LEADERSHIP & ORGANIZATIONAL PRACTICES

1.01 Internal Controls **(Rev. 10/15/16)**

Written policy, procedure and practice document a well-defined internal control/quality improvement plan for assessing and improving organizational quality.

Reference:
DBHDD Policy 01-341, CSU: Performance Improvement Plans and Activities
DBHDD Provider Manuals for Community Behavioral Health Providers, page 243-244
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 14-16

Approaches to evaluate this standard include, but are not limited to:
Review:
• QI/PI plan
• Reviews conducted of records
• Surveys of staff, individuals, families, stakeholders, management
Interview:
• Director regarding QI/PI processes, how issues are identified and corrected
• Other staff regarding the reporting of issues

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy (QI/PI Plan) in place and substantially practiced that addresses, at the minimum, the following: (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 risks for individuals and staff; (5) the processes used for assessing and improving organizational quality are identified; and, (6) the quality improvement plan is reviewed and updated at least annually.		
2	The organization documents the following indicators of performance, at minimum: (1) all areas of risk; (2) record reviews; (3) human resources; (4) satisfaction surveys; and, (5) cultural competency.		

3	The organization documents the following for each indicator of performance: (1) method of routine data collection and reporting; (2) method of routine measurement; (3) method of routine evaluation; and, (4) target goals/expectations.		
4	A quarterly quality/performance improvement meeting is held to report QI efforts, the outcome measurements determined from the performance indicators, and identified issues.		
5	For DD providers, quality/performance improvement findings are distributed on a quarterly basis to individuals served or their representatives (as indicated in the plan), the organization's staff, the organization's governing body, and other stakeholders as determined by the governing body.		
6	For CSUs/BHCCs, the quality/performance improvement committee distributes findings on a quarterly basis to the nursing administrator, medical director, CEO and governing body for their review and appropriate action.		

	At a minimum, the following areas of risk are monitored:		
7	Healthcare standards and welfare		
8	Complaints and grievances		
9	Incidents, both critical and non-reportable		
10	Medication management and variance		
11	Infection control		
12	Individual rights violations		
13	Restrictive interventions utilized are reviewed by the organization's own internal Human Rights Committee. The organization utilizes the Regional Human Rights Council as needed.		
14	Emergency safety interventions		
15	Positive Behavior Support Plan tracking and monitoring, to include restrictive interventions		
16	Practices that limit freedom of choice or movement		
17	Breaches of confidentiality		
18	In CSUs/BHCCs, high risk situations and special cases (suicide, death, serious injury, violence, and abuse of an individual) are reviewed within 24 hours.		
19	In CSUs/BHCCs, environmental safety and maintenance, including an environment scan which assesses risk for individuals served by or staff working in the CSU/BHCC and also assesses identified strategies and subsequent plans for mitigating those risks.		
20	In CSUs/BHCCs, uses of seclusion and/or restraint		
21	In CSUs/BHCCs, medical emergencies		

22	When issues are identified, the organization identifies/documents the issue(s), implements solution(s), monitors the issue(s) and trains the individuals and staff (as applicable). Health and safety issues are resolved in accordance with organizational policy.		
23	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.		
24	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.		
25	Appropriate utilization of human resources is assessed, including but not limited to: (1) competency; (2) qualifications; (3) numbers and type of staff, for example, a behavior specialist, required based on the services, supports, treatment and care needs of persons served; (4) staff to individual ratios; and, (5) staff training needs and the development of activities to respond to those needs.		
26	The organization conducts quality improvements surveys with staff, individuals served, families, stakeholders, and management.		

1.02 Advisory Board **(Eff. 2/1/16)**

Written policy, procedure and practice document the governing body providing objective guidance to the organization.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 39
DBHDD Provider Manuals for Community Behavioral Health Providers, page 242

Approaches to evaluate this standard include, but are not limited to:
Review:
• Bylaws
• Meeting minutes
Interview:
• Advisory board members, as available

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy or bylaws in place and substantially practiced that addresses the advisory board/governing body.		
2	The organization has an advisory board that consists of citizens, local business providers, individuals and family members.		
3	The advisory board meets at least twice each year.		
4	At a minimum, the advisory board reviews policies and risk management reports, and assesses the budget and the utilization of financial resources.		
5	The advisory board evaluates internal control processes to ensure that the organization is providing a consistently high quality of services to individuals.		
6	For CSUs/BHCCs, the Community Service Board serves as the advisory board/governing body.		

1.03 Scope of Services / Program Description **(Rev. 10/15/16)**

Written policy, procedure and practice document a detailed description of the organization's scope of services.

Reference:
DBHDD Policy 01-328, CSU: Operation Scope of Services
DBHDD Policy 01-329, CSU: Program Description
DBHDD Policy 01-107, Payment by Individuals for Community Behavioral Health Services
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP), Part III, Sections 1701, 1901, 2001, 2501, 3001
DCH Policies and Procedures for New Options Waiver Program (NOW), Part III, Sections 1701, 1901, 2001, 2501, 3001
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 61-62

Approaches to evaluate this standard include, but are not limited to:
Review:
• Program description
Interview:
• All levels of staff regarding the vision, function, and purpose of the organization
• All levels of staff regarding the chain of command, types of services offered, population served, procedures, and their role in the organization
Observe:
• Staff and individual interactions
• Procedures

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a scope of service/program description in place and substantially practiced that addresses at a minimum the following: (1) the target population and age served; (2) how the organization plans to strategically address the needs and desires of those served; (3) the level, intensity, and length of services; (4) the services available to potential and current individuals; (5) a detailed expectation and outcomes for services offered; (6) the minimum staff to individual served ratios for each service offered; (7) if research is conducted; (8) support, care and treatment required for each community based setting (i.e., CSU/BHCCC, CSH (in-home, out of home), CRA (CLA, PCH, HH, CLS), CAS, Pre-Vocational, and Supported Employment service); (9) levels of observation; (10) how referrals for service are completed; (11) response times for service; and, (12) admission requirements for each service.		

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.

2	The CSU/BHCC has a scope of service/program description in place and substantially practiced that addresses, at a minimum, the following: (1) the capacity to serve both voluntarily and involuntarily admitted individuals; (2) that it is not a treatment facility, hospital or inpatient services; (3) operating agreements with other health care providers, updated at least every 5 years, to provide care beyond the scope of the CSU; (4) priority consideration is given to those without private health insurance; (5) prohibition against refusing services to receive, evaluate or stabilize any individual who meets criteria for services; (6) the CSU is designed to serve as a first-line community-based alternative to hospitalization, offering psychiatric stabilization and detoxification services on a short-term basis; (7) the distinct, yet interrelated roles of the CSU, CSC and/or Temp Obs are designed as an alternative and/or diversion to hospitalization; (8) the circumstances when emancipated minors will be served; (9) the identification and management of individuals who meet the diagnostic criteria for a substance dependence disorder; (10) the provision of 24 hour professionally driven receiving, evaluation, care and treatment; (11) services provided under the direction of a physician; (12) discharge procedures seven days per week; (13) identifying and managing individuals at high risk of assaultive behaviors, suicide or intentional harm; and, (14) the functions performed by staff.		
3	The CSU/BHCC scope of services/program description is annually approved by a licensed/certified clinician as documented by signature and date of review.		
4	The CSU/BHCC has protocols for the stabilization and transfer of individuals to a different level of care.		

