

# Connecticut Statewide HCBS Transition Plan Amendment

**Connecticut Statewide Transition Plan for Alignment with the Home and Community Based Services (HCBS) Final Regulation's Settings Requirements - Amendment**

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## **Introduction**

In January 2014, the Centers for Medicare & Medicaid Services (CMS) issued a final rule for home and community-based services (HCBS) that requires states to review and evaluate home and community based (HCB) settings, including residential and non-residential settings. Connecticut developed a Statewide Transition Plan (STP), *Connecticut Statewide Transition Plan for Alignment with the Home and Community Based Services (HCBS) Final Regulation's Settings Requirements*, to determine compliance with the HCB settings requirements. The STP has been updated several times to respond to CMS issues. The STP can be found at:

State Plan- **DSS HCBS Statewide Transition Plan**

Plan Amendment- **DSS Final Regulation's Setting Requirements - Amendment**

In correspondence dated October 21, 2016, CMS granted initial approval of the STP. However, CMS noted additional issues that need to be addressed before final approval can be granted. In October 2018 and March 2019 communications with DSS CMS identified additional issues. This amendment addresses the outstanding issues identified by CMS. Edits to the amendment are noted in red font. It is important to note that this amendment does not replace the STP. Instead it is a supplement to and builds on the STP and demonstrates the evolution of the State's activities to determine compliance with all applicable federal requirements. The amendment should be viewed along with the STP to provide the comprehensive picture of Connecticut compliance activities. The STP (and any amendments) is a living document that will continue to be updated as activities are completed and issues are identified.

As a recap, the following provider settings, per Department, will be assessed as part of the STP. It is important to note that this information is included in the STP by waiver. In some instances, provider settings for Department of Developmental Service (DDS) are the same as those for Department of Social Services (DSS). Therefore, these settings are assessed only once and are included under DSS. Details can be found in the STP on pages 31-34.

### Department of Social Services (DSS)

- Assisted Living
- Adult Family Living
- Adult Day Health
- Residential Care Homes
- Prevocational Services
- Supported Employment
- Group Day

### Department of Developmental Service (DDS)

- Residential Habilitation: Community Living Arrangements
- Residential Habilitation: Community Companion Homes
- Continuous Residential Supports

- Prevocational Services
- Group Supported Employment
- Group Day Support Options

## Site Visits

### ***A. Outcomes for Each Provider Setting and Significant Differences Between Previous Assessment and Current Assessment Activities***

As noted in the STP, prior to implementation of the HCBS final rule, the State undertook systemic reviews of HCB settings. Settings are also assessed as part of an ongoing quality review process which features the Universal Assessment (UA) tool. This tool (whose purpose and scope became operational effective 07/01/18), will now be completed annually for all participants across all programs and waivers and administered by contracted Access Agency Care Managers. The following describes the outcome of each provider setting review and any significant difference between the previous assessment and current assessment activities.

#### **1. DSS**

- a) **Assisted Living Definition:** A special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who require help with activities of daily living and instrumental activities of daily living. Supportive services are available 24 hours a day to meet scheduled needs in a way that promotes maximum dignity and independence for each resident and involves the resident's family, neighbors, and friends. Connecticut has developed alternatives to nursing facility care and assisted living has been a major focus of these efforts. Connecticut offers assisted living services through three programs providing services to persons in managed residential communities: 1) Private Assisted Living Pilot, 2) State Funded Congregate and Housing and Urban Development (HUD) Communities and 3) Assisted Living Demonstration Program.

Connecticut does not license assisted living facilities; instead, it licenses and regulates "assisted living service agencies" (ALSAs) that provide assisted living services in a variety of settings including Managed residential communities (MRCs). The Department of Public Health (DPH) surveys these agencies every other year. Standards for ALSAs were developed to be consistent with the anticipated HCBS regulations. The survey process includes a site visit where approval for licensure requires that all of the settings criteria outlined in the final rule at 42 CFR 441.301(c)(4) are met. All survey results are available to DSS and reviewed by DSS staff. DSS is involved follow-up and remediation activities and any concerns that arise are evaluated to determine if they meet the department's criteria for a critical incident so that appropriate action may be taken.

Managed residential communities (MRCs) are privately owned communities that provide a variety of services including three meals a day, laundry, scheduled transportation, social and recreational activities and chore services for routine domestic tasks that an individual is unable to perform themselves. They must provide an on-site service coordinator. Individuals reside in private, leased units that include a full bath and access to facilities and equipment for the preparation and storage of food. They may not provide health services unless they are also licensed as an ALSA. MRCs are not licensed but do have regulatory requirements and must register with the DOH.

The following is a description of each of the three programs that offer assisted living services.

- **Private Assisted Living Pilot:** The State has determined that the only provider owned and controlled settings where assisted living services are provided to Medicaid recipients are those that participate in the Private Assisted Living Pilot. This Pilot grew from recognition that some elders, after living in a Private Assisted Living Facility for a time, have spent down their assets and thus require help with their living expenses. To assist these waiver participants, the Pilot provides Medicaid waiver funding for their assisted living services provided in MRCs. The Pilot does not pay for room and board; in many instances waiver participants in the Pilot have family members who are willing and able to assist with some of those expenses. This Pilot is based on the premise that it will be cost effective for the State to provide for such waiver participants, for in doing so they will not require admission to a nursing facility. Each program participant has an individually leased apartment. Some communities permit individuals to have roommates by the individual's choice situation in order to keep the room and board affordable to its residents. Currently, as of April 2019, there are 30 individuals who receive assisted living services residing in 16 different MRCs.
- **State Funded Congregate and HUD Housing Complexes:** With status as a MRC, assisted living services are funded through DSS or the State Department of Housing (DOH) and are provided by an assisted living services agency (ALSA). These apartment communities, most often thought of as "senior" housing, are subsidized through State and HUD funding. HUD assists in funding privately owned and/or managed senior housing through mortgage insurance for developers or a federal mortgage interest subsidy. This assistance helps to keep rents affordable to low- or very-low income persons. These projects may also receive ongoing assistance including subsidies to keep rents affordable. Most fall under Title 24 HUD programs such as Section 202, Section 221(d)(3), Section 236, Section 231, Section 232 or Section 8 rental assistance. The assisted living services agency (ALSA) provides the personal care services, core services and supplemental services based on the care needs of qualified waiver participants. Residents have individual, leased apartments with a private kitchen and may receive assistance with some housekeeping, personal care and transportation. Persons residing in HUD or congregate housing who qualify for the waiver have the choice to receive the on-site ALSA services or a full array of services through a fee for service model from outside providers. In this setting a

mixture of individuals use either options. They may at any time decide to change from one service delivery model to another. For example, if any individual residing in a HUD apartment complex has been receiving ALSA services and is dissatisfied for any reason, a care manager will make a home visit and reassess and review service options. They may opt to change to a fee for service program of providers or may opt to continue to receive ALSA services. There are currently 107 individuals receiving Medicaid funded assisted living services in 18 different communities throughout the state.

- Assisted Living Demonstration Project: DSS in collaboration with the Department of Public Health (DPH), DOH and the Connecticut Housing Finance Authority (CHFA) developed the Assisted Living Demonstration Project that provides subsidized assisted living units in both urban and rural settings. This unique project combines financing for the necessary housing component through rental subsidies from DOH and providing services through DSS' Connecticut Home Care Program for Elders. Residents of these apartment complexes developed through the Connecticut Housing Finance Authority LIHTC (26 U.S. Code § 42) program (commonly referred to as tax credit buildings) receive subsidies to help cover their rent and if waiver eligible may receive assisted living services in their own private apartments. Individuals have their own apartments and hold individual leases. In this project the ALSA is affiliated with the building and residents must receive their assisted living services from this provider. The demonstration project consists of 4 settings and currently 91 participants are receiving Medicaid funded assisted living services. The state invested in four free standing projects that were new construction and were built over a 5 year period. The communities are located in the towns of Glastonbury, Hartford, Middletown and Seymour.

**Outcomes** – Community Options (DSS) staff determined that there are 38 total sites where DSS Medicaid waiver participants either reside in an assisted living setting or receive assisted living services in their individual apartments. This number fluctuates as Medicaid members move in or out of a participating provider community. To ensure consistency of approach and evaluation, survey questions were directly taken from a similar survey developed by Mercer in 2015 to assess provider compliance with HCBS requirements. Staff conducted 86 telephone surveys with waiver participants of the 38 Assisted Living settings from July 1 through September 13, 2016. This was considered to be a valid, representative sample. All settings were contacted in advance and requested to provide volunteers to participate in the survey. DSS assured that participants were not in the presence of staff and free to express their responses openly during the telephonic survey process.

This survey consisted of 9 yes/no questions and 3 open-ended questions for additional detail and context. All (100%) Assisted Living settings were surveyed. At some locations only one (1) resident was interviewed because:

- There was only 1 DSS waiver participant in residence.
- Only 1 resident agreed to participate.



- Alzheimer's, dementia or other condition prevented survey participation.
- Contacted family members asked the client not participate.
- No participant response was received despite additional calls and messages.

A number of survey questions were responded to positively with some having almost 90% favorable results across all 3 types of ALSAs. However, just under half (47%) of all participants surveyed considered their residence as located near private homes and retail businesses with access to the surrounding community. DSS' Community Options will focus on this component of community integration through future surveys and site visits, and work directly with Assisted Living sites to address participant feedback.

Overall, 82% of waiver participants interviewed at all three types of ALSA settings responded positively to questions regarding life quality. Although responses to open-ended questions showed a high degree of satisfaction with their respective sites and activities, DSS' Community Options will follow-up in this area. Participant responses also elicited comments confirming that often, individual choice was primary reason for wanting (or not wanting) to join each/all activities available. There were no negative comments from participants regarding activities, quality/availability of food, or treatment received by staff or other waiver participants.

At the conclusion of each survey, the assigned DSS staff person confirmed with ALSA personnel the names of who attended and answered any questions or concerns. Follow-up telephone calls and emails also addressed any outstanding items such as confirming resident responses. DSS considered these surveys validated.

In December of 2018 on-site resident interviews were conducted at the 4 Assisted Living Demonstration Project sites. On-site visits occurred at these site because this is where the majority of waiver participants receive their assisted living services and the other locations where assisted living services are provided are in individually leased apartments, DSS determined that there are currently 91 program participants among the 4 sites and conducted 34 on-site surveys of waiver participants across all 4 sites. Community Options Clinical Nursing and Health Program staff interviewed waiver participants using a standardized survey (including questions addressing provider-owned and controlled settings) in a closed environment free of any paid staff. The state is confident that the survey size is sufficient and determined that these communities remain in full compliance.

Aggregate resident outcome data confirmed that 96% of these communities consistently practice client choice, respect of living space, promote staff interaction and respect resident privacy, and value resident satisfaction.

An additional feature of this 2018 in person survey were three questions designed to better understand the participant's level of overall satisfaction and experience. Similar to the other aspects of the survey, these questions were asked apart from setting staff or employees. The questions and selected responses are provided below. Participants responses were overwhelmingly positive.

1. What do you like best about living here?

*I like being taken care of without worry, adds ease to my life.  
 My medication is distributed daily, unlike the previous home where it was only one a week.  
 This feels like home. I do what I want.  
 I like the special attention due to being handicapped.  
 I'm not herded into activities or things I don't want to do. I am in my home; I am the Boss.*

2. What do you like least about living here?

*Meals  
 Would keep everything the same.  
 Too much Hispanic food.  
 Would like more alternative food choices.*

3. What would you like others to know about this community?

*I feel privileged to live here. There should be more places like this.  
 This is the best place. It's like living with your grandmother watching over you.  
 You're treated as a person here, as a human being, not just a number.  
 [This is] the gem of Seymour Connecticut.*

A total of 34 individuals out of 91 were surveyed during December 2018. The breakdown is as follows:

<b>Demonstration Site Name</b>	<b>Number of Individuals Interviewed</b>	<b>Number of Individuals Receiving AL services</b>	<b>% Interviewed</b>
Retreat	15	56	27%
Herbert T Clark	5	9	56%
Smithfield	9	15	60%
Luther Ridge	5	11	45%

In March and April of 2019, Community Options staff conducted resident surveys in MRCs participating in the Private Assisted Living Pilot. In preparation for the survey, 30 Medicaid Assisted Living Service recipients residing in 16 distinct locations were identified to be interviewed.

Training was held with Community Options staff prior to conducting the surveys. Each training session lasted approximately 25 minutes. During two training opportunities, 10 Community Nurse Coordinators (CNCs) were briefed on:

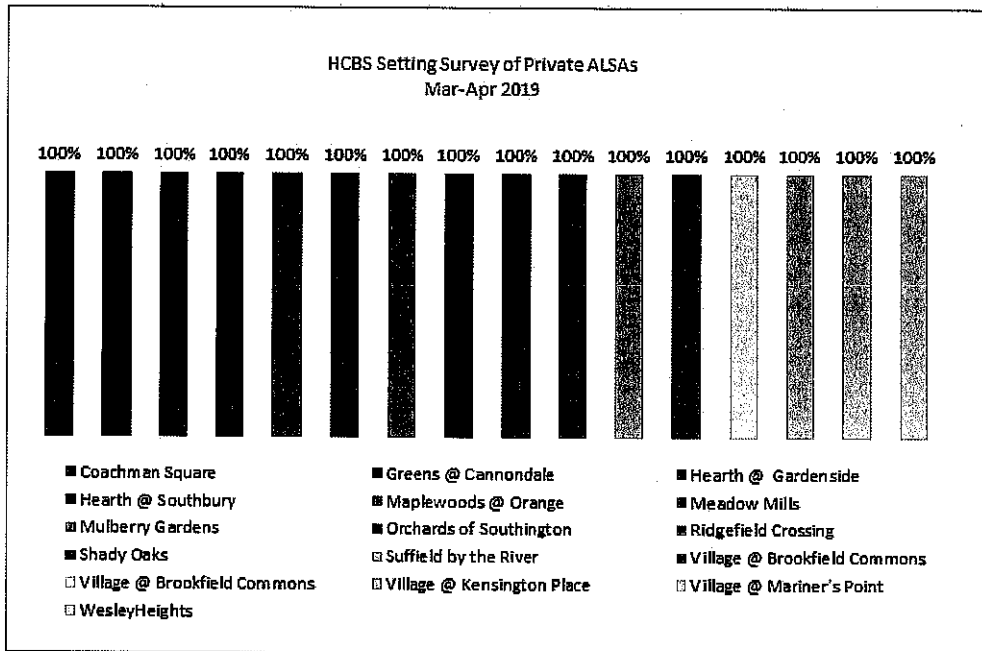
- How to administer a 9-question yes/no survey (these questions have been used consistently in other HCBS settings).
- An additional 3 open-ended questions included to prompt residents to report out on experiences in their own words.
- Use of a second document prompting staff to note observations on criteria useful to determining compliance with HCBS settings criteria.
- The importance of administering the survey apart from ALSA staff or employees and ensuring confidentiality.

CNC teams of 2 completed the first surveys on March 29<sup>th</sup>, 2019; the last was completed on April 18<sup>th</sup>, 2019. Below are both the survey and open ended questions used during the interviews.

- 1) Is the community near private homes and retail businesses?
- 2) Does the community support participant access the surrounding community through walking groups and/or field trips?
- 3) Are your privacy rights protected?
- 4) Are you treated with dignity and respect and free from coercion?
- 5) Are your choices respected and do staff work to meet your individual needs?
- 6) Are a wide range of social, recreational and physical activities available to you?
- 7) Are you able to socialize with peers, including non-HCBS participants and engage in various interactive activities?
- 8) Are you able to choose which activities you wish to participate in?
- 9) Do you have a choice of nutritious meals and snacks that accommodates your daily needs?
- 10) What do you like about the activities here?
- 11) Are there day trips available that take you out of the community?
- 12) What do you like the best about living in this community?

A summary of the outcomes of the surveys are described below:

- 1) 30 residents were identified in 16 ALSA locations.
- 2) 24 completed the survey, (3 were in the hospital on date of survey, 1 had just transferred to a Long Term Care facility, 1 was not able to respond, and 1 was deceased).
- 3) All survey respondents (100%) responded affirmatively to the 9 survey questions.



- 4) Responses to open-ended questions were overwhelmingly positive with residents liking the activities offered, their frequency, and overall satisfaction with residing in that location.
- 5) There were some residents who shared they were not regular participants in location activities. A main driver of non-participation was age:
  - I don't like to go on the day trips anymore, it's just too much for me these days.
  - Not anymore, they are too far for me to walk.
  - I don't go day trips because I can't handle it.
  - At 103 years old, I can't really participate and my vision is poor.
- 6) All teams requested and were provided a walk-through of each location where HCBS settings criteria was noted.
- 7) Exit meetings were held by each team when surveys were completed. Responses and overall impressions were recorded. There were no locations identified where a lack or gap in service, or response to resident needs were reported or observed. (setting location, activities and outings, meal service/food availability, setting-options, etc.)
- 8) Community Options' CNCs did record several recommendations that are under consideration and will be shared with all locations.

**Significant Difference** – Prior to 2015, Assisted Living settings had not previously been surveyed. DSS has now completed three distinct surveys in three years and is confident that these communities fully comply with the settings criteria. To ensure ongoing compliance, DSS will monitor outcomes of annual participant reassessments conducted by contracted Access Agency Care Managers. The reassessment tool incorporates questions that address all the settings criteria including those of provider-owned and controlled settings. As all waiver participants residing in these settings are reassessed annually, a more than representative sample is ensured. Contracted Access Agency Care

Managers have also been trained to assure that privacy and confidentiality is maintained during the process.

- b) **Adult Family Living Definition:** Personal care and supportive services are furnished to waiver participants who reside in a private home by a principal caregiver who lives in the home. Adult Family Living is furnished to adults who receive these services in conjunction with residing in the home. Services also include social and recreational activities and cueing or reminders to take medications. The agency that provides the Adult Family Living service will supervise the supports delivered by the direct care provider. This service may be provided in the home of either the care provider or the participant, whichever is preferable to the participant. The direct provider may be a relative of the client as long as they are not a legally liable relative.

**Outcomes** – Because this setting is fully located in the community and services take place both in the home and include social and recreational activities, DSS concludes that compliance is met.

DSS recognizes that less than 1% of the 1869 participants of this waiver service are in households served by non-family members and are residing in either their own home or the home of their caregiver. DSS determined that the most efficient mechanism to ensure ongoing compliance, was through the monitoring of outcomes of annual reassessments via the new Universal Assessment tool conducted by contracted Access Agency Care Managers. The reassessment tool incorporates all the settings criteria including those of provider-owned and controlled settings. As all waiver participants residing in this setting are reassessed annually, a more than representative sample is ensured. Contracted Access Agency Care Managers are trained to assure that privacy and confidentiality is maintained during the process. Additionally, this service is provided as an agency based service which requires the agency to supervise and monitor the service delivery bi-monthly at a minimum. This supervision ensures that the setting is responsive to the individual's needs, and in combination with the annual reassessment which includes settings questions, ensures adequate monitoring of compliance.

**Significant Difference** – Adult Family Living has not previously been surveyed in the same manner as other settings. The Department has determined that since 99% of the recipients of this service reside either in their own homes or with family that the most efficient way to assess and monitor compliance for this small number of settings was via reassessment using the Universal Assessment Tool.

- c) **Adult Day Health Definition:** The service is provided 4 or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting and shall encompass both health and social services needed to ensure the optimal functioning of the participant. Transportation to and from the center is included in the service definition and in the rate structure. Meals provided as part of these services shall not constitute a full nutritional regimen.

Based on a full systemic review of Adult Day Health (ADH) settings, the Department initially determined that all sites fully comported with the CMS settings requirements. In 2015, DSS issued a survey (based on CMS guidance) to care managers to gain feedback on their direct observations of ADH settings. Upon reviewing this information, DSS determined that 10 sites merited on-site reviews due to their physical location being on the grounds of or near an institutional setting. DSS staff made visits to these 10 sites and of these 10, 5 appeared to merit heightened scrutiny.

A second field survey was completed in 2017-18 finding all 5 settings in compliance with documented outcomes however they were submitted to CMS for heightened scrutiny review due to their physical locations.

**Outcomes** – All Adult Day settings were surveyed. Based on the results of that survey it was determined that 10 sites merited additional visits. We conducted a second on-site review at 10 settings and determined that 5 needed to be submitted for Heightened Scrutiny solely due their physical location. All 5 settings were submitted to CMS for Heightened Scrutiny review due to concerns about their physical location however, all 5 were found to comply with the settings rule and stand as examples of promoting participant choice, community integration, privacy, program activities and staff involvement.

