



INTRODUCTION TO CERTIFICATION

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Health Facilities Administration

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Certification Numbers

- Five full-time Licensing and Evaluation Coordinators
- Complete approximately 1000 certification reviews per year
- Current Certifications:
 - Approximately 1200 1-3 person homes (certified only)
 - Approximately forty-five (45) 4 or more person homes (certified and licensed)
 - Approximately sixty-five (65) stand-alone CPS programs

Why do we need certification?

- State law indicates, in part, that the Commissioner shall adopt rules to govern the establishment and operation of community living facilities and day services, and that the certifications of these sites shall be based on these rules. The law also indicates that “certifications shall be subject to periodic review and renewal” by the Commissioner.

Why do we need certification?

- The State of NH (BDS) receives Medicaid reimbursement through the Medicaid waiver program.
- BDS then contracts with Area Agencies, who are enrolled Medicaid providers.
- Area agencies can either provide the service themselves or sub-contract with a vendor agency.
- Medicaid is a publicly funded program which requires State oversight to “protect the health, safety, and welfare of individuals served”.

Rules That We Enforce

- **He-M 310**: Rights of Persons Receiving Developmental Services or Acquired Brain Disorder Services in the Community
- **He-M 503**: Eligibility and the Process of Providing Services
- **He-M 506**: Staff Qualifications
- **He-M 507**: Community Participation Services
- **He-M 1001**: Certification Standards for Community Residences
- **He-M 1201**: Healthcare Coordination and Administration of Medications

Types of Certifications

- We certify:
 - 1-3 person homes (with or w/o CPS)
 - 4 or more person homes (with or w/o CPS)
 - Stand alone CPS programs
- The 4 categories of reviews are:
 - Emergency
 - Temporary / Initial
 - Annual / Renewal
 - Biennial

Emergency Certifications

- For true emergencies only!
- Certificates can be backdated up to 7 days
- No Life Safety Report required (LSR)
- If LSR has been done, you are no longer eligible for an emergency certification
- Issued for 45 days
- Option for a one time emergency certification extension for another 45 days
- Can be issued in an already certified home

Emergency Certification Application

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF OPERATIONS SUPPORT
HEALTH FACILITIES ADMINISTRATION
129 Pleasant St, Concord, NH 03301-6527
603-271-9040 FAX: 271-4968 TDD Access: 1-800-735-2964

Emergency Certification for Community Residence – 3 or fewer beds

Name of Residence/Program: _____ Region: _____

Physical Address: _____
(street) (town) (state) (zip)

Mailing Address: _____
(street) (town) (state) (zip)

Home Provider name: _____ Telephone #: _____

Vendor Agency: _____
(street) (town) (state) (zip)

Vendor Contact Person: _____ Contact Phone#: _____

E-Mail Address: _____

Area Agency: _____
(street) (town) (state) (zip)

AA Contact Person: _____ Telephone #: _____

Name of Residence Administrator: _____

Is residence currently certified Yes No If yes, indicate certificate number: _____

Number of beds currently certified: _____ Total number of beds to be certified: _____

Is this consumer served by: DD BH ABD Waiver Other _____

Number of Community Participation slots requested for this Emergency placement: _____

Number of hours of supervision per day per ISP: _____

I Certify that:	
A. _____, born on _____	needed immediate placement on _____ to protect his/her health and safety because _____
B. There is no condition within the above residence that would pose a health or safety threat to the client.	
C. This residence is in full compliance with the statutes and regulations governing Community Residences.	
Area Agency Executive Director or Community Mental health Executive Director:	
_____ Signature	_____ Date
_____ Print Name and Title	
Emergency, as defined by He-M 1001.02 and He-M 1002.02 is an unexpected occurrence or set of circumstances in an individual's life which consists of, culminates in, or has resulted for a serious physical and/or psychological injury and requires immediate remedial attention.	
Application must be completed and received by Health Facilities Administration within 7 days of placement. (Faxes acceptable)	
Emergency certification is granted in accordance with He-M 1001.13 and shall be valid for maximum of 45 days . Refer to He-M 1001.13(f)(g) if an extension of this certification is necessary.	

