of constipation, impaction, and/or bowel obstruction. | | |
| 6 | Each individual has a bowel tracking record that includes, at a minimum: (1) number of bowel movements per day; (2) list of the individual's medications that increase the risk of constipation, impaction, and/or bowel obstruction; (3) abdominal pain reported by the individual; (4) consistency of bowel movement; and, (5) treatment intervention(s) if needed. An accurate recording of eacch individual's bowel status is maintained each shift. | | |
| 7 | The DDP trained in assessing the effection of intervention(s) or a licensed healthcare professional checks the bowel tracking record a minimum of once per week to assess the effectiveness of the intervention(s) and health status of the individual. | | |
| 8 | The organization has a protocol for medication schedule for critical and non-critical timings. | | |
| 9 | The organization follows the protocols in place for each individual. | | |

## RIGHTS AND PROTECTION

**3.01 Rights and Responsibilities** **(Eff. 2/1/16)**

Written policy, procedure and practice safeguard the rights and responsibilities of the individuals served.

Reference:
DBHDD Policy 02-1101 and 15-112
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 22-24
DHS Rules and Regulations for Client Rights, Chapter 290-4-9

Approaches to evaluate this standard include, but are not limited to:
Review:
• Rights and responsibilities signed on admission and at least annually thereafter
• Human Rights Committee - composition, meeting minutes
• Legal status; competent/adjudicated incompetent
• Services, supports, care and treatment provided per ISP with referrals as needed
Interview:
• Staff are aware of individual's rights as designated in Chapter 290-4-9
• Individuals/guardians about their rights and appeal process
• Staff/administrator about any rights restrictions in place
Observe:
• DBHDD "You Have Rights" poster is displayed in a prominent area accessible to individuals
• Staff interactions protect and respect the rights and dignity of the individual

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: (1) practices that do not discriminate; (2) equitable supports, care and treatment in the least restrictive environment possible; (3) the use of teaching functional communication, functional adaptive skills to increase independence, and the least restrictive interventions that are likely to be effective; (4) Clients Rights and the Human Rights Council policy, and the rights and responsibilities of persons served; (5) under no circumstances will threats of harm or mistreatment, corporal punishment, fear eliciting procedures, abuse or neglect of any kind, withholding nutrition or basic necessities, or withholding services occur; (6) humane treatment or habilitation that affords protection from harm, exploitation, or coercion; (7) unless adjudicated incompetent, the individual is considered legally competent to maintain civil, political, personal and property rights; (8) the process utilized when rights issues need to be reviewed; and, (9) the review and appeals process to protect the human rights of the individuals served. | | |
| 2 | The organization has the DBHDD "You Have Rights" poster displayed in a prominent area accessible to individuals. | | |
| 3 | Individuals/guardians are informed of their rights and responsibilities and sign an acknowledgement upon admission, at least annually thereafter and whenever there are changes. Rights and responsibility information is prepared in the language/format understandable by the individual. | | |
| 4 | For consents and documents other than medical informed consent, competent individuals sign for themselves. The guardian signs for adjudicated incompetent individuals. | | |

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| 5 | The organization protects and respects the rights and dignity of the individuals served. When issues are identified, the organization takes the actions required. | | |
| 6 | The organization ensures that individuals can access services, supports, care and treatment. When the organization does not provide a service/support/care/treatment, the organization makes the necessary arrangements. | | |

**3.04 Organizational Crisis Plan** **(Eff. 2/1/16)**

Written policy, procedure and practices demonstrate the use of crisis intervention as needed.

Reference:
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual, Part II, Section 706.3

DBHDD Provider Manual for Community Developmental Disabilities Providers, page 27

Approaches to evaluate this standard include, but are not limited to:
Review:
• Organizational crisis plans
• Individuals' records
• Staff training
Interview:
• Individuals / guardians and staff
Observation:
• Organizational crisis plan implementation

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: (1) approved/allowed interventions to be utilized by staff; (2) availability of additional resources to assist in diffusing the crisis; (3) if the acute crisis presents a substantial risk of imminent harm to self and others, that community based crisis services to include the Georgia Crisis Response System (GCRS) as an alternative to emergency room care, calling 911, institutional placement, and/or law enforcement involvement (including incarceration) is implemented; (4) protocols to access community-based crisis services to include the Georgia Crisis Response System and staff training on the protocols; and, (5) notification process by Direct Support Staff that includes informing the designated on-call management staff and/or Director. | | |
| 2 | The organization implements crisis intervention as needed. | | |

**3.05 Developmental Disabilities Professional Services** **(Eff. 4/1/17)**

Written policy, procedure and practice demonstrate an employee or contractor attached to the organization who has professional experience in the field of expertise best suited to address the needs of the individuals served.
Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 11-12, 19, 41-45

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| 1 | The organization has at least one employee or contractor who serves as the DDP. The DDP is not a PRN employee. | | |
| 2 | Developmental Disabilities Professional (DDP) services are delivered only by a qualified DDP. | | |
| 3 | There is a specified DDP schedule for each of the organization's sites. | | |

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| 4 | There is documentation of attestation by the DDP that the scheduled or contracted hours do not conflict with his/her work with another provider agency. | | |
| 5 | Individuals receiving clinical services or changes in functional, medical, behavioral, or social status are identified for DDP ongoing review. | | |
| 6 | DDP documentation of necessary face-to-face visits includes date, location of service delivery, signature (title) and the beginning and ending time when the service was provided. Documentation will also contain the purpose of the visit or contact, assessment or evaluation, training, plan for intervention, and any changes in service delivery such as change in staff recommendations. | | |

**3.06 Individuals' Funds** **(Eff. 2/1/16)**

Written policy, procedure and practice demonstrate that the organization takes special care to assure that the funds are not mismanaged or exploited.