A feature of the 2017-2018 survey was an additional 5-question participant survey, conducted apart from setting staff or employees. To better understand the level of overall satisfaction across these 5 settings, the 5 questions and selected responses are provided below. Participant responses were overwhelmingly positive.

1. What do you like about the activities here?

*I've been coming here for a long time. I like what we do here (laughing) keeps me busy.*

*The ability to socialize with people my own age. I'm an only child and this a lot to me.*

*I enjoy getting out.*

2. Are outside activities available that take you into the community?

*Oh yes, we go on drives and out to lunch.*

*We go bowling, to the ocean. This center make people feel at home. I used to work at a Nursing Home and I know the difference.*

*We like to go out and make the most of it. I really like that we can go because we want to, not being pushed to.*

*Yes. We go different places. I don't know of any this month, but I know I'll want to go.*

3. What do you like best about this service?

*I like everything. The place is clean. I enjoy the company of others and the trips.*

*Everyone is sociable here. We mix very well and do a lot together.  
I have to say the people; they are all nice-my friends.*

4. What do you like the least?

*Sometimes I wish there was a week-end program here.  
Nothing really. I mean, you can't please everybody.  
Winter.*

5. Is your privacy respected?

*Yes, I believe it is. I've never wondered it wasn't.  
Oh yes, absolutely.  
Oh Lord yes. No problems*

**Significant Difference** – Based on the initial Mercer survey that was used to determine that these settings were in compliance, DSS followed up. On-site surveys were conducted for 10 ADC settings. These settings were selected based on their proximity to nursing facilities that also provide in-patient care. DSS believed that through the process of determining Heightened Scrutiny, additional, open-ended questions were needed. DSS confirmed that these Adult Day Programs comply with the settings requirements however 5 were submitted to CMS for heightened scrutiny due to concerns about their physical locations.

- d) **Residential Care Homes (RCHs) Definition:** Formerly known as “homes for the aged,” RCHs are private entities, often owned by individual citizens and are licensed by the Department of Public Health. The homes provide a single or double furnished room and shared common areas such as a lounge or recreation area. They provide waiver participants with three meals a day in a common dining area and some limited personal services as well as some hands-on personal care, but not extensive medical services like a nursing home. They serve not only the elderly, but can also house people with physical or mental disabilities.

**Outcomes** – The state recognizes the need for statutory changes to bring the statutes in line with the settings requirements. A cross agency workgroup that includes providers as well as the licensing entity continues to meet to draft new statutory language around the “discharge process.” The state also recognizes that most Residential Care Homes do not have leases or other types of similar arrangements with their waiver participants. The interagency workgroup will develop a lease-like template for the providers to utilize if they wish to be qualified as a setting for HCBS. This includes a reevaluation of the rate structure that currently is paid by the participants and state supplement. The goal would be to separate out the service component from the room and board for billing and claiming purposes (note that payment for room and board is prohibited for HCBS). Specific program regulations as modeled by the regulations for the brain injury program would specify the requirements the providers would need to meet in order to comply with settings requirements and expected to be rolled out and in place by 12/31/2020.

Community Options (DSS) conducted in-person site surveys in 2016. Clinical Nursing staff completed 43 surveys all using a 32 question survey tool. The RCHs reported an overall satisfaction (compliance) rate of 87.95%. There were several notable areas that fell below this percentage:

42.55% stated they could lock both bedroom and bathroom doors.

42.55% stated they are able to control meal time.

68.89% stated they choose their own schedule to meet their wishes.

Throughout 2017-2018, Community Options (DSS) increased outreach and communication with RCHs on these and other issues. Activities included DSS presentations to the statewide association of Residential Care Homes regarding the HCBs regulations, as well as direct contact with individual homes to discuss pathways to compliance. Community Options (DSS) staff again conducted in-person site surveys in the last quarter of 2018. There were 43 RCHs surveyed and all were asked the same 32 question survey used in 2016. The RCHs reported an overall satisfaction (compliance) rate exceeding 97.62%. There were three notable areas that fell below this percentage due to waiver participants reporting limitations in the following areas:

92.86% - Participants who currently have a lease or similar agreement.

95.24% - Participants who can lock the bathroom and bedroom doors.

95.24% - Residences where snacks are accessible and available.

Upon analysis following the 2016 survey, it was determined that virtually all RCHs were more than willing to hold meals for a later time and/or provide viable meal options. While most RCHs do not have kitchens that could be used by waiver participants, most have communal kitchenettes, refrigerators and microwaves available 24-hours a day in addition to those settings that feature in room mini-fridges and microwaves. Lastly, while some RCHs may not have actual personal computers available for resident use (although some do), waiver participants are welcome to use or otherwise synch-up their device with on-site Wi-Fi or allow waiver participants to install cable/Wi-Fi accounts for their own use.

**Significant Difference** – Once statutory and regulatory changes are completed Community Options Clinical staff will visit each residential care home providing services to current waiver participants. Each will be reevaluated using the same tool previously used, thereby ensuring a consistent approach and will include interviews of both providers and waiver participants. The Department has convened a workgroup of six Residential Care Home owners comprised of a mix of for-profit and non-for-profit homes. The goals for the group are to develop best practices of compliance for each setting requirements within the same timeframe for RCH regulation changes. As evidenced above the RCH's have made great strides in improving compliance since 2016. DSS is committed to continued work with them to address issues preventing compliance, however we are concerned that even with individualized guidance and support there will be some settings that are not willing to make all of the necessary



changes to comply with the settings requirements. Waiver participants in these homes will be provided information regarding their options including moving to a complaint setting and keeping their services or remaining in their current setting without their current HCBS services. This seems like an untenable choice and we do not anticipate that persons will be willing to leave their homes in order to retain services.

- e) **ABI Provider Owned and Controlled Homes Definition:** Provides twenty-four hour supports to adults living in private individual homes located across the state. Waiver participants living in these homes need significant support in identified areas as documented in personalized Plans of Care. Waiver participants benefit from rehabilitative, social and recreational choices promoting increased levels of independence and personal success. Every home offers a safe, comfortable home environment with its own unique décor. Each home may have between 2 and 4 waiver participants. Most have private bedrooms. Highly trained support staff are available on all shifts to assist waiver participants in all activities of daily living. Every home has an activity schedule developed with individual choices and preferences in mind. Homes provide individualized program plans, leisure and community integration opportunities that are meaningful to the waiver participants. In addition, persons residing in these private homes have the option of receiving the full range of services available through the two waiver programs.

**Outcomes** – Community Options (DSS) staff completed on-site surveys of 23 settings owned and operated by 8 providers in 2015 and 2016. In addition to asking standardized questions asked of all participating providers of HCB services, focus was placed on elements of community access and integration. Staff also interviewed waiver participants as part of this assessment process. Outcomes confirmed 2014 survey results indicating that overall, homes were being operated in a manner consistent with HCB setting requirements.

**Significant Difference** – Overall, the 2014 survey reported that these homes were being operated in a manner consistent with the HCB setting requirements despite variances in provider and participant responses. There were however, 4 specific areas while not rising to the level of provider non-compliance were enough of a concern to merit follow-up and possible remediation. These areas are:

- Availability/opportunity of paid work in the community,
- Work in an integrated setting,
- Staff access to participant bedrooms (keys), and
- Accessible public transportation.

For example, in regards to work and work settings, Community Options (DSS) staff surveys found that high participant desire to work and be part of an integrated work setting was at odds with local economies where job opportunities continue to be scarce in many areas and employer commitment to an integrated setting was insufficient for placement. In respect to staff access and participant privacy, on-site survey interviews with providers noted that (in one observation) better documentation of why staff may

need access to a participant's bedroom as a matter of health and safety might explain a resident's concern regarding his/her privacy. Community Options (DSS) staff intend to follow-up in this areas. And lastly, it was not always clear if alternative modes of public transportation such as municipal shuttles or even options such as Uber/Lyft are being fully examined by providers as well as to what extent waiver participants will/can utilize these services. This is another area for follow-up in the year(s) ahead.

Community Options (DSS) staff determined that all of the providers met basic criteria of the CMS settings requirements based on responses to survey questions and through witnessing first-hand the interactions of setting staff and waiver participants (with the notable exception of having a rental/lease agreement that includes language on tenant rights and eviction protections which is being addressed as noted above on page 5). Community Options (DSS) staff will work with providers in 2018 and beyond (Milestones attached) to clarify and strengthen for setting staff and waiver participants, 3 areas to better ensure and enhance service delivery. These are:

- Are waiver participants able to come and go from the home when they want to?
- Can waiver participants lock the bathroom/bedroom door(s)?
- Are waiver participants aware that surveillance cameras are present at the home, know their location and agree to their use?

Each of these area will be components of upcoming remediation activities for this and other HCBS settings and services.

None of the ABI provider settings meet the criteria for Heightened Scrutiny.

- f) **Prevocational Services Definition:** Provides learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process. Services are delivered in a participant's home or in a fully integrated work setting based on the participant's needs and preferences. Services are not delivered in facility based, congregate or sheltered work settings where waiver participants are supervised for the primary purpose of producing goods or performing services.

**Outcomes** – According to a 2014 survey conducted by Mercer, prevocational providers were operating services in a manner consistent with the HCB settings requirements despite variances in provider and participant responses. Community Options (DSS) staff completed on-site reviews of 25 providers in 2015/2016 and conducted selected follow-up visits in 2017. The same overall conclusion was reached; that providers are operating in accordance with HCB setting requirements.

There are no providers or sites meeting Heightened Scrutiny criteria.

**Significant Difference** – The previous Mercer survey (noted above) focused on feedback from DSS Social Workers and indicated that the prevocational settings were in compliance with HCB settings requirements. Through follow-up site surveys, Community Options (DSS) confirmed these findings, as well as identifying three specific areas for enhanced focus and follow-up.

- Integrated settings for instruction and learning,
- Participation in meaningful community events or non-work activities, and
- Familiarity with and use of public or other transportation options.

These areas are targeted as components of upcoming remediation activities for this and other HCBS settings and services.

- g) **Supported Employment Definition:** The ongoing supports provided to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by waiver participants without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

**Outcomes** – Community Options (DSS) staff completed on-site surveys of 15 providers in 2016. In addition to provider staff, direct feedback from Waiver participants was encouraged and included whenever possible.

Providers were asked 17 questions to determine how prepared participants were for employment, levels of program support, employment integration with the larger community and overall contribution to the participant's employment goals and future employability. Outcome data found 94% of all provider responses indicated full compliance with settings requirements.

Participant Feedback was received via a short (5-question) survey designed to avoid yes/no responses and elicit a broader measure of satisfaction with the program. Of the 19 participants across all providers who responded, Community Options was able to establish that:

- 19 participants responded very positively to the program and are satisfied with the opportunity to prepare for work and integrate into the community.
- 19 participants liked other community activities associated with the program.
- 11 participants expressed feelings of increased self-worth and value due to work and working with others.
- 6 participants would like more hours and higher pay.

Among the many responses received, the two below perhaps best encapsulate the overall tone of the participants:

- *My coach helps me. My co-workers say they miss me when I miss work. My coach says that the work environment is better because I'm nice to the co-workers. They like my personality. My coach taught me to ignore employees that are frustrated or upset, and not to let them upset me. My coach has changed my life tremendously.*
- *There should be more programs like this. I know more people with head problems who have been lost in the system. They should get the word out more about this program.*

**Significant Difference** – Community Options (DSS) was able to confirm findings of the 2014 Mercer survey and overall compliance with HCB settings requirements. In the most recent 2015-2016 site surveys, 14 providers were found fully compliant with only a single provider found noncompliant in how services are delivered, but can be compliant when services are delivered on a one-to-one basis. Each of these areas are targeted as components for upcoming remediation activities for this and other HCBS settings and services.

- h) **ABI Group Day Definition:** Provides services and supports that lead to the acquisition, improvement and/or retention of skills and abilities to prepare an individual for health and wellness, self-care or for work and/or community participation, or support meaningful socialization, leisure activities. This service is provided by a qualified provider in community locations. Meals may be provided as part of the group day service but shall not constitute a full nutritional regimen (3 meals per day). The service is not provided in a facility setting.

**Outcomes** – DSS Community Options initiated an ABI Group Day workgroup in 2017 because as this service had not been developed and offered by providers, the desired outcomes was program designs fully compliant with the settings requirements. Meetings were held throughout 2017 with several providers who were certified to provide the service. So, DSS has taken the opportunity to engage directly with the providers to consider and design activities. DSS worked with providers on modifying the service definition to include the following:

- Community socialization- day trips to local parks, beaches, bowling, restaurants, etc.
- Lifestyle Management- 'Dress for Success', punctuality and promptness, handling stress and disappointment in daily chores.
- Free Time Maximization – utilizing 'down-time' to best prepare for upcoming appointments, chores, meetings, etc.
- Music appreciation- practicing/learning instruments and can include recording original songs.

- Information Technology- increasing comfort and performance with a range of consumer products (PC, laptop, tablet, cell phone) with word processing drills/exercises.

Thus far, 3 providers are offering Group Day services with community integration opportunities as a primary focus assuring compliance with the CMS settings requirements. DSS continually engages with the provider network to further develop and ensure compliance.

**Significant Difference** – DSS will be developing and making available data from participating service providers and programs as it becomes available. This data will constitute a baseline for ongoing activities, monitoring and tracking.

## 2. DDS

### a) Residential Habilitation: Community Living Arrangements

**Outcomes** –The Quality Service Review (QSR) tool is a cornerstone of the DDS Quality System and is used extensively to measure our Waiver performance for both ongoing QA initiatives, as well all HCBS Waiver evidence reporting. The QSR is a robust tool with over 200 potential indicators to be rated. The QSR was cross-walked to the CMS Probing Questions for both Day and Residential settings, and the appropriate indicators were used to develop analytical reports to assist DDS in assessing compliance in the areas of Choice of Setting, Community Access, Choice in Living and Setting Space, Staff Interaction and Privacy, and Choice of Providers and Services. Overall there were 24 Indicators captured that were cross-walked to the settings requirements including 9 Individual (Consumer) Interview, 6 Observation, 4 Documentation, 3 Support Person Interview, and 2 Safety Checklist. See Appendix 2 and 3 for the crosswalk of the settings rule requirements to the QSR tool as well as the full QSR inventory of questions for a CLA/Group Homes. Between 10/1/2014 and 9/30/2017 there were 1,346 on-site Quality QSR reviews conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at 360 Community Living Arrangement Settings (CLAs). 326 of the 360 reviewed settings were 100% compliant. DDS continues to engage with providers identified as noncompliant via the quality review and oversight process including the use of Corrective Action Plans in the QSR system where necessary. Overall performance across all 24 rated indicators for CLAs was 93%, indicating very strong comporment with the settings requirements across all CLAs, with a large number requiring only minor modifications to fully comply. DDS reviewed the 24 rated indicators and the primary observation was that there were a small number of instances of non-compliance in two areas. DDS has identified two specific areas related to documentation; the first is related to documentation of the individual participation in their Individual Plan and the second is documentation of programmatic review for required program modifications as approved by the Programmatic Review Committee (PRC).

**Significant Difference** - NA

**b) Residential Habilitation: Community Companion Homes (CCH)**

**Outcomes** – Between 10/1/2014 and 9/30/2017 there were 121 on-site Quality QSR reviews conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at 63 Community Companion Home Settings. 63 of the 63 reviewed settings were 100% compliant. DDS continues to engage with providers identified as noncompliant via the quality review and oversight process including the use of Corrective Action Plans in the QSR system where necessary. Although performance was very high in this setting type, DDS has recognized the need to increase the frequency and number of assessments in these settings to gain a comprehensive picture of overall quality. The settings are typically a licensed family home where the individual(s) reside as a member of the family/community, often referred to as Host Homes or Mentor Homes in other states, they have traditionally not received a large number of site visits by QSI staff, instead relying on Provider technical assistance staff and Regional CCH support staff, and clinical staff to provide oversight and identify any concerns in relation to individual rights and choice. DDS reviewed the 24 rated indicators and the primary observation was a small number of non-compliance in two areas. DDS has identified two specific areas related to documentation; the first is related to documentation of the individual participation in their Individual Plan and the second is documentation of programmatic review for required program modifications as approved by the Programmatic Review Committee (PRC).

**Significant Difference - NA**

**c) Continuous Residential Supports**

**Outcomes** – Between 10/1/2014 and 9/30/2017 there were 7,429 on-site Quality QSR reviews conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at 275 Community Residential Supports (CRS) settings. 96 of the 275 reviewed settings were 100% compliant. DDS continues to engage with providers identified as noncompliant via the quality review and oversight process including the use of Corrective Action Plans in the QSR system where necessary. Overall Performance across all 24 rated indicators for CRSs was 94%, indicating very strong compliance with the settings requirements across all CRSs, with a large number requiring only minor modifications to fully comply. DDS reviewed the 24 rated indicators and the primary observation was a small number of non-compliance in two areas. DDS has identified two specific areas related to documentation; the first is related to documentation of the individual participation in their Individual Plan and the second is documentation of programmatic review for required program modifications as approved by the Programmatic Review Committee (PRC).

**Significant Difference - NA**

**d) Prevocational Services**

**Outcomes** – Between 10/1/2014 and 9/30/2017 there were 249 on-site Quality QSR reviews conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at 20 Prevocational Day (PVD) Settings. 19 of the 20 reviewed settings were 100% compliant. DDS continues to engage with providers identified as noncompliant via the quality review and oversight process including the use of Corrective Action Plans in the QSR system where necessary. Overall Performance across all 24 rated indicators for PVD was 90%, indicating that although there is very strong comportment with the settings requirements across almost all PVD settings, one setting with poor performance was able to skew the data due to the small size of the provider pool. DDS is working with the provider to improve comportment to 100%. DDS reviewed the 24 rated indicators and the primary observation was a small number of non-compliance in two areas. DDS has identified two specific areas related to documentation; the first is related to documentation of the individual participation in their Individual Plan and the second is documentation of programmatic review for required program modifications as approved by the Programmatic Review Committee (PRC).

**Significant Difference** – NA

e) **Group Supported Employment**

**Outcomes** – Between 10/1/2014 and 9/30/2017 there were 2,571 on-site Quality QSR reviews conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at 106 Group Supported Employment (GSE) Settings. 49 of the 106 reviewed settings were 100% compliant. DDS continues to engage with providers identified as noncompliant via the quality review and oversight process including the use of Corrective Action Plans in the QSR system where necessary. Overall Performance across all 24 rated indicators for GSE was 91%, indicating very strong comportment with the settings requirements across all GSEs, with a large number requiring minor modifications to fully comply. DDS reviewed the 24 rated indicators and the primary observation was a small number of non-compliance in two areas. DDS has identified two specific areas related to documentation; the first is related to documentation of the individual participation in their Individual Plan and the second is documentation of programmatic review for required program modifications as approved by the Programmatic Review Committee (PRC).

**Significant Difference** – NA

f) **Group Day Support Options**

**Outcomes** – Between 10/1/2014 and 9/30/2017 there were 3,504 on-site Quality QSR reviews conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at 215 Day Support Options (DSO) Settings. 49 of the 215 reviewed settings were 100% compliant. DDS continues to engage with providers identified as noncompliant via the quality review and oversight process including the use of Corrective Action Plans in the QSR system where necessary. Overall Performance across all 24 rated indicators for DSO was 92%, indicating very strong comportment with the settings

requirements across all DSOs, with a large number requiring minor modifications to fully comply. DDS reviewed the 24 rated indicators and the primary observation was a small number of non-compliance in two areas. DDS has identified two specific areas related to documentation; the first is related to documentation of the individual participation in their Individual Plan and the second is documentation of programmatic review for required program modifications as approved by the Programmatic Review Committee (PRC).

**Significant Difference – NA**

**B. *Residential Care Homes – State process for addressing areas where there are Discrepancies between Initial Provider Survey Responses and the State’s Original Analysis Conducted***

The state recognizes the need for statutory changes to bring RCHs in line with the settings requirements. A cross agency workgroup that includes providers as well as the licensing entity continues to meet with intent to draft new statutory language around the “discharge process.” The state also recognizes that most Residential Care Homes do not have residential leases or other similar arrangements with their waiver participants. The interagency workgroup will develop a lease like template for the providers to utilize if they wish to be qualified as a setting for home and community based services. This includes a reevaluation of the rate structure that currently is paid by the participants and state supplement. The goal would be to separate out the service component from the room and board for billing and claiming purposes. Due to number of stakeholders and various state agency mandates, this layered effort (with wide implications for all parties involved) involved, anticipates a viable template by July 2019. This includes a reevaluation of the rate structure that currently is paid by the participants and state supplement. The goal would be to separate out the service component from the room and board component for billing and claiming purposes. Specific program regulations as modeled after those of the brain injury program (ABI) would specify the requirements providers would need to meet to comply with settings requirements.

