ASSISTED LIVING QUALITY IMPROVEMENT TOOL—SIXTH EDITION (SEPTEMBER 2022)

A TOOL TO ASSIST WITH REGULATORY COMPLIANCE AND QUALITY IMPROVEMENT

MASS·ALA
Massachusetts Assisted Living Association

The tool can be downloaded from Mass-ALA's members-only website (www.mass-ala.org).

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INTRODUCTION

The Massachusetts Assisted Living Association (MA-ALA) is a non-profit association whose mission is to lead the assisted living industry in its service of seniors through advocacy, education, operational support, and enhanced growth opportunities. MA-ALA promotes the use of the *MA-ALA Quality Improvement Tool* by all its member s to aid in the achievement and maintenance of high operating standards and regulatory compliance.

VALUE STATEMENT

Members of MA-ALA subscribe to the values listed below. Use of the tool on a regular basis helps to monitor operations for adherence to these values.

1. Provide a safe, residential environment
2. Foster independence for each resident
3. Treat each resident with dignity and respect
4. Promote the individuality of each resident
5. Allow each resident choice of services and lifestyle
6. Offer cost-effective quality services that are personalized for individual needs
7. Protect each resident's right to privacy
8. Nurture the spirit of each resident
9. Involve family and friends, as appropriate, in-service planning, and implementation
10. Make the assisted living residence a valuable community asset

PURPOSES

The *MA-ALA Quality Improvement Tool* is designed for easy use at any size and type of assisted living residence. It provides suggestions for quality monitoring; however, not all indicators cited may be applicable to all residences. Each residence must review the tool in light of its services and resident population and adapt the tool to meet its particular needs. The tool provides a way to conduct self-evaluations on a regular basis and provides suggested indicators of quality and regulatory compliance. The tool strives to identify areas that may need further investigation. Based on that additional information, plans for improvement can be developed and implemented by staff. The regular use of this tool can help to foster an organizational culture committed to quality standards.

The indicators set forth in the tool were identified through consultation with MA-ALA members. The tool is intended to provide a format that assists an assisted living residence to improve its operations and monitor compliance with applicable regulations. It is not intended as the sole means for such monitoring or evaluation, nor are the measures provided intended as a complete list. It is not intended that the tool set standards for the operation of an assisted living residence, but rather it is intended to provide users with a simple tool for identifying operational areas that may require further exploration, improvement, or recognition for excellence. The criteria also can be used to train staff in understanding the assisted living regulations and performance requirements and expectations. The tool and your improvement plan also can help to prepare for re-certification visits by Massachusetts' Executive Office of Elder Affairs.

TOOL CONTENT

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MA-ALA's Quality Improvement Tool contains measures from a variety of sources. They are:

(1) **Items in bold directly relate to the Assisted Living regulations. These regulations are available at https://mass-ala.org/wp-content/uploads/2021/12/EOEA-Regulations-12_2021.pdf**
(2) **Shaded Gray** items pertain to Regulations regarding Special Care Residences only.
(3) *Items in italics relate to Executive Office of Elder Affairs ("EOEA") Circular Letters (CLs) (2013, etc.) and Frequently Asked Questions (FAQs) (2007).* EOEA issues the CLs and FAQs as interpretive, sub-regulatory guidance relative to its application of the Assisted Living Regulations, 651 CMR 12.00 *et seq.* ("Regulations") and any revisions to these regulations. Note that the CLs and FAQs are not statutes or regulations, but reasonable interpretations or applications of regulations by a governmental agency that are typically supported by courts if legally challenged. Thus, they are referenced herein as guidance in understanding EOEA's regulatory application, intent and interpretations of certain statutes or regulations.
(4) Items in regular typeface (as here) are practices or procedures that may be applicable or useful. They are examples to assist a Residence that wants to tailor the Quality Improvement Tool more specifically to address its specific operation.

TOOL ORGANIZATION

The *MA-ALA Quality Improvement Tool* has thirteen sections (see Table of Contents) and can be organized in a tabbed, three-ring notebook. The tool is designed to be used either as a complete set, or individual sections can be used independently of each other. For instance, department managers can be given the section that pertains to their area of responsibility. This enables various departments to facilitate integration and use of the tool throughout a residence. This electronic version (Microsoft Word) allows the user to customize the tool and add pertinent instructions, notes, or even additional evaluation elements. Whenever possible, common industry abbreviations have been used to keep the document as short as possible. For example, Assisted Living Residence = ALR; Special Care Residence = SCR; Executive Office of Elder Affairs = EOEA.

DISCLAIMER

The *MA-ALA Quality Improvement Tool* is part of an overall quality assurance and improvement plan. The tool is not intended to be the sole resource used in a residence's quality review process. The criteria stated in the tool are also not intended to be complete or authoritative interpretations or a complete list of statutes and regulations that pertain to the operation of ALRs in Massachusetts and should not be relied upon as such. MA-ALA will periodically issue an updated tool or new criteria to replace previously issued material. Please contact MA-ALA or log into the members-only website for the most current edition.

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SUGGESTIONS FOR USE

The *MA-ALA Quality Improvement Tool* has been designed to be adaptive and flexible. Its use at each ALR should be structured to best meet the objectives of the residence. Residence staff/evaluators should receive in-house orientation and training about how to consistently assess the items contained here.

Evaluation and Scoring Systems: The tool's evaluation and scoring system can have several components. The core system uses a simple Yes/No methodology to simulate a re-certification review by the Executive Office of EOEA, i.e., whether a policy or procedure is in place, or an activity is occurring or not. As an alternative, a numeric evaluation system can be used that measures whether an activity is:

1 = Missing Material Components
2 = Needs Improvement
3 = Average
4 = Above Average
5 = Exemplary

The ALR may opt to aggregate the scores (e.g., Yes vs. No responses, or numeric values) and analyze the results.

In the tool, you will notice that descriptive columns help identify a (potential) "finding" and then articulate an "action to achieve compliance/fulfillment." These headings are similar to how EOEA might identify problem areas or corrective action items during recertification.

Evaluator Teams: Department managers should be well-trained on the use of the tool, the importance of continuous quality improvement and EOEA's recertification review process. Rotation of evaluators reviewing different topics/sections is encouraged to promote objectivity and awareness. For example, a director of resident care/services may complete the chapter pertaining to the residence's physical environment and safety and vice versa. In companies that manage several residences, personnel from one residence may also conduct the review at a related residence.

Evaluation Schedule: The results of the tool are most effective when reviews are conducted on a regular schedule (i.e., at least semi-annually, or quarterly for some departments or issue areas.) Analysis of previous reviews' results will help identify both deteriorating and improving trends. The analysis can then be the basis of discussions with appropriate personnel on an ongoing basis. Written performance improvement plans and a periodic written follow up documenting the effect of the improvement plan are recommended. Content and results can provide input for writing EOEA' cover sheets that summarize a residence's quality assurance and improvement program activities.

Use of the Quality Improvement Tool in Memory Care/" Special Care" Settings: The *MA-ALA Quality Improvement Tool* can be used to evaluate a wide range of assisted living settings, including SCRs. An ALR that offers only traditional assisted living services may opt to use all chapters except the one pertaining to Dementia (section 4). SCRs can use the entire tool to evaluate their operations and service coordination and delivery systems. Such an approach would result in a quite comprehensive review and surface critical areas for improvement in the special care setting.

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REFERENCES, RESOURCES AND FORMS

Sections 12 and 13 of this tool contain informational resources pertaining to the quality review process. Users are encouraged to supplement these sections with their own sources and notes. Evaluators less familiar with a topic area can use the reference materials to assist with learning and residence review. MA-ALA welcomes suggestions of additional references and helpful resources to include in future updates of this tool.

COMMENTS, QUESTIONS AND SUGGESTIONS FOR IMPROVEMENT

Please email or call MA-ALA for assistance with the use of this tool. Contact:

MA-ALA
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Waltham, MA 02452
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Email: lcashman@mass-ala.org

A NOTE OF THANKS

Many people generously volunteered their time and talents to create this tool. The MA-ALA Board of Directors and staff appreciate the significant contributions of the original team that produced the first tool in 2002 and MA-ALA's legal counsel and the many volunteer committees and task force members who helped revise it in 2004, 2006, 2007, 2014, and 2022.

The Board, committee members, and staff hope that this tool will be an effective and practical tool that assists MA-ALA members to not only identify areas of concern, but also recognize quality practices and the staff who perform to such high standards. The goals of this tool are increased regulatory compliance and more importantly, improved quality of life and services for all residents in assisted living.

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SECTION ONE: Organizational Governance, Operations, Administration and Finance

1.1: Mission Statement
1.2: Organizational Structure and Plan
1.3: Certification and Re-Certification
1.4: Management Team
1.5: Reception
1.6: Business Office
1.7: Financial Review
1.8: Contract Management
1.9: Insurance
1.10: Data Management

Instructions:

1. **Bold-face items correspond with regulatory requirements (as found in 651 CMR 12.00). See regulation cross-references for further detail.**
2. **Shaded Gray** items pertain to Regulations regarding Special Care Residences only.
3. *Italicized items correspond with Elder Affairs' "Frequently Asked Questions" (FAQs) distributed June 2007. (These are Elder Affairs policy guidance relative to the amended Assisted Living regulations, promulgated in 2006).*
4. Items in regular font (as here) are issues, quality practices and procedures that may be applicable or useful for your Residence. They are presented only as examples to assist in tailoring this tool to address the specific needs of an individual Residence.
5. A "Yes" response states that the line item is in place and actively in use. A "No" response states that the line item is not occurring. Descriptive columns help identify a (potential) "finding" and then articulate an "action to achieve compliance/fulfillment." These headings are similar to how Elder Affairs might identify problem areas or corrective action items during recertification.
6. Tip: Each line item is presented as a statement that expresses a standard practice. Should this approach cause confusion, pose each statement as a question instead to reach evaluation response.

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
1.1. Mission Statement				
1.1.1. **The SCR provides prospective residents with a written statement describing its special care philosophy and mission and explains how it implements this philosophy and achieves the state mission. (651 CMR 12.08 (3) (r)**				
1.1.1 Incorporates community mission, vision, and values in daily operations				
1.1.2 Provides orientation and training to all associates regarding community mission, vision and values				
1.2. Organizational Structure and Plan				
6.2.1. There is a current description of the organizational structure and plan, which includes, at minimum the names of all key positions/departments and reporting relationships.				
1.3. Certification and Re-Certification				
1.3.1. **Certification is applied for and maintained per 651 CMR 12.03 (1)-(2): Certification)**				
1.3.2. Have all required documentation materials up to date and readily available in organized binders and or/files.				
1.3.3. **There is an approved operating plan meeting the requirements of 651 CMR 12.03 (2) (f) (1-17).**				
1.3.4. **If the ALR is a new residence, prior to the start of operations, the Applicant advertises as an uncertified ALR only if it initiates the application process for**				

certification by notifying EOEA, and if it clearly states in all advertising and marketing materials that it has not completed the EOEA certification process. (See 651 CMR 12.03 (1)(b)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
1.4 Management Team and Leadership				
1.4.1. Daily stand-up meetings conducted.				
1.4.2. Weekly department head meeting is conducted.				
1.4.3. Weekly sales meeting is conducted.				
1.4.4. Quarterly family council meeting is held.				
1.4.5. Monthly resident council meeting is held.				
1.4.6. Regular meetings with families are held to address community issues, communications, etc.				
1.4.7. Customer satisfaction surveys are conducted.				
1.4.8. Survey results are available for staff and family review upon request.				
1.4.9. Recertification review binder is in the ED's office and is up to date.				
1.4.10. Weekly resident review meetings with team are conducted with the resident care team as part of process.				
1.4.11 Within 10 days after an ALR manager leaves their position, the Residence is to contact EOEA and provide the contact information for the interim or new ALR manager 12.04(13)(B)2				
1.5. Reception				
1.5.1. Reception area is clearly visible.				
1.5.2. Receptionist greets all guests who enter the ALR within 15 seconds.				

1.5.3. Receptionist dress and physical appearance is appropriate for ALR.				
1.5.4. Receptionist has pleasant and appropriate phone etiquette.				
1.5.5. Marketing materials are available.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
1.5.6. Resident roster containing apartment number and assistance needed during an evacuation is up-to-date and available at reception desk.				
1.5.7. Placard is at each reception desk (if multiples) for visitors & guests to sign in.				
1.5.8. Guests sign in/out at reception area in appropriate book.				
1.5.9. Emergency Procedures Manuals are available at reception desk and are complete (i.e., policies have state and community specific information).				
1.5.10. Emergency Resident Information binders are kept up to date with all residents' current medication lists, photos, advanced directives, face sheets.				
1.5.11. Resident emergency contact book is updated and kept at reception desk.				
1.5.12. Community Emergency Telephone List is current and available at the receptionist desk and in all Emergency Procedures Manuals.				
1.5.13. Crisis Communication binder is located at receptionist desk and is up to date. ED and Manager on Duty (MOD) have additional copies in office, home, and car.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
1.5.14. Customer Grievance log is present with the business office or ED.				
1.5.15. Suggestion and comment box is visible.				
1.5.16. Mail and packages are distributed promptly.				
1.5.17. Daily resident activity and event information is available at reception desk.				
1.5.18. Basic First Aid kits are stocked and available at reception desk, in ALR van and on each floor.				
1.6. Business Office				
1.6.1. State certifications and licenses are posted in visible location(s) in the ALR. Originals are kept on file in the ED office.				
1.6.2. Business office is neat and well organized with a place for resident/ associate to sit and talk.				
1.6.3. A standard new hire packet is available.				
1.6.4. I-9 forms are organized, alphabetized, updated, and stored in a locked cabinet.				
1.6.5. Associate files are secured and contain documents identified in section 12.05(3); associate records include training documentation.				
1.6.6. CORI and background checks are organized, alphabetized, updated, and stored in a locked cabinet.				
1.6.7. All completed job applications are organized, alphabetized, updated, and				

stored in a locked cabinet.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
1.6.8. One petty cash box is locked, secured, utilizing a documentation system with slips, receipts and sign offs.				
1.6.9. Resident records are secured, organized, contain documents outlined in section 12.05(1)				
1.6.10. Resident records are retained for 6 years after the residency termination date 12.05(1)				
1.6.11. Community has established a documentation retention policy which includes, but not limited to documentation practices, storage of documents and destruction of documents				
1.7. Financial Review				
1.7.1. **A Financial Disclosure report is submitted annually to EOEA on a form prescribed by EOEA. (See 651 CMR 12.04 (13)(a)(1)**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
1.8. Contract Management				
1.8.1. Legal counsel reviews contracts.				
1.8.2. Contracts are reviewed annually for renewals, terms and modifications.				
10.9. Insurance				
1.9.1. The ALR has proof of insurance.				
1.9.2. The ALR periodically reviews its insurance needs.				
1.10. Data Management				
1.10.1. ALR complies with requirements to protect personal information of residents (per 201 CMR 17.00) by implementing and maintaining appropriate security measures.				
1.10.2. Follow Health Insurance Portability and Accountability Act of 1996 (HIPAA) Guidelines 45 CFR 164.102				
- Notice of Privacy Practices Acknowledgement and Consent for each resident record				
- Notice of Uses and Disclosures given to and acknowledged by each resident				
- Identified a HIPAA Privacy Officer				
- Upon hire, associate training on HIPAA guidelines, community policies and practices around confidentiality of resident information				
1.10.3. Key associates have available list of residents who have authorized picture				

taking, consent for publishing their name in the directory, on their door, social media if applicable				
1.10.4. Maintains physical, electronic, and procedural safeguards to protect the confidentiality and security of residents' personal information.				

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ADDITIONAL PROCESS IMPROVEMENT EFFORTS	
Description of Improvement	**Additional Issues Resolved or Improved**

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OTHER COMMENTS

Community: _____ Executive Director: _____

Reviewer of this Section: _____ Reviewer Title: _____

Date of This Review: _____ Date AL Certificate from EOEA Expires: _____

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SECTION TWO: Staffing Systems

2.1: Staffing and Staffing Levels
2.2: Recruitment
2.3: Staff Qualifications
2.4 Heath Screening and Vaccination
2.5: Professional Growth and Staff Retention
2.6: Supervision
2.7: Employee Records
2.8: Department of Labor and OSHA

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
2.1. Staffing and Staffing Levels (See 651 CMR 12.06)				
2.1.1. **ALR has sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled Resident needs as required by the Residents' assessments and service plans on a 24-hour per day basis. (See 12.06 (4)(b).**				
2.1.2. **ALR's staffing is sufficient to respond promptly and effectively to individual resident emergencies. (See 12.06 (4)(b).**				
2.1.3. **ALR has a plan to secure staffing necessary to respond to emergency, life safety and disaster situations affecting residents. (See 12.06 (4)(b).**				
2.1.4. **SCR has sufficient staff qualified by training and experience at all times to meet the 24-hour per day scheduled and reasonably foreseeable unscheduled needs of all residents of the SCR based on their assessments and service plans. 12.06(5)a**				
2.1.5 **SCR staff is awake and on duty at all times. (See 12.06 (5)**				
2.1.6. **SCR's staffing is sufficient to respond promptly and effectively to individual resident emergencies. (See 12.06 (5)**				
2.1.7. **SCR staffing is only sufficient when there are two staff members in SCR.**				

12.06(5)b				
AREA REVIEWED	**Y**	**N**	**Finding(s)**	**Action to Achieve Compliance/Fulfillment**
2.1.8. **SCR has a plan to secure staffing necessary to respond to emergency, safety, and disaster situations affecting residents. (See 12.06 (6)**				
2.1.9. **ALR has developed and implemented a process for determining its staffing levels. (See 12.06 (4)a)**				
-The plan includes an assessment of the appropriateness of staffing levels conducted at least quarterly but more frequently if the ALR chooses.				
2.1.10. A method exists for assessing hours per resident day for personal care tasks.				
2.1.11. There is a method for assessing times of day and staffing needed.				
2.1.12. There is a method for assessing hours needed to complete other tasks.				
2.1.13. ALR has policies that address issues regarding personal care or private duty workers that are hired by the resident (e.g., behavior, dress code, sign in, communications, training, screening, etc.)				
2.1.14 If outside agency is needed, community specific orientation is in place and documented for each agency personnel that reports for duty				
2.2. Recruitment (See 651 CMR 12.06)				
2.2.1. Methods are in place for a successful recruitment process.				
2.2.2. Formal recruitment and pre-screening policies are in place to facilitate the hiring of high-quality staff and these				

policies include:				
-Completion of job application				
-Verification of pre-employment educational programs				
-At least two professional reference checks				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Check of public Sex Offender Registry Board list				
-Competency based job descriptions used for all positions				
-Established probationary period				
-Criminal background checks (CORI) are completed prior to employee start date.				
2.2.3. No person working in an ALR shall have been convicted of a felony related to the theft or illegal sale of controlled substance				
2.2.4. No person working in the ALR has been found in violation of any local, state, or federal statute, regulation or ordinance, or other law reasonably related to the safety and well-being of a Resident or patient at an ALF or health care facility (See 651 CMR 12.06 (3)				
2.2.5. All staff possess appropriate qualifications to perform the job functions assigned to them.				
2.3. Staff Qualifications (See 651 CMR 12.06)				
2.3.1. **The ALR Manager meets the qualification requirements outlined in state regulations (see 651 CMR 12.06 (1) including:**				
-At least 21 years of age				
-Demonstrated experience in administration				
-Demonstrated supervisory and management skills				

-Bachelor's degree or equivalent experience in human service, housing or nursing home management				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Of good moral character (Per MA-ALA legal counsel, in regulatory contexts, this is typically interpreted as e.g., no convictions for crimes or certain misdemeanors, professional actions against licenses or permits or other official forms of action or sanctions against personal conduct.)				
2.3.2. **The ALR Service Coordinator meets the qualification requirements outlined in state regulations (see 651 CMR 12.06 (2) including:**				
-Minimum of 2 years experience working with elders or persons with disabilities				
-Possesses experience and training to develop, maintain and implement, or arrange for the implementation of individualized service plans				
-Bachelor's degree or equivalent experience				
-Knowledge of aging and disability issues				
2.3.3. **The SCR has a designated individual who is responsible for the operations of the SCR and meets the following requirements (See 12.06 (7):**				
-At least 21 years of age				
-Minimum of 2 years experience working with elder or disabled individuals				
-Knowledge of aging and disability issues				
-Demonstrated experience in administration				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Demonstrated supervisory and management skills				
-Bachelor's degree or equivalent experience in human service, housing, or nursing home management				
-Of good moral character. (Per MA-ALA legal counsel, in regulatory contexts, this typically is interpreted as no convictions for crimes or certain misdemeanors, professional actions against licenses or permits or other official forms of action or sanctions against a person's personal conduct.)				
-Never convicted of a felony				
2.4. Health Screening and Vaccination Requirements 651 CMR 12.06(8)(9)				
2.4.1. No person shall be permitted to work if infected with a contagious disease see 12.06(8)a				
2.4.2. All persons shall complete a pre-employment physical including an assessment for TB see 12.06(8)b				
2.4.2. All persons shall have a pre-employment assessment for TB				
2.4.3. Associates will have submitted evidence that they have completed a physical exam at least every two years				
2.4.4. All personnel are vaccinated annually against seasonal flu and other novel pandemic viruses (see 12.06 (9)a-f				