5	The CSU designates a specific number of beds that may be used as crisis beds or as transitional beds, with DBHDD approval.		
6	The Child and Adolescent CSU length of stay for any one episode of care does not exceed 29 calendar days. The Child and Adolescent CSU is not used for court ordered placement for the sole purpose of temporary placement.		

1.04 Confidentiality **(Eff. 2/1/16)**

Written policy, procedure and practice document the secure, organized and confidential management of information. Electronic records and electronic devices are also managed to ensure security, organization and confidentiality.

Reference:
DBHDD Policy 23-100, Confidentiality and HIPAA
DBHDD Policy 23-101, Notice of Privacy Practices
DBHDD Policy 23-102, Reporting and Notification of Breaches of Confidentiality
DBHDD Policy 23-103, Confidentiality and HIPAA Privacy Complaints
DBHDD Policy 23-104, Sanctions for Confidentiality Violations and Breaches
DBHDD Policy 23-105, Rights of Individuals regarding their Confidential and Protected Health Information
DBHDD Policy 23-106, Disclosure of Confidential and Protected Information
DBHDD Policy 23-107, Confidentiality and HIPAA Practices Involving Business Associates
DBHDD Policy 23-110, Authorization for Release of Information
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 38-40

DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual, Part II, Chapter 1100

Approaches to evaluate this standard include, but are not limited to:
Review:
• Notice of Privacy Practices poster accessibility
• Confidentiality and Notice of Privacy Practices are reviewed and signed by staff and individuals
• Business Associates signed agreements
• Release of Information form and PHI disclosure record
Interview:
• Staff and Individuals knowledge of identifying and reporting breeches of confidentiality, how to contact privacy officer
Observe:
• Records storage

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: (1) HIPAA/Confidentiality; (2) Notice of Privacy Practices; (3) reporting and notification of breaches; (4) privacy complaints, including designating the Privacy Officer; (5) rights of individuals' protected health information; (6) disclosure of protected health information; (7) business associates; (8) identification of violations and sanctions; (9) release of information; (10) training to be provided to staff; and, (11) corrective actions or sanctions of employees.		
2	The organization has a Notice of Privacy Practices that is posted in a prominent location accessible to the individuals served. The Notice is in plain language and includes the following: (1) A header stating, "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY"; (2) Information regarding uses and disclosures of PHI for treatment, payment, and health care operations; (3) A description of other purposes for which DBHDD can use or disclose PHI without the individual's written authorization; (4) A statement informing an individual of his/her privacy rights regarding his/her PHI; (5) DBHDD's responsibilities under the Privacy Rule; (6) A description of any federal or state laws or regulations that may apply in addition to, or instead of, HIPAA regulations; (7) How to file complaints with the provider, DBHDD, or the Secretary of Health and Human Services; (8) Name or title and phone number of the designated contact for more information on DBHDD's privacy rules; and, (9) Effective date of the Notice.		
3	The organization ensures all individual and personnel records, including electronic records, are kept organized, secure and confidential.		

4	The organization obtains an authorization for release of information from the individual/legal guardian to release PHI. Each release of information contains: (1) the specific information to be released or obtained; (2) the reason for the release of information; (3) to whom the information may be released; (4) the time period that the authorization remains in effect, not to exceed one year; and, (5) a statement that the authorization may be revoked at any time by the individual in advance of the exchange of information.		
5	Each medical record includes a PHI disclosure record for disclosures other than for treatment, payment or other healthcare, and which contains: date of disclosure, name of the entity or person who received the PHI, brief description of disclosure, copy of written request, and authorization from the individual or guardian to disclose PHI.		
6	The organization releases protected health information without consent only in the following circumstances: (1) as required and permitted by law, or as authorized as a valid exception to the law; (2) a valid court order or subpoena; (3) when required to share individual information with the DBHDD or any provider under contract or LOA with the DBHDD; and (4) in the case of an emergency treatment situation as determined by the individual's physician.		

1.05 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, Reporting and Investigating Deaths and Critical Incidents in Community Services

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	The organization has an internal process for the handling of non-reportable incidents and accidents that includes documentation, investigation and appropriate action.		
3	Critical incidents are reported to the DBHDD Office of Incident Management and Investigation within the time frames outlined in DBHDD policy.		
4	In CSUs/BHCCs, high-risk situations and special cases (such as suicide, death, serious injury, violence, and abuse of any individual) are reviewed within 24 hours.		
5	In Child and Adolescent CSUs, as soon as possible after any serious occurrence and in no case later than 24 hours after the serious occurrence, the CSU provides notice of the serious occurrence to the parent/legal guardian of each minor involved.		

1.06 Organizational Chart **(Eff. 2/1/16)**

Written policy, procedure and practice document an organizational chart that reflects structures of authority and promotes unambiguous relationships and responsibilities to support individual care.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 12
DBHDD Provider Manual for Community Behavioral Health Providers

Approaches to evaluate this standard include, but are not limited to:
Review:
• Organizational chart
Interview:
• Staff to determine their understanding of the structures of authority

#	Criteria	Deficient Practice	Effect/Outcome
1	Administrative and clinical structures are clear and promote unambiguous relationships and responsibilities to support individual care.		
2	The organizational chart identifies all of the organization's employees, contractors, volunteers, and consultants, including all job titles.		

1.07 Budget **(Eff. 2/1/16)**

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

Reference:
DBHDD Provider Manual for Community Behavioral Health Providers, page 244
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 12

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	The utilization of financial resources is assessed in the QI process and/or by the Advisory Board.		

1.08 Provider Enrollment Information **(Rev. 10/15/16)**

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

Reference:
DBHDD policy 01-326, CSU: General Certification Requirements
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 12

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

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization provides written notice to DBHDD within 10 calendar days of any change in provider data, including address of the business office or service location, payee changes, permit/license changes. If the contact person changes, the organization provides written notice to DBHDD within 30 calendar days of the change.		
2	In CSUs/BHCCs, the DBHDD certificate is prominently and conspicuously displayed in a public area accessible to individuals, employees and visitors.		
3	For DD providers, the organization has documentation of current general liability insurance (in the name of the organization) in the amount of $1 million per occurrence and $3 million aggregate.		

HEALTHCARE MANAGEMENT

2.01 Health Oversight **(Eff. 2/1/16)**

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

Reference:
DBHDD Policy 01-332, CSU: Documentation of Care
DBHDD Policy 01-331, CSU: Provision of Individualized Care
DBHDD Policy 01-330, CSU Evaluations and Admissions
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
DBHDD Policy 02-803, Health Risk Screening Tool (HRST)

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 has a primary care physician, designated in writing, who is responsible for their overall care and treatment.		
2	Each individual receives a physical examination at least annually. For CSUs/BHCCs, the physical examination must be conducted within 24 hours of admission.		

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3	For DD providers, 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.		
4	The organization documents the implementation of healthcare recommendations (e.g., lab testing, specialist appointments, etc.).		
5	There is documentation in the individual's record of all medical care received, including office visits, procedures, laboratory testing, etc.		
6	The individual's past medical history is documented in the record.		
7	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.		