**C. *Description of site visits for each setting that will receive or has received a review***

**1. DSS**

- a) **Assisted Living** – DSS Community Options staff conducted a telephone survey of 38 Assisted Living settings from July-September 2016. Of that number, 18 are State Congregate and HUD settings, 4 are Demonstration Pilot settings and 16 are Private Assisted Living settings. All 38 locations were advised by email in June 2016 of the survey and requested 2 DSS home-based waiver participants to respond to 9 questions eliciting feedback on community integration, privacy, choices, and activities. An additional 3 follow-up questions were offered to these same participants to elicit a more personal response to their overall satisfaction in that setting. Hard-copy response data was submitted and entered onto a survey spreadsheet and processed to determine compliance and areas for follow-up remediation.



After further review DSS determined in order to ensure compliance additional in-person surveys would need to be conducted at the Assisted Living Demonstration sites as well as the MRCs participating in the Private Assisted Living Pilot.

In December of 2018 on-site resident interviews were conducted at the 4 Assisted Living Demonstration Project sites. On-site visits occurred at these sites because this is where the majority of waiver participants receive their assisted living services. DSS determined that there are currently 91 program participants among the 4 sites and conducted 34 on-site surveys across all 4 sites. Community Options Clinical Nursing and Health Program staff interviewed waiver participants using a standardized survey (including questions addressing provider-owned and controlled settings) in a closed environment free of any paid staff. The state is confident that the survey size is sufficient and determined that these communities remain in full compliance. Details on the outcomes of these interviews can be found in Section A of this amendment.

In March and April of 2019 DSS completed additional on-site surveys for individuals receiving their assisted living services via the Private Assisted Living Pilot. Community Options clinical staff surveyed 24 individuals across 16 different sites using a tool that included both closed and open ended questions. Surveys were conducted at all sites participating in the pilot. The survey questions along with the survey results can be found in Section A of this amendment.

As part of DSS. Community Options Unit quality assurance/quality improvement activities, staff conduct site visits to several selected sites where assisted living services are provided annually. Our goal is to increase the number of on-site visits to one per quarter each year. During the site visits, clinical staff review administrative records but also engage with clients directly and monitor for on-going compliance with the HCBS setting regulations.

- b) **Adult Family Living (AFL)** – There are currently 1768 waiver participants receiving this service. Of those, 1752 are living in their own home or the home of a family member (whom they have chosen as their caregiver). There are 16 waiver participants receiving services by someone other than a relative. They reside in either their own home or the home of the caregiver. All AFL is provided through an agency based model in which the agency is the provider overseeing the care provided by the direct caregiver. In all cases, initial and ongoing annual assessments are completed by contracted, independent Access Agency Care Managers. The assessment instrument specifically asks for participant feedback addressing the setting in which the client resides, thereby assuring ongoing monitoring to determine compliance with the setting requirements. Care managers have been instructed to notify department's clinical staff of any responses that might suggest some challenges in complying with the settings requirements. In the 10 months that the assessment tool has been utilized, no concerns have been brought to the department's attention. Please see Appendix 4 for relevant assessment questions. Contracted Access Agency Care Managers are trained to assure that privacy and confidentiality is maintained during the process.

- c) **Adult Day Health** – DSS staff will monitor outcomes of annual reassessments conducted by contracted Access Agency Care Managers. The reassessment tool incorporates all the settings criteria including those of provider-owned and controlled settings. As all waiver participants residing in this setting are reassessed annually, a more than representative sample is ensured. Contracted Access Agency Care Managers are trained to assure that privacy and confidentiality is maintained during the process.
- d) **Residential Care Homes** – DSS Community Options staff conducted field surveys of 43 Residential Care Homes in 2015/2016. Introductory letters were sent out ahead of the field survey teams that requested participation from both setting staff and waiver participants. Two-person survey teams composed of Community Nurse Coordinators and Licensed Certified Clinical Social Workers were utilized to complete this requirement. In addition to gathering feedback from RCH staff, there was also built-in opportunity for waiver participants to be interviewed for valuable person-centered feedback. The survey was composed of 30 questions covering resident choice, community access, living space, staff interaction and privacy, and satisfaction with services. Hard-copy response data was submitted and entered onto a survey spreadsheet and processed to determine compliance and areas for follow-up remediation.
- e) **Prevocational Services** – DSS Community Options' staff completed on-site surveys of 25 existing providers in 2015/2016 and conducted selected follow-up visits in 2017. DSS staff conducted site visits unannounced. Site survey teams were conducted by a cross-section of DSS Community Options staff to include Social Workers, Licensed Clinical Social Workers, and Community Options Managers. Participants input and feedback was sought at every setting and documented whenever volunteers were available. There were no providers or settings requiring Heightened Scrutiny evaluation.
- f) **Supported Employment** – DSS Community Options' staff completed on-site surveys of 15 providers in 2016. Each provider was contacted at least a week in advance and asked (if possible) to have a program participant available to answer 5 additional questions. Two-person survey teams were composed of the following staff; Social Workers, Licensed Clinical Social Workers and Managers, all from Community Options. Participants input and feedback was sought at every setting and documented whenever volunteers were available. There were no providers or sites requiring Heightened Scrutiny evaluation.
- g) **Group Day** - Community Options (DSS) staff plans to conduct site surveys of active ABI Group Day activities throughout 2019. The format, content and follow-up will be similar to those conducted for other HCBS programs/waivers; field surveys comprised of multiple questions directly related to settings requirements and with participant feedback whenever possible.

## 2. DDS

- a) **Residential Habilitation: Community Living Arrangements** – In 2014 the DDS Settings Rule Transition team, comprised of state agency staff and provider staff

conducted a Settings Rule Provider Self-Assessment survey of all CLA providers. Following feedback and technical assistance from CMS, DDS committed to utilizing the QSR on-site tool to measure performance. The QSR was cross-walked to the CMS Probing Questions for both Day and Residential settings, and the appropriate indicators were used to develop analytical reports to assist DDS in assessing compliance in the areas of Choice of Setting, Community Access, Choice in Living and Setting Space, Staff Interaction and Privacy, and Choice of Providers and Services. Overall there were 24 Indicators captured that were cross-walked to the settings requirements including 2 Observation, 9 Individual (Consumer) Interview, 4 Observation, 4 Documentation, 3 Support Person Interview, and 2 Safety Checklist. The on-site QSR reviews are conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at all settings where LTSS Waiver services are provided. QSI staff are professional staff who have primary responsibility for the required quality assurance and improvement activities of facilities, programs and agencies for compliance with state and federal laws, regulations, policies, standards for licensure and participation in Medicaid Waiver programs for persons with developmental disabilities. Case Management staff are professional staff accountable for independently performing a full range of tasks in providing case management services for persons with intellectual disability and their families to ensure the delivery of appropriate medical, educational/vocational, social, residential and other services and conformance with Federal Medicaid Waiver Reimbursement Program. In 2014 the DDS Settings Rule Transition team, comprised of state agency staff and provider staff conducted a Settings Rule Provider Self-Assessment survey of all CCH providers. Following feedback and technical assistance from CMS, DDS committed to utilizing the QSR on-site tool to measure performance. The QSR was cross-walked to the CMS Probing Questions for both Day and Residential settings, and the appropriate indicators were used to develop analytical reports to assist DDS in assessing compliance in the areas of Choice of Setting, Community Access, Choice in Living and Setting Space, Staff Interaction and Privacy, and Choice of Providers and Services. Overall there were 24 Indicators captured that were cross-walked to the settings requirements including 2 Observation, 9 Individual (Consumer) Interview, 4 Observation, 4 Documentation, 3 Support Person Interview, and 2 Safety Checklist. The on-site QSR reviews are conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at all settings where LTSS Waiver services are provided. QSI staff are professional staff who have primary responsibility for the required quality assurance and improvement activities of facilities, programs and agencies for compliance with state and federal laws, regulations, policies, standards for licensure and participation in Medicaid Waiver programs for persons with developmental disabilities. Case Management staff are professional staff accountable for independently performing a full range of tasks in providing case management services for persons with intellectual disability and their families to ensure the delivery of appropriate medical, educational/vocational, social, residential and other services and conformance with Federal Medicaid Waiver Reimbursement Program regulations. By choosing to utilize the primary tool used to monitor and track performance for our Waiver Assurances, DDS has ensured that the state has an ongoing method to assess comporment into the foreseeable future. DDS has

identified the need to ensure each setting is evaluated on an ongoing basis at regular intervals, and believes this is the most effective and efficient method to do so.

- b) **Residential Habilitation: Community Companion Homes** – In 2014 the DDS Settings Rule Transition team, comprised of state agency staff and provider staff conducted a Settings Rule Provider Self-Assessment survey of all CCH providers. Following feedback and technical assistance from CMS, DDS committed to utilizing the QSR on-site tool to measure performance. The QSR was cross-walked to the CMS Probing Questions for both Day and Residential settings, and the appropriate indicators were used to develop analytical reports to assist DDS in assessing compliance in the areas of Choice of Setting, Community Access, Choice in Living and Setting Space, Staff Interaction and Privacy, and Choice of Providers and Services. Overall there were 24 Indicators captured that were cross-walked to the settings requirements including 2 Observation, 9 Individual (Consumer) Interview, 4 Observation, 4 Documentation, 3 Support Person Interview, and 2 Safety Checklist. The on-site QSR reviews are conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at all settings where LTSS Waiver services are provided. QSI staff are professional staff who have primary responsibility for the required quality assurance and improvement activities of facilities, programs and agencies for compliance with state and federal laws, regulations, policies, standards for licensure and participation in Medicaid Waiver programs for persons with developmental disabilities. Case Management staff are professional staff accountable for independently performing a full range of tasks in providing case management services for persons with intellectual disability and their families to ensure the delivery of appropriate medical, educational/vocational, social, residential and other services and conformance with Federal Medicaid Waiver Reimbursement Program regulations. By choosing to utilize the primary tool used to monitor and track performance for our Waiver Assurances, DDS has ensured that the state has an ongoing method to assess comporment into the foreseeable future. DDS has identified the need to ensure each setting is evaluated on an ongoing basis at regular intervals, and believes this is the most effective and efficient method to do so.
- c) **Continuous Residential Supports** – In 2014 the DDS Settings Rule Transition team, comprised of state agency staff and provider staff conducted a Settings Rule Provider Self-Assessment survey of all CRS providers. Following feedback and technical assistance from CMS, DDS committed to utilizing the QSR on-site tool to measure performance. The QSR was cross-walked to the CMS Probing Questions for both Day and Residential settings, and the appropriate indicators were used to develop analytical reports to assist DDS in assessing compliance in the areas of Choice of Setting, Community Access, Choice in Living and Setting Space, Staff Interaction and Privacy, and Choice of Providers and Services. Overall there were 24 Indicators captured that were cross-walked to the settings requirements including 2 Observation, 9 Individual (Consumer) Interview, 4 Observation, 4 Documentation, 3 Support Person Interview, and 2 Safety Checklist. The on-site QSR reviews are conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at all settings where LTSS Waiver services are provided. QSI staff are professional staff who have primary responsibility for

the required quality assurance and improvement activities of facilities, programs and agencies for compliance with state and federal laws, regulations, policies, standards for licensure and participation in Medicaid Waiver programs for persons with developmental disabilities. Case Management staff are professional staff accountable for independently performing a full range of tasks in providing case management services for persons with intellectual disability and their families to ensure the delivery of appropriate medical, educational/vocational, social, residential and other services and conformance with Federal Medicaid Waiver Reimbursement Program regulations. By choosing to utilize the primary tool used to monitor and track performance for our Waiver Assurances, DDS has ensured that the state has an ongoing method to assess comporment into the foreseeable future. DDS has identified the need to ensure each setting is evaluated on an ongoing basis at regular intervals, and believes this is the most effective and efficient method to do so.

- d) **Prevocational Services** – In 2014 the DDS Settings Rule Transition team, comprised of state agency staff and provider staff conducted a Settings Rule Provider Self-Assessment survey of all Prevocational providers. Following feedback and technical assistance from CMS, DDS committed to utilizing the QSR on-site tool to measure performance. The QSR was cross-walked to the CMS Probing Questions for both Day and Residential settings, and the appropriate indicators were used to develop analytical reports to assist DDS in assessing compliance in the areas of Choice of Setting, Community Access, Choice in Living and Setting Space, Staff Interaction and Privacy, and Choice of Providers and Services. Overall there were 24 Indicators captured that were cross-walked to the settings requirements including 2 Observation, 9 Individual (Consumer) Interview, 4 Observation, 4 Documentation, 3 Support Person Interview, and 2 Safety Checklist. The on-site QSR reviews are conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at all settings where LTSS Waiver services are provided. QSI staff are professional staff who have primary responsibility for the required quality assurance and improvement activities of facilities, programs and agencies for compliance with state and federal laws, regulations, policies, standards for licensure and participation in Medicaid Waiver programs for persons with developmental disabilities. Case Management staff are professional staff accountable for independently performing a full range of tasks in providing case management services for persons with intellectual disability and their families to ensure the delivery of appropriate medical, educational/vocational, social, residential and other services and conformance with Federal Medicaid Waiver Reimbursement Program regulations. By choosing to utilize the primary tool used to monitor and track performance for our Waiver Assurances, DDS has ensured that the state has an ongoing method to assess comporment into the foreseeable future. DDS has identified the need to ensure each setting is evaluated on an ongoing basis at regular intervals, and believes this is the most effective and efficient method to do so.
- e) **Group Supported Employment** – In 2014 the DDS Settings Rule Transition team, comprised of state agency staff and provider staff conducted a Settings Rule Provider Self-Assessment survey of all GSE providers. Following feedback and technical

assistance from CMS, DDS committed to utilizing the QSR on-site tool to measure performance. The QSR was cross-walked to the CMS Probing Questions for both Day and Residential settings, and the appropriate indicators were used to develop analytical reports to assist DDS in assessing compliance in the areas of Choice of Setting, Community Access, Choice in Living and Setting Space, Staff Interaction and Privacy, and Choice of Providers and Services. Overall there were 24 Indicators captured that were cross-walked to the settings requirements including 2 Observation, 9 Individual (Consumer) Interview, 4 Observation, 4 Documentation, 3 Support Person Interview, and 2 Safety Checklist. The on-site QSR reviews are conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at all settings where LTSS Waiver services are provided. QSI staff are professional staff who have primary responsibility for the required quality assurance and improvement activities of facilities, programs and agencies for compliance with state and federal laws, regulations, policies, standards for licensure and participation in Medicaid Waiver programs for persons with developmental disabilities. Case Management staff are professional staff accountable for independently performing a full range of tasks in providing case management services for persons with intellectual disability and their families to ensure the delivery of appropriate medical, educational/vocational, social, residential and other services and conformance with Federal Medicaid Waiver Reimbursement Program regulations. By choosing to utilize the primary tool used to monitor and track performance for our Waiver Assurances, DDS has ensured that the state has an ongoing method to assess compartment into the foreseeable future. DDS has identified the need to ensure each setting is evaluated on an ongoing basis at regular intervals, and believes this is the most effective and efficient method to do so.

- f) **Group Day Support Options** – In 2014 the DDS Settings Rule Transition team, comprised of state agency staff and provider staff conducted a Settings Rule Provider Self-Assessment survey of all DSO providers. Following feedback and technical assistance from CMS, DDS committed to utilizing the QSR on-site tool to measure performance. The QSR was cross-walked to the CMS Probing Questions for both Day and Residential settings, and the appropriate indicators were used to develop analytical reports to assist DDS in assessing compliance in the areas of Choice of Setting, Community Access, Choice in Living and Setting Space, Staff Interaction and Privacy, and Choice of Providers and Services. Overall there were 24 Indicators captured that were cross-walked to the settings requirements including 2 Observation, 9 Individual (Consumer) Interview, 4 Observation, 4 Documentation, 3 Support Person Interview, and 2 Safety Checklist. The on-site QSR reviews are conducted by Quality and Systems Improvement (QSI) staff and Case Management staff at all settings where LTSS Waiver services are provided. QSI staff are professional staff who have primary responsibility for the required quality assurance and improvement activities of facilities, programs and agencies for compliance with state and federal laws, regulations, policies, standards for licensure and participation in Medicaid Waiver programs for persons with developmental disabilities. Case Management staff are professional staff accountable for independently performing a full range of tasks in providing case management services for persons with

intellectual disability and their families to ensure the delivery of appropriate medical, educational/vocational, social, residential and other services and conformance with Federal Medicaid Waiver Reimbursement Program regulations. By choosing to utilize the primary tool used to monitor and track performance for our Waiver Assurances, DDS has ensured that the state has an ongoing method to assess comportment into the foreseeable future. DDS has identified the need to ensure each setting is evaluated on an ongoing basis at regular intervals, and believes this is the most effective and efficient method to do so.

#### **D. Staff Conducting Site Visits and Staff Training**

##### **1. DSS**

- a) **Assisted Living** - Settings surveys were conducted by a Health Program Associate staff with over 15 years' experience working directly with these 38 providers.

Staff training and orientation meetings were held prior to conducting the surveys and included an overview of settings criteria, survey practice sessions in anticipation of vague or incomplete responses and strategies for how to successfully ask probing questions for clarity. Staff was also instructed to ensure that participants were alone and/or able to respond, free from the influence of ALSA personnel. Also included in this training was a discussion and practice on how to distill extended or complicated responses (due to advanced age, possible senility/dementia or other complicating factors).

- b) **Adult Family Living** - DSS recognizes that less than 1% of these households are served by non-family members. To ensure ongoing compliance, DSS will monitor outcomes of annual reassessments conducted by contracted Access Agency Care Managers. The reassessment tool incorporates questions that address all the settings criteria including those of provider-owned and controlled settings. As all waiver participants residing in this setting are reassessed annually, the sample will be more than representative.

In conducting the Annual Assessment, contracted Access Agency Care Managers are trained to assure that privacy and confidentiality is maintained during the process.

- c) **Adult Day Health** - Settings surveys were conducted by DSS Community Nurse Coordinators, a Licensed Clinical Social Worker, and a Medical Administration Manager.

Staff training and orientation meetings were held prior and included an overview of settings criteria, survey practice sessions in anticipation of vague or incomplete responses and strategies for how to successfully ask probing questions for clarity. Staff was also instructed to ensure that participants were alone and/or able to respond free from the influence of setting personnel. Also included in this training was a discussion and practice on how to distill extended or complicated responses (due to advanced age, possible senility/dementia or other complicating factors). Staff were instructed to telephone senior unit Supervisors or Management if questions or concerns arose during the course of the setting survey beyond the parameters of the survey.

- d) **Residential Care Homes** - Settings surveys were conducted by 6, 2-member teams of Community Health Nurses all with multiple years of experience with waiver referral processing, Level of Care activities, and providing 'just in time' training as needed. Training and orientation meetings were held prior and included an overview of settings criteria and practice surveys to anticipate vague or incomplete responses and how to successfully ask probing questions for clarity. Instruction was given to ensure that participants were alone and/or able to respond free from the influence of setting personnel. Also included in this training was discussion and practice on how to distill extended or complicated responses for entries onto a survey spreadsheet. In addition to getting responses to 30 questions, teams were asked to make notes or observations that may impact quality of care or non-compliance with the HCBS settings requirements not captured by the survey.
- e) **Prevocational Services** - Settings surveys were conducted by members of the Community Options unit and included; Licensed Clinical Social Workers, Social Workers, Program Managers, and Operations Managers. Training and orientation meetings were held prior to sending survey teams out. An overview of HCBS settings requirements was provided as background. Training and orientation meetings were held prior and included an overview of settings criteria and practice surveys to anticipate vague or incomplete responses and how to successfully ask probing questions for clarity. Instruction was given to ensure that participants were alone and/or able to respond free from the influence of setting personnel. Also included in this training was discussion and practice on how to distill extended or complicated responses for entries onto a survey spreadsheet. In addition to getting responses to 30 questions, teams were asked to make notes or observations that may impact quality of care or non-compliance with the HCBS settings requirements not captured by the survey.
- f) **Supported Employment** - Settings surveys were conducted by members of the Community Options unit and included; Licensed Clinical Social Workers, Social Workers, Program Managers, Operations Managers. Training and orientation meetings were held prior to sending survey teams out. Training and orientation meetings were held prior and included an overview of settings criteria and practice surveys to anticipate vague or incomplete responses and how to successfully ask probing questions for clarity. Instruction was given to ensure that participants were alone and/or able to respond free from the influence of setting personnel. Also included in this training was discussion and practice on how to distill extended or complicated responses for entries onto a survey spreadsheet. In addition to logging responses to 17 questions, teams were asked to make notes or observations that may impact quality of care or non-compliance with the HCBS settings requirements not captured by the survey.
- g) **Group Day**- Settings surveys will be conducted by members of the Community Options unit and included; Licensed Clinical Social Workers, Social Workers, Program Managers, and Community Options Managers. Training and orientation meetings will be conducted prior and include an overview of settings criteria and practice surveys to anticipate vague or incomplete responses and how to successfully ask probing questions



for clarity. Instruction was given to ensure that participants were alone and/or able to respond free from the influence of setting personnel. Also to be included in this training will be discussion and practice on methods to distill extended or complicated responses for entries onto a survey spreadsheet. In addition to logging responses, teams will be expected to document observations that may impact quality of care or non-compliance with the HCBS settings requirements not captured by the survey.