Reference:
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual, Part II, Section 1106

DBHDD Provider Manual for Community Developmental Disabilities Providers, page 38-40

Approaches to evaluate this standard include, but are not limited to:
Review:
- Representative payee status
- PSA records, receipts, cash on hand
- Day to day living expense agreements, food stamps
- Independent reconciliation of bank/account records, individual/guardian review of PSA
- Personal inventory, life insurance, burial account, money management skills

Interview:
- Administrator/staff about handling of funds

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | When managing funds, the organization has a policy in place and substantially practiced that includes: (1) inventory of possessions at admission and then at least annually; (2) management of funds, without co-mingling or pooling; (3) reconciliation of account records monthly by at least 2 people, other than those having authorization to receive and disburse funds on behalf of an individual; (4) maintenance of records of each individual's personal funds and personal needs accounts when the provider is the representative payee; (5) the representative payee determines the current needs for day to day living and uses the individual's payments to meet those needs; (6) maintenance of financial records for at least 2 years; (7) a strict prohibition, punishable by termination, for any employee/representative of the organization to be listed or designated as a beneficiary, payee or other member of any funds; (8) maintenance of copies of the day to day living expense agreement in the individual's record; (9) timely deposits and accounting of funds; (10) use of insured deposit accounts; (11) interest earned accrued to the individual; (12) deposit of funds due to the organization in the individual's account prior to disbursement to the organization; (13) disbursement of funds only upon the request or authorization of the individual/family; (14) when possible, persons outside of the organization serve as the representative payee; and, (15) a process for the review of funds by the individual and his/her representative at least quarterly. | | |

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| 2 | The organization that doesn't manage/handle the individual(s) funds has a policy in place and substantially practiced that includes, at a minimum, the following: (1) the organization and its employees do not access, handle or manage any money of the individual(s); and (2) a strict prohibition, punishable by termination, for any employee, agency or representative of the organization to be listed or designated, directly or indirectly, as a beneficiary, payee of nay funds of the individual. | | |
| 3 | Funds are not pooled or co-mingled in any organizational account or other combined accounts, or with other individual's funds. The Social Security Administration has granted permission for collective accounts. The collective account, with a sub-account for each beneficiary, shows that the funds belong to the beneficiaries and not the payee. Documentation in current record keeping clearly indicates the amount of each beneficiary's share and clearly shows the individual's amount for deposits, withdrawals, and interest earned for each beneficiary. | | |
| 4 | At least two people, other than those having authorization to receive and disburse funds on behalf of any individual, independently reconcile the bank and/or account records of any individual served by the organization on a monthly basis. | | |

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| 5 | When providers are selected and become the payee of individuals' checks, there are records of each individual's personal funds and all other records pertaining to personal needs accounts (including bank statements and bank books). Documentation of personal spending is accounted for on the approved Personal Spending Account Record form, or a payee created document that contains all of the same elements as the approved form. Only the current month's Personal Spending Account Record is kept at the individual's place of residence, for immediate inspection, as applicable. All previous months' Personal Spending Account Records may be kept off site at the agency business office, but is to be available to the person served, his or her family, the Support Coordinators, the Regional Office, and any other legally authorized representative for inspection and copying upon request, or within one to two business days of request. | | |
| 6 | The representative payee of individuals served determines the current needs for day to day living and uses his/her payments to meet those needs (e.g., day to day living expenses including housing and utility bills that is equitably distributed among all individuals supported in the home based on specific residence cost, average cost of similar homes in a geographic area, current mortgage or rental payment; food where preferences and dietary needs are honored; medical/dental if not covered by Medicare, Medicaid and/or private insurance to the extent that SSI benefits and Social Security are available and personal items and clothing specified in Social Security Guidelines.). At a minimum (regardless of day-to-day expenses) each individual in DD residential services receives monies for personal needs and allowances as determined by the Department, Social Security Office or Medicaid. | | |

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| 7 | The organization keeps written records of at least two years of all payments from the Social Security Administration (SSA), bank statements, and cancelled checks, receipts or cancelled checks for rent, utilities, and major purchases. | | |
| 8 | Copies of each day to day living expense agreement are maintained in the individual's record. Day to day living expense agreements are signed by the provider at admission and thereafter annually and submitted to the Division of DD or when there is a change of provider serving the individual. | | |
| 9 | Funds not needed for ordinary use by the individual on a daily basis are deposited in an interest-bearing, FDIC-insured account. The account is in a form which clearly indicates that the organization has only a fiduciary interest in the funds. Any interest earned on such account accrue to the individual. | | |
| 10 | To the extent that certain funds are properly due to the organization for services, goods, or donations, said funds are deposited to the individual's account and then subsequently disbursed in accordance with these requirements and the written policies of the organization. | | |
| 11 | Individual funds are only disbursed upon request or authorization of the individual and/or his/her family, if appropriate, and in the case where the organization serves as the designee to receive and disburse funds on behalf of the individual, members or organizational representatives is needed. | | |

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| 12 | If Individual's funds are not personally managed by the individual, a mechanism is in place for the review of funds by the individual and his or her representative at least once a quarter, to include a review of the bank statement of funds received (including date of deposit, fund source), funds spent (date and source with receipt) and balance of funds available. The organization maintains documentation of the individual review. Financial assets such as annuity accounts, personal belongings and burial funds are reviewed and updated. | | |

**3.07 Records** **(Eff. 4/1/17)**

Written policy, procedure and practice document a record for each individual served.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 34-36
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW), Part II
DBHDD Provider Manual for Community Developmental Disabilities Providers

Approaches to evaluate this standard include, but are not limited to:
Review:
• Individuals records
Observation:
• Storage of records