- Personnel is to include contracted individuals, students, volunteers				
- Medical or religious exemptions/declinations on file				
- Proof of vaccination status for employee on file				
- Notification of vaccination requirement as well as risk/benefits given to each employee				
2.5. Professional Growth and Staff Retention				
2.5.1. A policy exists for career growth and promotion within the company.				
2.5.2. Methods are in place and used to identify skill and knowledge gaps and training needs.				
2.5.3. There is a method to check on appropriateness of job design and work loads (e.g., complaints, incident reports).				
2.5.4. There are objective, scheduled (e.g., at least semi-annual) evaluations and opportunities for feedback with immediate supervisor.				
2.5.5. Regular employee recognition / appreciation events are held (e.g., at least every six months)				
2.5.6. Internal promotions to the Manager, Service Coordinator or Special Care Residence Manager meet the eligibility criteria outlined in 12.06(1), (2), (7)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
2.6. Supervision (See 651 CMR 12.07(8)				
2.6.1. **A qualified nurse evaluates the Personal Care Services provided by personal care staff of the ALR or by contracted providers. (See 651 CMR 12.07 (7): Introductory Visit and Review and 12.07 (8): Supervision)**				
-These competency evaluations are conducted at least twice a year by a qualified nurse.				
-A written record of the staff or provider's performance of personal care skills is completed after each evaluation and is kept in the employee's personnel file.				
-Personal care workers demonstrate competence in the assigned personal care tasks either by demonstration or verbal review.				
-Personal care staff that provides SAMM is also evaluated on their awareness of and compliance with (1) SAMM/LMA regulations and (2) all applicable ALR policies and procedures.				
2.6.2. There is a review of the nurse's activities to assess that they are in compliance with the regulations:				
-Conducts Introductory Visits				
-Reviews competencies and skills of Personal Care Workers				
2.6.3. ALR assesses employee satisfaction by survey/other process.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
2.7. Employee Records (See 651 CMR 12.05 (3): Personnel Record Requirement				
2.7.1. **The ALR develops and maintains written personnel records and maintains copies of its personnel policies and procedures.**				
2.7.2. **Each personnel record includes at a minimum the following:**				
-Job description				
-Education preparation and work experience				
-Copy of current licensure or certification, or, if applicable, documentation of completion of 54-hour Personal Care Services Training set forth in 12.07 (6)				
-Documentation of attendance at orientation training				
-Documentation of CORI reports				
-Documentation of annual performance evaluations				
-Documentation of attendance at on-going in-service training				
-Copies of disciplinary letters or reports				
-Documentation of the evaluation of the Personal Care Services provided by personal care staff or by contracted providers. (See 651 CMR 12.07(8): Supervision)				
-This evaluation is conducted by a qualified nurse.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Evaluation is conducted at least twice per year.				
-Documentation of the evaluation of the Personal Care staff who provide Self-Administered Medication Management. (See 651 CMR 12.07(8): Supervision)				
--**Evaluation is conducted on staff's awareness of and compliance with SAMM/LMA regulations and the applicable ALR policies and procedures.**				
-The date of active employment if different from the date of hire (FAQ # 5, page 41) ("Active employment": date the employee performs any job function(s)				
2.7.3. Personnel records also include:				
-Completed and signed job application				
-Completed References (preferably at least two on file)				
-Completed W-4 Tax Form				
-Completed 1-9 Employment Eligibility Verification				
-Copy of a photo ID (e.g., driver's license)				
-Employee's Emergency Contact Info				
-Documentation of acknowledgement of receipt of employee handbook, and procedures (e.g., sexual harassment, handling of emergencies, call outs)				
Documentation of pre-employment physical and ongoing physical every 2 years including TB screening				
-History of salary & pay changes/increases				
-Insurance documents				

-Letters of commendation				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
2.8. Dept. of Labor and OSHA National Emphasis Program				
2.8.1. ALR has name and phone number of contact at occupational health clinic in the business office. The ALR recommends this clinic to all associates with work-related injuries.				
2.8.2. Exposure control plan is posted in a prominent place (e.g., by time clock or staff bulletin board).				
2.8.3. Worker's Comp file is set up for lost time cases to include medical notes, name of adjuster, correspondence.				
2.8.4. Copy of ALR disaster manual, including key phone numbers, is in the business office and/or reception desk.				
2.8.5. Accident reports related to vehicle usage, or anything related to motor vehicle plus all other vehicle safety program correspondences.				
2.8.6. OSHA 300 Log is current (i.e., updated every 7 days when open case.)				
2.8.7. OSHA SDS book is updated reflecting all chemical used and easily accessible to staff.				
2.8.8. Safety committee meeting held monthly with meeting minutes to include resident falls, safety related incidents, exposures, back safety measures, safety related trainings.				
2.8.9. Safety committee members				

represent diverse roles, multiple layers of the organization and a resident representative.				
2.8.9. Back safety program to include training upon hire and annually, back safety reinforcement measures				
Written COVID-19 compliance plan 29CFR1910.52				
- Infection control policies and training				
- Respirator fit testing				

Quality Improvement Tool (6th Edition)

ADDITIONAL PROCESS IMPROVEMENT EFFORTS	
Description of Improvement	**Additional Issues Resolved or Improved**

Quality Improvement Tool (6th Edition)

OTHER COMMENTS

Community: _____ Executive Director: _____

Reviewer of this Section: _____ Reviewer Title: _____

Date of This Review: _____ Date AL Certificate from EOEA Expires: _____

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SECTION THREE: Staff General Orientation and On-going In-Service Training Requirements

3.1: Training Requirements
3.2: General Orientation
3.3: Orientation for Staff working in Special Care Residences
3.4: Documentation of Staff Orientation
3.5: Ongoing In-Service Education and Training
3.6: Documentation of Ongoing In-Service Education and Training

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Instructions:

1. **Bold-face items correspond with regulatory requirements (as found in 651 CMR 12.00). See regulation cross-references for further detail.**
2. **Shaded Gray** items pertain to Regulations regarding Special Care Residences only.
3. *Italicized items correspond with Elder Affairs' "Frequently Asked Questions" (FAQs) distributed June 2007. (These are Elder Affairs policy guidance relative to the amended Assisted Living regulations, promulgated in 2006).*
4. Items in regular font (as here) are issues, quality practices and procedures that may be applicable or useful for your Residence. They are presented only as examples to assist in tailoring this tool to address the specific needs of an individual Residence.
5. A "Yes" response states that the line item is in place and actively in use. A "No" response states that the line item is not occurring. Descriptive columns help identify a (potential) "finding" and then articulate an "action to achieve compliance/fulfillment." These headings are similar to how Elder Affairs might identify problem areas or corrective action items during recertification.
6. Tip: Each line item is presented as a statement that expresses a standard practice. Should this approach cause confusion, pose each statement as a question instead to reach evaluation response.

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
3.1. Training Requirements (See 651 CMR 12.07)				
3.1.1. **The purpose of training in the ALR is to ensure employees have a clear understanding of:**				
-Their jobs and the way in which their work intersects with and supports the work of others				
-The policies and procedures of the ALR				
-The rights of the residents				
-The particular and distinctive service needs and health concerns of the residents				
3.1.2. **All training curricula:**				
-Reflects current standards of practice and care				
-Is designed to enhance the professionalism of employees				
-Enables employees to provide good service				
3.1.3. **Training requirements are met by the following:**				
-Practical demonstration				
-Lectures				
-Lectures with accompanying role playing				
-Video with facilitated discussion				
-Other general accepted techniques				
3.1.5. **Instructors and facilitators are appropriately qualified by training or demonstrated experience.**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
3.1.6. **The ALR maintains documentation in the employee's personnel file regarding the completion of training or eligibility for exemption.**				
3.2. General Orientation (See 651 CMR 12.07 (1)-(2)				
3.2.1. **Seven hours of orientation are provided to all staff and contracted providers who will have direct contact with Residents and all food service personnel.**				
3.2.2. **The 7-hour orientation includes all topics listed in 12.07 (1) (a-m).**				
3.2.3 At **least 1 hour of general orientation is devoted to elder abuse, neglect and financial exploitation**				
3.2.4. **At least 2 hours of the General Orientation is devoted to dementia and cognitive impairment. 12.07(2)b**				
-All curricula for training related to dementia reflect current standards of practice.				
3.2.5. **All personnel providing Personal Care Services receive <u>at least one additional hour</u> of General Orientation training devoted to the topic of Self-Administered Medication Management (SAMM). 12.07(2)c**				
3.2.6. **Both the ALR Manager and Service Coordinator receive <u>an additional two-hour General Orientation training</u> devoted to dementia care topics.**				

12.07(2)d				
AREA REVIEWED	**Y**	**N**	**Finding(s)**	**Action to Achieve Compliance/Fulfillment**
3.2.7. Prevention & Elimination of Discrimination based on Sexual Orientation; complete training within 12 mo of hire (Chapter 19A, section 43)				
3.2.8. OSHA National Emphasis Program training components to include back safety, infection control, chemical safety, lock out tag out, bloodborne pathogen				
3.2.9 One hour devoted to abuse, neglect, and financial exploitation 12.07(2)a				
3.2.10 A Residence may include the use of techniques such as shadowing of more experienced employees during the first five days of an employee's tenure				
3.2.11. **Seven hours of Orientation are counted and documented as distinctly separate requirements from the 10 hours of Ongoing In-service Training requirement.**				
3.2.12. **Video or Audio Technology: No more than 2 of the 7 hours required for initial orientation are conducted by unfacilitated media presentations.** *(See FAQ #9, bullets 2 and 3 for clarification of "facilitated" vs. "unfacilitated".)*				
3.2.13. *Orientation documentation states which sections, if any, were unfacilitated (See FAQ #9, page 42)*				
3.3. Orientation for Staff Working in Special Care Residences (See 651 CMR 12.07 (3)				
3.3.1. **All new staff who work in a SCR and**				

have direct contact with Residents complete the General Orientation requirements itemized in 651 CMR 12.07 (1) (a-m).				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
3.3.2. **In addition, all new staff who work in a SCR and have direct contact with residents receive 7 hours of additional Orientation training on topics related to the specialized needs of the resident population (e.g., creating a therapeutic environment, dealing with difficult behaviors, communication skills, competency, sexuality, and family issues.) 12.07(3)**				
3.4. Documentation of Staff Orientation				
3.4.1. **Completion of all orientation training is documented in the employee personnel record.**				
3.4.2. *Documentation of Orientation training includes (See FAQ #20, page 46):*				
-Name of employee				
-Date of orientation				
-Total length of orientation				
-List of topics covered				
-Length of time spent on additional topics, such as:				
--SAMM				
--Dementia / cognitive impairment				
--Instructor/Trainer				
--Signatures of employee and Instructor				
--Signature dates				
--Which orientations were unfacilitated, if any (See FAQ #9, page 42)				
3.4.3. **No more than two of the seven hours of staff orientation are unfacilitated (12.07)** *(See FAQ #9, page 42*				

for info re: "unfacilitated" vs. "facilitated".				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
3.5. Ongoing In-Service Education and Training (See 651 CMR 12.07 (4)				
3.5.1. **A minimum of 10 hours per year of ongoing education and training is provided for all employees.**				
3.5.2. **At least two hours of the required 10 hours of training is spent on the specialized needs of residents with Alzheimer's disease and related dementia.**				
3.5.3. **All employees receive training on the ALR's disaster and emergency preparedness plan (see 12.04 (11) (b)**				
3.5.4 Annual topics are to include abuse, behavior intervention, prevention of distress, de-escalation techniques and evidence based fall prevention policies				
3.5.5. **Employees working in a SCR receive an additional 4 hours of training per year related to the resident's specialized needs.**				
3.5.6. **Training includes the development of communication skills for Residents with dementia.**				
3.5.7. **Residence Managers (i.e., Executive Director) complete an additional 5 hours of training to complement their background and experience.**				
3.5.8. **Annual CEU requirements for Residence Managers (Executive Directors) are transferable to other Residences.**				
3.5.9. **No more than 50% of the ongoing**				

training requirement is conducted by unfacilitated media presentations by such means as video or audio.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
3.5.10. **All staff providing assistance with Personal Care Services are trained in the ALR's policy on emergency response to acute health issues and first aid**				
3.5.10. **All staff providing assistance with Personal Care Services also complete at least one hour of ongoing education and training per year regarding SAMM**				
3.5.12. **All employees and providers receive ongoing education and training that reinforces initial orientation trainings from among the topics listed in 651 CMR 12.07 (4) (f)(2) (a-o).**				
3.5.13. **The ALR does not use the General Orientation requirements to fulfill the requirements for ongoing in-service training.**				
3.5.14. **Personal Care Workers at the ALR and contracted providers of Personal Care Services receive an additional 54 hours of training prior to providing Personal Care Services to a resident that also meet the following requirements: (See 651 CMR 12.07 (6)**				
-20 hours are specific to the provision of Personal Care Services, and				
-These 20 hours of training specific to the provision of Personal Care Services are conducted by a qualified Registered Nurse with a valid Massachusetts license.				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-The 54 hours of training include all the topics listed in 651 CMR 12.07 (6) (a-m).				
-Documentation of completion of the 54-hour training for ALR staff and contract providers who provide Personal Care Services is transferable for each employee from one ALR to another.				
3.5.16. **For staff who are exempt from the Personal Care Services Provider Training (651 CMR 12.07 (6), they have completed the General Orientation and Ongoing In-Service Trainings requirements set forth in 651 CMR 12.07.(1-4) (See 651 CMR 12.07 (9): Exemptions.**				
3.5.17. Online learning can only be used for 50% of the total hour requirement				
3.5.18. All associates, regardless of hours worked, have the meet the ongoing educational requirement				
3.5.19. **Residence conducts annual training needs assessment to prepare the curriculum for required training (651 CMR 12.07 (5) see section four Quality Systems**				
3.5.20. **Residence has process to evaluate the efficacy of the training program (651 CMR 12.07 (5)**				
3.6 Documentation of Ongoing In-Service Education and Training				
3.6.1. **The ALR does not use the General Orientation requirements (651 CMR 12.07 (1) (a-m) (2) to fulfill ongoing in-service training.**				

3.6.2. **Completion of ongoing in-service training is documented and maintained in the associate record.**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
3.6.3. *Documentation of Ongoing In-service Training includes (See FAQ #20, page 46):*				
-Name of employee				
-Date of in-service				
-Topic				
-Length of training				
-Name of Instructor/Trainer				
-Signatures of employee and Instructor/Trainer				
-Signature dates				
-Track by calendar yr. or date of hire anniversary date				
3.6.4. **If training received within the past 18 months at another ALR, a similar facility or agency is used to satisfy ongoing in-service training requirements, documentation follows a form and manner prescribed by EOEA (See 12.07(4)(e)**.				
3.6.5. *Training completed within the past 18 months at another ALR that is used to satisfy current training requirements has reliable documentation that includes: (See FAQ #15, page 44)*				
-Name of employee				
-Date of in-service				
-Topic				
-Length of training				
-Name of Instructor/Trainer				
-Signatures of employee and Trainer				
-Signature dates				

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ADDITIONAL PROCESS IMPROVEMENT EFFORTS	
Description of Improvement	**Additional Issues Resolved or Improved**

Quality Improvement Tool (6th Edition)

OTHER COMMENTS

Community: _____ Executive Director: _____

Reviewer of this Section: _____ Reviewer Title: _____

Date of This Review: _____ Date AL Certificate from EOEA Expires: _____

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SECTION FOUR: Quality Systems and Reports to Elder Affairs

4.1: Quality Improvement and Assurance Program
4.2: Additional Quality Improvement and Assurance Methods
4.3: Reports to Elder Affairs (e.g., Annual and Additional Reports)

Instructions:

1. **Bold-face items correspond with regulatory requirements (as found in 651 CMR 12.00). See regulation cross-references for further detail.**
2. **Shaded Gray** items pertain to Regulations regarding Special Care Residences only.
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6. Tip: Each line item is presented as a statement that expresses a standard practice. Should this approach cause confusion, pose each statement as a question instead to reach evaluation response.

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
4.1. Quality Improvement and Assurance Program (See 651 CMR 12. 04 (10)				
4.1.1. **The ALR has established an ongoing quality improvement and assurance program to continuously improve services and operations.**				
4.1.2. **The program encompasses:**				
-Oversight and monitoring of services				
-Ongoing quality improvement				
-Implementation of plans that address improved quality of services				
-Periodically gathering, annually reviewing and analyzing data to evaluate the following items:				
--its provision of services				
--the overall outcome of services and planning				
--resident satisfaction				
4.1.3. **The ALR sets goals based on analysis of relevant information focusing on resident safety, well-being, and satisfaction**				
-Analyses are conducted on a regular, on-going schedule (e.g., quarterly)				
4.1.4. **The program includes, but is not limited to review and assessment of the following four areas:**				
-Service Planning (including resident assessments, service plans and progress notes)				
-Resident Safety Assurance				
-Medication Quality Plan				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Detection of Issues and Action to Resolve Problems				
4.1.5. **Service Planning QI/QA Program:**				
-ALR reviews a random sample *(i.e., minimum of 10%)* **of resident assessments, service plans and progress notes at least once each year.**				
-A majority of the resident files reviewed for the current quality audit are unduplicated from previous recent audits. (See FAQs 1-4, page 16 for this section.)				
-The Service Planning quality review is completed at least once per year.				
-A report on the results of the quality audit is completed within one month of completion of the review to facilitate timely action.				
-The Service Planning quality review documentation includes the following information:				
--Date(s) review was conducted				
--Name and title of the person(s) conducting the review				
--Name, move-in date, and Unit number of each Resident included in the review (Note: an alternative coding system can replace the resident's name if desired, but if so, the code must be made available to EOEA.)				
--Summary of the findings				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
--Applicable follow-up plans for improvement				
4.1.6. **Resident Safety Assurance QI/QA Program:**				
-ALR reviews policies and procedures designed to ensure a safe environment for all residents.				
-The Resident Safety Assurance quality review is completed at least once per year. (See FAQ #5, pages 16-17)				
-A report that documents this review is created at least once per year that includes the following:				
--List of policies and/or procedures which were reviewed				
--Date(s) these reviews were conducted				
--Name(s) and title of the person(s) conducting the review				
--Issues identified through the reviews				
--Actions taken to resolve the identified issues				
--Name and title of the person(s) responsible for taking each action				
--Timeframe within which the action was taken				
--Whether the action resolved the issue				
4.1.7. **Personal Emergency Response Systems (PERS)**				
-Traditional ALRs have in place a working system to ensure reasonable and timely response to a resident's urgent or emergency needs.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-The ALR has a policy and practice to monitor and test its emergency response system, tests it regularly and documents results for review by EOEA.				
-As part of its quality assurance program, the ALR oversees and monitors its response system to ensure functionality and effectiveness.				
- All shifts are monitored quarterly.				
- All quality assurance activities and reviews are accurately documented to demonstrate reasonable staff response times to residents' urgent and emergency needs.				
-E-call system reports are available for review by EOEA.				
4.1.8. **Medication Quality Plan for SAMM and if applicable, LMA. This plan includes, but is not limited to, the following: 12.04(10)c**				
-Semiannual evaluation of each Personal Care worker that:				
1) examines his/her awareness of SAMM regulations and applicable policies and				
2) verifies his/her demonstrated ability to comply with SAMM regulations and related ALR policies and procedures				
-A quarterly audit of a random sample of the ALR medication documentation sheets required under 12.04 (2)(b)(2) to ensure compliance with SAMM protocols				

and ALR policies.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Sample size: minimum of 10% of Resident medication sheets. (See FAQs #6-7, page 17)				
-Documentation of quarterly audits of Resident medication sheets include the following information:				
--Date(s) the reviews were conducted				
--Name(s) and title of the person(s) conducting the review				
--Name of the Residents (or use of a resident identifier) *whose medication sheets were audited*				
--Issues identified through the reviews				
--Actions taken to resolve the identified issues				
--Name and title of the person(s) responsible for taking each action				
--Timeframe within which the action was taken				
--Whether the action resolved the issue				
See also Section 5.4.5 and 5.4.6 of this QI Tool for additional quality and practices regarding medication management.				
4.1.9. **Detection of Issues and Action to Resolve Problems. A system is place to:**				
-Facilitate the detection of issues and problems				
-Expedite the implementation of action				
-Resolve problems				
-Communicate outcomes of actions taken or refused				