## 2. DDS

- a) **Residential Habilitation: Community Living Arrangements** – Participant surveys were delivered as part of the QSR review process. The QSR tool consists of over 200 questions organized around 6 main areas including Consumer (Individual) Interview. The Consumer Interview component of the QSR was used to assess comportment with the settings requirements across all applicable settings. Of the 16 QSR indicators being utilized to assess comportment, 9 are Consumer Interviews. The QSR tool is administered by both Quality and Systems Improvement staff and Case Management staff. These staffing classes were represented on the DDS Settings Rule Workgroup by leads that were tasked with sharing information and educating their coworkers about the settings requirements. DDS provided access to distance learning opportunities and created a section of the website where information regarding the settings requirements can be accessed by both internal and external users. Regular communication tools including newsletters and Executive Briefs are used to share information and educate staff about the settings requirements. Staff were trained in Regional Supervision meetings, and ongoing education and outreach is available as needed and for new staff.
- b) **Residential Habilitation: Community Companion Homes** – Participant surveys were delivered as part of the QSR review process. The QSR tool consists of over 200 questions organized around 6 main areas including Consumer (Individual) Interview. The Consumer Interview component of the QSR was used to assess comportment with the settings requirements across all applicable settings. Of the 16 QSR indicators being utilized to assess comportment, 9 are Consumer Interviews. The QSR tool is administered by both Quality and Systems Improvement staff and Case Management staff. These staffing classes were represented on the DDS Settings Rule Workgroup by leads that were tasked with sharing information and educating their coworkers about the settings requirements. DDS provided access to distance learning opportunities and created a section of the website where information regarding the settings requirements can be accessed by both internal and external users. Regular communication tools including newsletters and Executive Briefs are used to share information and educate staff about the settings requirements. Staff were trained in Regional Supervision meetings, and ongoing education and outreach is available as needed and for new staff.
- c) **Continuous Residential Supports** – Participant surveys were delivered as part of the QSR review process. The QSR tool consists of over 200 questions organized around 6 main areas including Consumer (Individual) Interview. The Consumer Interview component of the QSR was used to assess comportment with the settings requirements

across all applicable settings. Of the 16 QSR indicators being utilized to assess comportment, 9 are Consumer Interviews. The QSR tool is administered by both Quality and Systems Improvement staff and Case Management staff. These staffing classes were represented on the DDS Settings Rule Workgroup by leads that were tasked with sharing information and educating their coworkers about the settings requirements. DDS provided access to distance learning opportunities and created a section of the website where information regarding the settings requirements can be accessed by both internal and external users. Regular communication tools including newsletters and Executive Briefs are used to share information and educate staff about the settings requirements. Staff were trained in Regional Supervision meetings, and ongoing education and outreach is available as needed and for new staff.

- d) **Prevocational Services** – Participant surveys were delivered as part of the QSR review process. The QSR tool consists of over 200 questions organized around 6 main areas including Consumer (Individual) Interview. The Consumer Interview component of the QSR was used to assess comportment with the settings requirements across all applicable settings. Of the 16 QSR indicators being utilized to assess comportment, 9 are Consumer Interviews. The QSR tool is administered by both Quality and Systems Improvement staff and Case Management staff. These staffing classes were represented on the DDS Settings Rule Workgroup by leads that were tasked with sharing information and educating their coworkers about the settings requirements. DDS provided access to distance learning opportunities and created a section of the website where information regarding the settings requirements can be accessed by both internal and external users. Regular communication tools including newsletters and Executive Briefs are used to share information and educate staff about the settings requirements. Staff were trained in Regional Supervision meetings, and ongoing education and outreach is available as needed and for new staff.
  
- e) **Group Supported Employment**– Participant surveys were delivered as part of the QSR review process. The QSR tool consists of over 200 questions organized around 6 main areas including Consumer (Individual) Interview. The Consumer Interview component of the QSR was used to assess comportment with the settings requirements across all applicable settings. Of the 16 QSR indicators being utilized to assess comportment, 9 are Consumer Interviews. The QSR tool is administered by both Quality and Systems Improvement staff and Case Management staff. These staffing classes were represented on the DDS Settings Rule Workgroup by leads that were tasked with sharing information and educating their coworkers about the settings requirements. DDS provided access to distance learning opportunities and created a section of the website where information regarding the settings requirements can be accessed by both internal and external users. Regular communication tools including newsletters and Executive Briefs are used to share information and educate staff about the settings requirements. Staff were trained in Regional Supervision meetings, and ongoing education and outreach is available as needed and for new staff.

f) **Group Day Support Options** – Participant surveys were delivered as part of the QSR review process. The QSR tool consists of over 200 questions organized around 6 main areas including Consumer (Individual) Interview. The Consumer Interview component of the QSR was used to assess comportment with the settings requirements across all applicable settings. Of the 16 QSR indicators being utilized to assess comportment, 9 are Consumer Interviews. The QSR tool is administered by both Quality and Systems Improvement staff and Case Management staff. These staffing classes were represented on the DDS Settings Rule Workgroup by leads that were tasked with sharing information and educating their coworkers about the settings requirements. DDS provided access to distance learning opportunities and created a section of the website where information regarding the settings requirements can be accessed by both internal and external users. Regular communication tools including newsletters and Executive Briefs are used to share information and educate staff about the settings requirements. Staff were trained in Regional Supervision meetings, and ongoing education and outreach is available as needed and for new staff.

## Compliance Assessment

### **A. Facility-Based Respite Care (page 5 of STP)**

DSS clarifies that facility-based respite is excluded from assessment since this service is a time limited service capped at 30 days and therefore does not require an assessment of the settings in which it is provided. It is not the institutional nature of the setting that excludes the settings from site-specific assessment; it is the nature of time-limited respite service.

### **B. Clarification of Compliance Levels Across Settings Categories**

The following is the final estimated number of settings that are in each of the CMS compliance categories:

#### **1. DSS**

##### **a) Assisted Living**

- Fully comply: 38
- Do not comply but could with modifications: 0
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 0

##### **b) Adult Family Living**

- Fully comply: 1768
- Do not comply but could with modifications: 0
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 0

##### **c) Adult Day Health**

- Fully comply: 44
- Do not comply but could with modifications: 0
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 5

##### **d) Residential Care Homes**

- Fully comply: 0
- Do not comply but could with modifications: 36
- Cannot comply: 0

- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 7

e) **Prevocational Services**

- Fully comply: 4
- Do not comply but could with modifications: 18
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 0

f) **Supported Employment**

- Fully comply: 8
- Do not comply but could with modifications: 7
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 0

g) **Group Day - None**

- Fully comply: 3
- Do not comply but could with modifications: 0
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 0

2. **DDS**

a) **Residential Habilitation: Community Living Arrangements**

- Fully comply: 326
- Do not comply but could with modifications: 558
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 0

b) **Residential Habilitation: Community Companion Homes**

- Fully comply: 63
- Do not comply but could with modifications: 265
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 0

c) **Continuous Residential Supports**

- Fully comply: 96
- Do not comply but could with modifications: 205
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 0

**d) Prevocational Services**

- Fully comply: 10
- Do not comply but could with modifications: 7
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 0

**e) Group Supported Employment**

- Fully comply: 49
- Do not comply but could with modifications: 91
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 0

**f) Group Day Support Options**

- Fully comply: 113
- Do not comply but could with modifications: 291
- Cannot comply: 0
- Are presumed to have the qualities of an institution but for which the State will submit evidence for the application of heightened scrutiny: 0

## Site-Specific Remedial Actions

### *A. Promotion of Non-Disability Specific Settings*

Waiver participants have the choice of where they would like to receive services, and that choice includes private residences and non-disability specific settings. Connecticut's entire service delivery system has evolved over many years to become one that optimizes the ability of individuals to receive HCBS and remain in the community to the fullest extent possible. The State has made great strides in expanding the availability of HCBS services as well as non-disability specific housing options. The provision of services for all HCBS participants is based on the person-centered planning process, where individuals make informed choices about the type of care they receive, the providers from whom care is received and the settings in which care is provided.

Specifically, the State has undertaken a variety of activities to expand the availability of HCBS services as well as non-disability specific housing options including:

- Increased waiver slots across all target populations
- Implemented a 1915 (i) for individuals with disabilities and older adults who need HCBS but do not meet institutional level of care
- Implemented new 1915 (c) waivers for individuals with and acquired brain injury and children with autism
- Implemented an Employment First initiative that focuses on integrated employment opportunities for people with disabilities
- Adding services to DDS waivers that help support individuals in obtaining integrated, Competitive employment
- Increasing access to integrated, affordable housing:
  - Through participation in the Medicaid Innovative Accelerator Program Partnerships with the Connecticut Housing Finance Agency and the Department of Housing

Ongoing monitoring of the appropriateness of HCB settings also includes assessing to ensure that reverse integration does not occur. A provider setting periodically opening the doors to the broader community does not constitute community integration. If identified, measures will be put in place, such as CAPs, to remediate the practice.

As part of the ongoing monitoring process to measure and document that a provider setting is meeting the community integration requirements as outlined in the HCBS final rule, DSS will look at: how settings establish opportunities for individuals to participate in services and/or activities in the community, outside the walls of the setting; how settings ensure that participants are made aware of these opportunities; how settings ensure that individuals can freely choose from these services and/or activities; and how these services and/or activities are consistent with individual needs, as noted in the person-centered service plan. Non-compliant providers will be expected to remediate identified issues in a timely manner and document that all issues are addressed in order to continue to provide HCBS.

Case manager on-site touch point meetings will be used as the primary source to determine directly from members if they are residing in privately owned settings that are institutional in nature. If identified, these providers will be held to the same processes noted below regarding identification and remediation of non-compliant issues.

***B. Approach for Addressing Discrepancies Between Provider Self-Assessment and Participant Experience Survey-Community Options***

DSS reached out directly to providers in 2015-16 via setting surveys to address/determine discrepancies reported in the 2014 Participant Experience Survey. Outcomes were noted and as described below, DSS (Community Options) will continue to address these items with providers and with input from waiver participants whenever possible. Additionally, DSS anticipates that based on feedback from waiver participants obtained through the use of the Universal Assessment tool, there may continue to be instances where participant feedback differs from the feedback from providers. These discrepancies will be addressed and resolved through discussions between the waiver participant and case manager. The case manager will follow up with the provider as appropriate. Discrepancies that cannot be resolved will be elevated to DSS for follow up and remediation by Community Options staff. The remediation may include increased monitoring as well as the development of a provider CAP.

- **Choice of Residence and/or Choice of Roommate:** Providers across waivers noted that some participants express surprise that a greater number of residences or residence settings are not available. Providers also reported that they do work together to determine that if another setting is available, movement/transfer is facilitated. Similarly, the choice of a roommate is always supported but cannot always be made immediately due to space issues, gender, and the first-come-first-served nature of waiver participation. Still, Providers are keenly aware of the importance of pairing waiver participants with similar interests, habits and waiver needs. When space does become available, options and prior requests are respected to the fullest extent possible. Community Options, through ongoing setting surveys will continue to monitor this finding to ensure that participant choice remains a priority, that options are discussed as part of any in-processing for new waiver participants, and requests for change are honored whenever possible.
- **Options to have paid work:** Participant desire to seek and maintain employment includes a number of options such as prior work history, work shifts available, public or other transportation options for night shifts, and participant understanding of these variables. Pay and hours also need to be considered. In the 2015-2016 Community Options' survey of ABI Supported Employment fully 33% of those already employed stated more pay and more hours as desirable. Overall, Providers are keenly aware of participant interest in employment and do support any possible configuration of services and supports on behalf of participants. Community Options, through ongoing setting surveys will continue to monitor this finding to ensure that options and opportunities for paid work are supported with resident input whenever possible.



- Ensuring resident/participant privacy and who has access to room keys: Community Options will continue to communicate to all providers the importance of participate choice. Through upcoming surveys Community Options will also engage with Provider staff to ensure that Care Plans are updated to reflect any reasons and conditions why room keys may be held by staff.
- Access to a computer, I-pad or similar device and Wi-Fi: Community Options, through ongoing setting surveys, will monitor this finding to ensure that participants who own any internet-connecting device can do so. Options, to include reviewing internet access as part of in-processing for new waiver participants will be noted.

**C. *How the State will Determine that DDS Providers have Satisfactorily Addressed all Issues Requiring Remediation (page 36)***

DDS will continue to utilize the Quality Service Review (QSR) tool to assess compliance with the Settings requirements. The electronic QSR application generates Corrective Action Plans based on indicators within the tool. These plans require that the provider agency responsible for providing LTSS in the assessed setting submit a written systemic improvement plan within the QSR application. The plan is reviewed by Quality and Systems Improvement (QSI) staff, and may be accepted or referred back to the submitting agency for continued improvement until accepted. The data and analytical reports derived from the QSR application are reviewed with the Provider at the annual Quality Review meeting with DDS, and Providers are required to submit Continuous Quality Improvement Plans for any patterns of poor performance. DDS QSI staff will review provider performance and will immediately identify any issues of non-compliance. Overall performance is very high, with a large number of providers requiring minor modifications to fully comply.

**D. *Confirmation that all DDS Providers will have come into Compliance through the use of the Quality Services Review (QSR) On-site Tool by March 17, 2022.***

DDS has begun a multi-year project to ensure all settings are appropriately assessed and are fully compliant. DDS conducted a structured cross-walk of the HCBS Final Rule settings requirements outcome areas and probing questions to the QSR tool indicators. The QSR tool was developed to show provider performance and individual experience and outcomes. The cross-walk entailed reviewing each settings requirement outcome area and the associated exploratory questions provided by CMS as an “optional tool provided to assist states in assessing whether the characteristics of Medicaid Home and Community-based Services, as required by regulation are present”. Once a solid foundational understanding of the characteristics expected to be present in settings where HCBS are being provided, the staff reviewed the QSR indicators to identify if there were matching indicators currently being rated. Where the QSI staff determined that there was a match additional reviewers were brought in to validate the assessment. The QSR tool utilizes a number of methods to capture information, including Observation, Consumer Interview, and Documentation reviews. The QSI staff advocated for the use of multiple methods of assessment to allow for the rating of compliance to be as closely representative of the individual’s voice as possible. The cross-walk yielded a framework for the use of the QSR tool to assess Settings requirement compliance. The following outcome areas were identified; Choice of

Setting, Community Access, Choice in Living Space, Staff Interaction and Privacy, and Choice of Providers. Across the 5 outcome areas there were a total of 25 exploratory questions utilized to assess the characteristics of the setting. The QSR Indicators used to assess compliance include 7 Observation, 8 Consumer Interview, 3 Support Person Interview, and 4 Document Review. While DDS is confident that the QSR tool is a valid way to assess settings requirements compliance, it does not have an indicator to rate if the individual has a lease or lease protections. DDS identified this in the structured cross-walk review of the QSR tool and is poised to add this to the QSR tool as soon as DDS has a tenancy/residency rights agreement that is supported by regulatory, statutory, or procedural authority. Although the QSR tool helps DDS identify the performance and any issues requiring remediation, it is the use of the Quality Improvement Process which utilizes the QSR system and data that will ensure compliance across the system.

***E. Additional Efforts State will take to Address Issues of Major Systemic Non-Compliance that were Identified as Areas of Concern During Initial Assessment Activities***

The following are additional measures the State will put in place to address identified issues, per Department, per provider type.

**1. DSS**

- a) **Assisted Living** - Community Options (DSS) will utilize data taken from initial assessments and annual reassessments as completed by contracted Access Agency Care Managers.

**Remediation Strategy:** Community Options (DSS) staff will review annual assessments in an amount not to exceed 10% of the total completed monthly. The focus will be on questions/responses that directly address settings requirements. When concerns arise, providers will be contacted via email and given 45 days to fully respond to the concern noted. The Department will receive data reports summarizing the responses to the settings questions and will have the ability to drill down to both the provider and individual level. Individualized remediation will take place as the concern is identified through the assessment process.

**Quality Assurance and Monitoring:** Contacted providers will be instructed to respond to the remediation email with the action taken and initial outcomes within 45 days of the receipt of the email. Community Options (DSS) will review each response, note the action taken initiate follow-up monitoring as needed. Waiver participants and their applicable caregivers will be notified via an electronic or hard copy notice of the identified issue and the providers remediation to resolve issue. This notice will be sent within 14 days of issue resolution.

- b) **Adult Family Living** - Community Options (DSS) will utilize data taken from annual assessments as completed by contracted Access Agency Care Managers.

**Remediation Strategy:** Community Options (DSS) staff will review annual assessments in an amount not to exceed 10% of the total completed monthly. The focus will be on questions/responses that directly address settings requirements. When concerns arise,

providers will be contacted via email and given 45 days to fully respond to the concern noted. The Department will receive data reports summarizing the responses to the settings questions and will have the ability to drill down to both the provider and individual level. Individualized remediation will take place as the concern is identified through the assessment process.

**Quality Assurance and Monitoring:** Contacted providers will be instructed to respond to the remediation email with the action taken and initial outcomes within 45 days of the receipt of the email. Community Options (DSS) will review each response, note the action taken initiate follow-up monitoring as needed. Waiver participants and their applicable caregivers will be notified via a mailed notice of the identified issue and the providers remediation to resolve issue. This notice will be sent within 14 days of issue resolution.

- c) **Adult Day Health - Community Options (DSS)** staff will utilize data taken from annual assessments as completed by contracted Access Agency Care Managers.

**Remediation Strategy:** Community Options (DSS) staff will review annual assessments in an amount not to exceed 10% of the total completed monthly. The focus will be on questions/responses that directly address settings requirements. When concerns arise, providers will be contacted via email and given 45 days to fully respond to the concern noted.

**Quality Assurance and Monitoring:** Contacted providers will be instructed to respond to the remediation email with the action taken and initial outcomes within 45 days of the receipt of the email. Community Options (DSS) will review each response, note the action taken initiate follow-up monitoring as needed. Waiver participants and their applicable caregivers will be notified via a mailed notice of the identified issue and the providers remediation to resolve issue. This notice will be sent within 14 days of issue resolution.

- d) **Residential Care Homes (RCH) - Community Options (DSS)** staff will utilize data taken from annual assessments as completed by contracted Access Agency Care Managers.

**Remediation Strategy:** Community Options (DSS) staff will review annual assessments in an amount not to exceed 10% of the total completed monthly. The focus will be on questions/responses that directly address settings requirements. When concerns arise, providers will be contacted via email and given 45 days to fully respond to the concern noted. The Department will receive data reports summarizing the responses to the settings questions and will have the ability to drill down to both the provider and individual level. Individualized remediation will take place as the concern is identified through the assessment process.

**Quality Assurance and Monitoring:** Contacted providers will be instructed to respond to the remediation email with the action taken and initial outcomes within 45 days of the

receipt of the email. Community Options (DSS) will review each response, note the action taken initiate follow-up monitoring as needed. Waiver participants and their applicable caregivers will be notified via a mailed notice of the identified issue and the providers remediation to resolve issue. This notice will be sent within 14 days of issue resolution.

Additionally, to ensure that all waiver participants understand and actively participate in person-centered planning activities. DSS will provide contact information to forward questions, person-centered planning concerns, or service delivery gaps. Use of setting visits, participant surveys, and monitoring of HCBS settings requirements compliance may be employed as needed. telephone satisfaction surveys.