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses, at a minimum that the organization upon transfer/discharge: (1) Sends a complete certified copy of the record to the Department or the provider who will assume service provision, that includes the individual's Protected Health Information, billing information, service related information such as current medical orders, medications, behavior plans as deemed necessary for the purposes of the individual's continuity of care and treatment; (2) Sends unused Special Medical Supplies (SMS), funds, personal belongings, burial accounts to the receiving location; and (3) Discharge information is provided to the individual and the new service provider at the time of discharge that provides (i) Strengths, needs preferences and abilities of the individual, (ii) services supports care and treatment provided, (iii) achievements, (iv) necessary plans for referrals, and (v) a dictated or hand written summary of the course of serves, supports, care and treatment incorporating the discharge summary information provided to the individual and the new service provider, if applicable, must be placed in the record within 30 days of discharge. | | |
| 2 | The record includes precautions and allergies (or no known allergies – NKA) on the front. | | |
| 3 | The record includes "volume #x of #y" on the front. | | |
| 4 | The record includes the individual's identification on the front. | | |
| *The record includes, at a minimum the following:* | | | |
| 5 | Emergency contact information | | |
| 6 | Consent for services | | |
| 7 | Any psychiatric or advanced directive | | |
| 8 | Legal documentation establishing guardianship | | |

NOTE: This Compliance Review Report provides explanations of only the deficient practices identified during this review.
The criteria deemed "not applicable" or "not evaluated" are not identified and not included in the scoring.

**3.08 Documentation** **(Rev. 4/1/17)**

Information in the record is organized, complete, current and tells an accurate story of services, supports, care and treatment rendered and the individual's response. Should be changed to: Information in the record is organized, complete, and current and tells an accurate story of services, supports, care and treatment rendered and the individual's response.

Reference:
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW), Part II
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 34-36
Rules and Regulations for Personal Care Homes, Subject 111-8-62-.24

Approaches to evaluate this standard include, but are not limited to:
Review:
• Progress notes, legal status documents
Interview:
• Staff – when, how and why legal status can be changed, notifications that must be made by law, use and meaning of hold orders

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 2 | Items in the record are dated, timed, and authenticated with the author's signature and title. | | |
| 3 | Documentation is completed each shift or service contact by staff providing the service. | | |
| 4 | Notes entered retroactively into the record after an event or a shift are identified as a late entry. | | |
| 5 | If notes are voice recorded and typed or a computer is used to write notes that are printed, each entry is dated and the physical documentation must be signed and dated by the staff writing the note. Notes are then placed in the individual's record. | | |
| 7 | All supporting documentation relevant to service delivery is maintained in the individual's record at the service delivery site(s). | | |
| 8 | In personal care homes, the record includes a copy of the search results obtained from the National Sex Offender Registry website maintained through the Department of Justice, and any resulting safety plan for individuals, staff and visitors. | | |

## HOLISTIC & PERSON-CENTERED APPROACH

**4.01 Assessments** **(Rev. 4/1/17)**

Written policy, procedure and practice document multi disciplinary assessments supporting stabilization, recovery, care and treatment that are developed based on the needs of the individual.

Reference:
DBHDD Policy 02-803
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 30-31

Approaches to evaluate this standard include, but are not limited to:
Review:
• Process for integration of screenings / assessments into the development of the ISP

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 2 | Additional assessments, such as but not limited to abuse, trauma, suicide, functional, cognitive, behavioral, independent living skills, cultural, recreational, educational, vocational, nursing, etc. are performed or obtained by the organization as needed or as ordered by a physician or mid-level provider. | | |
| 3 | When a nutritional assessment is indicated, the organization ensures that it is completed as ordered by a physician. The nutritional assessment is completed by a registered dietitian. | | |
| 4 | The provider ensures the completion of the HRST, as required. (Residential providers are always the lead provider when the individual receives services from multiple providers. If the individual does not receive residential services, the responsible provider is designated in the ISP.) | | |
| 5 | The HRST is continually updated by a staff member who has completed the DBHDD-required HRST training. | | |
| 6 | The RN reviews, signs and ensures the accuracy of the information if the HRST level results is a score of 3 or higher. | | |

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| 7 | Ongoing updates of the HRST are completed when a person experiences significant changes in health, functional or behavioral status. | | |
| 8 | When an individual is determined to be at risk for developing constipation and/or bowel obstruction, the HRST is updated and a physical examination is conducted that includes, at a minimum: a thorough history of the individual's bowel pattern, dietary intake, laxative and/or suppository dependency, and activity level. Information gathered is documented in the individual's medical record. | | |
| 9 | The HRST is updated at least 90 days prior to annual ISP expiration date and whenever there is any change that may affect the score. | | |
| 10 | The HRST data tracking log that is maintained on site. | | |

**4.02 Individualized Service Plans** **(Rev. 4/1/17)**

Written policy, procedure and practice document an individualized service/resiliency/recovery plan developed by a multi-disciplinary team in collaboration with the individual/family and/or other stakeholders.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 31-34

Approaches to evaluate this standard include, but are not limited to:
Review:
• ISP/IRP goals should be specific, measurable, achievable, relevant, realistic and time limited
• Daily program schedule
Interview:
• Staff regarding ISP, goals, offerings that support individuals in reaching goals

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | A copy of the current ISP and all addenda are included in the record. | | |
| 6 | Documents are incorporated by reference into the ISP, such as medical updates, addenda, crisis plan, behavior support plan, safety plan, etc. | | |

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| 7 | The use of an Adaptive Supportive or Medical Protection Devices is authorized in the individual's ISP or addendum if necessary. | | |
| 8 | The organization implements the applicable goals at the frequency identified by the ISP. | | |
| 9 | Progress notes or learning logs describe progress toward goals. Notes document issues, situations, or events occurring in the life of the individual as well as the individual's response to the issues, situations or events. | | |
| 10 | The individual's data from progress notes or tracking sheets and learning logs have been reviewed, analyzed and summarized to determine progress at least quarterly. | | |

**4.03 Behavior Support Consultation Services**

The organization has the capacity to address each individual's behavior needs.