Quality Improvement Tool (6th Edition)

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Information solicited from residents is collected in a manner that offers anonymity *(e.g., annual resident satisfaction surveys, regular Resident meetings, suggestion box)* (*See FAQ #8, page 17 for this section)*				
-Documentation of this system includes either a summary report or meeting notes that includes:				
--Data collection method used (e.g., annual resident satisfaction surveys, regular Resident meetings, suggestion box)				
--Steps taken in response to the issue identified				
--Name(s) and title of the person(s) responsible for resolving the issue				
--Timeframe within which the action was taken				
--Whether the action resolved the issue				
--How the response to the issue was communicated (i.e., how the Residents were made aware of the availability of these systems or how if there were actions that were recommended by the representative body of the Residents but rejected by the ALR.)				
4.1.10. **Administrative staff of the ALR, qualified by training and experience, review the operations of the SCR twice each year. (12.04(4)(d)**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
4.1.11. **The ALR assesses, at least quarterly, the appropriateness of staffing levels. (12.06(4)(a)**				
4.1.12**Residence conducts an annual training needs assessment 12.07(5)**				
- Identify the training need; develop the content; deliver the content				
- D**evelop process to evaluate the efficacy of the training**				
4.2. Additional Quality Improvement and Assurance Methods				
4.2.1. It is clear who is accountable for collecting compliance information.				
4.2.2. ALR has either a staff person or committee to oversee quality initiatives.				
4.2.3. Resident councils are in place.				
4.2.4. Family councils are in place.				
4.2.5. Frequent quality appraisals are administered (at least twice a year)				
4.2.6. ALR staff is trained about Quality Assurance and Improvement.				
4.2.7. A Quality Improvement Process is in place that elicits input and participation from staff, as applicable.				
4.2.8. Staff is encouraged to report errors and incidents.				
4.2.9. Multiple additional opportunities exist for stakeholder input (e.g., resident council, staff suggestion box, exit interviews).				
4.2.10. Anonymous satisfaction surveys				

are completed at least annually for:				
-Residents				
-Families				
-Staff				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
4.2.11. The ALR asks residents and family members about the following:				
-Their specific needs and expectations				
-How well the ALR meets these needs and expectations				
-How the ALR can improve				
4.2.12. Additional Quality Improvement Strategies regarding Resident Emergencies and Incidents might include clearly defined quality indicators and mechanisms for measuring indicators, such as:				
-Falls				
-Documented falls with serious injury				
-Unscheduled hospital transports				
-Medication errors				
-Discharge of resident within six months of occupancy				
4.2.13. When possible, the ALR compares its performance on quality indicators / outcomes to other ALRs.				
4.2.14. Incidents and accidents are:				
-Investigated to establish common features				
-Analyzed for trends				
-Presented to a Quality Committee for review, analysis, and development of improvement plan.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
4.3. Reports to Elder Affairs (See 651 CMR 12.04 (11)(d) (e) and (13)				
4.3.1. **ALR reports Resident-specific emergencies to EOEA within 24 hours per the regulations** *and EOEA FAQ (#1-11, pg. 19-21) using EOEA's online system.*				
4.3.2. **ALR reports Residence-wide emergency situations to EOEA per the regulations** *and EOEA FAQ (#12-13, pg. 22) using EOEA's online system.* (See Chap. 6.2 here)				
4.3.3. Maintain printed copies of EOEA submissions and store in accordance with your community document retention policy				
4.3.4. *Reports of elder abuse or neglect are reported to the appropriate Protective Services agency. (See FAQ #14, page 23)*				
-These reports are also submitted to EOEA as a Resident-specific incident.				
4.3.5. *If Resident receives GAFC services, ALR also submits required reports to GAFC Program. (See FAQ #15, page 23)*				
4.3.6. **The ALR submits Annual Reports to EOEA including:**				
-Financial disclosure (within 90 days of the ALR's fiscal year) <u>on a form prescribed by EOEA</u> (12.04(13)(a)(1).				
-Aggregate Resident information <u>on a form approved by EOEA</u> based on the most recent Resident assessments and service plans, covering the reporting				

period of January 1 through December 31. This report is submitted no later than March 1 of the next year. (See 12.04 (13)(a)(2)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-The Aggregate Resident information report includes the following information, as of December 31:				
--Number of current residents, their ages, and genders				
--Percentage of all current residents with a medical diagnosis of Alzheimer's disease or related dementia				
--Number of residents currently residing in a SCR				
--Percentage of residents currently receiving SAMM, LMA or both				
--Average and numerical range of ADLs with which residents receive assistance				
--Percentage of residents in GAFC, SSI-G and receiving Section 8 Housing subsidy, as applicable per ALR				
-The Aggregate Resident information report includes the following information, for the entire reporting period:				
--Average resident census				
--Total number of resident tenancies concluded during the reporting period, categorized by the reason for termination (e.g., death, greater care needs, moved to another Residence)				
--Average length of stay for all resident tenancies concluded during report period				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
4.3.7. **Additional Reporting Requirements**				
-All information required by 651 CMR 12.03 (2): Certification is kept current.				
-EOEA is notified in writing at least 30 days prior to any alteration of the ALR, its Units, or its operating plan.				
-Such notice shall identify the specific changes made to any document which would amend, supplement, update or otherwise alter the operating plan, original Application or renewal for Certification is filed with EOEA at least 30 days prior to its effective date.				
-The Sponsor forwards to EOEA a copy of any report or citation of a violation of applicable provisions of the State Sanitary Code, State Building Code, fire safety regulations, or other regulations affecting the health, safety, or welfare of residents, within 7 days of receipt of such violation.				
-EOEA notified within 30 days after a new Residence Manager (Executive Director) begins employment with contact information, including telephone number and email address. See 12.04 13 (b) (2)				

Quality Improvement Tool (6th Edition)

ADDITIONAL PROCESS IMPROVEMENT EFFORTS	
Description of Improvement	**Additional Issues Resolved or Improved**

Quality Improvement Tool (6th Edition)

OTHER COMMENTS

Community: _____ Executive Director: _____

Reviewer of this Section: _____ Reviewer Title: _____

Date of This Review: _____ Date AL Certificate from EOEA Expires: _____

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SECTION FIVE: Marketing Administration

5.1: Resident Rights
5.2: Disclosure of Rights and Services
5.3: Residency Agreement
5.4: Move In / Move Out Criteria

Instructions:

1. **Bold-face items correspond with regulatory requirements (as found in 651 CMR 12.00). See regulation cross-references for further detail.**
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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
5.1 Resident Rights (See 651 CMR 12.08(1)				
5.1.1. **Written notice of Residents' Rights meets the following requirements:**				
-Includes all content from 12.08 (1)(a)-(v)				
-Published in typeface no smaller than 14-point type. (This is 11-point font.)				
-Posted in prominent place(s) in the ALR where it is seen by residents.				
-Includes address & phone # of EOEA's Assisted Living Ombudsman Program.				
-Includes phone # for Elder Abuse Hotline.				
5.1.2. **Prior to scheduling a formal meeting with the prospective resident, the ALR informs him/her of right to be accompanied by a Legal or Resident Representative or another advisor.**				
-ALR has a policy that directs/documents this process.				
5.1.3. **ALR is free from restraints. 12.08 (1)(s). Definition of restraint: see 12.02**				
-The Residence has a policy to review resident service plans so that they do not contain use of such restraints.				
- The Residence conducts environmental safety rounds checking for unauthorized side rails, seating that limits resident's freedom from mobility				
5.1.4. **The Resident Rights is part of the Residency Agreement (12.08(2)(a)(8).**				
-Note: if the Disclosure fully states all of				

the items required by sub-sections (2)(a)4,7,8,10, 11, and 13, the Residency Agreement incorporates those requirements by reference.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
5.1.5. **ALR has a procedure which provides that a Resident may not be evicted after termination of Residency Agreement except in accordance with landlord/tenant laws, M.G.L. c. 186 or M.G.L. c. 239. (See 651 CMR 12.08 (2)(f).**				
5.1.6. **ALR's grievance procedures are part of the Residency Agreement (See 651 CMR 12.08 (2)(a)(4).**				
5.1.7. **ALR meets the requirements of all applicable federal & state laws & regulations including, but not limited to, state sanitary codes, state building & fire safety codes, & laws & regulations governing use & access by persons with disabilities. (See 651 CMR 12.04 (1)(e)**				
5.2. Disclosure of Rights and Services (See 651 CMR 12.08 (3) Disclosure of Rights and Services)				
5.2.1. **Prior to scheduling a formal meeting with the prospective Resident, the ALR notifies him/her of the right to representation by a Legal or Resident Representative or another advisor.**				
5.2.3. **Disclosure Statement is written in plain language and large print (14-point font or larger). (This document is 11 pt.)**				
5.2.4. **Disclosure Statement includes:**				
-Number and type of Units the ALR is certified to operate.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Number of staff currently employed by the ALR, by shift, with an explanation of how the ALR determines staffing, and the availability of overnight staff, awake and asleep				
-Copy of Residents Rights (as in 651 CMR 12.08 (1)				
-Explanation of eligibility requirements for any subsidy program including a statement of any additional costs to the resident associated with services beyond the scope of the subsidy program. This also states the number of available Units, and whether Units are shared.				
-Copy of the ALR's medication management policy, including its SAMM policy for PRN medications and LMA.				
-Explanation of any limitations on the services the ALR will provide, including, but not limited to, any limits on specific services to address ADLs and any limitations on behavioral management.				
-Explanation of the role of the nurse(s) employed by the ALR.				
-Explanation of entry criteria and the process used for Resident assessment.				
-Statement of the number of staff who are qualified to administer CPR & ALR's policy on when CPR is used.				
-Explanation of the different or special types of diets available.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Explanation of the conditions under which the Residency Agreement may be terminated by either party, including criteria the ALR may use to determine that any of those conditions are met, and the length of the required notice period for termination of the Residency Agreement.				
-Explanation of the physical design features of ALR, including that of SCR.				
-Illustrative sample of the ALR's service plan, an explanation of its use, frequency of review and revisions, and the signatures required.				
-Explanation of ALR's security policy, including procedure regarding guests.				
-List of enrichment activities, including the minimum number of hours provided each day. (See also 12.04 (5)(b) for list of activities that "address Resident needs…(and) function".)				
-Copy of resident's instructions re: ALRs' Disaster and Emergency Preparedness Plan.				
-Statement of the ALR's policy and procedures, if any, on the circumstances under which it will, with the member's [sic] resident's permission, include family members in meetings and planning.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Each SCR provides a written statement describing its special care philosophy and mission, and how it implements this philosophy and achieves its mission.				
-If ALR allows non-residents to use facilities (i.e.) swimming pool, gymnasium, or other meeting/function room, will disclose such usage to residents. Disclosure includes informing residents of the existence of non-regulated programming on site; amount of interaction or shared use of the facilities and describes any resultant impact on ALR staffing. 12.08 (3)(s)				
5.2.5. *The Resident Record includes a statement signed and dated by the resident, affirming: (FAQ #5, pg. 8)*				
a) Timely receipt of notice regarding right to representation (i.e., to be accompanied by legal or resident representative or another advisor)				
b) Documentation of the ALR's timely delivery and review of:				
-EOEA Consumer Guide (i.e., at first formal meeting)				
-ALR's Disclosure Statement (i.e., at first formal meeting)				
5.2.6. *Disclosure Statement changes are filed with EOEA at least 30 days prior to implementation.*				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
5.2.7. *Disclosure statement is delivered as an independent document (not part of a Residency Agreement or Resident Handbook).*				
5.2.8. *Disclosure statement contains specific EOEA language regarding the risks associated with using a bed rail.*				
5.2.9. The customized portion of the disclosure statement is regularly checked for accuracy.				
- Copies of the above mentioned, including the Consumer Guide documents are clean, professional in their presentation to the customer				
5.3. Residency Agreement (See CMR 651 12.08(2) Residency Agreement)				
5.3.1. **Original Residency Agreement was submitted to EOEA for review (12.03(2)(f)(8).**				
-Residency Agreement revisions have been submitted to EOEA for review. (See FAQ #5, page 24)				
5.3.2. Standard residency agreement is used that is consistent with state regs. & has been reviewed by EOEA.				
5.3.3. **At the time of or prior to the execution of the Residency Agreement or the transfer of money to an ALR, the ALR delivers to the prospective Resident and verbally reviews a copy of the Residency Agreement. (651 CMR 12.08)**				

-ALR delivers a signed and dated copy of the Residency Agreement to applicable signatories (i.e., signatures of the ALR and Resident (or his/her Legal Rep.)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
5.3.4. **Residency Agreement contains, at a minimum, the following: (See 651 CMR 12.08 and 12.08 (2), et al.)**				
-All applicable costs and terms of payment (12.08)				
-Services offered (12.08)				
-Services not offered (12.08)				
-Shared risks (12.08)				
-Resident's Unit number (See 12.08(2)(d)				
-If the Resident changes Unit, an Addendum to the Residency Agreement is signed. (See FAQ #2, page 24)				
-Charges, expenses, and other assessments for the provision of Resident services, personal care Services, lodging and meals (12.08 (2)(a)(1)				
-The agreement of the resident to make payment of the charges specified (12.08 (2)(a)(2)				
-Arrangements for payment (3)				
-Grievance procedure (4)				
-ALR's covenant to comply with applicable federal and state laws and regulations concerning consumer protection and protection from abuse, neglect, financial exploitation of the elderly and disabled (5)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Termination conditions, including criteria the ALR may use to determine that any of those criteria has been met, and the length of the required notice period for termination of the Residency Agreement (See 651 CMR 12.08 (2)(a)(6).				
-Rules of conduct and behavior for staff, management and resident (7).				
-The Resident Rights required by 651 CMR (12.08 (1)				
-Explanation of the services included in any fees, description of all other bundled services & explanation of other services available at additional fee. (9)				
-Explanation of limitations on services, especially regarding ADLs and behavioral management (10)				
-Explanation of the role of the nurse (10)				
-Explanation of nursing and personal care worker staffing levels (10)				
-Explanation of eligibility requirements for available subsidy programs, including a cost statement associated with services beyond the scope of subsidy program for which Resident or his/her Legal Rep. would be responsible. (11)				
-Refund policies for Administrative Fees, deposits, and other charges (12). Administrative Fees defined as any charge billed to and payable by a Resident as a condition of admission, excluding room, board, and services.				

Quality Improvement Tool (6th Edition)

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Copy of the ALR's medication managements policies (i.e., SAMM, PRNs, and if applicable, LMA). (13)				
5.3.5. *To comply with 651 CMR 12.08(1)(r) regarding evictions, the Residency Agreement also includes: (See FAQ #11, page 26)*				
-Indication that certain protections under Massachusetts' landlord-tenant laws apply				
-Explanation of the conditions and criteria under which the Residency Agreement may be terminated				
-Assurances that the ALR and Resident will each give prior written notice regarding agreement termination				
5.3.6. *The ALR collects a signed acknowledgement of fee increases from each Resident, or his/her Legal or Resident Rep. as applicable, to confirm receipt of timely notice prior to the implementation of fee increase. (See FAQ #3, page 24)*				
-This acknowledgement is filed in the Resident Record.				
-If a signed acknowledgement is not returned, efforts to obtain signature(s) are documented.				
5.3.7. **Residency Agreement may also include the ALR's agreement to provide or arrange for the provision of the additional services, including but not limited to, the following (12.08(2)(b):**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Barber and Beauty Services				
-Sundries for personal consumption				
-Local transportation for medical and recreational purposes				
5.3.8. Residency Agreement may include:				
-Pet policies				
-Visitor policies				
5.3.9. **The Residency Agreement is written in plain language and published in typeface no smaller than 14-point type. (12.08) (This is 11 point font.)**				
5.3.10. **The Residency Agreement is in the Resident Record or may be kept in a separate location** *onsite*. **(See 12.05 (1)(g)** *(FAQ #4, page 24)*				
5.3.11. *The Resident's Record includes a confirmation that the ALR has timely delivered and reviewed the Residency Agreement with the prospective Resident (FAQ #1, page 24).*				
5.3.12. **The Residency Agreement is for a term not to exceed one year. (See 651 CMR 12.08 (2)(c)**				
5.3.13. *The Residency Agreement does NOT require a Resident to:*				
-Waive his/her right to assert any or all claims for loss or injury (See FAQ #9, page 25)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Indemnify, hold harmless or other exonerate the ALR for any liability for injury, loss, damage, or liability to the resident. (MGL c. 186, s. 15)				
-Residents who use motorized wheelchair or scooter, obtain, or maintain personal liability insurance (FAQ #8, page 25)				
-Obtain or maintain motor vehicle, property or renter's insurance				
5.3.14. *Changes to Residency Agreement are filed with EOEA at least 30 days prior to effective date (FAQ #6, page 25).*				
5.3.15. *Following the revision of the Residency Agreement, current residents sign the revised Agreement upon any of the following*: *(See FAQ #7, page 25)*				
-The earliest of executing of a renewal				
-The occasion of any "automatic" renewals				
-When Residency Agreement is amended				
5.3.16. *Respite Agreements meet all the same requirements as the Residency Agreement for a "long-term" residency. (See FAQ #14, page 28)*				
5.3.17 EOEA informational cover sheet for each residency agreement with the resident or legal representative signature and witness (see CMR 12.08(4)				
5.3.17 Provide a statement of apartment condition upon move in				
5.3.18. Agreement contains language addressing second occupant and				

condition of residency status if primary occupant terms residency.				
5.4. Move-in / Move-out Criteria				
5.4.1. **Disclosure Statement is given to prospective Resident (651 CMR 12.08)**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
5.4.2. **Residency Agreement includes the conditions under which the Residency Agreement may be terminated by either party, including criteria the ALR may use to determine that any of those conditions have been met, and the length of the required notice period for termination of the Residency Agreement. (See 12.08 (2)(a)(6).**				
-Procedures in place to notify a Resident and his/her Legal or Resident Rep. as appropriate, when ALR is no longer an appropriate environment for the Resident. Notice shall describe the changes in the Resident's service needs that justify such a finding, explain when those changes occurred, and describe how the Resident's needs can no longer be satisfied. 651 CMR 12.03 (2)(f)(10)				
5.4.3. Criteria used in making move-in and move-out decisions are clear, fair, and consistent with pertinent laws and regulations.				
5.4.4. The criteria are contained in a written residency agreement that also identifies the process and criteria for handling individual exceptions when permitted by the organizational plan, laws and regulations.				
5.4.5. The ALR's move-in / move-out criteria are reviewed as needed.				
5.4.6. New agreement, disclosure,				

handbook if resident transfers from AL to SCU				

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ADDITIONAL PROCESS IMPROVEMENT EFFORTS	
Description of Improvement	**Additional Issues Resolved or Improved**

Quality Improvement Tool (6th Edition)

OTHER COMMENTS

Community: _____ Executive Director: _____

Reviewer of this Section: _____ Reviewer Title: _____

Date of This Review: _____ Date AL Certificate from EOEA Expires: _____

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SECTION SIX: Risk Management and Resident Safety

6.1: Risk Management
6.2: Reporting Requirements for Emergencies resulting in Resident Displacement
6.3: Reporting Requirements for Resident-Specific Emergencies
6.4: General Safety (including Personal Emergency Response Systems (PERS)
6.5: Disability Accommodation
6.6: Evidence Informed Falls Prevention Program

Instructions:

1. **Bold-face items correspond with regulatory requirements (as found in 651 CMR 12.00). See regulation cross-references for further detail.**
2. **Shaded Gray** items pertain to Regulations regarding Special Care Residences only.
3. *Italicized items correspond with Elder Affairs' "Frequently Asked Questions" (FAQs) distributed June 2007. (These are Elder Affairs policy guidance relative to the amended Assisted Living regulations, promulgated in 2006).*
4. Items in regular font (as here) are issues, quality practices and procedures that may be applicable or useful for your Residence. They are presented only as examples to assist in tailoring this tool to address the specific needs of an individual Residence.
5. A "Yes" response states that the line item is in place and actively in use. A "No" response states that the line item is not occurring. Descriptive columns help identify a (potential) "finding" and then articulate an "action to achieve compliance/fulfillment." These headings are similar to how Elder Affairs might identify problem areas or corrective action items during recertification.
6. Tip: Each line item is presented as a statement that expresses a standard practice. Should this approach cause confusion, pose each statement as a question instead to reach evaluation response.