- e) **Prevocational Services** - Community Options (DSS) staff will utilize data taken from annual assessments as completed by contracted Access Agency Care Managers.

**Remediation Strategy:** Community Options (DSS) staff will review annual assessments in an amount not to exceed 10% of the total completed monthly. The focus will be on questions/responses that directly address settings requirements. When concerns arise, providers will be contacted via email and given 45 days to fully respond to the concern noted.

**Quality Assurance and Monitoring:** Contacted providers will be instructed to respond to the remediation email with the action taken and initial outcomes within 45 days of the receipt of the email. Community Options (DSS) will review each response, note the action taken initiate follow-up monitoring as needed. Waiver participants and their applicable caregivers will be notified via a mailed notice of the identified issue and the providers remediation to resolve issue. This notice will be sent within 14 days of issue resolution.

Additionally, DSS will monitor the length of time participants participate in this service, with emphasis on the 2-year mark. Provider networks will ensure that a 1:1 ratio (staff: participant) effectively meets identified goals and objectives that serve the participant. For those participants who reach the 2-year mark without sustained employment success, such networks will work to identify causes why and look to strengthen both Group Day and Supported Employment components along with Prevocational Services.

- f) **Group Day** - Community Options (DSS) staff will utilize data taken from annual assessments as completed by contracted Access Agency Care Managers.

**Remediation Strategy:** Community Options (DSS) staff will review annual assessments in an amount not to exceed 10% of the total completed monthly. The focus will be on questions/responses that directly address settings requirements. When concerns arise, providers will be contacted via email and given 45 days to fully respond to the concern noted.

**Quality Assurance and Monitoring:** Contacted providers will be instructed to respond to the remediation email with the action taken and initial outcomes within 45 days of the

receipt of the email. Community Options (DSS) will review each response, note the action taken initiate follow-up monitoring as needed. Waiver participants and their applicable caregivers will be notified via a mailed notice of the identified issue and the providers remediation to resolve issue. This notice will be sent within 14 days of issue resolution.

## 2. DDS

- a) **Residential Habilitation: Community Living Arrangements** – DDS will continue to utilize the on-site Quality Service Reviews including the ability to require and track provider corrective action plans. DDS has developed a set of analytical reports that allow real-time assessment of compliance at a system level, at a specific service type level, and at the provider level. The provider level analytics will be utilized by the Regional Resource management and Quality Improvement staff in the annual Provider Quality Review process. Providers will be given specific performance information allowing them to identify areas in need to improvement and will negotiate any areas requiring inclusion in the Continuous Quality Improvement Plan. In addition to these established methods of assessment, which include Consumer (Individual) Interview, Observation, Documentation, Support Person Interview, and Safety Checklist review, DDS is exploring the use of resident satisfaction surveys being utilized by DSS. Remediation Strategies and Quality Assurance and Monitoring as indicated below.

**Remediation Strategies:** DDS will employ a range of activities designed to track key focus areas and improvements as initiated by individual Community Living Arrangement settings. These will include:

- ✓ Continued use of on-site QSR Reviews
- ✓ Case Manager on-site reviews
- ✓ Use of the Corrective Action Plan for the QSR application requiring providers who receive a non-compliant rating to create a reviewable/approvable plan to address the issue identified at both the setting and system level

**Quality Assurance and Monitoring:** Business Intelligence/Analytical reports show state agency staff tasked with provider oversight when an issue of non-compliance has been identified. DDS will utilize analytics to identify system level performance, as well as to track provider and setting-level performance. Standardized reports will be utilized in the annual Provider Quality Review Meeting, and state staff will negotiate inclusion of any relevant improvement strategies into the provider Continuous Quality Improvement Plan. Escalation of issues not remediated in the required timeframe will go directly to Regional Directors, Assistant Regional Directors, Resource Management and Quality and Systems Improvement staff, as well as to the Executive Director of the specific agency. Potential for enhanced monitoring and contractual ramifications exist should providers continue to show a lack of marked improvement.

- b) **Residential Habilitation: Community Companion Homes** –

**Remediation Strategies:** DDS will employ a range of activities designed to track key focus areas and improvements as initiated by individual Community Living Arrangement settings. These will include:

- ✓ Continued use of on-site QSR Reviews
- ✓ Case Manager on-site reviews
- ✓ Use of the Corrective Action Plan for the QSR application requiring providers who receive a non-compliant rating to create a reviewable/approvable plan to address the issue identified at both the setting and system level

**Quality Assurance and Monitoring:** Business Intelligence/Analytical reports show state agency staff tasked with provider oversight when an issue of non-compliance has been identified. DDS will utilize analytics to identify system level performance, as well as to track provider and setting-level performance. Standardized reports will be utilized in the annual Provider Quality Review Meeting, and state staff will negotiate inclusion of any relevant improvement strategies into the provider Continuous Quality Improvement Plan. Escalation of issues not remediated in the required timeframe will go directly to Regional Directors, Assistant Regional Directors, Resource Management and Quality and Systems Improvement staff, as well as to the Executive Director of the specific agency. Potential for enhanced monitoring and contractual ramifications exist should providers continue to show a lack of marked improvement.

c) **Continuous Residential Supports**

**Remediation Strategies:** DDS will employ a range of activities designed to track key focus areas and improvements as initiated by individual Community Living Arrangement settings. These will include:

- Continued use of on-site QSR Reviews
- Case Manger on-site reviews
- Use of the Corrective Action Plan for the QSR application requiring providers who receive a non-compliant rating to create a reviewable/approvable plan to address the issue identified at both the setting and system level

**Quality Assurance and Monitoring:** Business Intelligence/Analytical reports show state agency staff tasked with provider oversight when an issue of non-compliance has been identified. DDS will utilize analytics to identify system level performance, as well as to track provider and setting-level performance. Standardized reports will be utilized in the annual Provider Quality Review Meeting, and state staff will negotiate inclusion of any relevant improvement strategies into the provider Continuous Quality Improvement Plan. Escalation of issues not remediated in the required timeframe will go directly to Regional Directors, Assistant Regional Directors, Resource Management and Quality and Systems Improvement staff, as well as to the Executive Director of the specific agency. Potential for enhanced monitoring and contractual ramifications exist should providers continue to show a lack of marked improvement.

d) **Prevocational Services**

**Remediation Strategies:** DDS will employ a range of activities designed to track key focus areas and improvements as initiated by individual Community Living Arrangement settings. These will include:

- Continued use of on-site QSR Reviews
- Case Manager on-site reviews
- Use of the Corrective Action Plan for the QSR application requiring providers who receive a non-compliant rating to create a reviewable/approvable plan to address the issue identified at both the setting and system level

**Quality Assurance and Monitoring:** Business Intelligence/Analytical reports show state agency staff tasked with provider oversight when an issue of non-compliance has been identified. DDS will utilize analytics to identify system level performance, as well as to track provider and setting-level performance. Standardized reports will be utilized in the annual Provider Quality Review Meeting, and state staff will negotiate inclusion of any relevant improvement strategies into the provider Continuous Quality Improvement Plan. Escalation of issues not remediated in the required timeframe will go directly to Regional Directors, Assistant Regional Directors, Resource Management and Quality and Systems Improvement staff, as well as to the Executive Director of the specific agency. Potential for enhanced monitoring and contractual ramifications exist should providers continue to show a lack of marked improvement.

e) **Group Supported Employment**

**Remediation Strategies:** DDS will employ a range of activities designed to track key focus areas and improvements as initiated by individual Community Living Arrangement settings. These will include:

- Continued use of on-site QSR Reviews
- Case Manager on-site reviews
- Use of the Corrective Action Plan for the QSR application requiring providers who receive a non-compliant rating to create a reviewable/approvable plan to address the issue identified at both the setting and system level.

**Quality Assurance and Monitoring:** Business Intelligence/Analytical reports show state agency staff tasked with provider oversight when an issue of non-compliance has been identified. DDS will utilize analytics to identify system level performance, as well as to track provider and setting-level performance. Standardized reports will be utilized in the annual Provider Quality Review Meeting, and state staff will negotiate inclusion of any relevant improvement strategies into the provider Continuous Quality Improvement Plan. Escalation of issues not remediated in the required timeframe will go directly to Regional Directors, Assistant Regional Directors, Resource Management and Quality and Systems Improvement staff, as well as to the Executive Director of the specific agency. Potential

for enhanced monitoring and contractual ramifications exist should providers continue to show a lack of marked improvement.

f) **Group Day Support Options**

**Remediation Strategies:** DDS will employ a range of activities designed to track key focus areas and improvements as initiated by individual Community Living Arrangement settings. These will include:

- Continued use of on-site QSR Reviews
- Case Manager on-site reviews
- Use of the Corrective Action Plan for the QSR application requiring providers who receive a non-compliant rating to create a reviewable/approvable plan to address the issue identified at both the setting and system level

**Quality Assurance and Monitoring:** Business Intelligence/Analytical reports show state agency staff tasked with provider oversight when an issue of non-compliance has been identified. DDS will utilize analytics to identify system level performance, as well as to track provider and setting-level performance. Standardized reports will be utilized in the annual Provider Quality Review Meeting, and state staff will negotiate inclusion of any relevant improvement strategies into the provider Continuous Quality Improvement Plan. Escalation of issues not remediated in the required timeframe will go directly to Regional Directors, Assistant Regional Directors, Resource Management and Quality and Systems Improvement staff, as well as to the Executive Director of the specific agency. Potential for enhanced monitoring and contractual ramifications exist should providers continue to show a lack of marked improvement.



## **Monitoring of Settings**

### ***A. Individual, Privately-Owned Homes – How the State will Monitor Compliance of this Category with HCB Settings Requirements Over Time***

Community Options (DSS) staff will conduct setting surveys on an annual basis conducted by cross-discipline teams composed of staff clinicians, social workers and other staff with waiver/program background. Key identified areas will be focused on regardless of discrepancies found in any previous assessments. The new Universal Assessment was implemented across waiver programs effective 7/1/19. There are 10 questions built into the new assessment instrument that specifically address the settings requirements.

### ***B. Clarification Regarding if the DSS workgroup with the Department of Public Health, the Long Term Ombudsman, Connecticut Legal Services, and the RCH or Smaller Workgroups will be Involved in Ongoing RCH Monitoring (pages 39-40 of STP)***

Community Options (DSS) staff will continue to actively meet with this work group work for feedback and guidance. Focus will continue to be placed on statutory change and development/use of a lease agreement with tenant protection provisions. Monitoring will be conducted through ongoing setting surveys.

### ***C. Explanation of Training on the Settings Requirements State Employees or Personnel within the State's Existing Infrastructure and Assigned to Completing the Ongoing Monitoring of Settings will Receive***

Training for Community Options (DSS) staff will be ongoing. In addition to introducing the settings requirements as regular agenda items for unit meetings (where specific areas will be discussed), training will also be provided across staff disciplines for those going into the field to conduct selected surveys and logging findings. A 'train the trainer' approach is anticipated to familiarize key staff with the Settings Requirements, of similarities across waivers, and alert staff of important distinctions. It is further anticipated that additional staff will be cross-trained and able to conduct surveys, site visits, conduct their own mini-training sessions as needed not solely on the settings requirements, but also directly with providers to strengthen person-centered planning goals and objectives. Training for DDS staff will be ongoing. In addition to inclusion of the settings requirements in regular supervision and supervisor meetings for Quality and Systems Improvement and Case Management staff, online resources and guides will also be available on the DDS website in the Medicaid Waiver/Settings Rule Section. DDS has also made available the TA and informational resources provided by CMS/ACL and other contracted entities to our state agency staff. The rollout of the revised Person Centered Plan base around Charting the Life Course offers additional opportunities for education of state agency staff, as well as a place to dialogue around common issues such as informed consent and freedom of choice, portability and personal control of resources, and other ways to support the best outcomes for waiver participants supported by DDS.

## Heightened Scrutiny

### ***A. State's Process for Identifying Settings that are Presumed to have the Qualities of an Institution Including Clarification if the State has Identified any Settings with the Effect of Isolating***

1. **DSS** – Based on our assessments, we did not identify any residences that have the effect of isolation waiver participants from the larger community. DSS did identify certain instances of survey feedback that might be characterized as isolation however follow-up analysis identified such comments as outcomes of personal choice; meaning waiver participants were made aware of options available and how to participate, but made an informed choice of whether or not to reside in a specific residence or participate in a specific service or activity. DSS has identified 5 Adult Day Centers and several Residential Care Homes that are located in a building that is also a publicly or privately operated facility that provides institutional care or settings located on the grounds of, or are immediately adjacent to a public institution. As described herein, the Adult Care Centers have been documented and forwarded to CMS. Continued surveys and site visits are planned throughout 2019-2022 to ensure compliance. DSS will submit packets for the Residential Care Homes identified as requiring heightened scrutiny.
2. **DDS** – Based upon our on-site assessments, we did not identify any settings that:
  - a) Have the effect of isolation waiver participants from the larger community, any survey feedback that might be characterized as isolation that was also identified as a result of personal choice; meaning waiver participants are aware of options available and how to participate, but have made an informed choice of whether or not to reside in a specific residence or participate in a specific service or activity.
  - b) Are located in a building that is also a publicly or privately operated facility that provides institutional care or settings located on the grounds of, or
  - c) Are immediately adjacent to a public institution.

### ***B. Timeline of Milestones and Specific Dates for Completing Heightened Scrutiny Process.***

1. DSS has submitted to CMS, five Adult Day programs for Heightened Scrutiny Review. In addition, by 12/31/19 we will submit any Residential Care Homes meeting Heightened Scrutiny criteria.
2. DDS has not and does not anticipate the need to submit any specific settings to CMS for heightened scrutiny. However, if through its oversight and monitoring activities, DDS discovers a setting that requires submission for heightened scrutiny they will follow the heightened scrutiny milestones and dates as specified in the Milestones chart.

## **Communication with Beneficiaries of Options when a Provider will not be Compliant**

### ***A. Timeline for when the State will Notify Beneficiaries and Begin the Process to Ensure Transition of all Waiver participants by March 2022 and Estimated Number of Beneficiaries that May Need to be Transitioned***

1. **DSS** - Notification will begin 12/31/2020 and be complete by 9/30/2021, with 25% of those waiver participants being notified each quarter as detailed in the milestone chart. At this time, no waiver participants have been identified as requiring relocation to another setting. For the settings presumed to be institutional, the number of waiver participants being served by the setting will be included in the heightened scrutiny packages submitted to CMS. While DSS does not anticipate having to move waiver participants if this is necessary, relocation would begin 5/1/21 and end 2/1/22, with 25% of identified waiver participants relocating each quarter as detailed in the milestone chart.

**DDS** - Notification will begin 12/31/2020 and be complete by 9/30/2021 with 25% of those waiver participants being notified each quarter as detailed in the milestone chart. At this time, no waiver participants have been identified as requiring relocation to another setting. While DDS does not anticipate having to move waiver participants if this is necessary, relocation would begin 5/1/21 and end 2/1/22, with 25% of identified waiver participants relocating each quarter as detailed in the milestone chart.

### ***B. Details on the Steps the State will take to Communicate with Beneficiaries and Who will be Responsible or Executing each Step of the Process***

1. DSS will identify waiver participants who will be impacted and need to have transition alternatives explained to them. The state will communicate directly with the participants via letter beginning 12/31/20 and ending 9/30/21 consistent with the milestone chart and then the care manager will follow up within 30 days of the mailing of the letter with an in person visit to discuss options available to the participant. If the person wishes to move to a setting that is compliant, the care manager will be responsible to assist with the transition.
2. DDS will identify waiver participants who will be impacted and need to have transition alternatives explained to them. The state will communicate directly with the participants via letter beginning 12/31/01 and ending 9/31/21 consistent with the milestone chart and then the care manager will follow up within 30 days of the mailing of the letter with an in person visit to discuss options available to the participant. If the person wishes to move to a setting that is compliant, the care manager will be responsible to assist with the transition.

### ***C. Description of How the State will Ensure that all Critical Services and Supports are in Place in Advance of Each Individual's Transition***

1. **DSS** - This will be identified through the person centered planning process with the care manager responsible for having the services in place. In the rare circumstance, where a

waiver participant would choose to remain in a non-complaint setting that is unable and unwilling to become complaint even with individual remediation support from DSS, the waiver participant will be disenrolled from the waiver and afforded their hearing rights.

2. **DDS** - This will be identified through the person centered planning process with the care manager responsible for having the services in place. In the rare circumstance, where a waiver participant would choose to remain in a non-complaint setting that is unable and unwilling to become complaint even with individual remediation support from DDS, the waiver participant will be disenrolled from the waiver and afforded their hearing rights.

## Milestones Chart

The following chart is updated from the STP to note outstanding assessment activities.

Milestone	Description	Proposed End Date	STP Page No.
<b>Systemic Assessment and Remediation</b>			
Completion of systemic assessment <i>[The date when overall completion of the systemic assessment, including review of all rules, regulations, and statutes]</i>	Documented systemic assessment	(11/6/15)	23
Complete modifying rules and regulations, including provider manuals, inspection manuals, procedures, laws, qualification criteria, etc.	<b>ABI:</b> Revise the Acquired Brain Injury Waiver Program regulations to reflect the HCB settings requirements.	12/31/16	40, 43
	<b>All waivers:</b> Draft guidance that requires provider owned or controlled residences to ensure waiver participants rights are protected by a lease or comparable legally binding agreement.  <b>All waivers:</b> Create a lease template that can be used by waiver participants living in provider owned or controlled residential settings and meets the requirements of the new CMS HCBS final rule.	12/31/16	51
	<b>All waivers:</b> Dignity of risk policy (risk mitigation). Develop policy that enables informed choice of participant.	6/30/17	50
	DSS expects that by June 30, 2020 all regulations or operating policies will be modified to reflect the HCB settings requirements.  <b>Residential Care Homes:</b> Work with DPH to update regulatory documents for RCHs to assure compliance with the HCB settings requirements  CHCPE and PSA: Revise the Home Care Program for	06/30/20	22, 34, 37, 43, 44

Milestone	Description	Proposed End Date	STP Page No.
	<p>Elders regulations and the Personal Care Assistance Services for Adults regulations to reflect the HCB settings requirements.</p> <p><b>Adult Family Living:</b> In addition, by June 30, 2018, DSS will add language to its program regulations to reflect the HCB settings requirements. Moreover, on an ongoing basis, as part of their home visits, care managers (who have been trained on the new rule) will review participants' settings to identify any inconsistencies with the HCB settings requirements.</p> <p><b>Assisted Living:</b> Regulations are already compliant with the settings requirements</p> <p><b>Adult Day Health:</b> Revise Adult Day Center standards. DSS will also revise its own program regulations to reflect the HCB settings requirements. This was accomplished by June 30, 2018.</p>		
<p>Implementation of new rules and regulations: 50% complete  <i>[The date when at least 50% of all rules, regulations, and statutes identified through the assessment will be implemented. Please specify which rules, regulations, and statutes in the description]</i></p>		12/31/19	
<p>Implementation of new rules and regulations: 100% complete  <i>[The date when all rules, regulations, and statutes (100%) identified through the assessment will be implemented. Please specify which rules, regulations, and statutes in the description]</i></p>	<p>Draft regulations are under development with expected promulgation by June 30, 2020</p>	12/31/21	34, 40

Milestone	Description	Proposed End Date	STP Page No.
<b>Site-specific Assessments</b>			
Completion of site-specific assessment <i>[The date when the overall completion of the site-specific assessment, including review of all settings and the validation of assessment results.]</i>	Conduct interviews of a representative sample of participants of all Assisted Living communities.	9/30/16	22-23
	Complete assessments of all Adult Day settings and interview waiver participants to evaluate compliance with the final rule.	02/01/18	13-14 (Amendment)
	Conduct site-specific assessments of RCHs.	12/31/18	15-17 (Amendment)
	Conduct site-specific assessments of Prevocational Services	07/01/18	18-19 (Amendment)
	Conduct site-specific assessments of all ABI Group Day providers.	12/31/19	20-21, 26 (Amendment)
	New assessment tool implemented across waiver programs and 1915i has specific settings questions embedded to be asked at each reassessment	7/01/18	6, 12 (Amendment)
Incorporate results of settings analysis into final version of the STP and release for public comment	<b>All waivers:</b> Revise STP based on analysis of survey results, remediation activities, ongoing monitoring, and public comments/feedback.	10/31/18	36, 44, 50
Submit final STP to CMS		07/31/19	
<b>Site-specific Remediation</b>			
Completion of residential provider remediation: 25% <i>[The date when approximately 25% of residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]</i>	<b>All Settings:</b> Following setting surveys in 2018, Community Options' staff will engage with each RCH to address any necessary remediation.	12/31/19	
Completion of residential provider remediation: 50% <i>[The date when approximately 50% of residential providers have completed the</i>	<b>All Settings:</b> Community Options will continue remediation activities with providers as identified and as	03/31/20	