Reference:
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP), Part III, Sections 1600, 3300
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP), Part III, Sections 1600, 3300
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 20, 26

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organizations has the capacity to address each individual's behavioral needs. If the cause of the challenging behavior cannot be determined or satisfactorily addressed by the provider, there is evidence of consultation with an outside professional who is licensed or qualified through education, supervised training and experience to address the behavior needs of the Individual. | | |

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| 2 | Behavior Support Consultants and providers of Behavior Support Services have documentation of proficiency trainings in behavioral support courses completed within 6 months of enrollment as a provider of services. | | |
| *The following is documented in the record of each individual receiving Behavioral Support Consultation Services:* | | | |
| 3 | The specific activity, training, or assistance provided | | |
| 4 | The location, date and the beginning and ending time when the service was provided. | | |
| 5 | Verification of service delivery, including first and last name and title (if applicable) of the person providing services | | |
| 6 | Progress toward goals outlined in ISP | | |
| 7 | Description of outcome specific to each target behavior intervention to include but not limited to behavioral changes, acquisition of new replacement skills, ability to increase community integration, and other positive life outcomes. | | |

**4.04 Time Out and Interventions of Last Resort** **(Eff. 2/1/16)**

Written policy, procedure and practices demonstrate that the organization has the capacity to serve complex behavioral needs.

Reference:
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual, Part II, Section 706.3

Approaches to evaluate this standard include, but are not limited to:
Review:
• Individuals' records
• Staff training
Interview:
• Individuals / guardians and staff
Observation:
• Use of time out, interventions of last resort

NOTE: This Compliance Review Report provides explanations of only the deficient practices identified during this review. The criteria deemed "not applicable" or "not evaluated" are not identified and not included in the scoring.

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: (1) time out (also known as withdrawal to a quiet area); (2) manual hold/restraint (also known as personal restraints); (3) mechanical restraint (also known as physical restraints); (4) seclusion; (5) chemical restraint; and (6) PRN anti-psychotic medications for behavior control are not permitted. In addition, the organization has policies and procedures that address all aspects of managing behaviors that is in accordance with the Guidelines for Supporting Adults with Challenging Behaviors in Community Settings. | | |
| 2 | Time out periods are brief and do not to exceed 15 minutes if allowed. Restrictive time out and seclusion, or the involuntary confinement of an individual alone in a room or in any area of a room where the individual is prevented from leaving, are not permitted. | | |
| 3 | Manual hold is used as an emergency safety intervention of last resort affecting the safety of the individual or of others, and as an approved intervention in the individual's safety plan. Manual hold does not exceed 5 minutes and use of a manual hold is documented. (Manual holds (personal restraint) may be used in all community settings except residential settings licensed as personal care homes.) | | |

**4.05 Positive Behavior Support Plans** **(Eff. 2/1/16)**

Written policy, procedure and practice demonstrate an organizational approach to developing a Positive Behavior Support Plan (PBSP), including a safety plan, and treatment for individuals demonstrating challenging behaviors consistent with the Guidelines for Supporting Adults with Challenging Behaviors in Community Settings. Behavior support activities outlined in the PBSP are guided by an overall emphasis on not only decreasing target behaviors but also concurrently increasing skills in appropriate areas.

Reference:
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual, Part II, Section 706.3

DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 24-27

Approaches to evaluate this standard include, but are not limited to:
Review:
• Individuals' PBSPs and records
• Staff training
• Data collection
• Informed consent for PBSP
• Behavior consultation services
Interview:
• Individuals / guardians and staff
Observation:
• PBSP implementation

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses Positive Behavior Support Plans (PBSP). | | |
| 2 | The PBSP is developed and overseen by a Psychologist, Behavior Specialist, or Board Certified Behavior Analyst. | | |
| 3 | There is documented evidence of a clinical assessment and validation of behavior support needs. The clinical assessment is based on HRST & SIS eligibility criteria. e.g., HRST score of 4 on Item Q for 1:1 staffing; SIS score of 7 or higher for behavior support. | | |
| 4 | The PBSP is individualized, based on a functional assessment, and addresses potential medical causes. | | |

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| 5 | The PBSP is inclusive of rationale for the following: (1) use of identified approaches; (2) the time of their use; (3) an assessment of the impact on personal choice of the individual; (4) the targeted behavior; and, (5) how the targeted behavior will be recognized for success. | | |
| 6 | The PBSP has monitoring plans for reviewing, analyzing trends, and summarizing the effectiveness of the plan and termination criteria. In addition, PBSP are routinely monitored to ensure provider compliance with prescribed data collection and interventions. | | |
| 7 | A copy of the individual's PBSP is available at the provider's service sites where services to the individual are delivered. | | |
| 8 | A PBSP is developed and implemented for individuals with developmental disabilities who receive psychotropic medications for symptom management of challenging behavior that continues to pose a significant risk to the individual, others, or the environment AND is not specifically related to mental illness or epilepsy. The positive behavior support plan minimally includes: (1) An operationally defined behavior(s) for which the drug is intended to affect; (2) Measuring target behaviors which shall constitute the basis on which medication adjustments will be made; and, (3) A focus on teaching replacement behaviors in an effort to replace the use of medication with behavioral programming. | | |