Quality Improvement Tool (6th Edition)

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
6.1. Risk Management				
6.1.1. A policy exists that describes the "managed resident risk" philosophy and the procedures for establishing such an arrangement with a resident and documenting it.				
6.1.2. Appropriate and sufficient liability, worker's compensation, property insurance and other insurance coverage are in place.				
-Limits of liability and policy language are adequate for assisted living exposures.				
6.1.3. Employees are required to report immediately accidents or illnesses.				
6.1.4. Incidents and accidents are:				
-Investigated to establish related factors				
-Documented carefully and objectively				
-Analyzed for trends or common factors				
-Presented to a Quality Committee and/or safety committee for review and interventions.				
6**.1.5. Observed or suspected incidents of elder abuse, neglect, and self-neglect are reported to EOEA per MGL Ch 19A Sec. 15**				
-Elder abuse, neglect, and self-neglect laws and reporting policies are communicated to staff, residents, family members				

Quality Improvement Tool (6th Edition)

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
6.2. Reporting of Emergency Situations That Result in Resident Displacement (from their Units for 8 hours or more) (See 651 CMR 12.04 (11)(c)(e)				
6.2.1. **The ALR Manager or his/ her designee immediately provides a report to EOEA' Assisted Living Certification Unit of the situation.**				
6.2.2. **The report contains at least:**				
-Name and location of the ALR				
-Nature of the problem				
-Number of residents displaced				
-Number of Units rendered unusable due to the occurrence				
-Anticipated length of time before the residents may return				
-Remedial action taken by the ALR				
-Other state and local agencies notified about the problem				
6.2.3. **ALR reports Residence-wide emergency situations to EOEA per the regulations via EOEA's online filing system** *and EOEA' FAQs (#12-13, page 22).*				
-Temporary report by fax and telephone is used when online filing system is inaccessible, submission of official report via online filing system when accessible.				
- Printed copies of the incident reports filed electronically are kept on file in accordance with the residence document retention policy				
6.2.4. ALR reports clusters of				

communicable disease/illness, per public health standard.				

Quality Improvement Tool (6th Edition)

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
6.3. Reporting of Resident-Specific Emergencies (See 651 CMR 12.04 (11)(d)(e)				
6.3.1. **The ALR reports to EOEA the occurrence of an incident or accident that arises within a Residence or its property, that has or may have a Significant Negative Effect on a resident's health, safety, or welfare, as defined by 651 CMR 12.02. A Significant Negative Effect shall be assumed whenever, as a result of an incident or accident, any unplanned or unscheduled visit to a hospital or medical treatment is necessary**				
6.3.2. **ALR reports Resident-specific emergencies to EOEA per the regulations via EOEA's online filing system within 24 hours** *and EOEA' FAQs (#1-11, pages 19-21 as well as under the definitions12.02).*				
-Temporary report by fax and telephone is used when online filing system is inaccessible, submission of official report via online filing system when accessible.				
- Printed copies of the incident reports filed electronically are kept on file in accordance with the residence document retention policy				
6.3.3. *Reports of elder abuse or neglect are reported to the appropriate Protective Services agency. (See FAQ #14, page 23)*				
-These reports are also submitted to EOEA as a Resident-specific incident.				

6.3.4. *If Resident receives GAFC services, ALR also submits required reports to GAFC Program. (See FAQ #15, page 23)*				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
6.4. General Safety				
6.4.1. **ALR meets requirements (12.04(1)(e):**				
-State sanitary codes				
-State building codes				
-State fire safety codes				
6.4.2. *Traditional ALRs have in place a working system to ensure reasonable and timely response to a resident's urgent or emergency needs.*				
6.4.3. *The ALR has a policy and practice to monitor and test its emergency response system, tests it regularly and documents results for review by EOEA.*				
6.4.4. *As part of its quality assurance program, the ALR oversees and monitors its response system to ensure functionality and effectiveness.*				
- All shifts are monitored quarterly.				
- All quality assurance activities and reviews are accurately documented to demonstrate reasonable staff response times to residents' urgent and emergency needs.				
-E-call system reports are available for review by EOEA.				
6.4.5. **Personal Emergency Response Systems (PERS) 12.04(11)a 3**				
-SCRs have in place a general system to ensure reasonable and timely response to a resident's urgent or emergency needs.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-In the absence of a technology-based e-call system, hourly visual resident safety checks between 7 PM and 7 AM is in use.				
-Visual monitors are used as an alternative to hourly checks with resident and/or legal guardian consent.				
-Visual resident safety checks in the SCR are accurately documented.				
-For alternative systems to visual checks, a detailed system description and related system activities are accurately documented to demonstrate effective and prompt response to resident's scheduled and unscheduled needs.				
-The ALR has a policy and practice to monitor and test its emergency response system, tests it regularly and documents results for review by EOEA.				
-As part of its quality assurance program, the ALR oversees and monitors its response system to ensure functionality and effectiveness.				
- All shifts are monitored quarterly.				
- Quality assurance activities & reviews are accurately documented to demonstrate reasonable staff response times to residents' urgent and emergency needs.				
-E-call system reports are available for review by EOEA.				
6.4.6. Policies are in place regarding:				
-Wandering				
-Elopement				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Chemical and physical restraints				
-Falls				
-Aggressive behavior				
-Sexually disinhibited behavior				
-Medical emergencies				
-Disruptive families/others				
-Refusal to secure skilled care for resident when needed				
6.4.7. All staff is trained regarding the general safety policies in 11.2.3.				
- Residence to conduct routine missing person's drills; varying times/days through out the year; evaluating response to the resident's missing person's policy/protocol				
6.4.8. An incident response team is identified for all shifts.				
6.4.9. Resident identification photographs are taken upon move in.				
-Resident consent is obtained to take and keep photos.				
-Pictures are incorporated into the resident's record.				
6.4.10. Policies exist for signing out residents.				
6.4.11. Policies exist so that volunteers, service providers, and outside contractors sign in/out.				
6.5 Disability Accommodation				
6.5.1. **ALR meets all laws and regulations governing use and access by persons with disabilities (See 651 CMR 12.04 (1)(e).**				
6.5.2. A policy and procedure is in place to				

screen for / establish if a resident has a qualified disability. The procedure:				
-Identifies a physical or mental impairment				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Determines if the impairment significantly interferes with one or more major life activities				
6.5.3. Reasonable accommodations are developed when such an accommodation is:				
-Necessary to provide equal access to ALR or its services				
-Likely to result in equal access				
-Does not cause undue financial or administrative burden				
-Does not require fundamental change in the operation of the ALR				
6.5.4. ALR assesses its physical facility so to facilitate the following:				
-Wheelchair and other mobility access (e.g., counter height, access to drinking fountain, elevation of ramps, ability to automatically open doors, availability of elevators, delays on door closings, bathroom grab bars for transfers, transportation)				
-Access for those with visual impairment (e.g., lighting, signage, no pathway obstructions)				
-Access for those with hearing impairment (e.g., PA system, visual signs of alarms)				
- Programming/Activities, events, outings allow for equal participation by all residents				
6.5.5. Staff is knowledgeable about the Americans with Disabilities Act, Titles II				

and III, the Fair Housing Act and Mass. Chapter 151B Requirements.				
6.6 Evidence Informed Falls Prevention Program (see CMR 12.04(10)b and under definitions 12.02)				
6.6.1. Associate training on the causes and prevention of falls 12.07(f)e				
- **Policies and procedures for an Evidence Informed Falls Prevention Program**				
6.6.2. Safety committee review: data analysis of resident falls, identification of interventions to mitigate falls reflected in meeting minutes				
6.6.3. Identify operational programs to mitigate falls; examples may include exercise programs, PT consults, nutrition programs, safety rounds				

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ADDITIONAL PROCESS IMPROVEMENT EFFORTS	
Description of Improvement	**Additional Issues Resolved or Improved**

Quality Improvement Tool (6th Edition)

OTHER COMMENTS

Community: _____ Executive Director: _____

Reviewer of this Section: _____ Reviewer Title: _____

Date of This Review: _____ Date AL Certificate from EOEA Expires: _____

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SECTION SEVEN: Assessments and Service Planning

7.1: Screening and Assessment
7.2: Resident Elopement Risk
7.3: Risk for Falls
7.4: Use of Bed Rails
7.5: Behavioral Expressions
7.6: Service Plan Development
7.7: Service Plan Requirements (including service plan reviews)
7.8: Service and Service Coordination Requirements
7.9: Introductory Visits
7.10: Resident Information
7.11: Progress Notes
7.12: Additional Record Requirements – Census Documentation and Staff Correspondence Log
7.13: Communicable Disease Control Plan

Instructions:

1. **Bold-face items correspond with regulatory requirements (as found in 651 CMR 12.00). See regulation cross-references for further detail.**
2. **Shaded Gray** items pertain to Regulations regarding Special Care Residences only.
3. *Italicized items correspond with Elder Affairs' "Frequently Asked Questions" (FAQs) distributed June 2007. (These are Elder Affairs policy guidance relative to the amended Assisted Living regulations, promulgated in 2006).*
4. Items in regular font (as here) are issues, quality practices and procedures that may be applicable or useful for your Residence. They are presented only as examples to assist in tailoring this tool to address the specific needs of an individual Residence.
5. A "Yes" response states that the line item is in place and actively in use. A "No" response states that the line item is not occurring. Descriptive columns help identify a (potential) "finding" and then articulate an "action to achieve compliance/fulfillment." These headings are similar to how Elder Affairs might identify problem areas or corrective action items during recertification.

6. Tip: Each line item is presented as a statement that expresses a standard practice. Should this approach cause confusion, pose each statement as a question instead to reach evaluation response.

Quality Improvement Tool (6th Edition)

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
7.1. Screening and Assessment (See 651 CMR 12.04 (6)				
7.1.1. **Prior to resident move in, a nurse conducts an initial screening to assess and determine: (651 CMR 12.04(6)**				
-**Resident's service needs and preferences and the ability of the Residence to meet those needs (See 12.04(6)(a)(1)**				
-Resident's functional abilities based on his/her cognitive status (12.04(6)(a)(2-3)				
-Whether SAMM is appropriate for the Resident based on: (12.04(6)(a)(4)				
--Completion of an observational assessment by a nurse to determine whether the resident is capable of performing the particular method(s) of independent medication administration				
--Written statement by that nurse documenting the Resident's capability of performing the particular method(s) of independent medication administration				
-**Whether the Resident is at risk for elopement (12.04(6)(a)(5) See 7.2 below.**				
-Whether the Resident is suitable for SCR (12.04(6)(a)(6)				
7.1.2. **Assessments document, include at a minimum: (12.04(7)(a)(1-8)**				
-Allergies (e.g., dust, medications, food, latex)				
-Diagnoses/medical conditions				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Medications (dosage, method of administration and frequency) (See Section 8 of this QI Tool for additional information)				
-Dietary needs				
-Need for assistance in emergency situations				
-History of psychosocial issues, including disruptive behaviors, or behaviors which may present a risk to the health of and safety of the resident or others				
-Level of personal care needs, including ADLs and IADLs				
-Ability of the resident to manage medications, including the ability to take them on an as-needed basis				
7.1.3. **Preadmission assessment notes the name of any Legal Representative or any other person who has been documented as having decision making authority for the Resident and the scope of his/her authority (12.04 (6)(b)**				
7.1.4. **Initial Screening findings are documented and disclosed to the Resident, his/her Legal Rep., and Resident Rep., if any, before the Resident moves into the ALR. (12.04 (6)(c)**				
7.1.5. **The resident or his/her representative has a physician or authorized practitioner conduct an evaluation within the three months prior**				

to move in, which includes (12.04(7):				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Physical condition				
-Cognitive condition				
-Psychosocial condition				
7.1.6. *Efforts to encourage the Resident, or his/her Legal Rep. to obtain the physician's assessment are documented in the Resident's record. (FAQ #1, pg. 29)*				
7.1.7. Assessments may also include:				
-Sensory Issues				
-Communication				
-Social Skills				
-Sexuality				
-Recreational Interests				
-Spirituality				
-Cultural				
-Educational/Vocational				
7.1.8. *Each person who participates in the assessment* (including resident, if applicable) *appropriately documents his/her participation (FAQ 5, pg. 30)*				
-The Resident's current needs and preferences are accurately documented. (FAQ #5, page 30)				
7.1.9. *The Resident or Legal Rep.'s participation in the assessment process is documented via either 1) their signature and date of the assessment or 2) signing an acknowledgement stating that the Resident has participated in the assessment and understands that he/ she has a right to review the assessment. (See FAQ #6, page 30)*				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
7.1.10. *All changes, additions or deletions are clearly and legibly written in ink.*				
7.1.11. *All changes are signed or initialed and dated by the Service Coordinator who did the assessment, so that EOEA can determine when each change was made.*				
7.1.12. *Liquid paper, correction tape or similar products are not used.*				
7.1.13. All residents have current assessments in their resident record.				
7.1.14. Assessments identify the need for or continuation of the integration of other available resources/services.				
7.1.16. The ALR has a procedure for determining when a new or different form of assessment is needed to gather updated (re)assessment data.				
7.1.17. The ALR has a policy/procedure outlining residency appropriateness based on assessment outcome				
7.1.18. Clear communication process amongst sales, the nurse and ED to determine appropriate care level is provided to the prospective new resident				
7.2. Resident Elopement Risk				
7.2.1. **All residents are assessed for elopement risk. (12.04(6)(a)(5)**				
7.2.2. This assessment covers topics such as mental status, mobility, expressions of leave-taking, wandering history, etc.				
7.2.3. Recommends prevention strategies for those identified as an elopement risk.				

7.2.4. **ALR has protocols in place for participation in the Silver Alert System. (12.04 (11)(a)(1)(f)**				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
7.2.5. The ALR has policy and procedure to conduct regular elopements drills.				
-Elopement drills occur on all shifts.				
-Creation of a missing person's emergency kit which may include local maps, warming blanket, first aide supplies, current resident photos				
7.3. Risk for Falls (see section 6.6 Evidence Informed Fall Prevention Program)				
7.3.1. Residents are assessed for fall risk.				
7.3.2. This assessment covers topics such as mental status, mobility, falls history, etc				
7.3.3. Recommends prevention strategies for those identified as a fall risk.				
7.3.4. Institutes measures for resident identification at time of move-in.				
7.3.5. Falls related data is tracked and analyzed to identify quality issues.				
7.4. Use of Bed Rails				
7.4.1. *ALR has a policy regarding the prohibition on the use of bed rails as a restraint.* **See CL 13-1, as well as the Definition of restraint (651 CMR 12.02).**				
7.4.2. *A physical or occupational therapist conducts an assessment of a resident's capacity to navigate independently around a bed rail, U-bar or other similar device and safely get out of bed.*				
7.4.3. *The PT or OT assessment above is maintained in the resident's file at the ALR.*				
7.4.4. *The ALR maintains updated bed rail*				

assessments, at least every six months or upon a significant resident condition.				
7.4.5. *The Disclosure Statement contains specific EOEA language regarding the risks associated with using a bed rail.*				
7.5 Resident Behavioral Expressions				
- Identification of any behavioral expression regardless of DX of dementia (ex may include anxiety, hoarding, pacing, aggression)				
- Identification of past interventions used to deescalate behavioral expressions				
- ALR has policy around residency guideline as they relate to behavioral expressions				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
7.6. Service Plan Development (See 651 CMR 12.04 (7)				
7.6.1. **The Service Coordinator or nurse develops an individualized service plan prior to resident move in based on the results of the initial screening described in 12.04(6).**				
7.6.2. **Said service plan is developed before the Resident moves into the ALR.**				
7.6.3. **The service plan is based on information provided by the Resident, his/her Legal Rep, or Resident Rep.**				
7.6.4. **Resident, Legal Rep. & Resident Rep. are involved in development of the service plan to the maximum extent possible, authorized, willing and able to be involved.**				
7.6.5. **The Service Plan includes an evaluation, conducted within the past three months by the Resident's physician or authorized practitioner, of the prospective Resident's physical, cognitive and psychosocial condition.**				
7.6.6. **The Service Coordinator or nurse reviews Resident's initial service plan within 30 days of the commencement of residency and documents the review to ensure the Resident's needs and preferences are accurately incorporated 12.04 (7)(b).**				
7.6.7. **EOEA may review the service plan at anytime with the consent of the**				

resident or legal representative (see CMR 12.04(8)c)				
- written consents are obtained from the resident/legal rep upon move in				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
7.7. Service Plans Requirements (see 651 CMR 12.04 (8). [Includes ISP Reviews]				
7.7.1. **Service plans are based on a current assessment (12.04(8)(a).**				
7.7.2. **Service plans indicate:**				
-The services needed (12.04(8)(a)(1)				
-**The minimum service package provided for a monthly** (or daily) **fee** (or even services not charged a special fee) **(1).**				
-Any additional services the Resident needs (1).				
-Resident's goals (2).				
-Resident's needs and preferences (See FAQ #1, page 34)				
-<u>Frequency</u> of all services to address the resident's physical, cognitive, psychological and social needs (2).				
-<u>Duration</u> of all services to address the resident's physical, cognitive, psychological and social needs (2).				
7.7.3. **The Service Plan addresses the resident's cognitive, psychological and social needs, including but not limited to the following (12.04(8)(a)(2)(a-d):**				
-Details of 24-hour, on-site staff (2)(a)				
-Details of on-site staff capability (2)(a) *(See FAQ #10, page 36 for guidance re: "staff capability")*				
-The manner in which personal emergency response devices or procedures are provided (2)(a)				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-For residents with cognitive impairment and/or lack the ability to use a call system, the service plan indicates how the ALR will ensure that such Residents can access services 24 hours per day (e.g., frequent checks by staff)*. (See FAQ #9, page 36)*				
-If there are identified behavioral management needs, the service plan describes the assistance or intervention staff would provide with any behavioral issues. (See FAQ #9, page 36)				
-Types of assistance with medications the ALR provides the resident, if any (SAMM, LMA) **12.04(8)(a)(2)(b)**				
-Description of services (that the ALR is aware of) **that are provided by a person/entity not affiliated with the ALR or by a certified provider of ancillary health services (e.g., VNA, private duty aides, etc.) (12.04(8)(a)(2)(c).**				
-The need for a meal plan prescribed or ordered by Resident physician (12.04(8)(a)(2)(d).				
-If resident has other dietary needs (e.g., cut meat, cuing where food is on plate), this is on service plan (FAQ #9, page 36)				
-ALR has a qualified dietician review the Resident's dietary needs. (d)				
-ALR provides the Resident with diet management counseling. (d)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-As part of a Resident's service plan, either a kitchenette or access to a refrigerator, sink and heating element (12.04(1)(d). Such access may be limited to supervised access (based on resident assessment for safety).				
-Whether keys/access codes are available to specific shift staff (12.04 (1)(a).				
-The description specifies which individuals, or at least which types of staff (e.g., by job title, shift, and wing of the ALR) have such access (See FAQ #1, pg 15).				
-Specific types of assistance that will be provided for ADLs and IADLs. (e.g., specific types of help with bathing, such as cueing or hands-on assistance.) (see CMR 12.04 (2) (b) 1 and FAQ #9, pp 35-36)				
-If ALR holds money for a Resident, this is noted on the service plan (see CMR 12.04 (5) (c) and FAQ #9, pg. 36)				
-If there is a need for medication to be locked (see CMR 12.04 (2)(b)(4) and FAQ #10, page 33)				
-If the family is responsible for obtaining medications and filling medication planners/cassettes, this is noted on the service plan (FAQ #11, page 37, 2nd bullet)				
-To the extent that the ALR is aware of services being provided by an outside org., documentation of outside services on the service plan includes name of agency and service type frequency and duration.				