Effective 12/23/13

Temporary Certifications

- Completed Application, open same day
- Approved Life Safety Report (LSR) within the past 90 days
- Community Participation Services Policies and Procedures, if applicable
- Directions to home or CPS site
- Waiver Application(s)/Approvals, if applicable
- Temporary Certificate issued for 90 days
- Site review around the 90 day mark

Certification Application

- The application is also used for the following:
 - Renewal request
 - Add/remove a bed or CPS slot
 - Add/remove an individual from the home or CPS site
 - Changing the level of supervision
 - Changing any contact information (home provider, contact person, phone number, etc.)

Life Safety Report

- Reasons to obtain a new Life Safety Report (LSR):
 - Opening a new home or CPS site
 - Adding a bed or CPS slot, if applicable
 - Changing an individual's bedroom to another room in the home
 - Any change in an egress (door/window)
 - Any time that work is completed at the home or CPS site that required a building permit

Life Safety Reports

STATE OF NEW HAMPSHIRE
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 OFFICE OF OPERATIONS SUPPORT
 BUREAU OF HEALTH FACILITIES-LICENSING
 129 Pleasant Street, Brown Building, Concord, NH 03301-3307
 603-271-4592 FAX 603-271-4968 TDD Access: 1-800-735-2964

**LIFE SAFETY REPORT FOR
 ONE-TO-THREE PERSON PLACEMENT
 COMMUNITY RESIDENCE**

The Department of Health and Human Services, Office of Operations Support, Health Facilities, has the responsibility for certifying residences for individuals with a developmental disability, acquired brain disorder, or mental illness. Prior to the initial certification of a home or before an increase in the number of clients is approved, the Office of Operations Support requires inspection of the residence by the local fire authority to determine compliance with New Hampshire RSA 125-A:21.

NAME OF RESIDENCE: _____
 ADDRESS OF RESIDENCE: _____
 CONTACT PERSON: _____
 PHONE # OF RESIDENCE: _____
 Number of Beds for non-terribly mentally ill/individuals with developmental disabilities or Behavioral Health Issues: _____

This City/Town used the following fire code(s) for this inspection as specified in RSA 125-A:21; please check any or all options:
 NFPA 101, One & Two Family Dwelling Occupancy, Edition: _____
 NFPA 104, Existing Apartment Buildings, Edition: _____
 NFPA 101, New Apartment Buildings, Edition: _____

AT A MINIMUM YOU MUST REVIEW THIS OCCUPANCY UNDER THE CURRENTLY ADOPTED EDITION OF THE LIFE SAFETY CODE LISTED IN SAC-C 6000

The above named residence was inspected on _____ and on that day found it to be in compliance with the State Fire Codes listed above.

The above named residence was inspected on _____ and on that day found it to be non-compliant with the State Fire Codes listed above.

Items, which are non-compliant: (If more space needed, please attach a separate sheet)

I certify that I re-inspected the above named residence on _____ and on that day found it to be in compliance with the State Fire Codes listed above.

Signature of Inspector: _____ Date: _____
 Print Name: _____
 Title/Department: _____
 Additional Information: _____

Additional health and safety items will be returned by DHHS under file # 1031
 White - Health Facilities Administration Yellow - Local Fire Authority Pink - Provider

STATE OF NEW HAMPSHIRE
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
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 129 Pleasant Street, Brown Building, Concord, NH 03301-3307
 603-271-4592 FAX 603-271-4968 TDD Access: 1-800-735-2964

**LIFE SAFETY REPORT FOR
 DAY SERVICE PROGRAM**

The Department of Health and Human Services, Office of Operations Support, Health Facilities has the responsibility for certifying day programs for individuals with a developmental disability, acquired brain disorder, or mental illness. Prior to the initial certification of a day program, the Office of Operations Support requires inspection of the facility by the local fire authority to determine compliance with state and local fire codes.