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| 9 | Intrusive or restrictive procedures are clearly justified through documentation of less restrictive procedures ineffectiveness and/or the need for more intrusive procedures due to the safety or health risks presented by the targeted behaviors. These procedures are authorized, incorporated into the safety plan, approved by ISP interdisciplinary team, reviewed by organization's Rights Committee and supervised by qualified professional(s) and may not be in conflict with Federal or State Laws, Rules and Regulations, Clients Rights or Department standards to include but not limited to the document Guidelines for Supporting Adults with Challenging Behaviors in Community Settings when developing a behavior support plan/safety plan. | | |
| 10 | Person-Centered Behavior Supports Planning (PCBS) | | |
| 11 | Programmatic guidelines for staff that address the individual's preferences and values | | |
| 12 | Collaborative teamwork by all service delivery providers to assist the behavioral professional conducting the functional behavioral assessment across settings (such as residential, day service, supported employment) | | |
| 13 | Development of interventions that will be most effective for each setting or situation | | |
| 14 | Lifestyle and competency improvements based on the individual's strengths, skills, abilities, personal preferences and choices | | |
| *When Enhanced Service Delivery and/or Exceptional Rate is approved for specialized behavioral supports, training and skilled service delivery, the following must be addressed in the PBSP:* | | | |
| 15 | Safety checks, staff oversight and ratio are clearly outlined and defined (such as 1:1 support, 2:1 support, line of sight, and arm's length, 1:1 inclusive line of sight); | | |

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|---|---|---|---|
| 16 | ER Crisis Plan to support the exceptional behavioral or medical needs | | |

**4.06 Safety Plans** **(Eff. 2/1/16)**

Written policy, procedure and practice demonstrate the use and recognition of Safety Plans.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 24-27
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual, Part II, Section 706.3

Approaches to evaluate this standard include, but are not limited to:
Review:
• Safety plans
• Individuals' records
• Staff training
Interview:
• Individuals / guardians and staff
Observation:
• Safety plan implementation

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: (1) safety plans that begin with the use of interventions written in the PBSP except that further specify additional steps to take in response to challenging behaviors that are dangerous to the psychological or physical health and safety of the individual or others; and, (2) the least restrictive interventions that would reduce or eliminate risk. | | |
| 2 | The safety plan begins with the use of interventions written in the PBSP. | | |
| 3 | A safety plan is written when there are indications of challenging behavior(s) that may jeopardize the psychological or physical health and safety of individual or others. | | |

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| 4 | All interventions in a safety plan begin with the least restrictive intervention that would reduce or eliminate risk. | | |
| 5 | Notification of the stakeholders occurs when a safety plan is first developed. | | |
| 6 | The safety plan is reviewed and reauthorized more frequently if the PBSP undergoes a significant revision or if it is determined that it is not meeting the needs of the individual. | | |

**4.07 Individual Crisis Plan** **(Rev. 10/15/16)**

Written policy, procedure and practices demonstrate the use of a crisis plan for individuals who have the cognitive and verbal or expressive skills to describe how they feel and what helps them feel better or worse.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 24-27
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual, Part II, Section 706.3

Approaches to evaluate this standard include, but are not limited to:
Review:
• Individual crisis plans, wellness recovery action plans
• Individuals' records
• Staff training
Interview:
• Individuals / guardians and staff
Observation:
• Individual crisis plan implementation
• Wellness recovery action plan implementation

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses, at a minimum, individual crisis plans in lieu of safety plans for individuals who have the cognitive and verbal or expressive skills to describe how they feel and what helps them feel better or worse. | | |

NOTE: This Compliance Review Report provides explanations of only the deficient practices identified during this review. The criteria deemed "not applicable" or "not evaluated" are not identified and not included in the scoring.

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| 2 | Crisis Plans include the following components: (1) what the individual is like when he/she is feeling well; (2) the symptoms to indicate when someone needs to take over responsibility for their care; (3) the individual's supporters and what they should do; (4) information about the individual's medications; (5) the treatments the individual would like in a crisis situation; (6) the options for community care; (7) a safe facility; and, (8) how to know when the crisis is over. Crisis plans are written in first person. | | |

## ENVIRONMENT OF CARE

**5.01 Food Service** **(Rev. 4/1/17)**

Written policy, procedure and practice document the provision of three regularly scheduled, well balanced meals and two snacks per day.

Reference:

DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual, Part II, Section 1102
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 28-31
Rules and Regulations for Personal Care Homes, Subject 111-8-62-.21

Approaches to evaluate this standard include, but are not limited to:
Review:
• Menus (general/special)
• Temp logs (freezer/refrigerator)
• Cleaning logs for kitchen
Interview:
• Direct care staff regarding meal schedules and cooking procedures
• Individuals regarding their meal selection input
Observe:
• Preparation/service of meals
• Thermometers vs. temp logs
• Safe food storage in refrigerators/lunches (open food labeled, proper temp of lunches)
• Cleanliness of food service prep area
• Check that appliances are in working order

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 2 | The organization serves a minimum of three regularly scheduled, well balanced meals and two nutritious snacks per day. For PCH and CLA, there should be no more than 14 hours between the evening meal and the start of the breakfast meal the following morning. | | |

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| 4 | The temperature of all refrigerators and freezers is checked and documented daily. All refrigerators and freezers have a working inside thermometer. Refrigerator temperatures are maintained at 34 to 40 degrees F. Freezer temperatures are maintained at 0 to 10 degrees F. | | |
| 5 | All (open and unopened) food items have the expiration date indicated on the item. | | |
| 7 | The organization has a written cleaning schedule for food service areas, which is adhered to. | | |
| 9 | Nutritional treatments, such as special diets or supplements, have an active, current physician's order that is renewed at least annually. | | |
| 10 | When a special diet is ordered, the residential organization has menus that correspond to the ordered diet and the diet is provided to the individual, including in instances of emergencies. | | |
| 11 | Staff are trained regarding special diets and staff have access to information about the individual's dietary needs readily available. | | |

**5.02 Emergency Preparedness** **(Rev. 4/1/17)**

Written policy, procedure and practice demonstrate that the organization is prepared for responding to natural and manmade disasters in a manner that provides safety to the individuals served.