2.02 Medication Management **(Rev. 10/15/16)**

Written policy, procedure and practice document safe medication management.

Reference:
DBHDD Policy 01-334, CSU: Pharmacy Services and Management of Medication
DBHDD Policy 01-335, CSU: Laboratory Services
DBHDD Policy 02-1101, Human Rights Council for Developmental Disabilities Services
DBHDD Policy 02-803, Health Risk Screening Tool (HRST)
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 39-41
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.		
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 assessment report, a photocopy of the license of the reviewer, and an attestation that any deficiencies identified are corrected.		
3	Pharmacy services are licensed and under the direct supervision of a Registered Pharmacist or contracted with a licensed pharmacy operated under a pharmacist.		
4	Stat medications ordered in a CSU must be available within 1 hour of the physician's order.		
5	Medications ordered in a CSU must be available within 8 hours of the physician's order.		
6	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.		
7	In personal care homes, when an over-the-counter medication is taken daily as prescribed in a written order by a physician, nurse practitioner, or physician's assistant, there is an individual bottle of the prescribed medication that is kept for the individual's use.		

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8	All PRN medications are accessible for each individual as ordered.		
9	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.		
10	Medications are stored under lock at all times in a clean and secure location.		
11	Refrigerated medications are locked and stored separately from food. (A separate refrigerator for medications is not required.)		
12	The temperature of the refrigerator used to store medications is maintained at the temperature required for the medication being refrigerated. (CSU refrigerators are maintained at 36 to 41 degrees F.) The refrigerator temperature is recorded daily.		
13	Controlled substances are double locked. Refrigerated controlled substances are double locked. (A separate refrigerator for medications is not required.)		
14	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.		
15	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.		
16	Medication is disposed of via a method that is environmentally friendly or by a pharmacy or law enforcement.		
17	Medications are stored, secured and refrigerated (if required) when transported to service settings (day program, outings, home visits, etc.)		

18	There is documented evidence that medication education has been provided to individuals and/or their families in a way that is understandable.		
19	The physician monitors for medication side effects via laboratory testing when indicated.		
20	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).		
21	For individuals in residential services, there is documentation of a the pharmacist, physician and/or mid-level provider review of polypharmacy usage to ensure that intra-class and inter-class polypharmacy use is justifiable.		
22	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.)		
23	CSUs/BHCCs have a process to identify, track and correct deviations in medication prescribing, transcribing, dispensing, administration, documentation, or drug security of ordering or procurement of medication that results in a variance.		
24	There is documented oversight by the physician in a CSU for accounting and dispensing of sample medication.		
25	CSUs/BHCCs that process laboratory tests onsite have evidence of a current Clinical Laboratory Improvement Amendment (CLIA) waiver.		

2.03 Medication Orders and Informed Consent **(Rev. 10/15/16)**

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 Policy 01-334, CSU: Pharmacy Services and Management of Medication
DBHDD Provider Manual for Community Behavioral Health Providers
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 39-43
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).		
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. (In CSUs, medications are ordered by members of the medical staff.)		

5	In CSUs/BHCCs, there are no standing orders for psychotropic medications.		
6	For DD providers, there are no orders for psychotropic PRN medications.		
7	Authentication by the physician/designee signature of all verbal medication orders is completed. In CSUs/BHCCs authentication is completed within 24 hours.		
8	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.		
9	There is documented evidence that: (1) the physician/designee completed the informed consent; (2) the individual was personally examined for capacity to consent; (3) in lieu of capacity, a substitute decision maker is identified; and, (4) risks and benefits have been explained.		

2.04 Rights of Medication Administration/Assistance **(Eff. 2/1/16)**

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

Reference:
DBHDD Policy 01-334, CSU: Pharmacy Services and Management of Medication
DBHDD Provider Manual for Community Developmental Disabilities Providers

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. Each medication has a label affixed by a licensed pharmacist, dentist, or physician.		
4	Right Time: The organization has a policy that designates medication administration times. Medications are administered at the correct time and in accordance with the medication's special instructions.		
5	Right Dose: For DD providers, each time the medication is administered, the dosage on the medication label, order and MAR are compared to ensure they are identical. For CSUs/BHCCs, each time the medication is administered the dosage on the medication label 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.		
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 CSUs/BHCCs or DD Crisis Homes)*		
12	A proxy caregiver assists the individual with medications. *(does not apply to CSUs/BHCCs or DD Crisis Homes)*		

2.05 Medication Administration Records (MAR) **(Eff. 2/1/16)**

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

Reference:
DBHDD Policy 01-331, CSU: Documentation of Care
DBHDD Policy 01-334, CSU: Pharmacy Services and Management of Medication
DBHDD Provider Manual for Community Behavioral Health Providers, page 257
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 40-43

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).		
2	An MAR is in place for each calendar month that an individual 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.		

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 CSUs or 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 40-43 and 70-72
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.		
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	Provider 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 is providing assistance.		

2.07 Adaptive Equipment **(Rev. 10/15/16)**

The individual has access to adaptive supportive equipment to assist the individual with medical treatment or corrective supportive needs.

Reference:
DBHDD Policy 01-337, CSU: Infection Prevention and Control
DBHDD Provider Manual for Community Behavioral Helath Proviers, p. 244
DBHDD Policy 02-409, Family Support Services Brokered Goods and Services List and Protocols
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 addresses, at the minimum, adaptive equipment as ordered by a physician or mid-level provider. *(For DD providers)*		
2	A current physician's order is documented for all adaptive devices utilized by an individual. The physician's order is renewed at least every 6 months.		
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.		

4	The use of a device is authorized in the individual's ISP or addendum if necessary.		
5	Adaptive equipment belongs to a specific individual. All equipment remains with the individual upon discharge or transfer.		

2.08 Protocols for Specialized Healthcare Needs *(for DD providers only)* **(Eff. 2/1/16)**

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

Reference:
DBHDD Policy 02-801, Prevention of Choking for Individuals with Developmental Disabilities Living in the Community
DBHDD Policy 02-802, Bowel Management for Individuals Diagnosed with Developmental Disabilities Living in Community Settings
DBHDD Provider Manual for Community Developmental Disabilities, page 42

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 that addresses, at the minimum, the following protocols for preventive healthcare maintenance: (1) bowel elimination; (2) hypertension; (3) weight management; (4) skin care; (5) seizures; (6) fluid intake; (7) aspiration; (8) falls; (9) diabetes; and, (10) medication schedule.		
2	The organization has individual specific treatment protocols signed by the physician for high risk diagnoses, such as, but not limited to hypertension, diabetes, seizures, cardiac issues, etc.		
3	The organization follows the standard and/or individualized protocols in place for each individual.		
4	The staff have documented training on the standard and/or individualized protocols in place for each individual.		

BEHAVIOR SUPPORTS, RIGHTS & 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 01-338, CSU: Rights and Responsibilities of Individuals
DBHDD Policy 15-112, Communication Assessment Procedures for Individuals with Hearing Loss
DBHDD Policy 02-1101, Human Rights Council for Developmental Disabilities Services
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 47-48
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.		

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	Legal guardians of minors are informed partners in the assessment and treatment of individuals. Individuals under the age of 18 are also an informed participant in assessment and treatment.		
6	The CSU shall designate and empower at least one person employed or affiliated with the CSU to serve as the Human Rights Officer.		
7	The organization protects and respects the rights and dignity of the individuals served. When issues are identified, the organization takes the actions required.		
8	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.		