Milestone	Description	Proposed End Date	STP Page No.
<i>necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]</i>	necessary.		
Completion of residential provider remediation: 75% <i>[The date when approximately 75% of residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]</i>	<b>All Settings:</b> Community Options will continue remediation activities with providers as identified and as necessary.	08/30/20	
Completion of residential provider remediation: 100% <i>[The date when all residential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]</i>	<b>All Settings:</b> All providers to be advised that this is an ongoing process and not simply a one-time objective. Field activities will be built in to ensure that follow-up and check-in activities continue.	12/31/20	
Completion of nonresidential provider remediation: 25% <i>[The date when approximately 25% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]</i>	<b>ABI Prevocational Services, ABI Group Day (as applies) Supported Employment:</b> Focus will continue to be placed on key waiver provisions such as ratio of staff to client, 2-year participation, community integration, employment-related skill development.	06/30/19	
Completion of nonresidential provider remediation: 50% <i>[The date when approximately 50% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]</i>	<b>ABI Prevocational Services, ABI Group Day (as applies) Supported Employment:</b> <b>All Settings:</b> Community Options will continue remediation activities with providers as identified and as necessary.	03/31/20	
Completion of nonresidential provider remediation: 75% <i>[The date when approximately 75% of nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]</i>	<b>ABI Prevocational Services, ABI Group Day (as applies) Supported Employment:</b> Community Options will continue remediation activities with providers as identified and as necessary.	08/30/20	
Completion of nonresidential provider	<b>All Providers &amp; Settings:</b>	12/31/20	



Milestone	Description	Proposed End Date	STP Page No.
remediation: 100% <i>[The date when all nonresidential providers have completed the necessary remediation (of those providers that require remediation). Please provide additional details on settings in the description.]</i>	To be advised that this is an ongoing process and not simply a one-time objective. Field activities will be built in to ensure that follow-up and check-in activities continue.		
Identification of settings that will not remain in the HCBS System <i>[The date those settings that are considered institutional or are not willing to remediate will be identified for removal from the HCBS System]</i>	<b>All Providers &amp; Settings:</b> Community Options will continue to engage and remediate with any setting willing to meet/comply with HCBS criteria. The larger objective to create as many options as possible for waiver participants interested in the community.	12/31/21	
<b>Heightened Scrutiny<sup>2</sup></b>			
Identification of settings that overcome the presumption and will be submitted for heightened scrutiny and notification to provider		10/31/18	
Complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS		12/31/18	
Incorporate list of settings requiring heightened scrutiny and information and evidence referenced above into the final version of STP and release for public comment	Provider settings ultimately determined to have HCB qualities and are not institutional in nature, along with sufficient evidence, will be submitted to CMS for heightened scrutiny review following a public comment review period.	12/31/18	58
Submit STP with Heightened Scrutiny information to CMS for review	Submit to CMS heightened scrutiny evidence for settings that are presumed to be institutional	3/17/19, 7/31/19	44, 51
<b>Relocation:</b>			
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 25% <i>[The date when waiver participants, guardians, case managers, etc. in</i>	<b>RCH:</b> If an RCH is unable or unwilling to comply with the HCB settings requirements, DSS will notify the care manager(s) for the affected participant(s), and the care manager will help the participant select and then	12/31/20	51-52 (Amendment)

Milestone	Description	Proposed End Date	STP Page No.
<p><i>approximately 25% of providers have been notified that relocation is required. Please provide additional details on settings in the description.]</i></p>	<p>transition to a setting that meets the HCB settings requirements.</p>		
	<p><b>DSS:</b> If CMS determines a setting is not an appropriate HCB setting, participants will be notified of the need to select an alternate provider and care managers will assist in finding appropriate placement (see Sections III.A and III.B for relocation processes).</p>	12/31/20	51-52 (Amendment)
	<p><b>DDS:</b> If a setting is not an appropriate HCB setting, providers will be given the opportunity to remediate and if compliance is not achievable the participants will be notified of the need to select an alternate compliant setting and case managers will assist in finding appropriate placement (see Section III.B for relocation process).</p>	12/31/20	51-52 (Amendment)
<p>Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 50% <i>[The date when waiver participants, guardians, case managers, etc. in approximately 50% of providers have been notified that relocation is required. Please provide additional details on settings in the description.]</i></p>		3/30/21	51-52 (Amendment)
<p>Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 75% <i>[The date when waiver participants, guardians, case managers, etc. in approximately 75% of providers have</i></p>		6/31/21	51-52 (Amendment)

Milestone	Description	Proposed End Date	STP Page No.
<i>been notified that relocation is required. Please provide additional details on settings in the description.]</i>			
Complete notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 100% <i>[The date when waiver participants, guardians, case managers, etc. in all providers have been notified that relocation is required. Please provide additional details on settings in the description.]</i>		9/30/21	51-52 (Amendment)
Complete beneficiary relocation across all providers: 25% <i>[The date when beneficiaries in approximately 25% of providers have been relocated. Please provide additional details on settings in the description.]</i>		5/1/21	51-52 (Amendment)
Complete beneficiary relocation across all providers: 50% <i>[The date when beneficiaries in approximately 50% of providers have been relocated. Please provide additional details on settings in the description.]</i>		8/01/21	51-52 (Amendment)
Complete beneficiary relocation across all providers: 75% <i>[The date when beneficiaries in approximately 75% of providers have been relocated. Please provide additional details on settings in the description.]</i>		11/01/21	51-52 (Amendment)
Complete beneficiary relocation across all providers: 100% <i>[The date when beneficiaries in all providers have been relocated. Please provide additional details on settings in the description.]</i>	<b>RCH:</b> If necessary, transition participants residing in a non-compliant RCH to a compliant setting	2/01/22	51-52 (Amendment)

## **RESPONSE TO AUGUST 2018 PUBLIC COMMENTS**

### **COMMENTS FROM LEADING AGE CT**

The Department thanks Leading Age CT for their comments regarding the transition plan. We have made every effort to make this process a collaborative one and we appreciate the positive feedback. We expect to continue to work collaboratively with the community of providers to ensure that the settings requirements are met and that we have the ability to offer a range of services to our waiver participants.

### **COMMENTS FROM ERIN LEAVITT-SMITH, DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES**

The Department thanks its sister agency, the Department of Mental Health and Addiction Services for their comments regarding Residential Care Homes. We acknowledge that in order for individuals to be successful in the community, the state needs to offer a range of settings and services to best meet the individual participants' needs and preferences. We agree that the Residential Care Home Model is ideally situated to be part of the continuum of resources.

### **COMMENTS FROM THE ALLIANCE VOICE OF COMMUNITY NONPROFITS**

The Department thanks the alliance for their comments. While we acknowledge your recommendations about rates in CT, the settings requirements and required transition plan are unrelated to rates. In general, rates adjustments are part of the budgetary process developed in the state legislature. It should be noted that both DDS and DSS providers have received a rate increase. DSS waiver providers have been notified that they can expect an additional 2% rate increase effective January 1, 2018. Providers will be offered ongoing feedback from the Department staff regarding compliance assessment with the settings requirements.

The addendum to the transition plan constitutes an update to the original plan.

Service definitions for the waiver services are aligned with CMS core definitions. The services are reviewed every time the waiver is being renewed and public comments are always sought when waivers are being renewed.

While we appreciate your further comments, we find they are unrelated to the content of the transition plan. We would suggest that if either the Alliance or waiver providers have specific

questions, they can address those directly with the Department that oversees the waiver. All ABI providers who have had site visits have been notified in writing of the areas identified for improvement and the Department has engaged individually with each of them.

CMS HCBS Settings Rule Expectations mapped to QSR Indicators



Settings Rule Area Description	Settings Rule Probing Questions	QSR Indicator	Description of Indicator
<b>Choice of Setting</b>			
Individual has choice over where they live and have a lease or agreement protecting their residency rights.	Did Individual choose where to live?	Observation 6	<p>The environment supports the individual's needs, abilities, and interests and promotes integration and does not isolate</p> <p>The intent of this indicator is to observe and determine if the environment supports the needs, abilities and interests of the individual. For example, has the environment been adjusted for a person with limited mobility or visual impairment? Does the environment have accessible bathrooms for individuals who use adaptive equipment? Is there enough room to navigate around the environment for individuals using walkers and wheelchairs? Is space available for individuals to pursue personal hobbies? Modifications must be documented for each individual and need to be supported by an assessed need and justified in the person-centered plan (IP).</p>
	Same	Observation 7	<p>Sufficient support persons are available to meet the individual's support and service needs identified in his or her Plan and promotes integration and does not isolate</p> <p>The intent of this indicator is to determine if sufficient support persons are on duty to carry out the individual's IP, as well as, meet the needs of the other people receiving support in the setting. Review the support person schedule for the visit day, as needed, and compare to on duty support persons. If possible, observe during times identified as needing enhanced staffing to verify that the support is provided as specified. Refer to specific needs and support person requirements as identified in the individual's Individual Plan.</p> <p>"Sufficient support persons" is defined in the individual's Individual Plan (e.g., two-person transfer required, a requirement for a support person to be within visual sight of the individual at all times). If immediate jeopardy situation refer to Jeopardy Guidelines: J18 Inadequate number of staff (supervision, implementation of behavioral interventions, evacuation).</p>
	Same	Consumer Interview 27	Did you choose the people you live with and where you live? The intent of this indicator is to determine the involvement the individual had when choosing who/where to live (or not to have housemates).
	Does Individual have a lease or residency protections?	N/A	CT does not currently have a lease agreement for individuals residing in licensed group homes. CT DDS is working with our provider community to develop a lease agreement/protections for tenancy rights and will incorporate the questions into the QSR application.

**Community Access**

<p>Individuals are integrated in the community and have the same access to community as anyone else living in the broader community.</p>	<p>Is the home on the grounds of, or adjacent to, an institution or nursing</p>	<p>N/A</p>	<p>CT does not ask this question as there are no assessed settings that meet this criteria.</p>
	<p>Are visitors restricted to specified visiting hours?</p>	<p>Observation 5</p>	<p>The individual exercises rights as he or she chooses. The intent of this indicator is to observe that the individual's rights are supported and promoted. Examples include but are not limited to; food, entertainment use of the telephone or internet, access to personal mail, access to funds, access to privacy, to be free from unnecessary restraint, to be free from unnecessary restrictions, to be free from abuse and neglect, the right to prompt medical and dental treatment, the right to vote, the right to practice chosen religious beliefs, and the right to make daily choices about what to eat, wear and who to associate with.</p>
	<p>Are visitors restricted to a specific meeting area in the home?</p>	<p>Observation 5</p>	<p>See Above</p>
	<p>Are participants able to come and go from the home when they want to?</p>	<p>Observation 5</p>	<p>See Above</p>
	<p>Is transportation available to access community?</p>	<p>Observation 5</p>	<p>See Above</p>
	<p>Can participants access the community?</p>	<p>Support Person Interview 29 and Consumer Interview 23</p>	<p>SPI 29: How do you help the individual to choose and participate in experiences and activities that he or she wants to promotes integration and does not isolate Give some recent examples. The intent of this indicator is to determine if the support person assists the individual to participate in chosen activities and to learn about community resources and activities. Support person is able to give recent examples of the how the individual was assisted to choose and participate. CI 23: Are you able to do activities that you choose when you want to and is there staff support if you need it? The intent is to determine if this individual is allowed to choose and participate in an activity that is different than what others in the home are doing.</p>
	<p>Do participants have access to their funds?</p>	<p>Consumer Interview 66</p>	<p>Do you get to control your money as much as you want to? The intent of this indicator is to determine how much control the individual has regarding his/her personal finances. Control includes the involvement or reasonable participation that the individual has in the administration of his or her finances. For example, is the individual able to control their money in order to make choices of what to purchase. Does the individual carry money on their person? This indicator should be rated based on the service type being reviewed.</p>

**Choice in Living/Setting Space**

<p>Individual has choice in how they live their life within their support setting. This includes their schedule, routines, décor, activities and dining preferences.</p>	<p>Does the home have supports (e.g., grab bars, seats in the bathroom, and ramps for wheelchair such as ramps, lifts and elevators) for participants who need them?</p>	<p>Safety Checklist 29</p>	<p>Safety Checklist relating to adaptive equipment</p>
	<p>Do participants choose and control their schedule (e.g., eating, sleeping, exercising, visitations) to meet their</p>	<p>Observation 5</p>	<p>See Above</p>
	<p>Do participants have access to a telephone or cell phone for personal communication in private at their convenience?</p>	<p>Observation 5</p>	<p>See Above</p>
	<p>Do participants have access to a computer, iPad, or similar devices in private at their convenience?</p>	<p>Observation 5</p>	<p>See Above</p>
	<p>Are participants able to participate in leisure activities (e.g., TV, radio, cards, reading, board games, etc.) at their convenience?</p>	<p>Documentation 17</p>	<p>The record indicates the individual is engaging in activities that reflect personal preferences. Review the individual's documented personal preferences in his or her Individual Plan. Review documentation of preferred activities in which the individual participates.</p>
	<p>Can participants lock the bathroom/bedroom door(s)?</p>	<p>Safety Checklist 32</p>	<p>Bathrooms, common areas, and personal living spaces afford privacy and have the ability to be locked. The intent of this indicator is to determine that the individual's environment meets their need for privacy, as appropriate. For example, doors on bathrooms and bedrooms, partitions and/or privacy screens in common areas, window coverings, locks in bathrooms and bedrooms.</p>
	<p>Are participants able to furnish and decorate their bedroom in a way that suits them?</p>	<p>Observation 12 and Consumer Interview 37</p>	<p>O 12: The individual has personal belongings and his or her environment has a personalized decor. The intent of this indicator is to determine if the person expresses his or her individuality as desired. Is personal décor consistent with the personal interests of the individual? Does the individual own personal belongings and have these items in his/her possession? Consider how personal belongings are regarded when the individual shares with a roommate. CI 37: Are you able to make choices, express your opinions, and give input? The intent of this indicator is to determine if the individual feels that his or her ideas, opinions and input are respected. This indicator should be rated based on the service type being reviewed. Do people ask you what you think? Do people ask you how you feel about things?</p>
	<p>Do participants have access to a kitchen with cooking facilities?</p>	<p>Observation 5</p>	<p>See Above</p>
	<p>Can participants choose when to have a meal or snack?</p>	<p>Observation 5 and Consumer Interview 37</p>	<p>O 5: See Above CI 37: Are you able to make choices, express your opinions, and give input? The intent of this indicator is to determine if the individual feels that his or her ideas, opinions and input are respected. This indicator should be rated based on the service type being reviewed. Do people ask you what you think? Do people ask you how you feel about things?</p>



**Staff Interaction and Privacy**

Staff treat individuals in a respectful manner and support their requests. This includes knowing their rights, how to file a complaint, ability to lock doors and have privacy unless a modification to the plan is made due to team-documented decisions based upon an individuals needs.

Do participants know how to file a complaint and/or advocate for themselves and their rights?

Support Person Interview 10, Consumer Interview 49 and Consumer Interview 60

SPI 10: How do you support the person to know their rights and be able to speak up for them self and attend self advocacy? The intent of this indicator is to determine if the support person actively supports the individual to exercise rights. Examples may include, but are not limited to: assisting to make choices, request changes, refuse requests, use the phone, have privacy, maintain confidentiality and send and receive mail.  
 CI 49: Do you have someone you can talk to if you have a problem? Are you able to speak to someone privately/by yourself and feel safe talking to them?  
 The intent of this indicator is to determine that the individual has someone with whom they can privately share problems, complaints or personal matters. This indicator should be rated based on the service type being reviewed. This refers to formal and informal complaints or grievances.  
 CI 60: Do you know how to ask for help if you have a problem or if someone has hurt you or someone else you know? Are you able to speak to someone privately/by yourself and feel safe talking to them?  
 The intent of this indicator is to determine if the individual can effectively ask for help if someone is hurting him or her or others.

Are staff members friendly and attentive to participants' requests and needs?

SPI 30 and CI 56

SPI 30: If the individual chooses, what would you do to support the individual to change his or her lifestyle, personal activities and/or routines and promotes integration and does not isolate. The intent of this indicator is to determine if the support person knows how to support the individual to make changes to his or her lifestyle, personal activities and/or routines should the individual choose.  
 CI 56: Are you happy with the people who provide help and assistance to you at home or at your job? Does support staff listen to you?  
 The intent of this indicator is to determine the individual's level of satisfaction with his or her support persons at the service being reviewed. For example, for a day service, ask about daytime support person; at a work service, ask about happiness with work support persons; at a residential setting, ask about happiness with home support persons.

Do staff members always request and receive permission prior to entering a participant's bedroom/bathroom?

Observation 3 and Consumer Interview 9

O 3: The individual has privacy when he or she wants or needs it, their own room, locks on door if requested, key to home?  
 The intent of this indicator is to determine if the person is afforded privacy. Privacy may involve having locks on doors, personal access to a phone, access to own mail, personal space for possessions, visits with friends and family in private, etc. The individual's confidential information is not posted in view. Support staff discuss health care needs and personal issues with the individual privately. If desired, is there opportunity for the person to have privacy and/or time away from others? If sharing a room, consider how comfortable the person is with privacy arrangements with roommate. CI 9: Do people respect your private space? Do people ask to come into your bedroom/home?  
 The intent of this indicator is to determine if the individual's privacy is respected.

Can participants lock the doors, do they have access to keys if desired?	Observation 3	See Above
If a Modification to the Settings Rule is necessary, it must be documented for each individual and needs to be supported by an assessed need and justified in the person-centered plan (IP). Does documentation note if positive interventions and supports were used prior to any plan modifications? Are less intrusive methods of meeting the need that were tried initially documented? Does the plan include a description of the condition that is directly proportional to the assessed need, data to support ongoing effectiveness of the intervention, time limits for periodic reviews to determine the ongoing necessity of the modification, informed individual consent, and assurance that the intervention will not cause the individual harm?	Documentation 26	The individual's record contains necessary Human Rights Committee (HRC), Program Review Committee (PRC), and consent documents, as applicable. The intent of this indicator is to ensure that there are applicable HRC, PRC and consents available in the individual's record as required.

**Choice of Providers/Services**

Individual choices are incorporated into the services and supports received, The individual, or a person chosen by the individual, has an active role in the development and update of the individual's person-centered plan.	Do participants, or a person chosen by a participant, have an active role in the development and update of their person-centered plan/plan of care?	Documentation 1	The individual's plan indicates he or she directed or participated in the planning process to the extent that he or she chose to participate. The intent of this indicator is to ascertain if the individual has involvement in the planning process to his or her desire and capability. Family members sometimes participate along with the consumer. Individuals and their family members are encouraged to participate in the planning process to the greatest degree possible; they may or may not choose to participate in the process. Individuals and their family members are encouraged to communicate their needs and preferences and to choose from among support options and providers. Every effort will be made to schedule the planning meeting at times and locations that will facilitate participation by the individual and his or her family, guardian, advocate or other legal representative, as applicable. If the individual chooses not to attend his or her planning meeting, a personal support team member will seek from the individual his or her feedback that will be used at the planning meeting to develop his or her Individual Plan. If the individual chooses not to attend his or her planning meeting, the plan is to be reviewed with the individual by a support team member, dated and documented on IP. 11 Signature Sheet, of the Individual Plan. If the individual's guardian is
	Are participants generally satisfied with the services they receive from staff at the home (e.g., personal care, independent living skills training)?	Consumer Interview 56 and Documentation 21	CI 56: Are you happy with the people who provide help and assistance to you at home or at your job? Does support staff listen to you? (See Above) D 21: The Individual Plan or Individual Progress reviews document the individual's satisfaction with supports and services.

