

COMMUNITY MENTAL
HEALTH PROGRAMS
AND
THERAPEUTIC GROUP
HOMES

SURVEY PROCESS



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The following describes the Office of Health Care Quality's Community Mental Health Units (C-MHU) process for the certification, licensure, complaint, incident and/or follow up surveys and investigations.

Currently, surveys conducted by C-MHU can be announced or unannounced. It is anticipated that within the next year all surveys will be unannounced. Survey schedules are provided in advance to the Local Core Service Agency (CSA), the Mental Hygiene Administration (MHA) and MAPS-MD. The Departments of Human Resources and Juvenile Services are given advance notification of Therapeutic Group Home surveys. Representatives of the various agencies are welcome to attend the survey.

TYPES OF SURVEYS:

Initial: A review process that occurs before the applicant is approved (Licensed or Certified). The review process should include a physical site walkthrough, interview of licensee personnel, and a review of applicable policies and procedures.

Mid-License Review: Therapeutic Group Home licensees are subject to annual inspection.

Monitoring: Assesses a programs compliance, with their approved Program Improvement Plan (PIP). The PIP completion dates are used to establish the timing of the monitoring review.

Recertification/Licensure Renewal: A comprehensive review of a licensee's overall operation to determine compliance with applicable COMAR regulations.

Complaint/Incident: Assesses the health and safety of an individual, as well as, the license's compliance with COMAR, as the result of an incident or complaint.

Programmatic: A review conducted when a licensee desires to increase capacity, relocate or expand a program, etc. A determination as to the format of the survey is made based upon the issue presented

ENTRANCE CONFERENCE:

An Entrance Conference is held at the beginning of a survey in order to introduce the surveyors to the licensee's staff, provide the licensee with an overview of the survey process, and to collate materials needed for the survey. This will include:

1. Verification of the services provided, the current census of each program, the addresses of physical sites, and a list of the clients served.
2. The provider will be asked fundamental questions regarding each of their programs including but not limited to its program specific service modalities and interventions
3. Establishment of the survey sample size of individuals reviewed is determined by the size of the provider and its specific program approvals. The sample will include both active and discharged records. The selection process also considers the following factors:
 - A) incident reports of psychiatric and medical emergency room visits and unplanned hospitalizations, involvement of law enforcement or other client specific health and safety incidents, medical/nursing concerns, specialized nursing needs, restrictive techniques, behavior modifying drugs, special diets, age, mental health diagnosis and levels of supervision
4. The survey sample size for personnel records is also determined based on the size of the program. The focus of the review is on clinical and administrative staff and the verification of training and credentials
5. All program locations (except RRP's of 1-3 beds) will receive an onsite physical plant inspection as a component of the initial licensure/certification review. For RRP providers with multiple 1-3 bed homes, an attempt is made to perform on-site visits of 10% of those homes.
6. The licensee will be given an opportunity to discuss any irregular circumstances that may have an impact on the survey process

7. An estimated date and time of exit will be established.
8. A staff member should be established who will serve as liaison(s) to assist in the location of client records, personnel records, administrative records, etc.

DURING THE SURVEY

Each individual selected as part of the sample will have their entire record reviewed. The surveyor will communicate openly with you throughout the survey. The surveyor may also request copies of documentation.

The following is a listing of the different aspects of the program which are reviewed during a survey. This listing does not limit the surveyor nor preclude the application of related regulations to which the licensee may be accountable. Usage of the Program Survey Tools will aid in completion of a full record review:

1. The client record which includes:
 - a. Identifying information and documents
 - b. Assessments
 - c. Treatment/Rehabilitation plans and review
 - d. Medical Information
 - e. Clinical/Rehabilitation notes
 - f. Release of information
 - g. Pertinent background/historical information, evaluations, assessments
 - h. Current medications and treatments
2. Personnel Records
 - a. Criminal Background Check/Child Protective Services completion and date (If Applicable)
 - b. Licensure/Certificates
 - c. Children's Residential Programs (COMAR 14.31.06)—need to also review:
 - i. Completed CJIS Report
 - ii. Initial physical and TB screening
 - iii. Direct Care Staff - Additional trainings per COMAR 14.31.06.05
3. Program Overview
 - a. Medication Protocol
 - b. Governing Body/Advisory Committee
 - c. Seclusion/Quiet Room/Restraint
 - d. Staffing Schedule
 - e. Program implementation including rehabilitation and clinical services;

- f. Policies and procedures; and
 - g. Quality assurance measures.
 - h. Client Rights;
4. Physical Plant Inspection - This may include:
- a. Is the home or site free of health and safety hazards
 - b. Is the home or site in good repair
 - c. Does the site or home have a secure area for records, medication and personal belongings

If you have questions or concerns during the survey process, please contact Mr. William Dorrill, Deputy Director at 410-402-8047 or Ms Gwen Winston, Quality Improvement Coordinator at 410-402-8008.