3.02 Visitation **(Eff. 2/1/16)**

Written policy, procedure and practice allow for individuals to receive visitors.

Reference:
DBHDD Policy 01-338, CSU: Rights and Responsibilities of Individuals
DBHDD Policy 15-112, Communication Assessment Procedures for Individuals with Hearing Loss
DBHDD Policy 02-1101, Human Rights Council for Developmental Disabilities Services
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 48
DHS Rules and Regulations for Client Rights, Chapter 290-4-9

Approaches to evaluate this standard include, but are not limited to:
Review:
• Policy, documentation, staff training
Interview:
• Individuals / guardians and staff
Observation:
• Designated area used for visitation

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: the visitation rights of individuals, including a requirement that any reasonable restrictions must be based on the seriousness of the individual's mental or physical condition as ordered in writing by the attending physician.		
2	Each individual (or guardian, parent or custodian of a minor) is informed of his or her visitation rights, including any clinical restrictions.		
3	Each individual (or guardian, parent or custodian of a minor) has the right, subject to his or her consent, to receive the visitors he or she designates.		
4	The provider ensures all visitors enjoy full and equal visitation privileges consistent with the preferences of the individual. Visitation is not restricted, limited or otherwise denied based on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability.		
5	Visitation by the individual's attorney or physician is not restricted.		
6	Reasonable restrictions are ordered and incorporated into the safety plan if visitation facilitates/results in problematic behaviors. Reasonable restrictions must be based on the seriousness of the individual's mental or physical condition as ordered in writing by the attending physician. The order is reviewed as needed or at least annually. Visitors/guardians adhere to any reasonable restrictions as ordered by the attending physician (such as diet).		

3.03 Complaints and Grievances **(Rev. 10/15/16)**

Written policy, procedure and practice document a complaint and grievance process whereby complaints and grievances are accepted, reviewed, and investigated with a timely response to the individual. No person can be denied services for making a complaint or grievance.

Reference:
DBHDD Policy 01-346, CSU: Complaint Reporting and Incident Investigations Procedures
DBHDD Policy 19-101, Complaints and Grievances Regarding Community Services

Approaches to evaluate this standard include, but are not limited to:
Review:
• Internal complaints filed
Interview:
• Individuals / guardians and staff
Observation:
• Posted complaint/grievance process

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: (1) instructions on how a complaint or grievance may be filed; (2) a description of the review/investigation process for resolving the complaint or grievance, including reasonable applicable timeframes and extensions, if permitted; (3) a description of the Client's Rights complaint and grievance process; (4) directions for the complainant to appeal to the field office if a satisfactory resolution is not reached at the provider level; (5) directions for the complainant to appeal to DBHDD if an unsatisfactory decision is made by the field office; (6) maintenance of copies of all complaints and grievances received and reviewed by the provider, field office, or DBHDD, including copies of all "final" rulings or resolutions; (7) method to ensure that each individual served by the provider receives information explaining the complaint and grievance process, including appeals, in a manner that is understandable to the person; (8) assurance that the filing of a complaint or grievance will not result in retaliation or barriers to service; (9) requirement that all staff receiving training regarding the policy; and, (10) description of how complaint and grievance information is utilized for continuous quality improvement.		

2	Complaints and grievances are received, processed, investigated, resolved and followed up as indicated in the organization's policy. Individuals are notified of the resolution of their complaint/grievance in a manner understandable by the individual.		
3	The complaint and grievance process and the contact information for the designated person responsible for handling complaints/grievances are displayed in a prominent area readily accessible to individuals.		
4	The organization notifies individuals of their right to file a complaint/grievance directly with the organization, field office, or DBHDD.		

3.04 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

#	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.		
3	Time out is only utilized when included as an intervention in a Behavior Support Plan (BSP).		
4	During time out, the egress is never physically or manually restricted.		
5	The justification for time out as well as the details regarding the use of time out are documented.		
6	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.)		
7	Mechanical/physical restraints are prohibited in community settings.		
8	The use of physical control or verbal threats to prevent the individual from leaving an area is not permitted.		

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.

9	In DD services, 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.		

3.05 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 50-51

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	Staff are trained on the individuals' PBSPs.		
4	The PBSP is individualized, based on a functional assessment, and addresses potential medical causes.		

5	The PBSP is inclusive of methods outlined to teach alternative appropriate behaviors that will achieve the same results as the challenging behavior(s).		
6	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.		
7	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.		
8	The individual or guardian is given a choice to select the qualified person to develop the PBSP and/or Safety Plan. Consent is provided by the individual and his/her legal guardian. The PBSP is discussed with the individual and		
9	A copy of the individual's PBSP is available at the provider's service sites where services to the individual are delivered.		
10	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.		

11	The following is documented in the record of each individual receiving Behavioral Support Consultation Services: (1) the specific activity, training, or assistance provided; (2) the date and the beginning and ending time when the service was provided; (3) the location where the service was delivered; and, (4) verification of service delivery, including first and last name and title (if applicable) of the person providing services.		
12	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.		

	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:		
13	Person-Centered Behavior Supports Planning (PCBS)		
14	Programmatic guidelines for staff that address the individual's preferences and values		
15	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)		
16	Development of interventions that will be most effective for each setting or situation		
17	Lifestyle and competency improvements based on the individual's strengths, skills, abilities, personal preferences and choices		
18	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);		
19	ER Crisis Plan to support the exceptional behavioral or medical needs		
20	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.		
21	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.		

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

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

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:
• 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.		
4	Staff are trained on the individuals' safety plans.		
5	All interventions in a safety plan begin with the least restrictive intervention that would reduce or eliminate risk.		

6	Review and approval by all of the stakeholders occurs when a safety plan is first developed. 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.		

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

Should be changed to: 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 51

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	Staff are trained on the organization's crisis plan.		

3.08 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:
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. *(DD providers only)*		
2	DD 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.		
3	In CSUs/BHCCs, the Wellness Recovery Action Plan is developed by the individual. A professional may give guidance, but the plan is the individual's work and wishes.		

3.09 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

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	The organization that manages funds for individual(s) has a policy in place and substantially practiced that includes, at a minimum, the following: (1) a procedure to inventory an individual's possessions and valuables at admission and then at least annually; (2) the management of individuals' funds, without co-mingling or pooling; (3) reconciliation of account records monthly by at least two 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 payee of individuals' checks; (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 written financial records for at least two years; (7) 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 or other member of any funds of the individual; (8) maintenance of copies of the day to day living expense agreement in the individual's record; (9) timely deposits and accounting of all individuals' funds; (10) use of insured deposit accounts; (11) interest earned is 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 at all possible, persons outside of the organization serve as the representative payee; and, (15) when funds are not personally managed by the individual, a process for the review of funds by the individual and his/her representative at least quarterly.		

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		
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.		

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.		

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 account insured by agencies of or corporations charted by the state or federal government. The account is in a form which clearly indicates that the organization has only a fiduciary interest in the funds.		
10	Funds received from an individual or on his/her behalf may be deposited in an interest bearing account; provided, however, that any interest earned on such account accrue to the individual.		
11	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.		
12	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.		