NAME OF THE DAY PROGRAM: _____
 ADDRESS: _____
 CONTACT PERSON: _____
 PHONE # OF DAY PROGRAM: _____
 Number of Individuals to receive services at the day program: _____

This City/Town uses the following fire codes; please check any or all options:
 NFPA 101, Chapter 16 New Day Care Occupancies
 NFPA 101, Chapter 17 Existing Day Care Occupancies
 International Building Code (IBC) _____
 NFPA 1 _____

AT A MINIMUM YOU MUST REVIEW THIS OCCUPANCY UNDER THE CURRENTLY ADOPTED EDITION OF THE LIFE SAFETY CODE, UNDER THE AUTHORITY OF THE STATE OF NH, FIRE MARSHAL (unless local codes are more stringent)

I certify that I inspected the above named Day Program on _____ and on that day found it to be in compliance with the State Fire Codes listed above.

I certify that I inspected the above named Day Program on _____ and on that day found it to be non-compliant with the State Fire Codes listed above.

Items, which are non-compliant:

I certify that I re-inspected the above named Day Program on _____ and on that day found it to be in compliance with the State Fire Codes listed above.

Signature of Inspector: _____ Date: _____
 Print Name: _____
 Title/Department: _____
 Additional Information: _____

White-Health Facilities Administration Yellow-Local Fire Authority Pink-Provider

Preparing For The Review

- Typically you will have 1-2 months to prepare for all certification reviews. Your preparations should include:
 - Review all files to ensure that the information that we review is present. You can use the Residential Certification Tool or the CPS Certification Tool to assist you with this process, both of which we will review shortly.
 - Completing the Residential Information Packet or CPS Information Packet
 - Remember that your certification inspection is an “open book test”.

Residential Information Packet

DS-ABD RESIDENTIAL INFORMATION PACKET FOR CERTIFICATION

Name of Program:

Cert #:

INDIVIDUAL NAME(S)	SERVICE COORDINATOR

- Please bring copies of returned NH criminal record checks, NH DMV record checks and BEAS Registry checks for all staff, providers, and household members over 18 years old to the certification visit.
- Self-reported deficiencies must be written in letter format prior to the certification. Self-reports must be given to the surveyor at the beginning of the inspection.
- Complete entire packet prior to certification. Incomplete packets with attachments will not be accepted.
- Attach copies of all fire drill evacuation reports dating back to last certification inspection. If an initial or emergency program, attach copies of all completed fire evacuation drills.
- Attach copies of Fire Safety Risk Assessments for all Individuals, along with a current floor plan that indicates where the individual(s) bedroom is located.
- When filling out the packet, please only use the original criminal record check and training dates from the date of hire/contract. Do not use updated training dates or more recent criminal record check dates.
- When filling out the insurance information, please list all home and auto insurance as applicable to the certified residence.

IMPORTANT: I swear or affirm that the information provided is accurate to the best of my knowledge and belief. I understand that providing false information shall be grounds for denial, suspension or revocation of the certification.

Signature and title of agency representative verifying that all information provided is complete and accurate Date

(If signing electronically, please indicate, "Electronically signed and dated")

Certification Review Day

- Ensure that the Residential Information Packet or CPS Information Packet are complete, with all accompanying documentation available.
- When the surveyor conducts the review, they will use either the Residential Certification Tool or the CPS Certification Tool.

Residential Certification Tool

COMMUNITY RESIDENCE/DEVELOPMENTAL DISABILITIES AND ACQUIRED BRAIN DISORDER CERTIFICATION TOOL FOR 1-3 PERSON HOMES

Residence Name		Certification Number	
Service Provider		Date of Review	
City/Town		Region	
Surveyor Name			
Number of Certified Beds		Number of Day Service Slots	
Total number of Individuals		Type of Inspection	Initial / Annual / Biennial (please highlight or circle one)
Name(s) of Individuals Living in Residence		People Interviewed at Inspection	