## Report Filters:

Service: "CLA4+" Active Indicator? "Yes"

## AP Application Packet

1. AP 2 There is documentation of sprinkler and fire alarm system servicing for a building that has a sprinkler and/or a fire alarm system.
- The intent of this indicator is to ensure that there is documentation available showing that the fire alarm system has been serviced on a semi-annual basis (two times per year) and the sprinkler system has been serviced on a quarterly basis (four times per year). More frequent servicing is performed in accordance with manufacturer's specifications.
- Refer to DDS Fire Safety & Emergency Guidelines, reissue 08/09.
2. AP 3 There is an annual fire marshal's certificate.
- The intent of this indicator is to ensure that there is documentation available showing that the Fire Marshal has conducted an annual inspection, as required.
- For Private: Look for Fire Marshal's certificate  
For Public: Report of Inspection
- Refer to DDS CLA Licensing Regulation: 11b
3. AP 4 There is documentation that a local fire or building official has approved the installation of a wood stove.
- The intent of this indicator is to ensure that there is documentation available showing that the local Fire Marshal and/or building official have approved the installation of a wood stove, if applicable.
- Refer to DDS CLA Licensing Regulation (CLA3-): 11c  
Refer to DDS CLA Licensing Regulation (CLA4+): 11d
4. AP 5 There is documentation of annual chimney cleaning when a fireplace or woodstove is used.
- The intent of this indicator is to ensure that there is documentation available showing that there has been an annual chimney cleaning for a fireplace or wood stove, if used.
- Refer to DDS CLA Licensing Regulation (CLA3-): 11c  
Refer to DDS CLA Licensing Regulation (CLA4+): 11d
5. AP 6 There is documentation of annual furnace servicing performed at the individual's residence, as applicable.
- The intent of this indicator is to ensure that there is documentation available showing that the furnace has been serviced annually, or according to manufacturer's specifications.
- If a question is raised as to who is qualified to perform maintenance, the authority having jurisdiction in the town in which the home is located can make the determination regarding who is qualified.
- The manufacturer or service agent provides documentation to validate appropriate furnace servicing that occurs less frequently than annual.
- Refer to DDS CLA Licensing Regulation (CLA3-): 11c  
Refer to DDS CLA Licensing Regulation (CLA4+): 11d
6. AP 7 There is documentation from a public health official or certified septic contractor stating the septic system is functioning properly.
- The intent of this indicator is to ensure that there is documentation available from a public health official or certified septic contractor showing that the septic system is functioning properly.
- This indicator shall be rated "N/A" for homes using a city sewer system.
- Refer to DDS CLA Licensing Regulation: 3a4
7. AP 8 There is documentation of a certificate of occupancy for new construction, as required by state or local codes.
- The intent of this indicator is to ensure that there is documentation available showing that there is a Certificate of Occupancy available for any new construction, as required.
- A Certificate of Occupancy is required for new construction of a residence or structural changes made to an existing residence as defined by state and local codes governing construction.
- Look for new construction when conducting a review (e.g., new deck, new wiring, plumbing, etc.). If new construction or renovations requiring a permit have occurred, a new Certificate of Occupancy, and/or a permit, should be available.
- Refer to DDS CLA Licensing Regulation: 11a

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**I 8. AP 10**

There is documentation that well water is tested for potability every five years and found to be safe.

The intent of this indicator is to ensure that there is documentation available showing that well water has been tested for potability every 5 years and has been found to be safe. Ensure any findings from testing agent have been addressed.

For CLA: A bacteriological report from a certified water analysis company is required for initial licensure to certify the water is potable.

Refer to DDS CLA Licensing Regulation: 3a3

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**CI Consumer Interview**

9. CI 1 Are you happy with where you live, work, and day program?  
The intent of this indicator is to determine the person's level of satisfaction with his or her life experience. Tell me about your home, your work or day program. How long have you been there? What are the things you like about being there? What things do you not like? If you're not happy here, what would make you happy? If you don't like where you live, work or your day program what don't you like about it?  
This indicator should be rated based on the service being reviewed.  
When interviewing, an individual may be reluctant to speak negatively about others or their life circumstances.
10. CI 56 Are you happy with the people who provide help and assistance to you at home or at your job? Does support staff listen to you?  
The intent of this indicator is to determine the individual's level of satisfaction with his or her support persons at the service being reviewed.  
For example, for a day service, ask about daytime support person; at a work service, ask about happiness with work support persons; at a residential setting, ask about happiness with home support persons. An open, general question such as "Tell me what it's like to get help from the people who support you here" is suggested to avoid a yes or no response.  
This indicator should be rated based on the service type being reviewed.
11. CI 9 Do people respect your private space? Do people ask to come into your bedroom/home?  
The intent of this indicator is to determine if the individual's privacy is respected.
12. CI 9a At home, are you able to be alone and have privacy when you want without people questioning you?
13. CI 5 Are you ever afraid or scared when you are at home, in your neighborhood or at work (day program)?  
The intent of this indicator is to determine if the individual has a fear of physical and/or emotional harm from other people in their environments.  
This indicator should be rated based on the service type being reviewed.  
Is there anything about the people in your home, work or neighborhood that makes you feel unsafe?
14. CI 37 Are you able to make choices, express your opinions, and give input?  
The intent of this indicator is to determine if the individual feels that his or her ideas, opinions and input are respected.  
This indicator should be rated based on the service type being reviewed.  
Do people ask you what you think? Do people ask you how you feel about things?
15. CI 40 Are you doing things you want to do in your life?  
The intent of this indicator is to determine if the individual is doing things that he or she wants to do. Like going to sporting events, exercising, going to a religious service, or any other activities of your interest.  
Ask the individual if there are things that he or she wants to do and does not do now. Are these new things or things that the individual wanted to do for a long time? Ask the individual if they have discussed these desires with anyone? Have the things that the individual wanted to do been incorporated in the planning process?  
If it has not been addressed through the individual's planning process, then rate "Not Met".
16. CI 80 Did you choose the people that support you in your home and/or at your work/day services?  
The intent is to determine if the individual chose the agency/vendor supporting them.  
This indicator should be rated based on the service type being reviewed.  
Did anyone tell you about other providers and their supports? Did you visit this and other sites before the service provider was chosen?
17. CI 23 Are you able to do activities that you choose when you want to and is there staff support if you need it?  
The intent is to determine if this individual is allowed to choose and participate in an activity that is different than what others in the home are doing.

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

- 18. CI 58** Are you able to express yourself by sharing your culture, your religious ideas and traditions?
- The intent of this indicator is to determine if the person has opportunities to express his or her cultural preferences as he or she desires. Do you celebrate certain holidays? Do you have special traditions? Do you speak another language? Do you have favorite ethnic foods? Do you have a religious preference? Do you attend religious services?
- Consider how important cultural identity and preference is to the person being interviewed. Observe the individual in his/her environment and review the IP for expressions of cultural heritage and/or ethnic or religious preference. Ask the person about those things (e.g., native language, nationality flags, religious statues, artwork that reflects heritage and culture, etc.).
- If the individual identifies no preferences, rate "Met". "N/A" should not be used for this indicator.
- 19. CI 13** Do you have friends that you like to talk to or do things with? Do you have a best friend or someone you are really close to?
- This indicator is "Not Met" if the person expresses the desire to have friends and doesn't have any or if more/enhanced relationships are desired. Paid support persons should not be considered friends unless they spend unpaid time with the individual.
- 20. CI 15** Can you see and contact your friends and/or family when you want to?
- The intent of this indicator is to determine if the individual can contact his or her friends and/or family as much as they want to.
- Do you contact friends/family? How often does this contact occur? Do support persons help you when you need it?
- This indicator is rated "Not Met" if the person expresses an unfulfilled desire to see or contact friends/family. Contact with friends/family may be contraindicated by the individual's IP, Behavioral Support Plan, or court orders. Reviewer may defer this question if contraindicated. If contraindicated, rate "Not Rated".
- 21. CI 36** Are you participating in a self advocacy group or participated in any self advocacy meetings, conferences, or events?
- Have you participated in any meetings that help you speak for yourself?
- If the individual identifies that they have no desire to participate in any meetings, rate "N/A".
- 22. CI 49** Do you have someone you can talk to if you have a problem? Are you able to speak to someone privately/by yourself and feel safe talking to them?
- The intent of this indicator is to determine that the individual has someone with whom they can privately share problems, complaints or personal matters.
- This indicator should be rated based on the service type being reviewed.
- This refers to formal and informal complaints or grievances.
- 23. CI 66** Do you get to control your money as much as you want to?
- The intent of this indicator is to determine how much control the individual has regarding his/her personal finances. Control includes the involvement or reasonable participation that the individual has in the administration of his or her finances. For example, is the individual able to control their money in order to make choices of what to purchase. Does the individual carry money on their person?
- This indicator should be rated based on the service type being reviewed.
- 24. CI 70** Do you get the help you need to manage your money?
- The intent is to determine if the individual gets the support he or she needs to manage his or her money. Ask the individual to explain what support he or she receives. Rate "Not Met" if the individual wants additional support and it is not sufficiently provided.
- 25. CI 18** Does your case manager help you get what you need?
- Have you asked your case manager for help? What did you ask for? Did your case manager help you? Did you get what you needed?
- This indicator should be rated based on the service type being reviewed.
- 26. CI 68** Are you getting the supports you need? Do you get enough hours of support to meet your needs?
- What help do you get at home, at work, and in the community? Is there other help that you need? Are you satisfied with the amount and type of help you receive?
- This indicator should be rated based on the service type being reviewed.
- 27. CI 21** If you wanted to change your supports, do you know who to contact and how to make the change?
- The intent of this indicator is to determine if the individual is aware of the processes by which he or she can initiate a change in supports and services. Individuals can talk to their service provider, case manager, parents/family member, and guardian or advocate to initiate supports and service changes.
- This indicator should be rated based on the service type being reviewed.
- If the individual does not know that he or she can change supports, rate as "Not Met".

Report Filters:

Service: "CLA4+" Active Indicator? "Yes"

- I 28. CI 39 At your planning meeting, did people ask you what you like to do?  
The intent of this indicator is to determine if the individual's opinions are respected and elicited during their planning meeting or before the planning meeting if he or she chose not to attend. Did you talk about your life at the planning meetings? Did people listen to what you had to say? Did people ask what you would like to do in the coming year?  
This indicator should be rated based on the service type being reviewed.
- I 29. CI 27 Did you choose the people you live with and where you live?  
The intent of this indicator is to determine the involvement the individual had when choosing who/where to live (or not to have housemates). This indicator may be rated "Not Rated" if a significant amount of time has elapsed since the individual chose and does not remember the process.
- I 30. CI 28 Do you choose the support staff who help you?  
The intent of this indicator is to determine the involvement the individual had in choosing his or her support persons. Is the individual involved in the hiring process at any level? On a day-to-day basis, are support persons assigned to an individual or can the individual choose what support person helps him or her?  
This indicator should be rated based on the service type being reviewed.
31. CI 81 Do you know who to talk to if you don't feel good or have questions about how you feel or how to be healthy? Do you have a person that supports you that you can feel safe talking to them about your health?  
The individual is better able to make an informed decision about his or her health if he or she knows someone to contact about health concerns or circumstances.  
This indicator should be rated based on the service type being reviewed.  
In family settings (FAM), when there is not an agency providing supports: If this indicator is "Not Met", choose "Not Met - DDS Responsible." When an agency is providing the FAM supports: If this indicator is "Not Met", choose "Not Met".
- I 32. CI 60 Do you know how to ask for help if you have a problem or if someone has hurt you or someone else you know? Are you able to speak to someone privately/by yourself and feel safe talking to them?  
The intent of this indicator is to determine if the individual can effectively ask for help if someone is hurting him or her or others. What would you do if you felt in danger in the community or at home? Who would you tell?  
This indicator should be rated based on the service type being reviewed.  
Connecticut General Statutes 17a-238(b) states that individuals "shall be protected from harm and receive humane and dignified treatment which is adequate for such person's needs and for the development of such person's full potential at all times".  
If an Immediate Jeopardy situation, refer to: J1 Abuse or Neglect Observed or Reported.
- I 33. CI 43 Do you know what to do if there is a fire or some kind of an emergency?  
The intent of this indicator is to determine if the individual can appropriately respond to an emergency event.  
This indicator should be rated based on the service type being reviewed.  
What would you do in an emergency? For example, if you feel ill, if there is a fire, if you lost electricity, etc.

Report Filters:

Service: "CLA4+" Active Indicator? "Yes"

**O Observation**

34. O 1 The individual likes others he or she spends time with.
- The intent of this indicator is to determine if the individual is comfortable around people he or she spends the most time with including housemates, support staff, and/or co-workers. The individual is at ease, may smile or show other signs of feeling content. Other people are friendly and speak respectfully to the person. The individual interacts with others during the course of experiences observed. Consider body language and other means of communication.
- RES: The individual's visit at the respite is with others with whom he or she is compatible.
- OH/SL: Rate only if others are present. Others can include: housemates, guests, support staff, etc.
- FAM: If the individual lives with his or her family, do not rate the person's relationship with family members. Rate based on observations between paid support persons and the individual.
35. O 26 The individual shows satisfaction with things that he or she chooses to do.
- The intent of the indicator is to determine through observation, if the individual appears satisfied with activities around the home, at work or in the community. This also includes satisfaction with leisure activities, relationships and lifestyle preferences.
36. O 2 The individual is treated by staff in a respectful and dignified manner.
- The intent of this indicator is to determine if support persons treat the individual respectfully. The individual is referred to by name and spoken to in friendly, respectful tones. The individual is introduced to new people and included in conversations. The individual is not touched nor is his/her wheelchair moved without permission. Support persons do not ignore the individual. The individual is provided with personal appearance/grooming support as desired and/or needed.
- If immediate jeopardy situation refer to: J1, Abuse or neglect observed or reported.
37. O 19 The individual chooses the support staff who assist him or her at home.
- The intent of this indicator is to determine if the individual can choose or is provided opportunities for choice in relation to the support staff who assist him or her.
38. O 5 The individual exercises rights as he or she chooses.
- The intent of this indicator is to observe that the individual's rights are supported and promoted. Examples include but are not limited to; use of the telephone or internet, access to personal mail, access to funds, access to privacy, to be free from unnecessary restraint, to be free from unnecessary restrictions, to be free from abuse and neglect, the right to prompt medical and dental treatment, the right to vote, the right to practice chosen religious beliefs, and the right to make daily choices about what to eat, wear and who to associate with.
- Refer to Connecticut General Statutes, 17a-238
39. O 9 Support persons follow policies and procedures, as applicable, that affect restrictions of the individual's rights.
- Are restrictive procedures, as identified on the individual's PRC/HRC request approvals, implemented correctly? Rate this Indicator based on observations of support person's actions relevant to the individual that may involve restrictions of his or her rights.
- Observe if restrictive procedures are done according to DDS policy and procedure. Refer to: DDS Manual, Service Delivery – I.D. PR.009 Incident Reporting Attachments A-K, I.D. PR.011 Incident Reporting own home, I.E. PO.003 Behavior Medications, I.E. PO.004 PRC, IE PR.003 Behavior Modifying Medication Attachments A+B, IE PR.004 PRC Attachments A-F, IE PR.006 Pre-Sedation, I.F. PO.001 Abuse and Neglect, I.F. PR.001 Abuse and Neglect.
- If immediate jeopardy situation, refer to: J19 Untrained staff (safety issues, behavioral interventions, medication administration, emergency plan).
40. O 3 The individual has privacy when he or she wants or needs it.
- The intent of this indicator is to determine if the person is afforded privacy. Privacy may involve having locks on doors, personal access to a phone, access to own mail, personal space for possessions, visits with friends and family in private, etc. The individual's confidential information is not posted in view. Support staff discuss health care needs and personal issues with the individual privately. If desired, is there opportunity for the person to have privacy and/or time away from others? If sharing a room, consider how comfortable the person is with privacy arrangements with roommate.
- Refer to behavior program and/or supervision guidelines as needed.
- Refer to Connecticut General Statute 17a-238(b)
41. O 12 The individual has personal belongings and his or her environment has a personalized decor.
- The intent of this indicator is to determine if the person expresses his or her individuality as desired. Is personal décor consistent with the personal interests of the individual? Does the individual own personal belongings and have these items in his/her possession? Consider how personal belongings are regarded when the individual shares with a roommate.
- Refer to Connecticut General Statutes 17a-238(e)(5)
42. O 20 The individual has preferred belongings that identify his or her ethnicity, cultural heritage and/or religious preferences, as desired.
- The intent of this indicator is to determine if the person expresses his or her culture, ethnicity, and/or religion as desired through his or her belongings and environment. Consider how important cultural identity and preference is to the person.



**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

43. O 6 The environment supports the individual's needs, abilities, and interests.  
The intent of this indicator is to observe and determine if the environment supports the needs, abilities and interests of the individual. For example, has the environment been adjusted for a person with limited mobility or visual impairment? Does the environment have accessible bathrooms for individuals who use adaptive equipment? Is there enough room to navigate around the environment for individuals using walkers and wheelchairs? Is space available for individuals to pursue personal hobbies?
44. O 15 Adaptive equipment and assistive technology, if needed, is used by the individual to increase his or her independent participation in daily activities.  
The intent of this indicator is to determine if the person is using adaptive equipment/assistive technology as identified in the Individual Plan. Look for physician's orders to identify needed equipment, technology. This may include hearing aides, glasses, switch plates, communication boards and devices, dining equipment, barrier-free lifts, transportation needs, etc. Observe if support persons ensure that identified equipment, technology is used. Observations should be consistent with appropriate and safe use of adaptive equipment as identified in the IP. Observe during times that the person would typically use the adaptive equipment.  
If Immediate Jeopardy situation, refer to: J19 Untrained Staff.
45. O 4 The individual is supported to make choices in all areas observed.  
The intent of this indicator is to determine if the person is routinely afforded choice. Support staff offer and encourage personal choice of activities, food and beverages, privacy, entertainment, etc.  
If not observed, rate "Not Rated".
46. O 10 Support persons communicate in effective ways the individual can understand and takes the time to listen to the individual and are responsive when the individual communicates.  
The intent of this indicator is to determine if support staff communicate effectively with the person. Support persons rephrase comments to assure the person understands the discussion, and give the individual time, as needed, to respond. Support persons use speech, signing, gestures, question cues, communicate in the individual's native language, use adaptive equipment if applicable, offer clear choices and acknowledge the individual's responses, etc.  
Refer to behavior and/or communication guidelines as applicable.
47. O 17 Support persons respond to the individual's needs for assistance.  
The intent of this indicator is to observe if support staff respond to an individual's need for assistance. Responses must be prompt, meaningful and respectful.
48. O 16 Support persons give assistance to the individual only when necessary.  
The intent of this indicator is to observe that support persons are assisting an individual when needed while allowing the individual to be as independent as possible.
49. O 14 Support persons recognize and use naturally occurring opportunities when teaching.  
Support persons use incidental and informal teaching that occurs naturally and spontaneously in the course of daily events. Teaching that occurs naturally may or may not be related to an IP goal. If there is no opportunity to observe natural teaching, rate "Not Rated."
50. O 13 The individual is supported to accomplish outcomes as identified in his or her plan.  
The intent of this indicator is to determine if the plan is being implemented as designed. The supports and services identified in the individual's plan are coordinated and integrated in observed settings.  
The supports and services identified in the DDS Family Respite Center visit forms are coordinated and integrated as necessary.
51. O 7 Sufficient support persons are available to meet the individual's support and service needs identified in his or her Plan.  
The intent of this indicator is to determine if sufficient support persons are on duty to carry out the individual's IP, as well as, meet the needs of the other people receiving support in the setting. Review the support person schedule for the visit day, as needed, and compare to on duty support persons. If possible, observe during times identified as needing enhanced staffing to verify that the support is provided as specified. Refer to specific needs and support person requirements as identified in the individual's Individual Plan.  
"Sufficient support persons" is defined in the individual's Individual Plan (e.g., two-person transfer required, a requirement for a support person to be within visual sight of the individual at all times).  
If immediate jeopardy situation refer to Jeopardy Guidelines: J18 Inadequate number of staff (supervision, implementation of behavioral interventions, evacuation).  
Refer to DDS CLA Licensing Regulation: 13b
52. O 8 Support persons are able to demonstrate the skills needed to assist the individual to achieve his or her outcomes.  
Support staff should demonstrate competence in all aspects of the individuals care.  
Refer to IP.7 for skill/training requirements and observe for evidence of these skills.
53. O 18 Support persons protect the individual's safety.  
Observe if support persons are available and protect the individual's safety.

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**54. O 21**

The individual's health needs are addressed during daily activities.

This may include specialized health needs such as dietary, nursing delegated tasks, etc.

Refer to DDS CLA Licensing Regulation: 18a3A, 18c2

**55. O 25**

Support providers follow applicable DDS Health Regulations, policies, and procedures, advisories and directives.