EXIT CONFERENCE

An Exit Conference is held with the Licensee upon completion of the survey. During the exit the surveyors will:

1. Review the preliminary findings and final stages of the survey process, review with the program the due date for the Program Improvement Plan (PIP), if applicable, encourage the providers collaboration with the CSA in the development of the PIP, review the Impact and Scope Determination
2. Review the programs opportunity to request an Informal Dispute Resolution (IDR) See below.
3. Provide a dated signature sheet to document attendance.

STATEMENT OF DEFICIENCIES:

C-MHU will submit a Statement of Deficiency to MHA for review and comments prior to submitting it to the authorized program representative. It may also be sent to the Governors Office for Children (GOC), Department of Juvenile Justice (DJS), Department of Human Resources (DHR), CSA, MDLC and MAPS-MD.

The Community Mental Health Regulation by which the program is licensed/approved under will determine the time for the program to submit a Plan of Correction (POC) or Program Improvement Plan (PIP) to the Office of Health Care Quality.

The POC/PIP must contain the following for each deficiency cited:

1. What corrective action will be taken for those residents found to have been affected by the deficient practice;
2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
3. What measures or system changes you will make to ensure that the deficient practice does not recur, i.e., how your operating procedures will ensure this;
4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and who will be responsible; and
5. A specific, reasonable date by which the violation will be corrected (actual date) - not "by the end of the month" or "as soon as possible", etc.

INFORMAL DISPUTE RESOLUTION

Programs may request an Informal Dispute Resolution (IDR) if they disagree with a cited deficiency. Unless OHCQ has initiated sanctions and there is a right to a formal administrative appeal, IDR is the sole means of questioning deficiencies.

To avail yourself of this opportunity you must send OHCQ, a written statement requesting an IDR. You must include with your request a complete description of why you disagree with cited deficiencies and forward copies of any supporting documents. **This request must be sent within 10 days of receipt of the deficiencies.**

You may request to have this process conducted in person, over the telephone or in writing. While every effort will be made to conduct an IDR in-person if it is requested, at the discretion of this office, the IDR may be held in-person, over the telephone or in writing.

This request must be submitted prior to the PIP/POC's due date. Deficiencies not disputed must be addressed in the PIP/POC and submitted by the PIPs due date.

What to expect at an IDR

You will be asked to present information to show why the cited deficiencies are incorrect. You may, at your discretion, bring staff members, or you may summarize what they have to say. **If you contend that there are records or written documents to support your contention, please bring them to the IDR.**

In addition to the surveyors who wrote the deficiencies, members of OHCQ staff who did not participate in writing the deficiencies will attend each IDR. At the conclusion of the meeting, OHCQ staff will consider the information presented and may request additional documents or information. After the IDR, your representative will receive a telephone call, during which results will be discussed in detail. A brief letter summarizing the findings and any changes in the deficiencies will follow. Modified reports are forwarded to each state and local agency as appropriate.

Programs should send their written request, along with the specific deficiency being disputed, and an explanation of why the deficiencies are being disputed to:

**Mr. William Dorrill, Deputy Director,
Office of Health Care Quality,
Bland Bryant Building,
55 Wade Avenue,
Catonsville, Maryland 21228**

Please note: This information is being provided as a general guide to assist providers in the survey process. We will make every effort to follow these protocols, however; here may be occasions where circumstances dictate deviation. In the event OHCQ deviates from the procedures outlined here, findings remain valid if they are otherwise supported.



Martin O'Malley
Governor

Anthony G. Brown
Lt. Governor

John M. Colmers
Secretary

Wendy A. Kronmiller
Director

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The Department, in compliance with the Americans with Disabilities Act, ensures that qualified individuals with disabilities are given an opportunity to participate in and benefit from DHMH services, programs, benefits, and employment opportunities.