

**High-Risk Violations in Community Homes and Indicators of Risk in Incident Management**  
**Office of Developmental Programs**  
**December 7, 2018**

**Background / Purpose**

A Provider Oversight Subcommittee of the Information Sharing and Advisory Committee has been created to discuss provider performance and quality improvement in agencies licensed pursuant to 55 Pa.Code Chapter 6400 (Relating to Community Homes for Individuals with an Intellectual Disability or Autism). The subcommittee will:

- Review provider performance data related to licensing, incident management, and provider monitoring data obtained through the Quality Assessment and Improvement (QA&I) processes.
- Make quality improvement recommendations to the ISAC.
- Meet quarterly, or more often if needed.

This document presents regulatory violations with 55 Pa.Code Chapter 6400 (Relating to Community Homes for Individuals with an Intellectual Disability or Autism) identified as posing the highest risk of harm to individuals and indicators of risk to individuals identified through the Incident Management Process.

**High-risk Regulatory Violations**

While all regulations are important to protect participants' health, safety, and rights. ODP has identified eleven (11) regulations that most pose the highest risk of actual harm and have a strong correlation with licensing enforcement action in Community Homes:

1. § 6400.16. Abuse / § 6400.33(a) - Abuse of an individual is prohibited / an individual may not be neglected, abused, mistreated or subjected to corporal punishment.
2. § 6400.62(a) - Poisonous materials shall be kept locked or made inaccessible to individuals who cannot safely use them.
3. § 6400.68(b) - Hot water temperatures in bathtubs and showers may not exceed 120°F.
4. § 6400.141(c)(11) An assessment of the individual's health maintenance needs, medication regimen and the need for blood work at recommended intervals.
5. § 6400.141(c)(14) The physical examination shall include: Medical information pertinent to diagnosis and treatment in case of an emergency.
6. § 6400.144. - Health services, such as medical, nursing, pharmaceutical, dental, dietary and psychological services that are planned or prescribed for the individual shall be arranged for or provided.
7. § 6400.163(c) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a review with documentation by a licensed physician at least every 3 months that includes the reason for prescribing the medication, the need to continue the medication and the necessary dosage.
8. § 6400.167(b) Prescription medications and injections shall be administered according to the directions specified by a licensed physician, certified nurse practitioner or licensed physician's assistant.
9. § 6400.185(b) The ISP shall be implemented as written.
10. § 6400.213(11) Each individual's record must include the following information: Content discrepancy in the ISP.

## Indicators of Risk in Incident Management

In addition to reviewing each individual incident for accuracy and potential harm to individuals, ODP performs aggregate analyses of incidents to identify trends and potential issues. ODP has identified the following indicators of risk based on provider performance through the analytical process:

- 1. Excessively-low or high reporting when controlled for size.** All providers report incidents. There will naturally be a relationship between the number of incidents reported and the size of the provider. To account for this, ODP controls for size by dividing the number of incidents reported by the number of locations operated by the provider.

When a provider of any size reports an excessively low number of incidents (generally considered to be less than two standard deviations from the mean number of incidents reported by all providers) it is a potential indicator of failure to recognize incidents that need to be reported or deliberately not reporting incidents to mask issues.

When a provider of any size reports an excessively high number of incidents (generally considered to be greater than two standard deviations from the mean number of incidents reported by all providers) it is a potential indicator of failure to recognize the need to implement risk mitigation strategies either proactively or in response to prior events, or a potential indicator of systemic issues within the provider agency.

- 2. Repeat inpatient hospitalizations for physical or psychiatric reasons within a 30 day period.** Repeated hospitalizations is a potential indicator of failure to recognize the need to implement risk mitigation strategies either proactively or in response to prior events, failure to implement recommended or prescribed health care services, or failure to update individuals' records relating to care and services to reflect a potential change in need or healthcare conditions.
- 3. Repeated incidents of accidental or unexplained injuries that require treatment beyond first aid.** Repeated accidental or unexplained injuries are potential indicators of failure to recognize the need to implement risk mitigation strategies either proactively or in response to prior events, failure to implement recommended or prescribed health care services, or failure to update individuals' records relating to care and services to reflect a potential change in need or healthcare conditions.
- 4. Descriptions of actions taken in response to incidents to protect the individual's immediate health and safety needs are inadequate or lack sufficient detail.** Inadequate actions to protect health and safety are potential indicators that the individual may still be at risk and/or are not being provided with the protections and services afforded to all Pennsylvanians such as access to victim's assistance services, law enforcement, or needed health services.
- 5. Descriptions of corrective actions taken in response to incident in total are inadequate, lack sufficient detail, and/or are not sufficient to prevent reoccurrence of the event to the individual or other individuals receiving service by the provider.** Inadequate actions in response to the incident are potential indicators that the circumstances that resulted in the incident will recur and result in harm to the same or another individual served by the provider.