ADMINISTRATIVE REVIEW	Y/N	COMMENTS
Is there a current and complete application? New: He-M 1001.11(a)/Renewal He-M 1001.12(a-d)		Date Received
Is there a Life Safety Report? He-M 1001.12(c)(3)		Date Issued Number of Approved Beds Issued By
For a biennial review, did the provider agency holding the certificate complete a one-year QA visit and is the documentation available in the home? He-M 1001.12(k)(1,2)		
Does the residence serve individuals under 18 at the same time it serves individuals over age 18? He-M 1001.03(e)		Guardian Approval Date Area Agency Approval Date
Is a Foster Care License required (under 18)? He-M 1001.03(f)		License Date License Number Total Number of Children Allowed
Do any household members/staff have applicable convictions? (excludes individual) He-M 1001.15 (a),(2)(3)		Waiver Date
Do any household members/staff have any founded BEAS complaints? He-M 1001.15(a)(1)		Waiver Date
Is the attendance record complete with all LOAs recorded? He-M 1001.08(d)(1-3) / He-M 507.08(f)(2)		Residential Attendance Day Services Attendance

CPS Certification Tools

COMMUNITY PARTICIPATION ANNUAL/BIENNIAL ADMINISTRATIVE REVIEW CERTIFICATION TOOL

Name of Program : _____ Cert Number: _____
 Service Provider: _____ Review Date: _____
 City/Town: _____ Phone Number: _____ Region: _____
 Surveyor: _____
 Number of Community Participation Slots Certified: _____ Census: _____

ADMINISTRATIVE REVIEW	Y/N	COMMENTS
Is there a current and complete application? He-M 507.06(d)		Date Received: _____
Is there a Life Safety Report? He-M 507.06(d)(5)		Date Issued: _____ #: _____ Issued by: _____
If medications are administered at the day service program, is there an Agency Medication Review Form completed by the nurse-trainer? Have monthly quality reviews been completed? He-M 1201.09(c)(4)		Dates of quality reviews: _____
Are there evacuation drill records if services are provided for more than an hour a day at a centralized service site? He-M 507.08(b)(2)b., He-M 507.08(f)(4)		
Are any waivers required? He-M 507.17(a)		

I swear or affirm that the information provided in this packet is accurate to the best of my knowledge and belief. I understand that providing false information shall be grounds for denial, suspension or revocation of the certification.

Authorized Signature

 Residential Coordinator or Director
 Print name and title

 Date

Eff 12/23/13

COMMUNITY PARTICIPATION SERVICES CERTIFICATION TOOL

Name of Program : _____ Cert Number: _____
 Surveyor Name: _____ Review Date: _____
 Individual Name: _____

ADMINISTRATIVE REVIEW	Y/N	COMMENTS
Does the Individual's record contain an Emergency Information sheet? He-M 507.08(d)(1)		Guardian Name and Phone Number: _____
Are there current and previous service agreements that conform to the requirements of He-M 503.11?		Current ISA Date: _____ Previous ISA Date: _____ AA Approval Date: _____ AA Approval Date: _____ Current Day Service Goals: _____ Previous Day Service Goals: _____ _____ _____ _____
He-M 507.07(a)/He-M 507.08(e)(1)/He-M 503.11		
Are the monthly progress notes specific to the service agreement goals, and the services to be provided? He-M 507.08(e)(4)		
Do weekly calendars/schedules document the days, times and locations of activities? He-M 507.08(e)(2)		
Is there daily documentation that includes the name of the individual, the date the service was provided, activities that took place, locations of activities, and who provided the service? He-M 507.08(e)(3)		
Has the guardian(s) been notified of rights within the last year, and has the rights notification been updated as required? He-M 310.03 (b)(3)		
Is there a daily census record? He-M 507.08(f)(2)		
Is a current annual health assessment found? RSA 171-A-11,(a)		Current Health Assessment Date: _____ Previous Health Assessment Date: _____
Are PRN medications being administered per an order and a PRN protocol? He-M 1201.04(h)(1)(2)		
Are there medication orders present for all medications being administered? He-M 1201.04(f)(g)		
Have self-administering individuals been assessed as required? He-M 1201.05(d)(1)(2)		Date of Current Nurse Trainer Approval: _____ Date of Previous Nurse Trainer Approval: _____
Has the individual's health history been reviewed as required? He-M 507.08(e)(5)		Person Completing Form and Date: _____