13	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.		

HOLISTIC & PERSON-CENTERED APPROACH

4.01 Assessments **(Rev. 10/1/16)**

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 01-330, CSU: Evaluations and Admissions
DBHDD Policy 01-331, CSU: Provision of Individualized Care
DBHDD Policy 01-334, CSU: Pharmacy Services and Management of Medication
DBHDD Policy 01-340, CSU: Documentation of Legal Status
DBHDD Provider Manual for Community Behavioral Health Providers, pages 273-274
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 55

Approaches to evaluate this standard include, but are not limited to:
Review:
- Screenings that are initially completed
- By discipline, screenings / assessments used to determine disposition
- How is the determination for disposition made? For Temporary Observation? For the CSU?
- Process for integration of screenings / assessments into the development of the IRP / ISP
- Types of issues addressed / suitable to address upon admission to Temporary Observation or the CSU

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: (1) initial assessment of the Individual by a licensed clinician; (2) documentation of the rationale for proposed interventions; (3) the individuals' response to care and services; (4) determination of the appropriate staff to deliver services; (5) the status of the individual to determine appropriate continuity of care; and, (6) individualized services, supports, care and treatment determinations made on the basis of an assessment of the needs of the individual.		
2	Individualized services, supports, care and treatment determinations are made on the basis of an assessment of the needs of the individual.		

	Assessments include, but are not limited to, the following:		
3	Medical history and current health status		
4	Mental health history		
5	Suicide history		
6	Substance abuse history, including substance withdrawal issues		
7	Allergies or adverse reactions to medications that have occurred		
8	Other risk factors including biological, environmental, circumstantial and disease-related		
9	Review of legal concerns to include advance directives; legal competence; legal involvement of the courts; and legal status as adjudicated by a court		
10	Additional assessments, such as but not limited to abuse, trauma, suicide, functional, cognitive, behavioral, independent living skills, cultural, recreational, educational, vocational, nutritional, nursing, etc. are performed or obtained by the organization as needed or as ordered by a physician or mid-level provider.		
11	CSUs/BHCCs maintain assessments, to include psychiatric, physical health, nursing, and psychosocial status.		
12	In CSUs/BHCCs, the physician, at a minimum: (1) conducts the initial assessment of the individual (2) documents the rationale for medications prescribed to each individual within 24 hrs of admission; (3) assesses the individual's response to care and services provided, including the rationale for changes in orders or levels of observation; (4) assesses the individual risk for suicide; and, (5) conducts an assessment of the individual at the time of discharge.		

13	The Child and Adolescent CSU ensures that a Licensed Clinical Social Worker or Licensed Professional Counselor assesses the individual within 48 hours of admission.		

4.02 Individualized Service/Resiliency/Recovery Plans **(Rev. 10/15/16)**

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 Policy 01-331, CSU: Provision of Individualized Care
DBHDD Policy 01-325, CSU: Behavioral Health Provider Certification and Operational Requirements for Certified Crisis Stabilization Units
DBHDD Policy 01-331, CSU: Provision of Individualized Care
DBHDD Policy 01-333, CSU: Protection and Safety of the Individual and Others
DBHDD Provider Manual for Community Behavioral Health Providers, pages 277-278
DBHDD Provider Manual for Community Developmental Disabilities Providers, pages 56-57

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	The development of the ISP/IRP proceeds from a combination of the reason for admission; the individual's goals and choices; treatment, recovery and independence as identified by multidisciplinary assessments; interventions; and, discharge criteria.		
2	A copy of the current ISP is included in the record.		
3	The plan is driven by the individual and focused on outcomes the individual desires to achieve.		
4	The plan is fully explained to the individual using language/communication he/she can understand and agreed to by the individual.		
5	The plan is attainable by the individual, using goals that are measurable, relevant, realistic, time-limited and consistent with the individual's needs.		

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.

6	The plan and support, care and treatment provided to the individual is person-centered.		
7	The plan is signed by the individual/legal guardian, and all staff participating in the development of the plan.		
8	The plan identifies the staff/provider responsible for delivery of specific services, support, care and treatment.		
9	The plan is reassessed annually or within specific timeframes as indicated by changing needs, circumstances and responses of the individual.		
10	The CSU documents evidence of the individual's progress toward stabilization and recovery, or lack thereof. The IRP is reviewed at a minimum every 72 hours by the treatment team to assess the need for the individual's continued stay in the CSU.		
11	When more than one physician is involved in the individual's care, there is evidence that there is an RN or MD who has reviewed all in-field information to assure there are no inadvertent contraindications within the care and treatment orders or plan.		

	Documents incorporated into an plan include, but are not limited to:		
12	Medical updates as indicated by physicians' orders or notes		
13	Addenda as required when a portion of the plan requires reassessment		
14	A personal crisis plan which directs in advance the individual's desires/wishes/plans/objectives in the event of a crisis		
15	A behavior support plan (PBSP) and/or a safety plan for individuals demonstrating challenging behaviors and/or for individuals who receive psychotropic medications for symptom management		
16	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.		
17	The organization implements the plan as written.		

4.03 Wellness **(Rev. 10/15/16)**

The organization ensures wellness is facilitated through individualized practices.

Reference:
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual, Part II
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 57

Approaches to evaluate this standard include, but are not limited to:
Review:
- Activity schedule
- Routine health screening
- Vaccine record
- ISP has wellness goals
- Wellness education documentation
- Nutritional assessment by qualified professional as needed
- Current physician orders for special diets and/or supplements
- Menus correlate with dietary orders

Observe:
- Meal(s) served to individuals

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 wellness activities that are sensitive to gender, culture and age. These activities are person centered and facilitated through advocacy, individual care practices, and education.		
2	Wellness goals are included in the ISP/IRP as applicable.		
3	Wellness education and/or activities are documented as applicable.		
4	Nutritional treatments, such as special diets or supplements, have an active, current physician's order that is renewed at least annually.		
5	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.		
6	For DD providers, 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.		

4.04 Community Integration and Inclusion **(Eff. 2/1/16)**

Community integration and inclusion into the larger natural community is supported and evident.

Reference:
DBHDD Letter of Agreement with Provider/Agency
DBHDD Policy 02-601, Community Integration in Residential Service Options and Supervised Apartment Living Arrangements for Individuals with Developmental Disabilities

Approaches to evaluate this standard include, but are not limited to:
Review:
• Outing schedule & progress notes
• Vehicle attendance log
• Staff schedule
• Membership cards to YMCA, health clubs, etc.
Interview:
• Individuals and staff regarding outings

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	There is evidence that the individual has access to community resources that are available to other citizens.		
2	There is documentation of individualized preferences, person-centered integration, informed choice, autonomy and inclusion in the community.		

4.05 Referrals **(Eff. 2/1/16)**

Written policy, procedure and practice document referrals based on ongoing assessments of the individual's needs.

Reference:
DBHDD Policy 01-331, CSU: Provision of Individualized Care
DBHDD Provider Manual for Community Behavioral Health Providers, page 240
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 56

Approaches to evaluate this standard include, but are not limited to:
Review:
- Initial and current assessment/recommendations of physician, psychologist and other evaluating professionals
- Referrals and follow-up visits

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: (1) internal referrals to different programs or staff; (2) external referrals to services, supports, care and treatment not available within the organization (healthcare, diagnostic testing, dental services, etc.).		
2	The organization makes internal referrals to different programs or staff based on individual needs.		
3	The organization makes external referrals to services, supports, care and treatment not available within the organization.		