Reference:
DBHDD Policy 02-704, Process for Enrolling, Matching, and Monitoring Host Home/Life-Sharing Sites for DBHDD Developmental Disabilities Community Service Providers
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 28-29
OCGA 35-3-170 (Mattie's Call Act)

Approaches to evaluate this standard include, but are not limited to:
Review:
• Emergency preparedness policy, inspection reports and related documents listed in this section
• Signed relocation agreement
• Fire/disaster drill reports
• Fire alarm/fire extinguisher inspection reports
Interview:
• Direct care staff regarding their knowledge of revisions to emergency preparedness policy/plans and protocols and fire extinguishers
Observe:
• Supplies needed for emergency evacuation
• Emergency evacuation equipment (location and contents)
• Safety mechanisms such as sprinklers, smoke detectors, emergency lights, and kitchen range/hood
• Fire extinguishers
• Emergency preparedness drills
• 3 day food and water supplies

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: (1) emergency evacuation; (2) relocation; (3) preparedness; (4) disaster response; (5) emergency supplies; and, (6) procedures for training staff in all emergency and disaster drills, and in the execution of the fire prevention and fire/disaster safety plan. | | |

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|---|---|---|---|
| 2 | The organization has an Emergency Response Plan that includes, at a minimum, the following: (1) detailed information regarding evacuating, transporting and relocating individuals with the local Emergency Management Agency; (2) evacuation preparation for individuals served; (3) medical emergencies; (4) missing persons that references Georgia's Mattie's Call Act; (5) natural disasters known to occur; (6) power failures; (7) continuity of medical care as required; (8) notifications to families or designee; (9) Continuity of Operation Planning (COOP) to include identifying locations and providing a signed agreement where individuals will be relocated temporarily in case of damage to the site where services are provided. COOP must also include plans for sheltering in place. For DD Crisis homes, the organization's plan may include the use of another crisis home, even if it is not in the same area. The plan includes the method of transportation to the nearest and safest DD Crisis Home, along with the name of the Crisis Home. | | |
| 3 | The Emergency Response Plan is reviewed annually. | | |
| 4 | The organization has a 3-day supply of non-perishable emergency food and water for each individual served in a residential setting. The supply can be readily transported. Three distinct meals are planned. The supply provides for physician ordered special diets for the individuals served. There is at least 1 gallon of water per person per day available. | | |
| 5 | The organization conducts fire drills on a monthly basis at alternate times during the day. Two fire drills per year are conducted during sleeping hours. The drills are documented to include follow-up recommendations for drills that are unsatisfactorily completed. | | |

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|---|---|---|---|
| 6 | When a drill is required during the onsite review or an emergency situation occurs, the organization follows the emergency plan and ensures the health and safety of all individuals and staff. | | |
| 7 | The organization conducts disaster drills on a quarterly basis. Disasters that could occur locally are drilled on a more frequent basis. | | |
| 8 | The organization has fully charged fire extinguishers that are tagged/dated on a yearly basis. (In CLAs, there is monthly documentation of fire extinguisher inspection.) There is at least one extinguisher for each floor. | | |
| 9 | The organization has a signed agreement where individuals will be relocated temporarily in case of damage to the site where services are provided. The agreement is reviewed annually to ensure the locations and agreement are current. | | |
| 10 | The facility has documentation on file for annual inspections of other safety mechanisms such as sprinklers, smoke alarms, emergency lights, kitchen range/hood, etc. Any issues identified are corrected. | | |
| 11 | Supplies needed for emergency evacuation are maintained in a readily accessible manner, including individual (s) information, family contact information and current copies of physician's orders for all individuals' medications. | | |

**5.03 Housekeeping/Maintenance** **(Rev. 4/1/17)**

Written policy, procedure and practice demonstrate that the organization has a system to maintain the cleanliness and maintenance of the service environment.

Reference:
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual, Part II, Section 1102

DBHDD Provider Manual for Community Developmental Disabilities Providers, page 54

Approaches to evaluate this standard include, but are not limited to:
Interview:
• Ask staff how often cleaning is conducted
Observe:
• Posted cleaning schedules
• Cleaning logs

| # | Criteria / Standard | | |
|---|---|---|---|
| 2 | The environment is clean and safe. | | |

**5.04 Laundry** **(Rev. 4/1/17)**

The management of laundry ensures the accessibility of clean linens and clothing. Clothing and linens are collected, sorted, transported, washed and stored in a manner that prevents the spread of infections and contamination of the environment.

Reference:
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual, Part II, Section

DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 54, 81, 83

Approaches to evaluate this standard include, but are not limited to:
Interview:
• Ask staff how often washcloths, towels and other linens are washed, process for laundry transportation, sorting, washing, storage, etc.
Observe:
• Number of towels and washcloths in the home and or facility
• Amount of bedding

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 2 | Clothing and linens are collected, sorted, transported, washed and stored in a manner that prevents the spread of infections and contamination of the environment. | | |

NOTE: This Compliance Review Report provides explanations of only the deficient practices identified during this review.
The criteria deemed “not applicable” or “not evaluated” are not identified and not included in the scoring.