Revised 04/14/14

Responding To Deficiencies and Concerns

- All Plans of Correction Are Due Within 21 Days of Receipt of Results
- The Plan of Correction Must Include:
 - How The Program Corrected or Intends To Correct The Issue(s)
 - The Date By Which It Will Be Corrected
 - How The Program Intends To Prevent This Issue From Being Repeated
 - Please submit the ENTIRE plan of correction when it is complete. Do **NOT** send it in piecemeal!

Future Reviews

- After your initial certification review, you will receive another review at the end of your first year. For example, if the home or CPS site came on line on 9/28/2017, our initial visit typically would happen in late December of 2017 and your first annual certification inspection will come in late August, as your certificate expiration date will be 8/31/2018.

Future Reviews

- Once you have completed your first two reviews, future reviews will happen as follows:
 - 1-3 person homes (with 4 or fewer deficiencies) and CPS programs with 50 or fewer slots (with 2 or fewer deficiencies) are eligible for a two-year certificate.
 - 4 or more person homes (licensed) and CPS programs with more than 50 slots are reviewed yearly, regardless of performance.

Renewal / Annual Certification

- You must submit a renewal application at least 60 days prior to your expiration date (120 days for your licensure application, if applicable).
- You will always have two reviews during your first year of operation. Again, future reviews will depend on size and performance.

Biennial Reviews

- Conducted At The End of A 2-Year Certification Period.
- Oversight Agency Is Responsible For Conducting QA Review At Midpoint, Which Includes Completing The Residential or CPS Information Packet, Along With The Appropriate Certification Tool(s).
- Surveyor Will Review Only Most Current Year, Unless There Are Questions Regarding Agency QA
- Entire 2-year Period Is Subject To Review
- If QA Is Not Done, A Deficiency Is Issued and Review Of Two Years Is Mandatory

Review of Licensed Homes

- Review by HFA staff is similar to any other residential inspection, although there are some additional requirements
- A Life Safety Code inspector will conduct random unannounced inspections of licensed homes
- Failure to comply could potentially lead to the oversight agency being fined.

Additional Tool for Licensed Homes

Additional Tool for Licensed Homes

ADMINISTRATIVE REVIEW	Y/N	COMMENTS
In accordance with RSA 151:20, does the licensee have a written policy setting forth the rights and responsibilities of individuals receiving services at the CR, as well as written procedures to implement its policy to ensure that rights set forth in RSA 151:21, "Patients Bill of Rights" are upheld? He-P 814.15 (b)		
Does the licensee have a written chain of command that sets forth the line of authority for the operation of the CR? He-P 814.15 (l)(3)		
Has Licensee admitted anyone with a diagnosis of dementia, Alzheimer's disease, or a primary or secondary diagnosis of mental illness? If yes, have all direct care personnel been trained in the special care needs of individuals with dementia, Alzheimer's disease or mental illness? He-P 814.15 (o)(1)		Respondent: _____ Name and Title
RESIDENCE TOUR	Y/N	COMMENTS
Are the following posted in a public area? 1. Current license 2. All inspection reports for the previous 12 months 3. Patients' bill of rights 4. Licensee's policies and procedures relative to the implementation of patient rights and responsibilities 5. Licensee's complaint procedure 6. Licensee's plan for fire safety, evacuation and emergencies, identifying the location of, and access to all fire exits He-P 814.15 (p) (1-6)		
Are solid waste, garbage & trash stored in a manner to make them inaccessible to insects & rodents, outdoor animals & facility pets? He-P 814.21 (j)		
Are tight fitting screens provided for all doors, windows, or other outside openings that are kept open during the season when flies, mosquitoes and other insects are prevalent? He-P 814.21 (r)		
Are all bathrooms equipped with soap dispenser, paper towels or hand drying device, and hot and cold running water? He-P 814.22 (r)		
Are all bathroom and closet doors designed for easy opening from the inside and outside in an emergency? He-P 814.22 (t)		
Does each individual have the following? 1. Bed 2. Firm mattress with cover 3. Pillow, linens, and blankets 4. Personal hygiene and grooming equipment 5. Bureau with mirror 6. Bedside table 7. Lamp 8. Upholstered chair He-P 814.22 (x)(1-8)		