4.06 Records **(Eff. 2/1/16)**

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

Reference:
DBHDD Policy 01-332, CSU: Documentation of Care
DBHDD Provider Manual for Community Behavioral Health Providers
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	Financial information		
7	Consent for services		
8	Any psychiatric or advanced directive		
9	Legal documentation establishing guardianship		
10	For NOW/COMP providers, the organization maintains a copy of the current and approved DMA-6/DMA-6A or DMA-7 forms covering all periods of services rendered, in the individual's record.		
11	In CSUs, the record includes the evaluation for admission and outcome of the evaluation including the date, time, name and credentials of the professional who conducted the evaluation.		
12	In CSUs, the record includes continued justification for stay.		
13	In CSUs, the record includes documentation at least once per day by an RN as to the status of the individual.		
14	The entire individual record is retained for a minimum of 6 years from the date of creation or the date when last in effect (whichever is later).		
15	Records are returned to the contracting region(s) after specified retention period or termination of contract/agreement.		

4.07 Documentation **(Rev. 10/15/16)**

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:
DBHDD Provider Manual for Community Behavioral Health Providers, page 229
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 58
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
1	The organization has a policy in place and substantially practiced that addresses, at a minimum, the organized, complete and accurate documentation of services, supports, care and treatment renders and the individual's response.		
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	Individuals receiving clinical services or changes in functional, medical, behavioral or social status are identified for DDP ongoing review. 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.		
5	Handwritten records are in black or blue ink.		

6	Notes entered retroactively into the record after an event or a shift are identified as a late entry.		
7	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.		
8	If handwritten notes are transcribed electronically at a later date, the handwritten note is kept.		
9	Corrections are made by drawing a single line through the error; labeling the change with the word "error"; inserting the corrected information; and initialing and dating the correction.		
	Progress notes or learning logs (for DD individuals) describe progress toward goals. Notes document the following, at a minimum:		
10	Issues, situations or events occurring in the life of the individual		
11	The individual's response to the issues, situations or events		
12	Relationships and interactions with family and friends, if applicable		
13	Missed appointments and strategies to avoid future missed appointments		
14	Records or reports from previous or other current providers		
15	Correspondence regarding care and treatment between the agency and external stakeholders		
16	Ongoing communication between staff members working with the same individuals in different programs, activities, schedules or shifts		
17	The organization maintains a copy of all approved waiver requests and/or exceptional rate approval documents. These documents are readily available for review.		

18	The organization has the approved Prior Authorization for review.		
19	All supporting documentation relevant to service delivery is maintained in the individual's record at the service delivery site(s).		
20	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.		
21	Daily engagement in community-based services is documented in progress notes for those occupying transitional beds in a CSU.		
22	The CSU documents the location and type of treatment or education provided, including the date, time of treatment or education, the name and credentials of the professional or other staff providing the service, and the response to treatment by the individual.		

ENVIRONMENT OF CARE

5.01 Food Service **(Eff. 2/1/16)**

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

Reference:
DBHDD Policy 01-336, CSU: Food Services

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 53
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)
- Food service permit for CSU/BHCC
- Cleanliness of food service prep area
- Check that appliances are in working order

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: (1) guidelines for safe food handling and storage; (2) guidelines for food preparation; (3) safe food consumption and storage of food in refrigerator, freezer and cupboards to maintain temperature; (4) expiration dates on food items to include open items; and, (5) prevention of foodborne illnesses.		
2	The organization serves a minimum of three regularly scheduled, well balanced meals and two nutritious snacks per day. For PCH, CLA and CSUs/BHCCs, there should be no more than 14 hours between the evening meal and the start of the breakfast meal the following morning.		
3	The PCH has planned menus that contain all food groups and are substantially followed. Food preference is taken into consideration when planning the menu. Both PCHs and CLAs maintain records on file for 30 days of the meals as served.		
4	A copy of the current food service permit is posted for CSUs/BHCCs and providers that have food services/cafeteria. For providers with contracted food services, a copy of the current food service permit is on file.		
5	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.		
6	In CLAs, food storage practices ensure the sanitary, temperature-controlled storage of all foods. Leftovers are labeled and dated prior to refrigeration or storage. No expired foods are in food storage areas. Food stocks are dated and rotated to ensure that the oldest foods are used first. Chemicals are stored away from food.		

7	The organization has a written cleaning schedule for food service areas, which is adhered to.		
8	In CSUs/BHCCs, all staff who work in food service wear hairnets/caps and beard nets (if applicable).		
9	The organization can choose to either provide the meals within the facility or contract with an outside vendor/contractor. The outside vendor must obtain required certifications. When an outside food service is utilized the organization is still responsible for non-perishable emergency food and water.		

5.02 Pest Control **(Eff. 2/1/16)**

Written policy, procedure and practice demonstrate that services are provided in an environment that is free from the infestation of insects, bed bugs, rodents or pests.

Reference:
DBHDD Policy 01-337, CSU: Infection Prevention and Control
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 54

Approaches to evaluate this standard include, but are not limited to:
Review:
• Pest control plan, contract
Observe:
• Signs of rodent droppings; dead bugs/insects or live bugs/insects; spider webs; multiple ant hills and storage of pest control chemicals if treated by provider

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization maintains documentation of the pest control service provided, either by the organization or an outside contractor.		
2	There is no evidence by observation of pest problems seen in the service setting.		

5.03 Emergency Preparedness **(Rev. 10/15/16)**

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 01-341, CSU: Environment of Care
DBHDD Policy 01-343, CSU: Fire Prevention and Fire or Disaster Safety Requirements
DBHDD Provider Manual for Community Behavioral Health Providers
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 52 to 53, 86

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.		

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 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 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. The supply provides for physician ordered special diets for the individuals served.		
4	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. In CSUs/BHCCs, fire drills are rotated so that each shift has at least one drill quarterly.		
5	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.		
6	The organization conducts disaster drills on a quarterly basis. Disasters that could occur locally are drilled on a more frequent basis.		

7	In CSUs/BHCCs, there is an annual review and revision of the fire prevention and fire/disaster safety plan and the disaster drill protocols.		
8	The organization has fully charged fire extinguishers that are tagged/dated on a yearly basis. (In CLAs/CSUs/BHCCs, 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.		
10	Installation of fire alarm system and inspection of equipment meets safety code.		
11	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.		
12	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.		

5.04 Housekeeping/Maintenance **(Rev. 10/15/16)**

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

Reference:
DBHDD Policy 01-341, CSU: Performance Improvement Plan and Activities
DBHDD Policy 01-342, CSU: Environment of Care
DBHDD Provider Manual for Community Behavioral Health Providers
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		
1	The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: guidelines for environmental cleaning and sanitizing.		
2	There are posted schedules for cleaning the living areas, bedrooms and bathrooms. These schedules are regularly checked.		
3	There are posted logs for cleaning the living areas, bedrooms, kitchen and bathrooms. These logs are regularly checked.		
4	The environment is safe.		