(NOTE: Progress notes regarding services provided by an outside agency are not, by themselves sufficient.) (FAQ #11, pg. 37.)				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
7.7.4. Per 12.04(8)(a)(3), **Service Plans for residents in the SCR indicate the enrichment activities provided, as outlined in 12.04(4)(b) including:**				
-Gross motor activities				
-Self-care activities				
-Social activities				
-Sensory and memory enhancement activities				
7.7.5. **Service plans are in writing, signed and dated by Resident or Legal Rep. and by the (Sponsor)Residence representative (12.04(8)(b).**				
7.7.6. **The resident's initial service plan is reviewed within 30 days of the commencement of residency. (12.04(7)(b)**				
7.7.7. **The service plan review is documented.**				
7.7.8. **The service plan review assesses whether the Resident's needs and preferences are accurately incorporated and that the ALR is capable of meeting the Resident's needs in accordance with 651 CMR 12.00.**				
7.7.9. The resident assessment is reviewed within 30 days of the date when the resident moves in (to facilitate service plan and assessment review synchronization.)				
7.7.10. **Each service plan is reviewed at least once every six months or upon a significant change in resident condition. (12.04(8)(c), in order to:**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-(See also FAQ #3, page 29 for examples of "significant change")				
-Assess achievement of the resident's goals, and (12.04(8)2)				
-Determine if services remain appropriate to the resident's current needs and the ability of ALR to meet those needs.				
-These reviews are documented.				
7.7.11. (If the assessment indicates that) *no change to the service plan is necessary, this fact is documented on the service plan and Service Coordinator, Resident or his/her Legal Rep. signs and dates the service plan (FAQ #2, page 34)*				
7.7.12. The service plan identifies types, approach, intensity, and frequency of services and supports.				
7.7.13. Scheduling of services (to be provided internally, and externally, if possible) is decided as part of the service planning process.				
7.7.14. Service provision documentation is current with service plans and documents services that were received/not received or refused.				
7.7.15. *If a resident needs a service that the ALR cannot, will not or is not capable of providing, the service plan includes documentation to this effect* (e.g., service plan lists alternative method of meeting needs, such as an outside agency (VNA), or risk agreement) *(FAQ #4, page 29).*				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
7.8. Service and Service Coordination Requirements (See 651 CMR 12.04 (2)				
7.8.1. **The ALR has designated at least one Service Coordinator (12.04(2)(a).**				
7.8.2. **The Service Coordinator meets the qualification identified in 12.06 (2): Staffing Requirements.**				
7.8.3. **The Service Coordinator (12.04(2)(a)(1-5):**				
-Reviews with the resident the assessment and service options				
-Implements the service plan				
-Monitors resident needs and services provided by ALR				
-Coordinates with and participates in the Quality Assurance Program				
-Maintains complete and accurate records of service plan				
7.8.4. **The ALR provides or arranges for the provision of the following services (12.04(2)(b) (1-4):**				
-For residents whose service plans specify, supervision of and assistance with (12.04(2)(b)(1):				
--ADLs (including at a minimum, bathing, dressing, ambulation, and similar tasks)				
--IADLs (including at a minimum, housekeeping, laundry, and socialization)				
-SAMM (12.04(2)(b)(2)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Presence of 24-hour per day on-site staff capability (12.04(2)(b)(3)				
-Personal emergency response devices or procedures (12.04(2)(b)(3)				
-Sodium restricted, sugar restricted, and low-fat diets (12.04(3)(b)(4)				
-Up to three nutritious meals daily (minimum 1 per day) (12.04(2)(b)(4)				
-A qualified dietician reviews the ALR's dietary plan at least every six months (12.04(2)(b)(4)				
7.8.5. **The ALR may provide or arrange for the provision of the following optional services, including but not limited to (12.04 (5)(a-d):**				
-Local transportation (medical and recreational) (5)(a)				
-Barber/Beauty services (5)(b)				
-Sundries for personal consumption and other amenities (5)(b)				
-Money management and other financial arrangements with an independent party (5)(c)				
-Limited Med. Administration (5)(d)				
7.8.6. The ALR may arrange for the provision of the following optional services:				
-Adaptive Equipment / Assistive Tech.				
-Health Screening				
-Health Care Services (i.e., skilled care, ancillary services-PT, OT, speech therapy)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Education on Health Issues				
-Equipment and Supplies				
-Social Services (i.e., mental health services)				
-Specialized Foods				
7.8.7. The Personal Care Worker/Asst.'s Assignment Sheet meets the following:				
-Customized per shift, per worker				
-Itemizes the assistance to be provided by resident, apartment number, ADLs, (i.e., SAMM, housekeeping, dressing, escorts, bathing/showering, incontinence)				
-Includes space for specific comments, instructions or resident preferences				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
7.9. Introductory Visit and Review (See 651 CMR 12.07 (7): Introductory Visits and Review)				
7.9.1. **Prior to or within 48 hours after the provision of personal care services to a resident, or when there is a significant change in the resident's personal care needs, a nurse reviews the resident's service plan with all relevant personal care workers. (12.07(7)**				
-The nurse conducts Introductory Visits in person with all applicable personal care workers. (See FAQ #4, page 11)				
7.9.2. **Personal care workers demonstrate competence in the assigned personal care tasks (including SAMM) either by demonstration or verbal review.**				
7.9.3. **Documentation of Introductory Visits is kept in the Resident Record and is kept current. (12.07(7)**				
7.9.4. *Documentation of an Introductory Visit includes (See FAQ #6, page 12)*				
-Name of the resident				
-Names and signatures of personal care worker(s), including the date(s) signed				
-Names and signatures of nurse(s) each time an Introductory Visit was conducted				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Date(s) the Introductory Visit was completed by the nurse (which may be different from the move-in date) (Note: Signature dates of personal care worker and nurse should match.)				
-Summary of topics covered				
-Indication of how competency in the assigned personal care task was demonstrated (e.g., verbal review, skills demonstration, direct observation)				
7.10. Resident Information (See 651 CMR 12.05 (1) (a-g): Record Requirements)				
7.10.1. Policies and procedures are in place regarding the following:				
-Each resident has access to his or her Resident Record.				
-Residents and legally responsible party(s) are kept informed about the services offered by ALR.				
-Only individuals who need to access a resident's confidential record in order to perform their job have access to records.				
-Consistent documentation standards for making entries and correcting errors.				
7.10.2. **The ALR develops and maintains written resident records which shall remain confidential but for the limited exception of EOEA's enforcement of these regulations. (12.05(1)**				
-Records are kept in a secure area.				
7.10.3. **All records created or maintained by the ALR are (12.05):**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Legible				
-Recorded in ink				
-Signed and dated in the same time period and indicate the name and position of the individual who makes the entry				
7.10.4. **Computerized records systems meet the equivalent requirements for permanency and accessibility, and…**				
-…provide an auditable record of entries				
7.10.5. **The Resident Record and related documents are maintained for (12.05(1):**				
-The duration of a resident's stay				
-At least six years after the date of termination of the Residency Agreement				
7.10.6. *All records (i.e., Resident records, employment records, including those of contracted employees, whether employed individually, or as part of an agency) going back two years or since EOEA last compliance review, whichever is longer, are easily accessible at all times. (See FAQ #4, page 4)*				
-This information is kept at the ALR or in a building located on the same campus as the ALR.				
-More than one staff member has access to these records.				
7.10.7. *A Resident's consent has been requested in accordance with 12.09(1)(c), prior to EOEA recertification visit. (See FAQ #6, page 4).*				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
7.10.8. Resident records are organized in a consistent and appropriate order.				
-Formal communications (letters, notices) with resident and/or legal or resident representative are kept				
7.10.9. **The Resident Record includes (12.05) (1) (a-f):**				
-Resident assessment (1)(a)				
-Resident service plan (1)(b)				
-Progress notes (1)(c) document significant occurrences either observed or reported include:				
--Significant or continued change in behavior or memory				
--Incidents involving injury, trauma, illness or abuse or neglect including but not limited to the recording of incidents in which a resident has been the victim of an assault by another Resident or the perpetrator of an assault on another resident regardless of which a report would be required by law				
--Alleged or violations of the resident's rights				
--Changes in the service plan				
--If a resident refuses to accept a service (or the level of assistance assessed by the Residence), the resident's record indicates that the resident's preferences differ from the assessed needs, for example, through an entry in a progress note. (See FAQ #7, page 35)				

-Documentation of Introductory Visits (1)(d) (See also 12.07 (7)				
-Documentation of SAMM (1)(e) including the SAMM assessment required by 12.04(6)(a)(3)				
-Documentation of LMA, if applicable, by the nurse who administers medication (1)(f); 12.04(5)d				
7.10.10. **The Resident Records also includes, and may be kept in a separate location (12.05(1)(g) 1-3:**				
-Applicable guardianship orders				
--Guardianships are current				
-Powers of attorney				
-Health care proxies				
-Living wills				
-Other relevant documents affecting or directing resident care, including DPH Comfort Care/"Do Not Resuscitate Order Verification Form", MOLST/POLST orders				
--All directives are complete (all pages), dated and signed by the appropriate parties				
--The limits of all directives are clear (e.g., ALR involves the applicable Legal Rep. as applicable based on the legal document)				
-These documents existence and location are conspicuously documented in the resident's record and are immediately available in case of emergency.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-The original Residency Agreement and any documents which extend of amend the Residency Agreement. (12.05(1)(h)				
-The original Disclosure of Rights and Services and any subsequent modifications to it.				
7.11 Progress Notes (see CMR 12.05(1)c				
Significant occurrences either observed or reported to by ALR staff; to include, but not limited to:				
- significant or continued changes in behavior or memory				
-incidents involving injury, trauma, illness or abuse/neglect				
-recording of incidents in which the resident has been a victim of assault by another resident or the perpetrator of an assault				
-alleged or actual violation of resident rights				
-changes to a service plan/service plan renewal				
7.11.1. Community policy on progress note documentation, who is authorized, what triggers a note				
7.12. Resident Information (See 651 CMR 12.05 (2) and (4): Additional Record Requirements – Census Documentation and Staff Correspondence Log				
7.12.1. Policies and procedures are in place regarding the following:				
-Each ALR that exists within a setting				

which does not consist exclusively of Assisted Living Units, shall maintain a current census document listing the name of each Resident residing in each occupied certified unit.				
-This document updated at least weekly				
-This document is kept for a minimum of two years				
7.12.2**. Policies and procedures are in place regarding the following:**				
-Residence must maintain a staff correspondence log for each 24-hour period that communicated information necessary to maintain the continuity of care for all Residents.				
-Correspondence log must be maintained for no less than 90 days.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
7.13. Communicable Disease Control Plan (See 651 CMR 12.04 (12)				
7.13.1. **The ALR has a plan to prevent and limit the spread of communicable disease.**				
-Effectiveness of plan is measured (e.g., number of incidents of communicable disease)				
7.13.2. **The plan conforms to currently accepted standards for principles of universal precautions based on OSHA guidelines.**				
7.13.3. **The plan includes but is not limited to the following:**				
-A system to effectively identify and manage communicable diseases				
-A process for maintaining records of illnesses and associate incidents involving staff pursuant to CMR 12.06(8)a				
-Organized arrangements to provide the necessary supplies, equipment, and protective clothing, consistent with universal precautions under OSHA guidelines.				
7.13.4. Communicable disease control policies are in place and procedures are practiced.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Residents are encouraged to get flu or other novel virus vaccine annually, and the ALR assists in this by scheduling on-site flu clinics (by VNA or other providers).				
-The ALR offers flu vaccine annually to employees at no charge				
7.13.5. OSHA standards are followed. Refer to OSHA section 2.8				

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ADDITIONAL PROCESS IMPROVEMENT EFFORTS	
Description of Improvement	**Additional Issues Resolved or Improved**

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OTHER COMMENTS

Community: _____ Executive Director: _____

Reviewer of this Section: _____ Reviewer Title: _____

Date of This Review: _____ Date AL Certificate from EOEA Expires: _____

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SECTION EIGHT: Medication Management

8.1: Medications – General Policies
8.2 Resident Medication Assessment and the Resident Service Plan
8.3: Non-Pharmacy Filled Cassettes
8.4: Self-Administered Medication Management (SAMM)
8.5: Limited Medication Administration (LMA)
8.6: Quality Assurance
8.7: Oxygen Usage

Instructions:

1. **Bold-face items correspond with regulatory requirements (as found in 651 CMR 12.00). See regulation cross-references for further detail.**
2. **Shaded Gray** items pertain to Regulations regarding Special Care Residences only.
3. *Italicized items correspond with Elder Affairs' "Frequently Asked Questions" (FAQs) distributed June 2007. (These are Elder Affairs policy guidance relative to the amended Assisted Living regulations, promulgated in 2006).*
4. Items in regular font (as here) are issues, quality practices and procedures that may be applicable or useful for your Residence. They are presented only as examples to assist in tailoring this tool to address the specific needs of an individual Residence.
5. A "Yes" response states that the line item is in place and actively in use. A "No" response states that the line item is not occurring. Descriptive columns help identify a (potential) "finding" and then articulate an "action to achieve compliance/fulfillment." These headings are similar to how Elder Affairs might identify problem areas or corrective action items during recertification.
6. Tip: Each line item is presented as a statement that expresses a standard practice. Should this approach cause confusion, pose each statement as a question instead to reach evaluation response.

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
8.1. Medications – General Policies				
8.1.1. **Residents have a choice of pharmacy. (See 12.08 (1)(g)**				
-The ALR does not restrict Residents' utilization of the pharmacy of their choice, subject to reasonable ALR rules.				
-If the ALR intends to set limits on medication packaging systems, it has submitted a policy regarding medication packaging systems to EOEA for prior approval before implementation.				
-The ALR policy allows a resident to make use of insurance coverage for medications and does not require a resident to use a certain or limited number of pharmacies.				
8.1.2. **Residents' medications are stored within their apartments. The ALR does not centrally store residents' medications in an area outside residents' units (12.04(2)(b)(2) (4th paragraph).**				
8.1.3. *Medication is delivered from the pharmacy directly to the resident.*				
-nurse accompanies pharmacy delivery person to each apt checking for accuracy of the refill				
8.1.4. **Residents have refrigeration available in their units if needed for medications that require appropriate temperature control (12.04(2)(b)(2) (4th paragraph).**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
8.1.5. **The ALR <u>may</u> employ a locked location in which to safely store medications within a Unit (12.04(2)(b)(2)(4th paragraph).**				
-If medications taken via SAMM need to be locked, both the medication assessment and the service plan indicate there is a need for medications to be locked.				
8.1.6. For residents with dementia or other cognitive impairments, residents' medications are stored safely in a designated area in their apartments.				
8.2. Resident Medication Assessment and the Resident Service Plan				
8.2.1. Residents are encouraged to seek a medication reconciliation assessment by their primary care physician or NP to address under- or overutilization of medications.				
8.2.2. **The ALR conducts and documents an initial assessment of a resident's ability to manage medication, including the ability to take medication on an as-needed basis. (See 12.04 (7)(a)(8)**				
8.2.3. Whether SAMM is appropriate for the Resident based on: (12.04(6)(a)(3)				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
--Completion of an observational assessment by a nurse to determine whether the resident is capable of performing the particular method(s) of independent medication administration				
--Written statement by that nurse documenting the Resident's capability of performing the method(s) of independent medication administration				
8.2.4. *The resident assessment for medications is not a simple "yes"/"no" question, but thoroughly and completely covers both the physical and cognitive aspects of self- administration (See FAQ 7, page 30 for more information).*				
8.2.5. *The ALR's medication assessment properly assesses and reassesses a resident's ability to safely request assistance with PRN medications.*				
8.2.6. *The assessment is specific to each of a resident's medication needs. E.g., for a resident who uses eye drops, an inhaler and oral medications, his/her ability to take each medication via its applicable route is assessed.*				
8.2.7. **ALR reviews the assessment upon 30 days of commencement of residency or identification of a significant change in the resident's condition (See 12.04 (7)(b) and 12.04(8)(b)** (thereby providing a method of monitoring a resident's ability to manage his/her medications.)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
8.3 Non-Pharmacy Filled Cassettes				
8.3.1. **If a family filled cassette is used by the Resident, the ALR and Resident has 1) a full written disclosure of the risks involved and 2) consent by the Resident. (See 651 CMR 12.04 (2)(b)(2)**				
8.3.2. *A written disclosure regarding providing SAMM assistance from a non-pharmacy filled container includes at a minimum:*				
- The resident may not receive the correct medication or dosage;				
- All of the med may not be included in the container;				
- The container may be filled improperly causing the resident to take the wrong medication or incorrect dosage, which could result in serious harm, up to and including death;				
-A consent form signed by the resident and/or Legal Rep.				
-The consent form is stored in the resident record.				
-If a third party (e.g., family, friend) is responsible for obtaining medications and filling medication planners/cassettes, this is noted on the service plan (FAQ #11, page 37, 2nd bullet)				
8.3.3. *A policy on non-pharmacy filled (e.g., family-filled) cassettes is in place and followed.*				

-community policy includes language on right to revoke usage of family filled cassettes				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
8.4. Self-Administered Medication Management ("SAMM") (651 CMR 12.04 (3)(b)(2)				
8.4.1. **When assisting a resident to self-administer medication, the individual performing SAMM must: (12.04(2)(b)2 a-d**				
-remind the resident to take the medication				
-check the package to ensure the name on the package is that of the resident				
-observe the resident take the medication				
-Document the observation of the resident's actions regarding the medication				
-hand over hand; hand under hand assistance is not permitted				
8.4.2. **SAMM Documentation is part of the Resident Record (12.05(1)(e).**				
8.4.3. *Documentation of SAMM includes at a minimum the following (See 13-2):*				
-Name of the resident				
-Time period assistance with SAMM was provided/offered (e.g., 8 AM, Noon, 8 PM)				
-Information indicating whether medication was taken or not				
-Reason medication was not taken (e.g., refused, Medical Leave of Absence (MLOA), Leave of Absence (LOA), no med available)				
-Signature and *initials of the employee*				

