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§7-909.

(a) In this section, the word “licensee” means a person who is licensed by the Administration under this title to provide services.

(b) (1) The Administration or its agent shall inspect each site or office operated by a licensee at least once annually and at any other time that the Administration considers necessary.

(2) The Administration or its agent shall evaluate periodically the performance of surveyors who carry out inspections under this subsection to ensure the consistent and uniform interpretation and application of licensing requirements.

(c) The Administration shall keep a report of each inspection.

(d) The Administration shall bring any deficiencies to the attention of:

(1) The executive officer of the licensee; or

(2) In the case of an intermediate care facility–intellectual disability, the State Planning Council and the State–designated protection and advocacy agency.

(e) (1) The Administration, in conjunction with the Office of Health Care Quality, shall adopt regulations that establish a system of prioritization to respond to and investigate serious reportable incidents, as defined by the Administration, in the areas of abuse, neglect, serious injury, and medication errors that threaten the health, safety, and well–being of individuals receiving services funded by the Administration in State–operated and community programs licensed by the Administration.

(2) The Administration shall seek input from individuals with disabilities and their families, licensees, and advocacy organizations in developing the regulations, prior to publishing the regulations in the Maryland Register for public comment.

(3) The regulations shall define and address:

(i) The procedures and timelines that providers must follow when reporting serious reportable incidents and deaths to the Administration and the Office of Health Care Quality;

(ii) The Department’s protocol to determine the necessity to investigate a serious reportable incident that takes into account:

1. The severity of the incident;

2. The quality of the licensee’s internal investigation; and

3. The number and frequency of serious reportable incidents reported by the licensee to the Department;

(iii) The specific roles and responsibilities of each governmental unit involved in any follow-up investigations that may occur due to a licensee's report of a serious reportable incident or death;

(iv) Methods of investigations, including on-site investigations;

(v) Time lines for response to serious reportable incidents and deaths and investigation of serious reportable incidents and deaths;

(vi) Time lines for issuing specified reports, including corrective action plans, to the Administration, licensee, Mortality and Quality Review Committee, Medicaid Fraud Unit, individuals receiving services from the licensee involved in the incident and their guardians or family members, and others; and

(vii) Follow-up protocols for the Office of Health Care Quality and the Administration to ensure that corrective action has been implemented by the licensee.

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