5.05 Laundry **(Eff. 2/1/16)**

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:
DBHDD Policy 01-337, CSU: Infection Prevention and Control
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
1	The organization has a policy in place and substantially practiced that addresses, at a minimum, the guidelines for laundry.		
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.		
3	At a minimum, the facility has available a quantity of clean bed linens and towels essential for the proper care of individuals at all times. For CLA/DD Crisis Home/PCH, bedding is provided for each individual including two sheets, a pillow, a pillow case, and a minimum of one blanket and bedspread. The CLA/DD Crisis Home/PCH must maintain a linen supply for not less than twice the bed capacity.		
4	The CLA/DD Crisis Home provides each individual clean towels and washcloths at least twice weekly and more often if soiled.		

5.06 Infection Control **(Eff. 2/1/16)**

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

Reference:
DBHDD Policy 01-337, CSU: Infection Prevention and Control
DBHDD Policy 01-333, CSU: Protection and Safety of the Individual and Others
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 (Infection Control Plan) and substantially practiced that addresses, at the minimum, the following: (1) standard precautions, including the use of personal protective equipment; (2) proper hand washing techniques; (3) proper disposal of biohazardous materials; (4) proper storage of personal hygiene items; (5) prevention and management of needle and sharp sticks; (6) the management of common illnesses such as but not limited to MRSA, pediculosis, tinea pedis, influenza, common cold, etc.; and, (7) specific procedures to manage infectious diseases, including but not limited to tuberculosis, hepatitis B, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or other infectious diseases.		

2	The Infection Control Plan is reviewed bi-annually for effectiveness and revised as needed. For CSUs/BHCCs, the Infection Control Risk Assessment and Plan is reviewed annually for effectiveness and revised if necessary.		
3	All barrier equipment is readily accessible and disposable (for single-use only).		
4	The organization has running hot and cold water and liquid soap for use in all kitchen, restroom and individual changing areas.		
5	Disposable paper towels or hand blowers must be available at all hand wash basins.		
6	Alcohol based hand rub may be utilized in addition to handwashing, but not in lieu of handwashing.		
7	Staff demonstrate appropriate hand hygiene techniques after each direct contact, between medication passes, and after eating, smoking or using the restroom.		
8	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.		
9	Waste bags and sharps boxes are available for use in areas where needed.		
10	The Crisis Support Home administrator or designee teaches each individual the techniques of “Standard Precautions,” as appropriate to the individual’s ability, or staff supports each individual in the performance of the techniques of “Standard Precautions,” including washing his or her hands thoroughly after toileting, sneezing, or any other activity during which the individual’s hands may become contaminated.		

5.07 Transportation **(Eff. 2/1/16)**

Written policy, procedure and practice demonstrate that the organization has a system to maintain the safety of individuals during transportation.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers, page 54
OCGA 40-8-74

Approaches to evaluate this standard include, but are not limited to:
Review:
- Emergency information packet
- Vehicle maintenance logs
- Registration and insurance

Observe:
- Vehicle horn, brake lights, signals, first aid kit, fire extinguisher, license plate
- Penny test on tires
- Staff operating lift

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: the transportation of persons supported or served in residential services and in programs that require movement of persons served from place to place. Further, the organization has a policy that addresses all vehicles that includes, at a minimum, the following: (1) those owned or leased by the organization; (2) those owned or lease by subcontractors; (3) use of personal vehicles of staff; (4) authenticating licenses of drivers; (5) proof of insurance; (6) routine maintenance; (7) requirements for evidence of driver training; (8) safe transport of persons served; (9) requirements for maintaining an attendance log of persons while in vehicles; (10) safe use of lift; (11) availability of first aid kits; (12) fire suppression equipment; and, (13) emergency preparedness.		
2	The organization has documentation of authentication of driver's licenses of staff that are authorized to transport individuals.		
3	The organization has documentation of proof of vehicle insurance for staff who transport individuals.		

4	The organization has documentation of routine maintenance of all vehicles used to transport individuals.		
5	The organization has documentation of driver training for staff that transport individuals.		
6	The organization has documentation of an attendance log for transporting individuals.		
7	The organization has evidence of a functioning lift to assist with accessibility to enter and exit vehicle (if applicable).		
8	The organization has first aid kit(s) available in vehicles while transporting individuals. First aid kits have the contents required by the service setting.		
9	The organization has fire suppression devices available in vehicles that are used to transport individuals.		
10	The organization has documentation of an emergency preparedness plan for transportation.		
11	Vehicles utilized for transport are safe. At minimum they must have operable lights, horn, windshield wipers, seatbelts and properly inflated tires with not less than 2/32 inch tread depth.		

HUMAN RESOURCES

An "X" in the column underneath the Staff identifiers indicates this staff member's record was missing the required documentation.

6.01 Staffing Requirements **(Rev. 10/15/16)**

Written policy, procedure and practice demonstrate that the organization has adequate staff to meet the 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:
• DDP attestation
• Employee job descriptions
• Exceptional rate letters
• Organizational chart
• All staffing schedules
Interview:
• Direct care staff
• DDP
• Administrative staff
Observe:
• Staffing patterns at service sites

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced that addresses, at a minimum, the following: (1) DDP services (except CSUs/BHCCs and DD Crisis Homes); and, (2) employed and contracted professional staff (by position).		
2	Developmental Disabilities Professional (DDP) services are delivered only by a qualified DDP. At least one agency employee or professional under contract with the agency is a qualified DDP. The DDP is not a PRN employee. *(does not apply to CSUs/BHCCs and DD Crisis Homes)*		

4	There is a specified DDP schedule for each of the organization's sites. 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. *(does not apply to CSUs/BHCCs and DD Crisis Homes)*		
5	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 Hiring **(Eff. 2/1/16)**

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

Reference:
DBHDD Provider Manual for Behavioral Health Providers
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:
• Employment applications
• Job descriptions
• Reference checks
• Credentials
• Resumes
• Diploma(s) or GED
• License(s) / certification(s)
• Training records
• Drivers license
• MVR
• Car insurance documents
• I-9 / Social Security card
• TB testing
• Annual physical exams
• NCIC records
• Contract staff agreements or contract
Interview:
• Personnel staff

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced that addresses at a minimum, the following: (1) hiring staff; (2) criminal history records checks for all staff, volunteers and contractors; and, (3) licensing, experience and certification verification to ensure licenses/credentials are current.		

#	Criteria	Staff A	Staff B	Staff C	Staff D	Staff E	Staff F	Staff G	Staff H	Deficient Practice	Effect/Outcome
2	All employees and contractors have a personnel record.										
	At a minimum, each personnel record includes the following:										
3	Application for employment and date of hire										
4	Job description or contract that includes: (1) qualifications for the job; (2) duties and responsibilities; (3) competencies required; (4) expectations regarding quality and quantity of work; and, (5) documentation that the individual staff has reviewed, understands, and is working under a job description specific to the work performed within the organization.										
5	Reference checks										
6	Credentials										
7	Resume										
8	Diploma or GED										
9	Current licenses and certifications, as applicable										
10	Driver's license										
11	Social Security card and I-9										
12	Proof that the employee is 18 years or older										
13	For employees who transport individuals, 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.										
14	For employees who transport individuals in their personal vehicles, current car insurance.										
15	Proof that the employee or contractor is not currently on the Department of Health and Human Services, Office of Inspector General's sanction or exclusions lists, General Service Administration's Excluded Parties List System (EPLS).										