who assisted with and observed SAMM				
8.4.4. Medication documentation systems are kept current.				
8.4.5. A current list of a resident's medications is kept updated in the service plan.				
8.4.6. Regulatory compliant policies related to SAMM are in place.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
8.4.7. The ALR has a consistent system for documenting PRN medications on SAMM.				
-The ALR encourages the resident or family to get PRN meds scheduled to at least every 4-hour intervals (as appropriate).				
8.4.8. *The ALR does not exclude certain prescription or over-the-counter medication from its SAMM service.*				
-An ALR may exclude a type or category of medication, if an essential characteristic of that category of medication conflicts with the underlying purpose of SAMM program.				
8.4.9. *ALR staff may assist with opening prepackaged medications*				
8.4.10. *The ALR prohibits the use of sole "medication reminders" as a form of assistance (e.g., phone calls or in-person reminders or leaving medications on a kitchen or bed side table as a cue or reminder). (See CL 13-2)*				
8.4.11. **All staff who provide Personal Care Services receive:**				
-At least one additional hour of orientation in SAMM (12.07(2)c				
-At least one hour of yearly ongoing training in SAMM (12.07(4)(f)(1)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
8.5. Limited Medication Administration ("LMA") (See 651 CMR 12.04 (5)(d)				
8.5.1. **LMA is provided a practitioner, as defined in MGL c.94C or a registered or licensed nurse, as defined in MGL c. 112, s. 74 or 74a.**				
8.5.2. **LMA allows nurses with a valid MA nursing license to administer non-injectible medications prescribed by an authorized prescriber by oral or other routes (e.g., topical, inhalers, eye or ear drops, medicated patches, as needed oxygen and suppositories).**				
8.5.3. **LMA performed by a licensed nurse is completed in accordance with all applicable laws, regulations and standards governing the medication administration process by a nurse, including, documentation requirements**.				
8.5.4. **LMA is provided only from an original, pharmacy-filled and pharmacy labeled container.**				
8.5.5. **All medications are kept in the Resident's unit and are stored in a manner that the nurse can adequately verify the integrity of the medication** *(e.g., locked box. See CL #13-3, page 2)*				
8.5.6. *The ALR discloses the availability and cost of LMA in the Residency Agreement and the Disclosure statement.*				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
8.5.7. T*he ALR has submitted a detailed and timely written policy statement to EOEA prior to implementation of LMA.*				
8.5.8. *The policy statement includes:*				
-Role or job title of the person(s) who will be responsible for providing LMA				
-Copy of the form that will be used to document LMA (e.g., Med. Administration Record Sheet (MARS)				
-Explanation of the manner in which medication will be secured and stored				
-If the individual performing LMA is a licensed nurse, copies of job description indicating that a licensed nurse will be responsible for performing LMA.				
-Description of the record-keeping system that will be used that reliably and consistently documents the information and authorizations that a licensed nurse must have to perform LMA				
8.5.9. *Documentation of LMA includes (FAQ #3, pages 13-14):*				
-A recent and accurate assessment of the need for LMA				
-A notation in resident service plan of need for LMA				
-A written medication order from an authorized prescriber and renewal date				
-A med administration sheet showing the name, dose, route, and time the medication is administered				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Documentation of any adverse reaction a Resident has to administered medication(s)				
-Notation of what, if any, action nurse took in response to resident's adverse reaction				
-Signature or initials of the nurse who administered the medication on MARS.				
8.5.10. *All documentation is:*				
-Complete				
-Accurate				
-Legible				
8.5.11 SAMM and LMA are to be stored/secured separately; LMA key access to the nurse only				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
8.6. Quality Assurance				
8.6.1. **The ALR reports annually to EOEA the percentage of residents currently receiving SAMM, LMA or both SAMM and LMA. (See 651 CMR 12.04 (13)(a)(2)(A)(iv.)**				
8.6.2. **Personal Care Staff who provide SAMM are evaluated at least twice per year by a qualified nurse on their awareness of and compliance with SAMM regulations and the applicable ALR policies and procedures. (See 12.07 (8)**				
8.6.3. **The ALR has developed and implemented systems that support and promote safe SAMM, and if applicable LMA. (See 12.04 (10)(c)**				
8.6.4. **The medication quality plan includes, but need not be limited to the following:**				
-Semi-annual evaluation of each Personal Care worker that:				
1) examines his/her awareness of SAMM/LMA regulations and applicable policies and				
2) verifies his/her demonstrated ability to comply with SAMM regulations and related ALR policies and procedures				
-A quarterly audit of a random sample of the ALR medication documentation sheets required under 651 CMR 12.04 (2)(b)(2) to ensure compliance with SAMM protocols and ALR policies.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Sample size: minimum of 10% of resident medication sheets. (See FAQ #6, page 17) 10% AL, 10% SCU, 10%SAMM, 10%LMA				
8.6.5. *Documentation of quarterly audits of resident medication sheets includes the following information: (See FAQ #7, page 17)*				
-Date(s) the reviews were conducted				
-Name(s) and title of the person(s) conducting the review				
-Name of the Residents (or use of a resident identifier) *whose medication sheets were audited*				
-Issues identified through the reviews				
-Actions taken to resolve the identified issues				
-Name and title of the person(s) responsible for taking each action				
-Timeframe within which the action was taken				
-Whether action resolved the issue				
8.6.6. A quality assurance system of medication review is in place and includes clearly defined systems for:				
-Delivery of medications				
-Tracking and analyzing medication errors				
-Storage of medications				
-Medication assistance program(s)				
-Incidents involving medications				
-Staff training and re-training in medication assistance				
-Comprehensive training of authorized				

staff upon hire & periodically, to include:				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
--Guidelines for self-administration assistance				
--Clarification of types of errors and how to avoid				
--Clear guidelines of how and to whom to report				
--Easy to use documentation forms				
-Consistent supervision of authorized staff:				
--Established frequency of regularly observed medication assists ("med pass")				
--Reviews documentation for completion and accuracy				
--Spot-checks of med. storage containers				
8.6.7. The ALR has implemented policies and procedures regarding:				
-SAMM Policy and Procedures				
-Resident identification policy				
-Pharmacy delivery of medications				
-**Residence has policies and procedures to prevent theft or diversion of Controlled Substances (Controlled Substances definition: 651 CMR 12.02) prescribed to Residents who participate in SAMM or LMA 12.04 (14). These include:**				
-Reporting process by which any incidents of theft or diversion are reported, documented and investigated.				
-**Safeguards are in place for storage and disposal of all controlled substances that have been prescribed for Residents participating in SAMM and LMA.**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
Additional policy suggestions for controlled substances in ALRs:				
-Initial inventory of controlled substances				
-Records and forms				
-Witnessed counts				
-Waste and accidental loss of dose				
-Witnessed destruction				
-Locked and unlocked medication supplies				
-Single vs. double locked storage				
-Control of keys				
-Suspected Loss (e.g., internal activity, investigation, reporting (to police, EOEA).				
-Drug testing for staff				
-Medications from other providers (e.g., home care, hospice)				
Additional policy suggestions for non-controlled substances in ALRs:				
-Eye drop and patch assistance				
-Cream assistance				
-Oxygen				
-SAMM for residents with dementia				
-Resident use of sample packs				
-Medication errors (e.g., management, tracking, reviews, etc.)				
-Documentation of medication refusals				
-Documentation of missing medications				
-Medication found on floor				
-QA/QI policy and procedure				
-Medication competency and training; limitations of family filled cassettes				
8.7 Oxygen Usage				
-Assessment to include resident's capacity				

to manage their O2 usage and delivery system; SAMM vs LMA				
-Staff trained by O2 company is assisting with the delivery devices; re-filling tanks, opening a new tank				
-PCA cannot adjust liter flow; turn O2 on				
-Tank storage: secured to wall, support stands in place, securement during van transportation				
-O2 in use signage				

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ADDITIONAL PROCESS IMPROVEMENT EFFORTS	
Description of Improvement	**Additional Issues Resolved or Improved**

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OTHER COMMENTS

Community: _____ Executive Director: _____

Reviewer of this Section: _____ Reviewer Title: _____

Date of This Review: _____ Date AL Certificate from EOEA Expires: _____

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SECTION NINE: Special Care Residences

9.1: Special Care Residence Operating Plan
9.2: Resident Safety
9.3: Resident Services
9.4: Disclosure Statement
9.5: Staffing Requirements
9.6: Staff Orientation in Special Care Residences
9.7: Ongoing In-Service Education and Training in Special Care Residences
9.8: Physical Environment
9.9: Quality Improvement Programs and Required Reports

Instructions:

1. **Bold-face items correspond with regulatory requirements (as found in 651 CMR 12.00). See regulation cross-references for further detail.**
2. **Shaded Gray** items pertain to Regulations regarding Special Care Residences only.
3. *Italicized items correspond with Elder Affairs' "Frequently Asked Questions" (FAQs) distributed June 2007. (These are Elder Affairs policy guidance relative to the amended Assisted Living regulations, promulgated in 2006).*
4. Items in regular font (as here) are issues, quality practices and procedures that may be applicable or useful for your Residence. They are presented only as examples to assist in tailoring this tool to address the specific needs of an individual Residence.
5. A "Yes" response states that the line item is in place and actively in use. A "No" response states that the line item is not occurring. Descriptive columns help identify a (potential) "finding" and then articulate an "action to achieve compliance/fulfillment." These headings are similar to how Elder Affairs might identify problem areas or corrective action items during recertification.
6. Tip: Each line item is presented as a statement that expresses a standard practice. Should this approach cause confusion, pose each statement as a question instead to reach evaluation response.

SECTION NINE: Special Care Residences (e.g., Dementia, Alzheimer's Disease, Huntington's Disease)

Introduction to Section Nine:

This chapter of MA-ALA's Quality Improvement Tool lists the following information:

1) **The required regulatory elements pertaining to providing Special Care in a Special Care Residence** (shown in **bold** typeface);

2) **Shaded Gray** items pertain only to Special Care Residences.

3) *Italicized items correspond with Elder Affairs' "Frequently Asked Questions" (FAQs) distributed June 2007. (These are Elder Affairs policy guidance relative to the amended Assisted Living regulations, promulgated in 2006), and*

4) Measures that are in addition to both the regulations contained in 651 CMR 12.00 *et seq*. and all Policy Statements. These measures are shown in regular typeface (as here) and may be applicable to the Special Care Residence.

NOTE: "Any Residence that chooses to advertise, market or otherwise promote or provide special care for residents shall administer such care and services in accordance with the requirements of…section (12.04 (4) in addition to all other requirements of 651 CMR 12.00 *et seq.*" (See 651 CMR 12.04 (4)

Therefore, MA-ALA advises that all information required of Special Care Residences per the regulations be submitted as either an "add-on" to the materials required throughout the rest of the regulations or developed as a separate document. This is the methodology used to create this chapter of the MA-ALA Quality Improvement Tool.

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
9.1. Special Care Residence (SCR) Operating Plan				
9.1.1. **An operating plan has been submitted to EOEA that explains how the Special Care Residence (SCR) will meet the specialized needs of its resident population, including those who may need assistance in directing their own care due to cognitive or other impairments. (See 651 CMR 12.04 (4): Special Care)**				
9.1.2. **The operating plan includes the following items that specifically pertain to SCRs (See 651 CMR 12.03 (2) (f):**				
-The number of single and double occupancy Units for which Certification is sought, the number of single and double occupancy Units designated as Special Care Units, and the number of residents per Unit. (See 651 CMR 12.03 (2) (f) (1)				
-The location of Units and Special Care Units, common spaces, and egresses by floor (See CMR 12.03 (2)(f)(2)				
-A copy of all policies and procedures related to the design and operation of a SCR required under 651 CMR 12.04 (4) (See 651 CMR 12.03 (2)(f)(11)				
-The physical design of the structure and the units (See 12.04 (4)				
-The physical environment (See 12.04 (4)				
-Specialized safety features (See 12.04 (4)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Enrichment activities (See 12.04 (4)				
-Trained staff (See 12.04 (4)				
9.2. Resident Safety				
9.2.1. **The SCR is administered in accordance with the following safeguards: (See 651 CMR 12.04 (4) (a)**				
-Entry and exit doors in the common areas within the SCR are secured in accordance with local, state, and federal laws and regulations. (See 12.04 (4) (a) (1)				
-All doors automatically unlock in case of fire, power outage, or emergency situation (See 12. 04 (4) (a) (1)				
-Staff are trained and assigned according to the requirements of 651 CMR 12.06 (Staffing Requirements) and 12.07 (Training Requirements) (See 12.04(4)(a) (2) Rec conducting elopement drills				
-The ALR has developed and implemented a 24-hour preparedness plan by assessing the needs of each occupant of the SCR for emergency assistance and devised an appropriate method to provide the necessary assistance. (See 12.04 (4) (a) (3)				
9.2.2. **Personal Emergency Response Systems (PERS)**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-SCRs have in place a general system to ensure reasonable and timely response to a resident's urgent or emergency needs.				
-In the absence of a technology-based e-call system, hourly visual resident safety checks between 7 PM and 7 AM is in use.				
-Visual monitors are used as an alternative to hourly checks with resident and/or legal guardian consent.				
-Visual resident safety checks in the SCR are accurately documented.				
-For alternative systems to visual checks, a detailed system description and related system activities are accurately documented to demonstrate effective and prompt response to resident's scheduled and unscheduled needs.				
-The ALR has a policy and practice to monitor and test its emergency response system, tests it regularly and documents results for review by EOEA.				
-As part of its quality assurance program, the ALR oversees and monitors its response system to ensure functionality and effectiveness.				
- All shifts are monitored quarterly. Manager overnight visits				
- Quality assurance activities & reviews are accurately documented to demonstrate reasonable staff response times to residents' urgent and emergency needs.				
-E-call system reports are available for				

review by EOEA.				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Policies and procedures are in place to assess and reduce the risk of potential hazards in the physical environment related to the special characteristics of the population. (See 12.04 (4) (a) (4)				
-Policies and Procedures include annual written statement describing in detail how the physical characteristics of the SCR have been or will be modified to promote the safety of Residents (See 12.04 (4)(a)(4)				
-Potential hazards policies include secured medications, toxic materials, or plants, maintaining clear pathways.				
-Housekeeping (cleaning and laundry) chemicals are locked and not left out.				
-Unsafe programming materials/chemicals are locked and kept secure.				
-Policies and procedures are in place to address potentially unsafe resident behaviors such as the following: (See 12.04 (4) (a) (5)				
-Wandering unsupervised				
-Verbally / physically aggressive behavior				
-Coercive / inappropriate sexual behavior				
-Policies and procedures are in place governing the transition of residents moving in/out of SCR (See 12.04 (4) (a) (6)				
9.2.3. **The ALR has a multipurpose activity space (See 12.04 4)(A)(7)**				
9.2.4. **From October 1, 2015 on, the SCR**				

has a secure outdoor space.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
9.2.5. **The ALR's Disaster and Emergency Preparedness Plan includes provisions related to individuals residing in a SCR.**				
-The Plan is amended and revised whenever any resident with unusual needs is admitted. (See 12.04 (11) (a) (3)				
9.2.6. *In addition to what is listed above from 12.03(2)(f) and 12.04(5), the following information and documents are included in the SCR operating plan (See FAQ #2, page 38):*				
-A 24-hour preparedness plan which is based upon the assessed needs of the Residents for assistance in a Residence-wide emergency, such as an evacuation Rec adding to resident roster at front desk				
-A policy to ensure Resident safety during power outages or other situations when the locking or unlocking mechanisms of the doors may not be functioning				
-Policies and procedures to assess and reduce the risk of potential hazards in the physical environment related to the special characteristics of the population served. At a minimum, these policies address the following:				
-Limiting odors and ensuring a sanitary environment				
-Responding to Resident emergency situations (e.g., when to call 911, what to do if a Resident falls)				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Storing potentially hazardous materials (e.g., cleaning materials, oxygen)				
9.2.7. *All policies developed as part of the operating plan include the following (See FAQ #3, page 38):*				
-How to determine when an unsafe behavior is present (e.g., wandering, verbally or physically aggressive behavior (including coercive or inappropriate sexual behavior)				
-How to manage the behavior appropriately				
-How to report or document the behavior, including when an outside agency must be notified (e.g., Protective Services)				
-Guidelines for when the behavior may be beyond the scope of the assistance offered by the SCR, and which may therefore lead to termination of the Residency Agreement				
-The title of the employee(s) responsible for implementation of the various aspects of each policy.				
9.3. Resident Services in SCR				
9.3.1. **The SCR has a planned activity program that provides structured activities with designated staff a minimum of 3x within a 24-hour period, seven days per week., to address resident needs in the following areas of resident function, as applicable (See 651 CMR 12.04 (4) (b):**				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Gross motor activities				
-Self-care activities				
-Social activities				
-Sensory and memory enhancement activities				
9.3.2. Services that meet the needs of those with dementia are available (e.g., escort service, incontinence care, medication assistance).				
9.3.3. Activities are available for those with special care needs that:				
-Foster resident choice				
-Incorporate past experiences				
-Extends into the evening hours beyond TV				
9.3.4. Residents are provided with cues and structure to maximize decision-making and participation (at the ALR and in the community).				
9.3.5. Resident preferences are incorporated into activity planning.				
9.3.6. A communication system is in place for staff to record their observations about resident issues.				
NOTE: EOEA will connect resident behaviors/incidents to program offerings or lack thereof				
9.3.7. **Service plans for residents in SCRs Care Units indicate the enrichment activities provided. (See 12.04 (8)(a)(3)**				
9.3.8. With resident consent, families are encouraged to be part of the ongoing				

planning process and information is shared and issues discussed (e.g., changes to ISP).				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
9.4. Disclosure Statement for SCRs				
9.4.1. **The ALR documents and makes available upon request all plans, policies, and procedures required under 651 CMR 12.04 (4) (a-d): Special Care, and in accordance with the disclosure requirements in 12.08 (3).**				
9.4.2. **The ALR has policies and procedures governing the transition of residents moving in or out of the SCR. (See 651 CMR 12.04 (4)(a)(6)**				
9.4.3. **The Disclosure Statement for the SCR includes in particular the following (See 651 CMR 12.08 (3):**				
-Explanation of the physical design features of the ALR including that of any SCR (12.08 (3) (k)				
-A written statement describing its special care philosophy and mission and explains how it implements this philosophy and achieves its stated mission. (12.08 (3) (r)				
9.4.4. **If the ALR chooses to advertise, market, or otherwise promote or provide special care for residents administers such care and services in accordance with the requirements of…section (12.04 (4) in addition to all other requirements of 651 CMR 12.00 *et seq.,* the ALR has submitted an operating plan to EOEA that explains how the SCR will meet the specialized needs of its resident population.**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
9.5. Staffing Requirements				
9.5.1. **SCR has sufficient staff qualified by training and experience at all times to meet the 24-hour per day scheduled and reasonably foreseeable unscheduled needs of all residents of the SCR based on their assessments and service plans. (See 651 CMR 12.06 (5)**				
9.5.2. **SCR staff is always awake and on duty. (See 12.06 (5)** Mgr. overnight visits				
9.5.3. **SCR staffing is sufficient to respond promptly and effectively to individual resident emergencies. Sufficient defined as having no less than two staff members in SCR (See 12.06 (5)**				
9.5.4. **SCR has a plan to secure staffing necessary to respond to emergency, life safety and disaster situations affecting residents. (See 12.06 (6)**				
9.5.5. **The SCR has a designated individual who is responsible for the operations of the SCRs and meets the following requirements (See 12.06 (7):**				
-At least 21 years of age				
-Minimum of 2 years of experience working with elder or disabled individuals				
-Knowledge of aging and disability issues				
-Demonstrated experience in administration				
-Demonstrated supervisory and management skills				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Bachelor's degree or equivalent experience in human service, housing, or nursing home management				
-Of good moral character (Per MA-ALA legal counsel, in regulatory contexts, this is typically interpreted as e.g., no convictions for crimes or certain misdemeanors, professional actions against licenses or permits or other official forms of action or sanctions against a person's personal conduct.)				
-Never have been convicted of a felony				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
9.6. Orientation for Staff Working in SCRs (See 651 CMR 12.07 (3)				
NOTE: See Section 3 of this tool for the complete list of requirements.				
9.6.1. **Staff are trained and assigned according to the requirements of 651 CMR 12.06 and 12.07.**				
9.6.2. **All new staff who work in a SCR and have direct contact with Residents complete the General Orientation requirements itemized in 12.07 (1) (a-m) and 12.07 (2) (a-e).**				
9.6.3. **In addition, all new staff who work in a SCR and have direct contact with residents receive 7 hours of additional Orientation training on topics related to the specialized needs of the resident population (e.g., communication skills, creating a therapeutic environment, dealing with difficult behaviors, competency, sexuality, and family issues.)**				
9.6.4 Training includes approaches for de-escalation of behaviors and communication				
9.7. Ongoing In-Service and Training for Staff Working in SCRs (See 651 CMR 12.07 (4)				
NOTE: See Section 3 of this tool for the complete list of requirements.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
9.7.1. **At least two hours of the required 10 hours of training is spent on the specialized needs of residents with Alzheimer's disease and related dementia.**				
9.7.2. **Staff in a SCR receive an additional 4 hours of training per year related to the resident's specialized needs.**				
-This training includes the development of communication skills for Residents with dementia				
9.7.3. **Using a form and manner prescribed by EOEA, the ALR submits proof that training received within the past 18 months at another ALR, a similar facility or agency is used to satisfy the ongoing in-service training requirements.**				
9.8. Physical Environment for SCRs				
9.8.1. **Entry and exit doors in the common use areas are secured in accordance local, state and federal laws and regulations. (12.04(4)(a)(1)**				
9.8.2. **All doors automatically unlock in case of fire, power outage or emergency situation. (12.04(4)(a)(1)**				
9.8.3. **ALR has policies and procedures to assess and reduce risk of potential hazards in physical environment related to special characteristics of the population. (12.04(4)(a)(4)**				
-Residence provides a multipurpose activity space (See 651 CMR 12.04 (4) (7)				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-If initial certification process after 10-1-15, a secure outdoor space is provided. (See 651 CMR 12.04 (4) (8)				
9.8.4. Common areas and resident units are safe from issues like:				
-Clutter and tripping hazards				
-Broken furniture or sharp edges				
-Access to chemical cleaners, toiletries, plants				
-Inadequate lighting				
-Visibility or navigation issues				
9.8.5. Common areas cue appropriate behavior.				
-Way-finding signs and cues are boldly marked and plentiful				
-Outdoor access is marked				
-Bathrooms are clearly marked and differentiated				
-Even lighting is used				
-Layout fosters social interaction				
9.8.6. Safe unencumbered indoor and/or outdoor spaces are available for resident use such as exercise and other meaningful activities, etc.				
9.8.7. Environment is comfortable, home-like, and cheerful, with appropriate and personalized accessories (e.g., memory boxes)				
9.8.8. Residents' bedroom doors are unlocked allowing residents access to their rooms unless specifically requested by resident or legal representative.				
9.8.9. Environmental safety rounds:				

restraints, window security, chemical storage, unsecured toiletries, plants/flowers, tripping hazards				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
9.9. Quality Improvement Programs and Required Reports				
9.9.1. **Administrative staff of the ALR reviews the operations of the SCR twice / year. (651 CMR 12.04 (4) (d) (Note: these reviews may be conducted as part of the ALR Quality Improvement and Assurance Program prescribed in 651 CMR 12.04 (10).**				
-The results of these reviews are documented.				
4.9.2. **Annual Reports to the EOEA includes the number of residents currently residing in a SCR (as of December 31) (See 651 CMR 12.04 (13) (2) (A) (3)**				

Quality Improvement Tool (6th Edition)

ADDITIONAL PROCESS IMPROVEMENT EFFORTS	
Description of Improvement	**Additional Issues Resolved or Improved**

Quality Improvement Tool (6th Edition)

OTHER COMMENTS

Community: _____ Executive Director: _____

Reviewer of this Section: _____ Reviewer Title: _____

Date of This Review: _____ Date AL Certificate from EOEA Expires: _____

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SECTION TEN: Additional Resident Services

10.1: Dietary and Food Services
10.2: Transportation
10.3: Activities
10.4: Coordination of Outside Services
10.5: Distribution of Information on Palliative Care and End of Life Options

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Instructions:

1. **Bold-face items correspond with regulatory requirements (as found in 651 CMR 12.00). See regulation cross-references for further detail.**
2. **Shaded Gray** items pertain to Regulations regarding Special Care Residences only.
3. *Italicized items correspond with Elder Affairs' "Frequently Asked Questions" (FAQs) distributed June 2007. (These are Elder Affairs policy guidance relative to the amended Assisted Living regulations, promulgated in 2006).*
4. Items in regular font (as here) are issues, quality practices and procedures that may be applicable or useful for your Residence. They are presented only as examples to assist in tailoring this tool to address the specific needs of an individual Residence.
5. A "Yes" response states that the line item is in place and actively in use. A "No" response states that the line item is not occurring. Descriptive columns help identify a (potential) "finding" and then articulate an "action to achieve compliance/fulfillment." These headings are similar to how Elder Affairs might identify problem areas or corrective action items during recertification.
6. Tip: Each line item is presented as a statement that expresses a standard practice. Should this approach cause confusion, pose each statement as a question instead to reach evaluation response.