Revised 12/23/13

R:\Program Support\Licensing\IFA-L\Group\Community ReAct, Forms\MOST CURRENT FORMS\DS-ABD Certification Tool For Licensed Homes.doc

Waivers

- The 3 categories of waivers are:
 - BDS Waivers to all rules accept for He-M 1201
 - Med Committee waivers in regard to He-M 1201
 - Epi-Pen Waivers

NJ BUREAU OF DEVELOPMENTAL SERVICES WAIVER REQUEST		
Submit completed requests to: Jamie Kelly, Office of Client and Legal Services Jamie.L.Kelly@dhs.state.nj.us 105 Pleasant Street, Concord NJ 07331		
*Criminal record checks <u>must be current</u> *Waivers are to be submitted by the Area Agency ONLY .		
Area Agency (circle): 1 2 3 4 5 6 7 8 9 10		
Indicate: Initial <input type="checkbox"/> Renewal <input type="checkbox"/>	If Renewal , indicate Waiver Number: Expiration Date:	
Provider Agency (if applicable)	Contractor Name (if applicable)	Staff Name (if applicable)
Waiver for Residence: <input type="checkbox"/> Day Service: <input type="checkbox"/>	Provide name and address as it appears on the Certificate:	Residence or Day Service Certificate #: Expiration Date:
Indicate specific standard from which you request a waiver: He-M Quote the specific language you seek to waive:		
Provide a full explanation of why a waiver to this standard is sought:		
Describe proposed alternative to satisfy regulatory intent:		
Individual signature (if applicable): _____ Guardian signature (if applicable): _____ Approval Date: _____		
Signature of AA Executive Director/ designee: _____ Date: _____		
Requested number of years for waiver to be effective (circle): 1 2 3 4 5		

Revised October 2012

Waivers (continued)

NH Bureau of Developmental Services Request for Waiver to He-M 1201

Responsible Area Agency (check one) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10		Date: ____
Request is for an Initial <input type="checkbox"/> or Renewal <input type="checkbox"/> waiver?		
Provider agency name and address (if applicable): _____		
Residence or Day Service name and address: _____		
Indicate specific section of He-M 1201 for which a waiver is being sought: He-M 1201.05 (e) (3) (I) (11)		
Provide an explanation of why a waiver to this standard is sought:		
What alternative is proposed to satisfy regulatory intent?		
Number of staff/providers authorized to administer medications: _____ Nurse Trainer phone # _____		
Number of people receiving medication within certified service: _____		
I certify that policies and procedures are in place for: <ul style="list-style-type: none"> • Nurse Trainer oversight of authorized staff • Communication protocols between Day and Residential Services 		
Nurse Trainer signature: _____		Date: _____
Individual/Guardian (if applicable) signature: _____		Date: _____
AA Executive Director or designee signature: _____		Date: _____
Medication Committee: Approve <input type="checkbox"/> Deny <input type="checkbox"/>		Date: _____
Medication Committee Chair signature: _____		Date: _____

Submit completed request to:
BDS
ATTN: Medication Committee
State Office Park South
105 Pleasant Street, Main
Building
Concord, NH 03301

NH Bureau of Developmental Services Request for Waiver to He-M 1201.06 (a) (3) (I) (11)