#	Criteria	Staff A	Staff B	Staff C	Staff D	Staff E	Staff F	Staff G	Staff H	Deficient Practice	Effect/Outcome
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.										
17	For contractors with direct contact with individuals: a current copy of their contract, criminal history record check eligibility letter, license, credentials, and experience.										

6.03 Communicable Disease Clearance **(Rev. 10/15/16)**

Written policy, procedure and practice ensure that staff who have direct contact with the individuals have an annual screening for TB, obtain communicable disease clearance and a yearly physical examination as required.

Reference:
DCH Policies and Procedures for Comprehensive Supports Waiver Program (COMP), Part III, Sections 1900
DCH Policies and Procedures for New Options Waiver Program (NOW), Part III, Sections 1900
DBHDD Provider Manual for Community Developmental Disabilities Providers

Approaches to evaluate this standard include, but are not limited to:
Review:
- Infection Control Policy
- TB Screening Records
- Physical Exam Records

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced that addresses annual communicable disease screening.		

#	Criteria	Staff A	Staff B	Staff C	Staff D	Staff E	Staff F	Staff G	Staff H	Deficient Practice	Effect/Outcome
2	For Community Access Services, Supported Employment Services, and Community Living Support Services staff, a physical examination is conducted before hire, and then at least annually.										
3	For Community Access Services, Supported Employment Services, and Community Living Support Services staff, a communicable disease release statement is obtained before hire, and then at least annually.										
4	For PCH staff, a physical examination within 12 months prior to employment, and then at least annually.										
5	For Host Home providers, a physical examination as part of the Host Home study, and then at least annually.										
6	For Host Home providers, a signed statement from a physician indicating they are free of communicable diseases.										
7	All staff providing direct support are required to have TB screening with PPD before hire, and then annually. If staff has had a positive PPD, then there is documentation of follow-up. (For staff working in a PCH, the TB skin test may initially be within 12 months of employment.)										

6.04 Training **(Eff. 2/1/16)**

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 01-344, CSU: Human Resources
DBHDD Provider Manual for Community Developmental Disabilities Providers

Approaches to evaluate this standard include, but are not limited to:
Review:
• Staff training records
Interview:
• Personnel staff
• Administrative staff
Observe:
• Staffing patterns at service sites

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced that details the training requirements by job classification, including: (1) training that must be refreshed annually; (2) additional training required for professional level staff; and, (3) additional training/recertification (if applicable) required for all other staff. In addition, CSUs/BHCCs has documentation of an annual training plan that ensures each staff member who delivers therapeutic content is trained annually in at least one clinical/programmatic content topic related to the delivery of care.		

#	Criteria	Staff A	Staff B	Staff C	Staff D	Staff E	Staff F	Staff G	Staff H	Deficient Practice	Effect/Outcome
2	All staff, direct support volunteers, and direct support consultants are trained and there is documented evidence of these required trainings.										
3	Orientation is provided prior to direct contact with individuals includes, at a minimum, the following: (1) the purpose, scope of services, supports, care and treatment offered including related policies and procedures; (2) HIPAA and confidentiality of individual information, both written and spoken; (3) rights and responsibilities of individuals; and, (4) requirements for recognizing and mandatory reporting of suspected abuse, neglect or exploitation of any individual.										

#	Criteria	Staff A	Staff B	Staff C	Staff D	Staff E	Staff F	Staff G	Staff H	Deficient Practice	Effect/Outcome
4	Within the first 60 days from date of hire, all staff having direct contact with individuals receive the following training, at a minimum: (1) person centered values, principles and approaches; (2) a holistic approach for providing care, supports and services for the individual; (3) medical, physical, behavioral and social needs and characteristics of the individuals served; (4) human rights and responsibilities; (5) promoting positive, appropriate and responsive relationships with persons served, their families and stakeholders; (6) the utilization of communication skills; (7) the utilization of behavioral support and crisis intervention techniques to de-escalate challenging and unsafe behaviors; (8) nationally benchmarked techniques for safe utilization of emergency interventions of last resort, as applicable; (9) the Georgia Crisis Response System; (10) ethics and cultural diversity policies; (11) fire safety; (12) emergency and disaster plans and procedures; (13) standard precautions; (14) preventive measures to minimize risks of HIV; (15) approaches to individual education; (16) first aid and safety; (17) Basic Cardiac Life Support (BCLS), both written and hands on competency training; (18) specific individual medications and their side effects; (19) suicide preventions skills training, such as AIM or QPRP, (20) ethics and corporate compliance training and training to work with individuals who have co-occurring/are dually diagnosed.										
5	A minimum of 16 hours of training must be completed annually to include, at a minimum: (1) human rights and responsibilities; (2) the utilization of communication skills; (3) the utilization of behavioral support and crisis intervention techniques to de-escalate challenging and unsafe behaviors; (4) nationally benchmarked techniques for safe utilization of emergency interventions of last resort; (5) fire safety; (6) emergency and disaster plans and procedures; and, (7) specific individuals' medications and their side effects.										

#	Criteria	Staff A	Staff B	Staff C	Staff D	Staff E	Staff F	Staff G	Staff H	Deficient Practice	Effect/Outcome
6	In addition to the previous 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.										
7	Staff are trained on their Organization's Crisis Plan and if applicable, any individuals' Positive Behavior Plans, Safety Plans and Crisis Plans.										
8	Staff are trained on all specialized needs of the individual and on training needs as outlined in the ISP.										
9	In a 24 hour or residential care setting, at least one staff on duty at all times on each shift is trained in Basic Cardiac Life Support and first aid. In CSUs/BHCCs, at least one staff trained in the use of Automated External Defibrillator (AED) equipment is on duty at all times.										
10	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.										
11	All contractors who have direct contact with individuals have the first 4 required trainings.										

6.05 Performance Management **(Eff. 2/1/16)**

Written policy, procedure and practice detail the job duties of professional staff, evaluate work performance and provide provisions for sanctioning staff when indicated.

Reference:
DBHDD Provider Manual for Community Developmental Disabilities Providers
DBHDD Provider Manual For Community Behavioral Health Providers

Approaches to evaluate this standard include, but are not limited to:
Review:
• Annual work performance evaluations
• Critical and internal incident reports
• Current and past staff schedules
Interview:
• Personnel staff
• Administrative staff
• Direct care staff

#	Criteria	Deficient Practice	Effect/Outcome
1	The organization has a policy in place and substantially practiced regarding the following: (1) performance management evaluations conducted by each staff person's supervisor; and, (2) sanctioning or removing staff when staff are determined to have deficits in required competencies; staff are accused of abuse, neglect or exploitation; or, staff are found to be under the influence of alcohol or drugs while on duty.		

#	Criteria	Staff A	Staff B	Staff C	Staff D	Staff E	Staff F	Staff G	Staff H	Deficient Practice	Effect/Outcome
2	Documentation is provided of annual work performance evaluations for all staff by their supervisor. These evaluations are conducted by managers who are clinically, administratively and experientially qualified to conduct these evaluations.										