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AREA REVIEWED	Y	N	Finding(s)	Comments and/or Action Steps
10.1. Dietary and Food Services				
10.1.1. **The ALR's Disclosure Statement contains an explanation of the different or special types of diets available. (12.08 (3)(m)**				
-The ALR discloses the special diets it can accommodate and the additional costs (if any) that are associated with providing such services.				
-The ALR discloses any limitations on addressing food allergies.				
10.1.2. **The resident assessment includes an assessment of the resident's dietary needs. (12.04 (7)(a)(4)** (This assessment does not have to be conducted by a dietician.)				
10.1.3. **The Service Plan includes the following:**				
-Dietary needs				
-If the resident's physician has prescribed or ordered a meal plan, the ALR has a qualified dietician review the resident's dietary needs and provide the resident with diet management counseling (12.04(8)(a)(2)(d).				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-The Dietician's review of residents' Therapeutic Diets is documented in each applicable Resident's Record. (See FAQ #5, page 6)				
-The Resident's record documents ALR's offer/communication that the dietician is available to speak with the resident about how to make food choices.				
-Information identifying any food allergies				
10.1.4. *The Introductory Visit is used to inform personal care staff of a resident's special diet needs including food allergies or other dietary needs.*				
10.1.5. ~~S~~taff is notified of a resident's special diet needs; diet board in place and up to date				
10.1.6. **Dietary plans include sodium restricted, sugar restricted and low fat. (12.04 (2)(b)(4)**				
-Resident choices are available.				
-Menus/signage are used to help identify food choices, e.g., "sodium restricted, low fat, sugar restricted". (See FAQ #1, page 5)				
-Menus/signage are readable, i.e., printed in large font.				
-If icons are used (e.g., "heart healthy") they are clearly defined on the menu to educate about food choices.				
-ALR has a written policy regarding therapeutic diets, including items such as costs, limitations, etc.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
10.1.7. Mealtimes are promoted as pleasant and enjoyable activities.				
10.1.8. Resident preferences are incorporated into planning to facilitate proper nutrition and hydration.				
10.1.9. Meals are adaptable or prepared to address individual needs such as finger food diets as needed by the resident.				
10.1.10 Texture-modified diets follow International Dysphagia Diet Standardization Institute (IDDSI) standards				
10.1.11. Staff observe for food intake warning signs, such as:				
-Difficulty chewing and swallowing				
-Poor utensil use				
-Refusing substitutions				
-Low attentiveness to a meal				
-Food uneaten during a meal				
10.1.12. Effective monitoring systems are in place to address concerns such as significant weight loss/gain.				
10.1.13. Dietician				
-The ALR has a qualified dietician review the ALR's dietary plans at least every six months. (See 12.04 (2)(b)(4)				
-Dietician provides the ALR with documentation which states s/he reviewed the meal plans, and they meet the following two criteria:(See FAQ #3, page 5)				
1) The meal plans meet current Dietary Reference Intake (DRI) and Dietary Guidelines for Americans				

(DG) guidelines				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
2) The meal plans allow the Resident to adhere to sodium and sugar restricted and low-fat diet.				
-Dietician signs the master copy of the menus				
-A dietician is available to residents who choose to receive counseling regarding diet plan adherence.				
10.1.14. Food Service Personnel				
-All food service personnel meet the General Orientation and Annual In-Service training requirements as stated in 651 CMR 12.07 (1) (2) (3) (4).				
-Before active employment in an ALR, the person(s) managing the dietary department (e.g., food services manager and chef) has completed a food service sanitation course which meets the requirements of 105 CMR 590.003(a)(2). (See 651 CMR 12.07 (10)				
-Chefs attend the MA Allergen Awareness training				
-The job description for the person(s) responsible for the dietary department indicates the completion of an acceptable food sanitation course is required prior to employment. (See FAQ #1-2, page 10 for organizations that offer acceptable courses.)				
-Documentation of completion of the required training is kept in employee's record per 651 CMR 12.05 (3)				

-Food "Servsafe" certificates are displayed in kitchen or dining room and have not expired.				
-A Servsafe certified associate is on duty at all times while the kitchen is open				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Staff are trained in abdominal thrusts maneuver.				
-Staff eating, drinking, gum chewing, and use of personal cell phones is not allowed in kitchen or dining areas.				
-Chef/Director of Dining Services, servers, kitchen staff and utility/dishwashers all wear attire per residence protocols, e.g., uniforms, hats/nets, gloves, no-slip shoes.				
10.1.15. Dining Room				
-Dining room is visually appealing & clean.				
-Room has clean, fresh aroma. Is free of stale food odors.				
-Carpeting is clean, free of stains & debris.				
-Walls & baseboards are clean, scuff-free.				
-Ceiling is clean.				
-Vents are free of dust build up or mold.				
-Side/server stations are clean, organized.				
-Lighting is set at appropriate levels and all bulbs and fixtures are all functioning.				
-Music selection & volume is appropriate for various times of day (e.g., breakfast & lunch are upbeat, dinner = slower tempo).				
-Room temperature: ambient room temp. is set at 72-76 degrees, for resident comfort, not to associate preferences.				
-Windows, treatments, and shades are clean and in good condition.				
-Table linens, napkins, etc. are clean and free of stains and visible damage.				
-Silver & glassware are clean, spot free.				
-Salt & pepper shakers are clean, spot free.				

-Menus are clean, in good condition.				
AREA REVIEWED	**Y**	**N**	**Finding(s)**	**Action to Achieve Compliance/Fulfillment**
10.1.16. Kitchen				
-Floors & drains are clean, free of build up.				
-Steam table is clean, free of build up.				
-Kitchen is clean (i.e., hood, counters, sides of appliances, walls, celling, lights, floors, drains, can opener, lips of counters)				
-Mop buckets are emptied and stored when not in use.				
10.1.17. Food Preparation on Site				
-Current food service permit is posted.				
-Kitchen space to meets federal, state, and local food safety standards for on-site food preparation and cooking.				
-Appliances and equipment for food storage, preparation and serving is evaluated and in good working condition.				
-Kitchen exhaust hood is clean and free of grease build up. Filters are clean, in place.				
-Safe and sanitary food handling policies and practices are in place.				
-Kitchen staff wash hands as needed, using proper techniques.				
10.1.18. Food Serving				
-Proper portion control tools (Spoodles) are in use during plating.				
-Chef conducts pre-meal meeting to review menu offering with service team.				
-All plates at all meals are presented attractively and garnished.				
10.1.19. Food Storage				
-Ice bin is clean, and scoops are stored in a clean holder.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Food storage area is well lit & ventilated.				
-Area is free of signs of insects or rodents.				
-Food is protected from contamination and stored off the ground (raw meats stored separately, food not at room temperature, salad items cold)				
-Food items in all refrigerators & freezers (including those in cafes and country kitchens) are covered, dated and labeled.				
-All dried food storage items are covered, dated, and labeled.				
-Hanging thermometers are in place in all refrigerated units.				
-Door gaskets are clean & in good repair.				
-Walk-in and reach in coolers are well organized and sanitary.				
-Raw food products are stored below prepared products.				
-Refrigeration temperature logs are complete and up to date.				
-Each freezer and refrigerator unit temperatures are documented on a daily basis with the initials of person documenting.				
-All freezer space is maintained at 0 degrees F or less.				
-All refrigerators are maintained at 40 degrees F or less.				
-Food temperatures are taken prior to and after all meals and documented.				
-Hot foods are held at 140 degrees F or above and cold foods at 40 degrees F or				

below.				
AREA REVIEWED	**Y**	**N**	**Finding(s)**	**Action to Achieve Compliance/Fulfillment**
10.1.20. Dishwashing				
-Dish machine & exhaust hood are clean.				
-Wash and rinse cycles are operating at proper temps: wash=150, rinse=180 deg.				
-Temperature log is maintained.				
-Chemical test strips are available in dish area. Staff can demonstrate proper use.				
-Pots & pans are stored inverted to allow for proper drying.				
-Chemical spray bottles are labelled.				
-Clean rubber mats are in dishwasher area.				
10.1.21. Emergency Preparedness				
-Emergency drinking water is on hand and stored per current ALR plans or policy.				
-Emergency food is on hand and stored per current ALR policy or other plans.				
-Back up food delivery plans and policies are in place.				
-First aid kit is stocked and available in kitchen or server area.				
-Choking poster is hung in kitchen or server area.				
-CPR shield is available in kitchen or server area.				
10.1.22. Policies and Procedures				
-Food is readily available for residents to eat when they choose (e.g., breakfast, snacks)				
-All appliances are inspected, and inspections are documented.				
-Cleaning and sanitizing policies are in place (e.g., hand washing, utensils, hair				

restraints)				
AREA REVIEWED	**Y**	**N**	**Finding(s)**	**Action to Achieve Compliance/Fulfillment**
-Local health department inspection reports and current permit are maintained at the ALR.				
-ALR is in compliance with waste disposal requirements.				
10.1.23. Quality Improvement Practices				
-A food services committee meets regularly with residents to evaluate food services, menus, quality, etc.				
-Mechanisms are in place to collect resident feedback (e.g., satisfaction surveys, suggestion box)				
-Director of Dining Services or chef interacts with residents regularly each week during meal service to solicit feedback relative to food quality, menus & overall resident satisfaction.				
-Action plans are developed using resident input.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
10.2. Transportation				
10.2.1. There are policies and training for transportation staff (i.e., safe driving, emergency procedures, and consequences for driving violations).				
10.2.2. Local, state, and federal regulatory standards are met, such as the following:				
-All vehicle registrations are current				
-Proof of current insurance exists (i.e., insurance company provides cards verifying insurance)				
-All drivers have current licenses – regular or commercial, depending on what is required for the size of vehicle(s)				
-The ALR conducts annual driving violations checks through the Registry of Motor Vehicles				
10.2.3. Record keeping system is present (includes verification of drivers' licenses, certificates of insurance on file, vehicle registrations and inspections up to date, visual inspection of vehicle, etc.).				
10.2.4. Drivers and related staff have received training on wheelchair securement				
10.2.5. Driver carries mobile phone and resident emergency information of passengers during transport				
10.2.6. Fully stocked first aid kit including water				
10.2.7. Vehicle inspection is current; insurance cards stored within				

10.2.8. Alternative sources of transportation are available.				
10.2.9. **If applicable, the residency agreement includes local transportation for medical and recreational purposes. (See 651 CMR 12.08 (2)(b)(2)**				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
10.3. Activities				
10.3.1. Resident information is available regarding interests, hobbies, education and work experience, abilities, etc. to facilitate resident participation in activities.				
10.3.2. Lifestyle and leisure assessments are conducted on all residents within 48 hours of move-in.				
10.3.2. Planning and coordination of activities reflects consideration for diverse needs, abilities and interests of residents.				
10.3.3. Programs meet physical, social, and spiritual needs of residents.				
10.3.4. Radio and TV use is appropriate and monitored.				
10.3.5. Residents engaged during planned activity time (i.e., small group, 1:1, etc.)				
10.3.6. Plans include major monthly event (e.g., birthday or anniversary party, etc.)				
10.3.7. Resident Council meeting minutes are on file and available for review.				
10.3.8. Activities Calendar is:				
-Posted (in several places)				
-Communicated				
-Available to residents and family				
-Inclusive of events for families too				
-Demonstrates diversity in activity types, times, locations, cultures, participants, etc.				
10.3.9. Scheduled activities occur according to calendar.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
10.3.10. **SCRs prepare a planned activity program that includes structured activities with designated staff a minimum of 3 times within a 24-hour period, seven days per week, to** address **resident needs, in the following areas of resident function, as applicable: 651 CMR 12.04 (4)(b)**				
-Gross motor activities				
-Self-care activities				
-Social activities				
-Sensory and memory enhancement activities				
10.3.11. Activity staff is familiar with at least one activity preference per resident.				
10.3.12. Activity director or activity leader carries emergency information for each resident during outing.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
10.4. Coordination of Outside Services				
10.4.1. *The ALR does not require residents to notify the ALR that they are receiving any outside services, as such a requirement would violate their right to privacy (12.08(1)(b) and FAQ # 11, page 37)*				
10.4.2. **The ALR's service plans include a description of services that are provided by a person or entity not affiliated with the ALR or by a certified provider of ancillary health services (e.g., VNA, private duty aides, adult day care) if the Resident, Resident Representative or Legal Rep. notifies the ALR that he/she has arranged for such services (12.04(8)(2)(c)**				
-If an outside service provider informs the ALR of a service they will provide, the ALR discusses this with the resident for inclusion on the service plan.				
10.4.3. *The service plan includes any information provided to the ALR regarding outside services including the following (See FAQ #11, page 37):*				
-Name of the program or agency				
-Frequency of service				
-Duration of service				
-Type of service				
10.4.4. The resident is offered a list of outside providers to choose from.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
10.4.5. ALR staff has a contact name and phone number for each outside provider to effectively resolve issues.				
10.4.6. ALR has a policy on private duty caregivers (e.g., screening, sign in/out, dress code, shared risks, communication, behavior standards, cell phone use, smoking, emergency management, etc.) *				
10.4.7. ALR has policies and procedures in place regarding the coordination of services by outside service providers* (e.g., problem resolution, communication).				
10.4.8. Outside service providers orient their staff to the nature and philosophy of assisted living, the assisted living regulations (e.g., the role of the nurse), and the policies of the ALR about outside service providers.				
10.4.9. ALR Staff roles and responsibilities are defined for when they work with an outside service provider.				
10.4.10. ALR's Disclosure statement includes policies regarding outside service providers.				

Also consult MA-ALA's tip sheet "Outside Service Providers and the Assisted Living Residence" for additional policy and procedure suggestions. This resource is available on MA-ALA's members only website.

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
10.5. Information on Palliative Care and End of Life Options CMR 12.04 (15)(a-d)				
10.5.1. **ALR distributes culturally and linguistically suitable information regarding the availability of palliative care and end of life options to all Residents who have provided information indicating that their attending health care practitioner has:**				
-diagnosed Resident with a terminal illness or condition which can be reasonably expected to cause the Resident's death within 6 months				
-determined Resident may benefit from hospice or palliative services.				
10.5.2. **Obligation fulfilled by:**				
-information made available to the Residence by EOEA or produced by the Residence satisfying requirements of M.G.L.c.111.227				
10.5.3. **ALR provides information to physicians and N.P.s providing care within or on behalf of the ALR regarding the requirement of M.G.L. c. 111. 227(c) that they offer to provide end of life counseling to Residents meeting the criteria established by 12.04 (15)(a)**				
10.5.4. **ALR is able to provide proof of compliance with 12.04 (15)(a)(b)(c) upon request or compliance review**				
10.5.5. Advanced Directives are in place which may include MOLST/POLST, DNR,				

DNH; refer to resident record 7.10				
- Residence has policy/procedure in place alerting staff and emergency personnel of resident code status				

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ADDITIONAL PROCESS IMPROVEMENT EFFORTS	
Description of Improvement	**Additional Issues Resolved or Improved**

Quality Improvement Tool (6th Edition)

OTHER COMMENTS

Community: _____ Executive Director: _____

Reviewer of this Section: _____ Reviewer Title: _____

Date of This Review: _____ Date AL Certificate from EOEA Expires: _____

Quality Improvement Tool (6th Edition)

SECTION ELEVEN: Physical Environment

11.1: Residential Character
11.2: Opportunities for Privacy and Socialization
11.3: Resident Apartments
11.4: Interior Environment
11.5: Preventative Maintenance
11.6: Environmental Safety
11.7: Access to Outside
11.8: Exterior Environment
11.9: Disaster and Emergency Preparedness Plan
11.10: Fire Safety

Instructions:

1. **Bold-face items correspond with regulatory requirements (as found in 651 CMR 12.00). See regulation cross-references for further detail.**
2. **Shaded Gray** items pertain to Regulations regarding Special Care Residences only.
3. *Italicized items correspond with Elder Affairs' "Frequently Asked Questions" (FAQs) distributed June 2007. (These are Elder Affairs policy guidance relative to the amended Assisted Living regulations, promulgated in 2006).*
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6. Tip: Each line item is presented as a statement that expresses a standard practice. Should this approach cause confusion, pose each statement as a question instead to reach evaluation response.