**5.05 Infection Control** **(Rev. 4/1/17)**

Written policy, procedure and practice effectively prevent, control and reduce the risk of the spread of infection.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 54

Approaches to evaluate this standard include, but are not limited to:
Review:
• Infection control risk plan and review dates
• Documentation of training on standard precautions as applicable to DD crisis homes
Interview:
• Agency staff on infection control procedures as needed
Observe:
• Availability of barrier equipment outlined in policy
• Indoor running hot and cold water
• Liquid soap and paper towel at all hand-washing locations
• Hand sanitizer as applicable
• Staff proper hand washing techniques
• Proper disposal of biohazard waste and sharps

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization has a policy in place and substantially practiced that addresses, at the minimum, the following: (1) guidelines for environmental cleaning and sanitizing; (2) guidelines for the proper disposal of biohazardous materials and sharps; and, (3) procedures for the prevention of infestation by insects, bed bugs, rodents or pests. | | |
| 2 | The organization has an Infection Control Plan that addresses, at the minimum, the following: (1) standard precautions; (2) hand washing guidelines; (3) proper storage of personal hygiene items; and, (4) prevention of the spread of common illnesses/infectious diseases likely to be emergent in the particular service setting. | | |
| 4 | All barrier equipment is readily accessible and disposable (for single-use only). | | |

NOTE: This Compliance Review Report provides explanations of only the deficient practices identified during this review. The criteria deemed “not applicable” or “not evaluated” are not identified and not included in the scoring.

| | | | |
|---|---|---|---|
| 5 | The organization has running hot and cold water and liquid soap for use in all kitchen, restroom and individual changing areas. | | |
| 6 | Disposable paper towels or hand blowers must be available at all hand wash basins. | | |
| 7 | Alcohol based hand rub may be utilized in addition to handwashing, but not in lieu of handwashing. | | |
| 8 | Staff demonstrate appropriate hand hygiene techniques after each direct contact, between medication passes, and after eating, smoking or using the restroom. | | |
| 9 | Proper disposal of biohazards, such as potentially infected waste and spills-management, needles, lancets, scissors, tweezers and other sharp instruments is managed according to the organization's policy and in such a manner that prevents injuries. | | |

## HUMAN RESOURCES

**6.01 Human Resources Administration** **(Eff. 4/1/17)**

Written policy, procedure and practice demonstrates a commitment to recruit, develop and retain competent employees and contractors.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 20

Approaches to evaluate this standard include, but are not limited to:
Review:
• Personnel records
Interview:
• Staff

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 2 | The organization has documentation that the following services are assigned to qualified employed or contracted professional staff: (1) overseeing the services, supports, care and treatment provided to individuals; (2) supervising the formulation of the individual service plan or individual recovery plan; (3) conducting diagnostic, behavioral, functional and educational assessments; (4) designing and writing behavior support plans; (5) implementing assessment, care and treatment activities as defined in professional practice acts; and, (6) supervising high intensity services such as screening or evaluation, assessment, and residential behavior support services. | | |

**6.02 Personnel Records** **(Eff. 4/1/17)**

Written policy, procedure and practice document hiring screening processes are completed for employee selection and managing personnel information and records.

Reference:
DBHDD Policy 04-104, Criminal History Checks for Contractors
DBHDD Provider Manual for Community Developmental Disabilities Providers

Approaches to evaluate this standard include, but are not limited to:
Review:
• Personnel records
Interview:
• Staff

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | All employees and contractors have a personnel record. | | |
| 3 | Each personnel record includes a date of hire | | |
| 7 | Each personnel record includes a resume. | | |
| 8 | Each personnel record includes a diploma or GED (if the staff does not have a professional license). | | |
| 9 | Each personnel record includes current credentials, licenses, and certifications, as applicable. The provider verifies the validity of the license or certificate prior to employment and at least annually thereafter. | | |
| 10 | Each personnel record includes a driver's license. The employee is 18 years of age or older. | | |

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|---|---|---|---|
| 13 | For employees who transport individuals, the personnel record includes a 7 Year Motor Vehicle Record that has no more than two chargeable accidents, moving violations, or any DUIs in a three year period within the last five years of the seven year MVR period. The MVR is obtained before hire and then annually. | | |
| 14 | For employees who transport individuals in their personal vehicles, the personnel record includes current car insurance. | | |
| 16 | All employees, volunteers and anyone contracted to perform direct care, treatment, custodial responsibilities, or any combination thereof has a fingerprint-based criminal history record check prior to employment. Criminal records checks are securely maintained separately from other personnel records, with access restricted to the person assigned the responsibility for human resources. The organization does not employ any applicant who has been convicted of a crime that excludes them from hire eligibility. | | |

**6.04 Orientation Training** **(Eff. 4/1/17)**

Written policy, procedure and practice ensure that all staff, volunteers and consultants are trained as required by DBHDD policy and the specialized needs of the individuals served.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers

Approaches to evaluate this standard include, but are not limited to:
Review:
• Staff training records
Interview:
• Staff

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | Orientation is provided to each employee/contractor prior to direct contact with individuals. | | |
| 2 | Orientation includes the purpose, scope of services, supports, care and treatment offered including related policies and procedures. | | |
| 3 | Orientation includes HIPAA and confidentiality of individuals' information, both written and spoken. | | |
| 4 | Orientation includes the rights and responsibilities of individuals. | | |
| 5 | Orientation includes the requirement for recognizing and mandatory reporting of suspected abuse, neglect or exploitation of an individual to DBHDD, within the organization, to appropriate licensing agencies and to law enforcement agencies.. | | |
| 6 | For residential providers, the initial orientation training includes the causes of constipation, impaction, and bowel obstruction. | | |

**6.05 Initial Training** **(Eff. 4/1/17)**

Written policy, procedure and practice ensure that all staff, volunteers and consultants are trained as required by DBHDD policy and the specialized needs of the individuals served.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers

Approaches to evaluate this standard include, but are not limited to:
Review:
• Staff training records
Interview:
• Staff

NOTE: This Compliance Review Report provides explanations of only the deficient practices identified during this review. The criteria deemed “not applicable” or “not evaluated” are not identified and not included in the scoring.