Area Agency (check one) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	Date of Application: ____
Individual or Program Name: _____	
Provider agency name and address (if applicable): _____	
Residence or Day Service name and address _____	
Indicate specific section of He-M 1201 for which a waiver is being sought: He-M 1201.06 (a) (3) (I) (11)	
Provide an explanation of why a waiver to this standard is sought:	
An Epinephrine auto-injector is used for the treatment of allergic reactions and anaphylaxis associated with food, drug, insect venom, and latex allergies. Anaphylaxis can be life-threatening where time is critical, and the use of an Epinephrine auto-injector will help stop the allergic reaction in order to give the individual time to get the emergency help they need. An Epinephrine auto-injector is an intramuscular injection, not a route included in the authorization to administer medications in accordance with He-M 1201. However, an Epinephrine auto-injector is manufactured for use by non-professionals in an "auto injector form", the administration of the injection is not complex, and the potential for making a mistake in the administration of the injection is minimal.	
What alternative is proposed to satisfy regulatory intent?	
The individual(s) has a specific prescribing practitioner's order for the use of an Epinephrine auto-injector for the prevention and/or treatment of anaphylaxis. All mad authorized staff who work with the individual(s) are specifically trained on the use of an Epinephrine auto-injector following the manufacturer's instructions and the RN's PRN protocol, with a return demonstration.	
Number of staff/providers authorized to administer medications: _____ Nurse Trainer phone # _____	
Number of people with prescription order for a Epinephrine auto-injector within certified service: _____	
I certify that policies and procedures are in place for: <ul style="list-style-type: none"> • Nurse Trainer oversight of authorized staff • Communication protocols between Day and Residential Services 	
Nurse Trainer signature: _____ Date: _____	
Individual/Guardian (if applicable) signature: _____ Date: _____	
AA Executive Director or designee signature: _____ Date: _____	
Medication Committee: Approved <input checked="" type="checkbox"/>	
Medication Committee Chair signature: Jen McLaren, M.D., State of NH He-M 1201 Medication Committee Chairperson	

This Epinephrine auto-injector Waiver can be applicable to all individuals with the need for an Epinephrine auto-injector in a program, residence, and/or all individuals with the need for an Epinephrine auto-injector served by a Vendor Agency or an Area Agency. This Epinephrine auto-injector waiver presumes that the Nurse Trainer is aware of each individual's needs.

By signing and dating this document, the Nurse Trainer is signifying that the authorized providers for the residence(s), day service(s), vendor or Area Agency listed above demonstrate competency in accordance with NH Code of Administrative Rules NUR 404 and have the knowledge, skills, and judgment in the proper use of a Epinephrine auto-injector for the prevention and/or treatment of anaphylaxis for named individuals; that authorized staff are specifically trained on the use of a Epinephrine auto-injector following the manufacturer's instructions and the RN's PRN protocol, with a return demonstration.

By signing and dating this document, the AA Executive Director or designee is signifying that guardians involved are aware of the individual's need for use of an Epinephrine auto-injector for the prevention and/or treatment of anaphylaxis.

This Epinephrine auto-injector waiver is valid for one year from the date of application. Nurse Trainer, individual, and AA Executive Director signatures must be up-to-date.

Certification Assessment Survey



Nicholas A. Tompao
Commissioner
Mary P. Caselli
Senior Division Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF OPERATIONS SUPPORT
BUREAU OF LICENSING & CERTIFICATION

129 PLEASANT STREET, CONCORD, NH 03301-3857
803-273-0944 1-800-852-3846 Ext. 3044
FAX: 603-271-4968 TDD Access: 1-800-735-3984

CERTIFICATION ASSESSMENT SURVEY

The staff at the Health Facilities Administration invites you to participate in an optional assessment of today's Certification Review and the service delivery system as a whole. If you choose to participate, you may acknowledge who you are or you may choose to remain anonymous by omitting any identifying information requested on this form. We thank you in advance for your willingness to help us assess the strengths and weaknesses of the certification process and the service delivery system as a whole.

Did you receive ample notice in the scheduling of this review?

Was the review appropriate in terms of time spent at the residence/program?

Would you describe the reviewer as professional?

Are you satisfied with the services received from the area agency / vendor agency?