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
11.1. Residential Character				
11.1.1. **All newly constructed ALRs provide a private bathroom for each Unit (See 651 CMR 12.04 (1) (b).**				
-All other ALRs provide, at a minimum, a private half-bathroom for each Unit and at least one bathing facility for every three residents (See 651 CMR 12.04(1) (c).				
11.1.2. **ALR provides, at a minimum, either a kitchenette or access to a refrigerator, sink and heating element for all residents (See 12.04(1) (d).**				
11.1.3. Common area furniture is similar to that of individual resident apartments.				
11.1.4. Staff communications systems (e.g., overhead page, walkie talkies) are as quiet and unobtrusive as possible.				
11.1.6. Establish a 'first impressions' tool reflecting residence specific identifiers that represent home-like and welcoming environment				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
11.2. Opportunities for Privacy and Socialization				
11.2.1. **Each resident's door has a working lock. (See 651 CMR 12.04 (1)(a): General Requirements: Physical Requirements)**				
-If outlined in resident service plan, keys or access codes may be readily available to specified shift staff.				
11.2.2. Visitors and residents can come and go 24 hours/day.				
11.2.3. Residents' apartments allow for personalization.				
11.2.4. Appropriate and sufficient space is available for an array of activities and socialization preferred by the residents.				
11.2.5. Space is available for residents to have small private functions with family and friends.				
11.3. Resident Apartments				
11.3.1. With resident consent, nameplate is provided day of move-in. If it's not ready, a temporary one is put in place until final one arrives.				
11.3.2. Resident rooms show evidence of routine housekeeping and maintenance by personnel, such as, but not limited to:				
-bathrooms are clean and odor-free				
-carpets and floors are debris and dirt-free				
-refrigerators are kept free of spoiled food and empty containers				
-refrigerator thermometers read between 34-40 degrees				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-bedding, furniture, and drapes are in place, clean and in good condition				
-apartment is free of any outstanding maintenance or housekeeping issues (e.g., painting, repairs, vacuuming, etc.)				
-phone and emergency cord work properly				
-emergency cords tested; staff responded in appropriate timeframe.				
11.3.3. If residents self medicate, all medications in the apartment are secured/ locked. Locks are functioning				
11.3.4. Window stops are in place to prohibit window opening more than 4".				
11.3.5. All lighting is in working order.				
11.3.6. Electrical outlets have limited capacity; extension cords used in moderation and have appropriate breaker bar feature				
11.3.7. SCU Electrical outlets have safety caps applied				
11.3.8. SCU Personal toiletries are stored and secured				
11.3.9. Night lights are in place				
11.4. Interior Environment				
11.4.1. Common areas are:				
-Free of clutter or debris				
-Clean				
-Odor-free (public areas and bathrooms)				
-Attractive and inviting				
-Well lit, with residential lighting used (with minimal use of institutional florescent fixtures whenever possible).				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
11.4.2. Common bathrooms are clean, odor-free, stocked (e.g., toilet paper, tissues, paper towels, soap) and tidy.				
11.4.3. Antibacterial soap and paper towels are available in all bathrooms, laundry rooms, serveries, and other hand washing sinks.				
11.4.4. Bathroom signs exist on public restrooms.				
11.4.5. Furniture is in good repair.				
-Furniture is appropriately arranged in common areas for resident access and safety.				
11.4.6. Carpets are clean, odor free and in good condition.				
11.4.7. Appropriate usage of cautionary signs (i.e., wet floors, etc.)				
11.4.8. Walls and doors are free from scuff marks, stains or dirt.				
11.4.9. Exit lights are illuminated.				
11.4.10. Elevators are clean and inspected, per contract.				
-Inspection certificate is current and posted inside cab.				
-Elevator's electrical room is not used for storage.				
11.4.11. Walkways/Hallways are clear of trip hazards (i.e., cords, uneven flooring)				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
11.4.12. Fire exits, hallways and stairwells are unobstructed and clearly marked. There are no mattresses or other resident furniture or large items in halls, stairwells.				
11.4.13. All chemicals in the building are located in locked cabinets, closets or cupboards or maintained on a safely secured cart.				
11.4.14. Beauty salon is neat and tidy.				
-Beautician's license is posted.				
11.4.15. Washers and dryers are free of lint and properly vented.				
11.4.16. Storage areas: items stored below 18in from ceiling for sprinkler clearance				
-Flammable items stored within fireproof containment box				
11.4.17 Laundry rooms free of debris; doors not wedged open; dryer vents routinely cleaned				
11.5. Preventative Maintenance				
11.5.1. An inspection and/or preventative maintenance schedule exists and is followed for at least the following equipment:				
-Elevators				
-Heating system and boiler rooms				
-Smoke detectors, fire alarms, sprinklers and CO2 monitors				
-Emergency response systems				
-Generators				
-Pest control				
-Fire extinguishers				

-Kitchen Ansul system				
-Walkways, entrances, and parking areas including egress lighting				
-Perimeter lighting and security				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
11.5.3. Preventative maintenance schedules are used, and logs are updated as completed.				
-Testing/inspections are current.				
11.5.4. Policies exist for the removal of equipment of items in need of repair.				
11.6. Environmental Safety				
11.6.1. The ALR conducts and documents regular environmental safety checks of common areas such as, but not limited to:				
-Common bathrooms				
-Hallways				
-Living rooms and seating areas				
-Activity rooms				
-Laundry rooms				
-Storage closets				
-Offices				
-Ergonomics				
-Outdoor walkways and gardens				
11.6.2. Emergency Exit signs are all lit and direction arrows, if any, lead out of the building.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
11.6.3. Exit doors are lit and free of obstacles.				
11.6.4. Interior and exterior common areas do not have any trip or slip hazards.				
11.6.5. Carpeting and other flooring are in good repair.				
11.6.6. Handrails are available on ramps and in hallways, bathrooms, and stairways.				
11.6.7. Air quality is evaluated regularly.				
11.6.8. ALR is in compliance with CO2 (Carbon Monoxide) monitoring				
11.6.9. Safety inspections are completed on all resident rooms per an established schedule. Results are documented and retained regarding the following:				
-Bathroom areas				
-Kitchen areas				
-Flooring				
-Lighting				
-Electrical outlets				
-Personal electronics and lamps				
-Fire detection and suppression systems				
11.6.10. Lifeline pendants are checked regularly (e.g., monthly).				
11.6.11. Board of Health inspection certificate posted (yearly inspection).				
11.6.12. Yearly building inspection certificate posted.				
11.6.13. All windows in Special Care Residences are located and secured (can open 4 inches max).				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
11.6.14. All windows in assisted living residence are secured (can open 4 inches max.)				
11.6.15. Water temperature log is up to date.				
11.7. Access to Outside				
11.7.1. Residents have keys or other unlocking capacity to come and go from the building as they please, unless otherwise specified.				
11.7.2. Property has porches, yards, patios, gardens, or other similar outside spaces.				
11.7.3. There is safe and accessible parking for visitors and the ALR's van(s).				
11.7.4. Public transportation via taxis or buses is routinely available.				
11.7.5. Signage to and on the property efficiently directs visitors.				
-Signage is visible, in good condition and is properly lit.				
11.7.6. Outdoor smoking areas are designated and receptacles are clean.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
11.8. Exterior Environment				
11.8.1. Outside property/grounds are:				
-attractive and neat, with general curb appeal, including driveway entrance, parking lot, landscaping, walkways, etc.				
-free of debris and litter				
-grass, flowers and shrubbery are attended				
11.8.2. Walkways and driveways are:				
-Free of debris and litter				
-Clear of any trip hazards (i.e., equipment, uneven terrain, etc.)				
-In good repair				
-Well lit with no burnt bulbs				
-Have salt/sand available in inclement weather				
11.8.3. Drop off / pick up area is clearly designated.				
11.8.4. All trash areas / receptacles are:				
-Visible and not overflowing				
-Odor free and orderly				
11.8.5. Handicapped access and signage is free and clear.				
-Handicapped parking is clearly marked.				
11.9. Disaster & Emergency Preparedness Plan (See 651 CMR 12.04 (11)				
11.9.1. **ALR has a comprehensive emergency management plan to meet potential disasters and emergencies:**				
-Fire				
-Flood				
-Severe weather				
-Loss of heat, electricity or water				

-Resident-specific crises (e.g., missing resident)				

AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
11.9.2. **The plan includes the following:**				
-It is developed in conjunction with local and state emergency planners and must include the following elements:				
-evacuation strategy for both immediate evacuations, (fires, gas leaks) and delayed evacuations (impending severe weather) 12.04 (11)(1)(a)				
-Mutual Aid Plan (see definition see 651 CMR 12.02 Mutual Aid) addressing essential issues (supplies, staff, beds) 12.04 (11)(1)(b)				
-actions necessary to ensure supply, equipment and pharmaceutical support is event such services are interrupted12.04 (11)(1)(c)				
-established relationships with local public safety officials and with local Emergency Management Services (EMS) officials12.04 (11)(1)(d)				
-participation in Health and Homeland Alert Network (HHAN) 12.04 (11)(1)(e)				
-HHAM/MassMAP is aware of the current community leadership and contact information				
-protocols for full participation in the Silver Alert System12.04 (11)(1)(f)				
-Indicates the location of emergency exits, evacuation procedures, and phone				

numbers of police, fire, ambulance, and emergency medical transport				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Provisions to address the physical and cognitive needs of residents, including special staff response and procedures needed to ensure the safety of any resident				
-Provisions related to residents in a SCR, which are revised when a resident with unusual needs is admitted				
-Provision for conducting annual simulated evacuation drills and rehearsals for all shifts. 12.04 (11)(a)(4)				
-Testing of emergency generator and other emergency systems				
-A procedure to collect current resident population and service need information, such as resident identifier information, special medical concerns or dietary needs, elopement risk, behavior issues, and physician, pharmacy and family contact information				
-Staffing plan identifies minimum staffing needed				
-Plan establishes staff teams for before, during and after the event, as appropriate				
-List of supplies needed based on emergency type (e.g., food, medical, materials) which is shared with appropriate vendors				
-Resident record policy and procedure that include a system to prevent lost, misplaced or separated records				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
-Physical plant considerations identified as applicable to a particular emergency type (e.g., generators, laundry operations, access to additional fuel, and hardening windows, doors, and HVAC units, roof tie downs and sealing, removal of possible projectiles from all areas, reinforcement of building structural supports, creation of safe areas within building core)				
-Operations logistics plans for 1) maintaining operations during an evacuation, 2) evacuation and 3) operations when sheltering in place				
11.9.3. ED has developed a relationship with local police (e.g., meeting within the past year; periodic visits by local police to the ALR to cover topics of interest to residents.)				
11.9.4. **Every resident is given a copy of and have available for review the instructions in the Disaster and Emergency Preparedness Plan 12.04 (11)(a)(5)**				
11.9.5. **All new employees are oriented to the ALR's Disaster and Emergency Preparedness Plan. 12.04 (11)(b)**				
11.9.6. **The ALR periodically reviews the Plan with all staff, making certain that all personnel are trained to perform the tasks assigned to them.**				
11.9.7. Community has identified evacuation sites both within the town and				

beyond				
11.9.8. Transportation contracts in place to transport residents to the evacuation sites				
11.9.9. Residence has established a pandemic response plan				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
11.10. Fire Safety				
11.10.1. Fire and other emergency procedures, including evacuation plans, are clearly and simply written to be understood by all employees, prominently displayed in public spaces, and are thoroughly reviewed with staff during orientation and other scheduled times during year.				
11.10.2. Residents and staff are provided with fire safety education upon admission and at least annually thereafter.				
11.10.3. Resident rooms are equipped with smoke/heat detectors.				
11.10.4. ALR is protected by required fire detection/ suppression systems.				
11.10.5. **Fire drills are conducted per state regulations and local requirements.**				
-Fire drills are conducted on different shifts and weekends.				
-Fire drill binder shows fire drill conducted for past year.				
-Every associate will have participated in a drill annually				
11.10.6. ED and Plant Operations/ Maintenance Director know the fire marshal and have had the first marshal or his/her rep. visit within the last year.				
-Fire extinguisher tags indicate annual inspections are completed.				
-Results of fire drills are incorporated into quality improvement activities.				

-Fire pump and sprinkler inspections are posted in sprinkler room.				

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AREA REVIEWED	Y	N	Finding(s)	Action to Achieve Compliance/Fulfillment
11.10.7. The fire detection and suppression systems are evaluated per state and local requirements.				
11.10.8. Reports from a licensed contractor indicate fire suppression and detection equipment is inspected as state requires.				
11.10.9. Fire evacuation drawing and fire safety plan are in place on each floor.				
11.10.10. Fire Doors are clear, not propped open and self-close entirely.				
11.10.11. Smoking rules and policies are enforced for common areas and resident rooms.				
-ALR has a smoking contract with such residents (i.e., resident's agreement to comply with ALR's smoking policy, smoking under supervision (if needed), refraining from smoking should the ALR determine that behaviors present a risk to health or safety of others.)				
-ALR has a safe smoking assessment (i.e., cognitive, and visual functions, able to manipulate cigarette, matches/lighter, has communication skills to understand rules)				

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ADDITIONAL PROCESS IMPROVEMENT EFFORTS	
Description of Improvement	**Additional Issues Resolved or Improved**

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OTHER COMMENTS

Community: _____ Executive Director: _____

Reviewer of this Section: _____ Reviewer Title: _____

Date of This Review: _____ Date AL Certificate from EOEA Expires: _____

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SECTION TWELVE: REFERENCES & RESOURCES

Below are some resources pertaining to a quality review process. Users are encouraged to supplement these resources with their own sources and notes. MA-ALA welcomes suggestions of references to include in future updates.

REFERENCES:

Keep the following handy for future reference:

- Massachusetts Assisted Living Statute, MGL Chapter 19D Assisted Living https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter19D
- Current Assisted Living Regulations, Certification Procedures and Standards for Assisted Living Residences (651 CMR 12.00) https://mass-ala.org/wp-content/uploads/2021/12/EOEA-Regulations-12_2021.pdf
- Current copies of your organization's mission statement, goals, philosophy, employee handbook and/or similar documents

RESOURCES:

Alzheimer's Association www.alz.org

American Association of Retired Persons (AARP) www.aarp.org

Alzheimer's Disease Education and Referral (ADEAR) Center www.alzheimers.org

American Seniors Housing Association (ASHA) www.seniorshousing.org

Argentum www.Argentum.org
Center for Excellence in Assisted Living (CEAL) http://www.theceal.org/

Executive Office of Elder Affairs (EOEA) https://www.mass.gov/orgs/executive-office-of-elder-affairs

Massachusetts Assisted Living Association (Mass-ALA) www.mass-ala.org

National Center for Assisted Living (NCAL) http://www.ahcancal.org/ncal

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SECTION THIRTEEN

APPENDICES

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QUALITY IMPROVEMENT COMMITTEE – MEETING SUMMARY

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Residence: _____ Date: _____ Time: _____

Chairperson: _____ Recorder: _____

ATTENDANCE (Print Name and Title)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

TEAM REPORTS

REPORT	**RESPONSIBLE PARTY**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IMPROVEMENT OPPORTUNITIES

OPPORTUNITY FOR IMPROVEMENT	**EXPECTED OUTCOME**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

NEXT COMMITTEE MEETING

Date/Time: _____ Proposed Agenda: _____
_____
_____

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QUALITY IMPROVEMENT ACTION PLAN

Page ___ of ___ Opportunity: _____ Expected Outcome: _____

Issue	Action Steps to Resolve Identified Issue	Responsible Party (Name and Title)	Timeframe/ Target Date	Outcome (Issue Resolved?)

Comments or Signatures and Dates: _____
_____
_____

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Elder Affairs Recertification Review Readiness Checklist

What do you do once Elder Affairs (EOEA) arrives?

- Set up EOEA staff in a private room (e.g., dining room) and collect the manuals and materials they will need.
- Activate your residence's procedure to communicate to your managers that EOEA is in the building.
- Conduct a thorough, last minute building check.
- Take the surveyors on a tour. Take your time and answer their questions calmly.

An Elder Affairs Recertification Visit may include the following:

- Examination of records and manuals
- Tour of the residence, including kitchen, a few resident apartments, and common areas
- Interviews with service coordinator. Questions to expect:
    - Orientation to documentation systems
    - Explain policies re: service plans, introductory visits, evaluations, SAMM, use of bed rails, staff response times to e-calls, resident safety procedures (e.g., evacuation in case of emergency)
- Interviews with personal care workers. Questions to expect:
    - Describe job
    - Explain procedures re: Orientation, In-services, SAMM, Introductory Visits, Communications with Service Coordinator, Evaluations
    - Demonstrate SAMM. Expect Elder Affairs to shadow personal care workers.
- Interviews with Residents.
- Wrap-up discussion. This may include a discussion of findings, an opportunity to ask/answer questions and anticipated time frame for receipt of letter.

Below are the documents that the surveyors may request to review:

- Resident List:
    - Their room numbers and move-in dates
    - Which residents receive assistance with medications and type of assistance (i.e., SAMM or LMA)
    - If applicable, which residents live in the Special Care unit and their move in dates
    - Participants in GAFC
- Employee List:
    - The date of hire, position, and title
    - Staff who are working on the day of the visit
    - If applicable, date s/he first performed duties in any Special Care unit, if different from date of hire
- Personal care worker assignment/task sheets (i.e., a detailed description of assigned residents and the tasks)
- Evidence that CORI is obtained for each staff prior to active employment
- Personal care staff skills evaluations
- Staff Orientation and On-going Education
    - Policy Statement
    - Individual *employee orientation* documentation tracking sheets (NOTE: the regulations require counting and tracking orientation hours separately from on-going in-service hours)
        - Document which orientation trainings were "facilitated" vs. "not facilitated"
    - Individual *employee on-going in-service education* tracking sheets (which can be filed either in a separate binder or in employee files)
        - Expect surveyors to focus on SAMM and Dementia training requirements
    - Sign-in sheets
    - In-service schedule for the current year (including number of hours/topic)
    - Training documentation for part-time staff (e.g., teenage kitchen staff)

- Resident Records
  - Disclosure documents (full document, not just signature page)
  - Most recent version of residency agreement and any signed addenda (e.g., rate increases)
  - Assessments (i.e., resident assessment, physician assessment)
  - *Individualized* Service plan (EOEA is very focused that ISPs are tailored to individual needs)
  - Progress notes (i.e., significant involvements, changes in service plan)
  - Resident satisfaction survey results
  - Introductory Visit (e.g., document topics covered, nurse and staff signatures and dates match)
- Policy manuals that pertain to the Assisted Living regulations including:
  - Emergency Preparedness
  - Quality Improvement and Assurance, as well as EOEA QI program summary cover sheets
  - Communicable Disease
  - Any policies designed to ensure a safe environment for all residents
- Food Service
  - Menus, including a consistent system for identifying low fat, sugar, and sodium restricted options (e.g., icons with explanations)
  - Dietician's menu plan review
  - Dietary Policy Statement
- SAMM
  - Policy
  - Medication sheets for each resident (if kept separate from Resident record)
  - Consistent systems for documenting missed or refused meds and PRNs
  - Consistent form and system for assessing resident appropriateness for SAMM
  - If applicable, informed risk agreement regarding resident use of non-pharmacy filled medication cassettes, signed by resident and/or legal guardian
- Special Care Residence current month's activity calendar
- Incident reports, including policies and procedures for provider follow-up on an incident
- Shift notes/communication logs
- Certificates, Permits, Reports
  - Certificates: Occupancy, EOEA Certificate, health inspections, liability insurance, ServSafe
  - Resident Rights and Ombudsman Program postings (post in SCRs too)
  - Fire Alarm Report
  - Elevator Permit(s)
  - Safety meeting minutes
  - Personal Emergency Response system logs
- Any other records they request. Once it is in writing, it's allowable. (NOTE: Secure resident's written consent to have surveyors review records.)

Other Tips

- Know the regulations.
- Recertification visits are unannounced. Be ready for a surveyor to walk in at any time.
- Be prepared and organized at all times. Use binders to help keep materials organized.
- Be sure all your residents' records are updated and in tip top shape.
- Present as calm and cooperative.

ELDER AFFAIRS OMBUDSMAN VISIT TIP SHEET

WHAT DO YOU DO WHEN AN OMBUDSMAN FROM ELDER AFFAIRS ARRIVES?

- The first greeter (e.g., receptionist) understands the rights of the Ombudsman to come into the residence, at anytime, without an appointment.
- The Ombudsman is not required to tell you the purpose of his/her visit or who may have called. The Ombudsman staff is following up on a concern which they have been informed about by two or more people.
- Ombudsman visits are unannounced.
- Activate your residence's internal procedure to communicate to your managers that the Elder Affairs' Ombudsman Program staff are in the building.
- Remain calm, cooperative, pleasant, and upbeat. Do not personalize the visit.

AN OMBUDSMAN VISIT MAY INCLUDE, BUT NOT BE LIMITED TO:

- Examination of records and manuals
- Tour of the residence
- Interviews with staff, and/or interviews with Residents, with their consent, in private
- A wrap-up conversation:
    - The Ombudsman will offer the Executive Director or other designated manager the opportunity to talk about the visit and review their findings. If it is not offered, you can ask for such a conversation. If a staff member is not available, call to follow up.
    - At this time, the Ombudsman may reveal the concern but will not necessarily tell you who it came from or give you details as to the purpose of the visit.
    - If asked additional questions, be open and honest with your answers, but do not necessarily offer additional information. Answer the questions they ask.
    - If additional information is requested, provide only the information requested.
    - Inquire if the issue is resolved. If not, are there further steps or actions needed? Focus on what can be done to resolve any remaining issues.

DEPENDING OF THE ISSUE UNDER EXPLORATION, BELOW ARE SOME OF THE DOCUMENTS THE OMBUDSMAN MAY REQUEST TO REVIEW:

- A list of all Residents
- A list of all Employees
- Personal care worker assignment and/or task sheets
- Resident records
- Policy manuals that pertain to the Assisted Living regulations.
- NOTE: Secure resident's written consent to have Ombudsman review records.

OTHER TIPS

- Educate staff, especially receptionist, about the rights and role of the Ombudsman.
- Know the regulations. (651 CMR 13.00) Be prepared and organized at all times.
- Be sure all your residents' records are in tip top shape.
- Strive to be ready for a regulator to walk through your door at any time.
- Have a proactive policy for your staff regarding the Ombudsman Program.

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