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | Within the first 60 days from date of hire, all staff having direct contact with individuals receive the required initial training. | | |
| 2 | The initial training includes person centered values, principles and approaches. | | |
| 3 | The initial training includes a holistic approach for providing care, supports and services for the individual. | | |
| 4 | The initial training includes medical, physical, behavioral and social needs and characteristics of the individuals served | | |
| 5 | The initial training includes human rights and responsibilities | | |
| 6 | The initial training includes promoting positive, appropriate and responsive relationships with persons served, their families and stakeholders. | | |
| 7 | The initial training includes the utilization of communication skills. | | |
| 8 | The initial training includes the utilization of behavioral support and crisis intervention techniques to de-escalate challenging and unsafe behavior. | | |
| 9 | The initial training includes the utilization of nationally benchmarked techniques for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization) . | | |
| 10 | The initial training includes the Georgia Crisis Response System to access crisis services. | | |
| 11 | The initial training includes ethnic and cultural diversity policies. | | |
| 12 | The initial training includes fire safety. | | |

NOTE: This Compliance Review Report provides explanations of only the deficient practices identified during this review. The criteria deemed “not applicable” or “not evaluated” are not identified and not included in the scoring.

| | | | |
|---|---|---|---|
| 13 | The initial training includes emergency and disaster plans and procedures. | | |
| 14 | The initial training includes techniques of standard precautions, including preventative measures to minimize risk of infectious disease transmission, current information as published by the CDC, and approaches to individual education. | | |
| 15 | The initial training includes first aid and safety. | | |
| 16 | The initial training includes BCLS, including both written and hands on competency training. | | |
| 17 | The initial training includes specific individuals' medications and their side effects. | | |
| 18 | The initial training includes suicide prevention skills training, such as AIM, QPRP. | | |
| 19 | The initial training includes ethics and corporate compliance. | | |
| 20 | The initial training includes training to work with individuals who have co-occurring / are dually diagnosed, as appropriate. | | |

**6.06 Annual Training** **(Eff. 4/1/17)**

Written policy, procedure and practice ensure that all staff, volunteers and consultants are trained as required by DBHDD policy and the specialized needs of the individuals served.
Reference:
DBHDD Policy 02-802
DBHDD Provider Manual for Community Developmental Disabilities Providers

Approaches to evaluate this standard include, but are not limited to:
Review:
• Staff training records
Interview:
• Staff

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | The organization documents a minimum of 16 hours of training annually for each employee and contractor. | | |
| 2 | The annual training includes human rights and responsibilities | | |
| 3 | The annual training includes the utilization of communication skills. | | |
| 4 | The annual training includes the utilization of behavioral support and crisis intervention techniques to de-escalate challenging and unsafe behavior. | | |
| 5 | The annual training includes the utilization of nationally benchmarked techniques for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization) . | | |
| 6 | The annual training includes fire safety. | | |
| 7 | The annual training includes emergency and disaster plans and procedures. | | |
| 8 | The annual training includes specific individuals' medications and their side effects. | | |
| 9 | For residential providers, the annual training includes the causes of constipation, impaction, and bowel obstruction. | | |

**6.07 Specialized Training** **(Eff. 4/1/17)**

Written policy, procedure and practice ensure that all staff, volunteers and consultants are trained as required by DBHDD policy and the specialized needs of the individuals served.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers

Approaches to evaluate this standard include, but are not limited to:
Review:
• Staff training records
Interview:
• Staff

| # | Criteria | Deficient Practice | Effect/Outcome |
|---|---|---|---|
| 1 | In addition to the orientation, initial and annual required trainings, the DDP(s) of the organization obtain the following trainings within the first year: (1) individual service planning (person-centered); (2) Support Intensity Scale overview; (3) Health Risk Screening Tool on line training overview; and, (4) DBHDD sponsored or other training in the area of developmental disabilities of at least 8 hours per year. | | |
| 2 | Staff are trained on their Organization's Crisis Plan and if applicable, any individuals' Positive Behavior Support Plans, Safety Plans and Crisis Plans. | | |
| 3 | Staff are trained on all specialized needs of the individual and on training needs as outlined in the ISP. | | |
| *DD Crisis Single Point of Entry staff participate in training and pass an examination demonstrating their competence in all crisis protocols and relevant applicable trainings including:* | | | |
| 6 | Mobile crisis dispatch criteria | | |
| 7 | Telephonic crisis intervention | | |

| | | | |
|---|---|---|---|
| *DD Crisis Mobile Team members and Intensive Support staff participate in training and pass an examination demonstrating their competence in all crisis protocols and relevant applicable trainings including:* | | | |
| 8 | Assessing the crisis (specific I/DD training and diagnosing problems) | | |
| 9 | Onsite operations | | |
| 10 | Referral decision criteria | | |
| 11 | One of the following Crisis Intervention Programs: (1) Crisis Prevention Institute (CPI); (2) Handle with Care Behavior Management System; (3) Mindset; (4) Safe Crisis Management; (5) Human Empowerment Leadership Principles (HELP); (6) Professional Crisis Management; or (7) Safety Care. | | |
| 12 | Person Centered Planning. | | |
| 13 | Trauma Informed Care | | |
| *For Host Homes:* | | | |
| 14 | The adult family member who has primary responsibility for the individual and for providing services to the individual has at least the following training prior to providing services: (1) person centered values, principles and approaches; (2) human rights and responsibilities; (3) recognizing and reporting critical incident; (4) Individual Service Plan; (5) confidentiality of individual information, both written and spoken; (6) fire safety; (7) emergency and disaster plans and procedures; (8) techniques of standard precautions; (9) basic cardiac life support (BCLS); (10) first aid and safety; and, (11) medication administration and management/supervision of self-medication. | | |

| | |
|---|---|
| Provider is in violation of laws, rules, regulations, and/or policies. | The organization failed to document a policy. |
| Provider is not providing necessary services, support and treatment for the individual(s). | The organization failed to document a policy that addresses any of the requirements of the criteria. |
| Provider is not providing necessary services, support and treatment for the individual(s). Insufficient services, support, treatment and/or documentation could result in immediate jeopardy. | |
| Documentation does not provide a clear understanding of the work performed. | |
| Deficient environment of care could result in immediate jeopardy. | |