Aside from certification, do you feel that there is adequate monitoring of this home/program?

Do you feel adequately supported by your area agency or vendor?

Does the individual have any outstanding needs that are not being addressed?

Other comments or suggestions?

Review Date: _____ Residence/Program: _____ Surveyor: _____

Signature: _____

The Department of Health and Human Services' mission is to join communities and families in providing opportunities for citizens to achieve health and independence.

Peter E. Bacon
Office of Operation Support
BHH Community Residence
129 Pleasant Street
Concord, NH 03301-3857

Closure Letter



Nicholas A. Tommaso
Commissioner
Mary P. Castelli
Senior Division
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF OPERATIONS SUPPORT
BUREAU OF LICENSING & CERTIFICATION
100 PLEASANT STREET, CONCORD, NH 03301-3657
603-271-8496 1-800-852-5346 Ext. 3496
FAX: 603-271-4068 TDD Access: 1-800-728-2964 www.dhhs.nh.gov

PROGRAM CLOSURE NOTICE

Dear _____:

Please be advised that the _____, Certificate #: _____
(Name of Residence or Day Service)

located at: _____
(Address)

has been closed effective: _____
(Date)

1. Individual(s) moved to (name of Community Residence and Certificate #):

2. Reason for Closure:

3. Are there any other individuals living in the home? YES NO

4. A copy of this form has been sent to the _____ Fire Department on _____
(Town/City) (Date)

(Print Name)

(Phone #)

(Signature)

(Date)

White Copy--- Return to the Office of Operations Support with copy of Current Certificate
Yellow Copy--- Send to Local Fire Department
Pink Copy--- Vendor Agency Copy

Revised/Reviewed 12/23/13

The Department of Health and Human Services Mission is to join communities and families in providing opportunities for citizens to achieve health and independence.



Related Information

- **Unannounced Inspections**
- **Scheduling/Canceling Inspections**
- **Appeals**

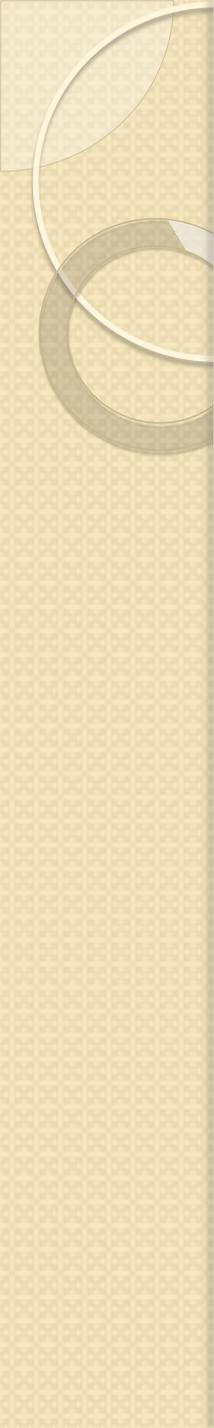
Training Assessment Form

Introduction to Certification Training Assessment / Survey

1. The training met my expectations.
Strongly Agree Agree Neutral Disagree Strongly Disagree
2. The content was organized and easy to follow.
Strongly Agree Agree Neutral Disagree Strongly Disagree
3. The materials distributed were pertinent and useful.
Strongly Agree Agree Neutral Disagree Strongly Disagree
4. The instructor(s) was/were knowledgeable.
Strongly Agree Agree Neutral Disagree Strongly Disagree
5. I will be able to apply the knowledge learned.
Strongly Agree Agree Neutral Disagree Strongly Disagree
6. My questions and/or concerns were answered.
Strongly Agree Agree Neutral Disagree Strongly Disagree
7. There was enough time allotted for discussions and questions.
Strongly Agree Agree Neutral Disagree Strongly Disagree
8. The time allotted for the training was appropriate.
Strongly Agree Agree Neutral Disagree Strongly Disagree
9. What was the most important thing that you learned today?

10. If you could change one thing about the certification process, what would it be?

11. Other comments/observations/suggestions?



Questions?