The intent of this indicator is to observe that support person(s) have knowledge and understanding of applicable DDS Health Regulations, standards, policies, procedures, advisories and directives and that they demonstrate that knowledge during the course of the observation period in regards to the support given to the individual being reviewed. For example, the individual's Level of Need, dysphagia risk assessments, bathing and personal care protocols, and bed safety and side rail assessments.

For FAM service type: For individual's receiving services from a provider agency, observation is to be done for the areas identified in the Individual Plan as the responsibility of the provider agency.

If immediate jeopardy situation refer to: J19 Untrained staff (Safety protocols, behavioral interventions, medication administration, emergency plan).

"Not Rated" would be used if there is no opportunity to observe implementation of the policies. "N/A" can never be used for this indicator.

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**SPI Support Person Interview**

- I 56. SPI 49 How do you help the individual express his or her satisfaction with his or her life?  
Does the support person understand that part of their role is to help the individual express their level of satisfaction with their life? Does the support person help the individual express his or her level of satisfaction?
- I 57. SPI 30 If the individual chooses, what would you do to support the individual to change his or her lifestyle, personal activities and/or routines?  
The intent of this indicator is to determine if the support person knows how to support the individual to make changes to his or her lifestyle, personal activities and/or routines should the individual choose.
- I 58. SPI 29 How do you help the individual to choose and participate in experiences and activities that he or she wants? Give some recent examples.  
The intent of this indicator is to determine if the support person assists the individual to participate in chosen activities and to learn about community resources and activities. Support person is able to give recent examples of the how the individual was assisted to choose and participate.
- I 59. SPI 39 How do you support the individual to express their ethnicity, cultural heritage, and religious preference if he or she wants?  
The intent of this indicator is to determine if the support person is knowledgeable of the individual's preferences regarding their ethnicity, cultural heritage and religion.  
Describe how you assist the individual to participate in activities that reflect his or her cultural, ethnic or religious preferences.  
For example, the individual may choose to attend cultural, ethnic or religious activities such as festivals, parades, movies, holiday traditions, celebrations, restaurants or shopping opportunities, etc.  
If there is no evidence of preference by the individual and the support person is aware of this, rate "Met".  
If the support person is unaware of recognized ethnic, cultural and religious preferences of the individual, rate this "Not Met."
- I 60. SPI 14 How do you support the individual to develop and maintain healthy relationships including those with family as he or she wishes?  
The intent of this indicator is to determine if the support person has knowledge of the individual's ability in developing relationships.  
How do you support the individual to understand the benefits and risks of developing new relationships?  
Are there obstacles that impede the individual from developing relationships (e.g., staff support levels, support staff schedules, finances, transportation, medical complications, and family relationships)? If so, how does this affect the support you provide?
- I 61. SPI 21 How are you supporting the person to have enough money to do the things they want to do and be part of their community?  
The intent of this indicator to determine the support person's knowledge of the individual's financial resources. Have there been any purchases or community activities delayed or cancelled due to finances?
- I 62. SPI 2 What activities in the person's action plan/IP are you working on to support the person in meeting their goals?  
Support persons are able to discuss identified goals from the individual's IP. The support person identifies and discusses how the individual's goals are integrated into his or her daily routine.  
For Family Respite Center guests – refer to information regarding pre-admission, admission and visitation as identified in DDS Family Respite Services Policy and Procedures.
- I 63. SPI 22 How are you supporting the person to learn money management skill and understand their benefits?  
The intent of this indicator is to determine if the support person is knowledgeable of his or her responsibility to help the individual participate and learn money skills. Examples include: incidental teaching opportunities, money exchange during a purchase, making selections, informing the individual during a transaction process, support independent purchase transactions, banking, formal programs, budgeting, identifying coins and bills.  
If the IP identifies that the individual is independent or another party is responsible for money management, then rate "N/A".
- I 64. SPI 11 What are the behavioral interventions used to support the individual?  
The intent of this indicator is to determine if the support person is knowledgeable of the individual's behavioral support needs as identified in his or her IP and behavior support plan.  
Any physical intervention techniques that support persons use are from a DDS approved curriculum, for example, P.M.T. (Physical and Psychological Management Techniques). Refer to DDS Procedure No.I.D.PR.009 – Incident Reporting, Attachment I - DDS Approved Training Curriculum for Use of Aversive and Physical Restraint Procedures for a complete list that is periodically updated.  
This indicator will be rated as "NA" if there are no behavioral support needs / interventions / guidelines.  
Refer to: DDS Policy No. I.F.PO.001 – Abuse and Neglect, and DDS Procedure No.I.F.PR.001 – Abuse/Neglect Prevention, Notification if unapproved behavioral interventions are used. I.F.PR.001 – Abuse/Neglect Allegations Reporting, I.F.PR.004 – Abuse/Neglect Investigations-Recommendations and Prevention Activities.

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

65. SPI 15 If the person expresses they do not feel safe, how are you addressing this concern?  
The intent of this indicator is to determine that support persons are knowledgeable of the individual's specific safety needs and how they are addressed. (e.g.: pica, bolting behavior, dietary needs, bed rails, water safety, ambulation, regulating hot water, bathing, etc.). Do you have any other concerns about the individual's safety that are not currently identified or addressed?
66. SPI 17 What are the individual's needs during an evacuation?  
The intent is to ensure that the support person is knowledgeable of the individual's specific needs and requirements. Information from the support person should coincide with the individual's needs as outlined in the site emergency plan. (Examples: Transfer guidelines, staffing, supervision, prompting.)
67. SPI 16 How is the individual taught to recognize and report unsafe situations to others?  
The intent of this indicator is to ensure that the support person is knowledgeable of their role in teaching the individual safety skills. This can be in the form of incidental teaching opportunities or formal teaching strategies. (Examples: Broken latches and locks, lack of heat, safe flooring, walkways, stove, cooking, hot water, overloaded outlets, safe transportation, staffing levels and supervision and public safety awareness.)
68. SPI 35 What are the individual's medical needs and how are these addressed?  
The intent of this indicator is to determine the staff person's knowledge of the individual's medical needs and how they are addressed. Refer to the individual's plan and other medical documents for information about the individual's medical circumstances and treatment expectations including guidelines and protocols (e.g., for seizures, psychiatric conditions, cardiac issues, diabetic conditions).  
Tell me about the individual's medical needs, how they are addressed and what support you provide, if any, to carry them out. Alternate question: Tell me about [name a specific condition identified in the individual's medical record], how the condition is addressed and what support you might provide.  
If the staff person's knowledge of the individual's medical needs is not in accord with treatment expectations for him or her, rate this indicator "Not Met."
69. SPI 34 How is the individual supported to learn about and live a healthy lifestyle and discuss his or her health concerns?  
How do you support the individual to participate in activities to stay healthy? If the support person indicates that the individual makes unhealthy lifestyle choices, how are these addressed to ensure the consumer has acknowledged the risk he or she is taking? Does the support person have access to educational health information and is this information shared with the individual?
70. SPI 40 How do you help the individual to learn to avoid potentially abusive and neglectful situations and speak up if you believe something is wrong?  
The intent of this indicator is to ensure that the support person is knowledgeable of their role in teaching the individual to avoid potential abusive and neglectful situations. Informal ways: support persons counsel the individual about the safe and unsafe places in town, people who you don't know who ask for favors and possible responses to them, keeping money in personal accounts, etc. Formal ways: harm prevention, "street-smart" classes, etc.
71. SPI 10 How do you support the person to know their rights and be able to speak up for them self?  
The intent of this indicator is to determine if the support person actively supports the individual to exercise rights. Examples may include, but are not limited to: assisting to make choices, request changes, refuse requests, use the phone, have privacy, maintain confidentiality and send and receive mail.  
Refer to Connecticut General Statutes, 17a-238(a)
72. SPI 45 How would you support the individual to make a complaint if he or she wants to?  
The intent of this indicator is to determine if the support person is knowledgeable of their role in supporting the individual to make a complaint if he or she wants to.  
Refers to Connecticut General Statutes, 17a-238(e)(7)
73. SPI 9 What would you do if you witness abuse or neglect occurring?  
The intent of this indicator is to determine if the support person is knowledgeable about the intervention and reporting requirements associated with witnessing abuse or neglect.  
A "Met" rating indicates that the support person identifies that he or she would intervene immediately on behalf of the individual if he or she witnesses abuse or neglect. The support person identifies he or she is to make a verbal report as a mandated reporter to the appropriate agency (OPA, DCF, DSS or DPH) and to the supervisor of the agency to which they are assigned, informing them of any apparent or suspected abuse or neglect. The support person initiates reporting the circumstances on a DDS Form 255.  
This indicator is rated "Not Met" when the support person's statements are not consistent with DDS policy and procedure.  
Refer to: DDS Policy No. I.F.PO.001 – Abuse and Neglect and DDS Procedure No.I.F.PR.001 – Abuse/Neglect Allegations: Reporting and Intake Processes
74. SPI 32 How is the individual supported to make a change in his or her services if desired?  
The intent of this indicator is to determine if the support person is knowledgeable of their role in supporting the individual to make a change in their services if he or she wants to. Examples include: Assisting the person in notifying the Case Manager or other team members, assisting the person to request meetings, assisting the person in identifying service and provider options.

**Report Filters:**

**Service:** "CLA4+" Active Indicator? "Yes"

**SC Safety Checklist**

- i **75. SC 1** An Emergency Relocation Plan, a part of the DDS Special Operations Plan for Emergency Relocation, is maintained in a special notebook, the "Red Book", easily accessible to the staff.
- Contents of the Emergency Relocation Plan "Red Book" must include: The DDS Special Operations Plan for Emergency Relocation, DDS Emergency Fact Sheets for all individuals, Emergency Relocation Plan for Levels 1, 2, and 3 emergencies with all necessary directions and personnel contact information. This book should be updated as any changes occur.
- Emergency Fact Sheets and identification badges must include a color photo of the individual. Fact sheets and badges must be reviewed at least annually, and more frequently if supports change for the individual, or revisions to the plan occur.
- Refer to DDS CLA Licensing Regulation: 12a
- i **76. SC 2** The emergency response plan accommodates the support needs of the individual, each person's role during an emergency, and the availability of necessary medical information when the individual is away from his or her service location.
- The emergency plan addresses the supports each individual requires to evacuate safely (e.g., independently evacuates, needs verbal or physical assistance), identifies individuals' ambulation capability and level of supervision needed, medical needs, the support person/staff levels and responsibilities, and any physical environment or fire safety accommodations (fire doors, sprinklers, egress doors, smoke detectors, fire extinguishers, etc.).
- Refer to DDS Fire Safety and Emergency Guidelines.
- Refer to DDS CLA Licensing Regulation: 12a
- i **77. SC 3** There is an accessible working telephone with emergency numbers readily available.
- The intent of this indicator is to determine if the individual has access to a working telephone and emergency numbers. Emergency numbers may include but are not limited to 911, Poison Control, etc. Consider the individuals specific health and safety needs when rating this indicator. In a SL or Own Home, an accessible telephone may be in the home; it may be the phone of a neighbor or a cell phone programmed to 911. In CLA4 and CLA3, emergency numbers are posted in an easily visible location.
- If immediate jeopardy situation refer to: J7 No access to phone. The individual should be able to access the phone in case of emergency.
- Refer to DDS CLA Licensing Regulation: 11j
- i **78. SC 4** There are practiced and documented monthly fire evacuation drills. There is documentation that one drill, quarterly, is conducted when the individual is routinely asleep.
- Fire evacuation drills familiarize and instruct individuals and support persons in the procedures to be followed for safe evacuation. Drills are conducted with the full participation of all individuals.
- Refer to site-specific Fire Safety and Emergency Plan fire evacuation drill procedures.
- Fire evacuation drills shall occur monthly. Each shift shall participate in a drill at least once in a three-month period or quarter. Quarters and shifts are determined by the provider. At least quarterly, one drill shall occur at times when the individuals are asleep. Monthly drills shall rotate simulated fire locations and egresses used and these conditions of simulation shall alternate on each shift. Each designated means of escape should be used during drills at least annually.
- The provider shall use the DDS Evacuation Drill Report form or any other that provides same information.
- CLAs with a total occupancy of four or more residents are required to have Evacuation Scores (E-Score). E-Scores shall be updated on at least an annual basis or if there are any changes in consumers' response capability, staffing levels, building features or within six months of a new admission or discharge. Evacuation time limits are determined by the E-Score. In a CLA with an E-Score rating of Prompt, drills shall be within 3 minutes or less. In a CLA with an E-Score rating of Slow, the drill may be over 3 minutes but not in excess of 13 minutes. In a CLA with an E-Score rating of Impractical, drills may be more than 13 minutes.
- For those CLAs that have an E-Score designation of "Impractical to Evacuate" or have written approval from the Authority Having Jurisdiction (AHJ), occupants may be exempt from participating in drills. In this circumstance, simulated evacuation drills shall be conducted. The staff shall practice all aspects of the fire safety plan except for activating the alarm and physically evacuating occupants. Where simulated fire drills do occur there may be additional fire code requirements, the Authority Having Jurisdiction (AHJ) shall be consulted.
- If a CLA has a DDS approved waiver for Licensing Regulation 17a-227-12b, ensure that the approved "Duration", "Method" and "Provisions" as outlined on the waiver are implemented.
- Refer to DDS Fire Safety and Emergency Guidelines
- Refer to DDS CLA Licensing Regulation: 12b
- i **79. SC 8** A written plan of corrective action is documented and implemented for problems identified during a fire evacuation drill.
- If any inefficiency or other problems are identified during the evacuation drill, a written plan of specific corrective action(s) should be completed. Documentation shall include the actual implementation/resolution of the Plan of Corrective Action.
- Refer to DDS CLA Licensing Regulation: 12c

Report Filters:

Service: "CLA4+" Active Indicator? "Yes"

80. SC 9 There are fully charged fire extinguishers available in the kitchen and furnace area.  
Annual fire extinguisher servicing and monthly checks are documented.  
Refer to DDS CLA Licensing Regulation: 11g
81. SC 10 There are working smoke detectors on each level of the location that meet the individual's needs.  
The intent of this indicator is to determine if there are working smoke detectors on each level of the location and that the smoke detectors are designed to meet the individual's specific needs.  
Whenever possible, test battery operated smoke detectors onsite to determine if the battery is working. Provider personnel should follow the manufacturer's specifications for battery operated smoke detectors to determine ongoing testing and replacement frequency for batteries and the smoke detectors.  
Review documentation to verify that fire alarm systems that are wired to a phone line are tested by a qualified or licensed professional e.g. an alarm company vendor, Fire Marshal, and that any recommendations are implemented.  
At residential and day service locations, audible and/or visual devices, e.g. smoke detectors, strobe lights, and fire alarm/bed shakers, are used and maintained according to manufacturers specifications.  
If immediate jeopardy situation refer to: J4 Non-functional fire alarm system or no working smoke detector.  
Refer to DDS CLA Licensing Regulation (CLA3-): 11c  
Refer to DDS CLA Licensing Regulation (CLA4+): 11d
82. SC 12 Designated means of escape are unobstructed.  
The intent of this indicator is to determine if the individual has unobstructed means of escape from the location. Egress doors and windows are not blocked and allow a clear path for evacuation. Obstructed means of escape are to be cleared when discovered.  
If immediate jeopardy situation refer to: J5 Obstructed means of egress.  
Refer to DDS CLA Licensing Regulation: 11d
83. SC 13 Exterior doors open from the inside without the use of tools or keys.  
Exterior doors shall open from the inside by using one or both hands engaged in a single unlocking motion. This is applicable to licensed residences with 3 individuals or less.  
In a CLA4+, use of other devices may be used with approval by the local Fire Marshal.  
In OH SL, hand operated dead bolts and safety chains are permissible unless contraindicated.  
If immediate jeopardy situation refer to: J6 Inability to open exterior doors from the inside without use of a key.  
Refer to DDS CLA Licensing Regulation (CLA3-): 11c  
Refer to DDS CLA Licensing Regulation (CLA4+): 11d
84. SC 14 Escape windows open without the use of tools.  
Reference the site specific evacuation plan to see if windows are part of the plan. Rate "N/A" if the plan does not include windows as an egress.  
Refer to DDS CLA Licensing Regulation (CLA3-): 11c  
Refer to DDS CLA Licensing Regulation (CLA4+): 11d
85. SC 15 Rooms and closets open from the inside.  
The intent of this indicator is to prevent individuals from being locked within rooms or closets. Locks on doors must not have the potential to prevent an individual's egress. Room and closet doors must open freely from the inside, without an individual needing to manipulate a locking device. If a door is locked, turning the doorknob from the inside will open the door, allowing egress.  
Refer to DDS CLA Licensing Regulation (CLA4+): 11d  
Refer to DDS CLA Licensing Regulation (CLA3-): 11c
86. SC 16 Rooms that lock have tools which open them readily available.  
Refer to DDS CLA Licensing Regulation (CLA4+): 11d  
Refer to DDS CLA Licensing Regulation (CLA3-): 11c

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

- 87. SC 52** The individual's bedroom has a minimum required size based on the number of occupants.  
Single occupant bedrooms contain at least 80 square feet. Multiple occupant bedrooms contain at least 60 square feet per individual.  
Look at the individual's bedroom and measure the room size, if necessary.  
Refer to DDS CLA Licensing Regulation: 11k
- 88. SC 17** Medications are to be kept locked, refrigerated as needed and access shall be limited to those authorized to administer medications except for individuals who self medicate and live independently.  
All medications shall be stored in a locked space solely used for the storage of medication. Controlled medications must be stored separately from other medications. Controlled medications must be stored under double lock in an immovable container. Medications requiring refrigeration shall be stored separately from food. Medications may be placed in a locked container in the same refrigerator in which food is stored. The temperature of the refrigerator shall be maintained between 36-46 degrees Fahrenheit. These requirements apply only to persons who cannot self-medicate as defined in the Medication Administration Regulations.  
Medications for individuals who self-administer shall be stored in such a way as to make them inaccessible to other individuals. Such medications shall be stored in a locked container or area unless the supervising nurse makes a determination that unlocked storage of the medication poses no threat to the health or safety of the individual or others.  
Controlled drug counts are completed at the beginning of each shift. Refer to Health Directive – DDS Medication Administration Practices for Controlled Drugs/ Medications, dated 7/25/08.  
If medicated items are found in an unlocked first aid kit, rate "Not Met".  
Potassium Iodide (KI) use for persons in the Emergency Planning Zone:  
This applies to the following public and private operated services in the EPZ: Community Living Arrangements, Individualized Home Supports, Continuous Residential Supports, Residential Centers, Family Respite Centers, Day Service Option locations, Sheltered Workshops, and Youth/Adult Camp.  
For individuals and support persons in the EPZ, DDS distributed KI, brand name IOSTAT, in April 2009 that have an expiration date of 2/2014. The KI tablets require a MD order and renewal every 180 days. The MD order shall state, "Potassium Iodide 130 mg po to be given per State of Connecticut Emergency Management Instructions". Only licensed personnel and certified unlicensed personnel can administer the KI tablets.  
Potassium Iodide Storage:  
For public services, the KI tablets are stored in the usual locked medication storage areas for safety reasons.  
For private services the provider should have a policy that addresses the storage area for KI tablets for safety reasons.  
The Department of Public Health (DPH) revised regulations for the "Emergency Distribution of Potassium Iodide in Youth Camps, Section 19-13-B27a (w)", that applies to Camp Harkness. The regulation requires that prior written consent is obtained for the voluntary ingestion of KI and that the documentation is maintained at the camp. Camps provide advice in writing to the person providing consent about the contraindications and possible side effects of KI. Only designated staff members can administer the potassium iodide tablets at camp, i.e. licensed personnel and certified unlicensed personnel. The KI tablets must be kept in a locked storage area or container in Youth Camps.  
Refer to DDS CLA Licensing Regulation: 18a1  
Refer to DDS Medical Advisory #99-3
- 89. SC 18** Basic first aid supplies are readily available at the individual's service location.  
Basic first aid supplies include only non-medicated items, excluding epi-pens. Refer to 11/2006 memorandum to providers from the DDS Director of Health and Clinical Services, regarding recommended first aid kit contents.  
If unlocked medications are found in first aid supplies, rate SC 17 as "Not Met" for individual's who cannot self-medicate.  
Refer to DDS CLA Licensing Regulation: 11h
- 90. SC 19** Basic first aid supplies are readily available in vehicles used to transport the individual.  
Basic first aid supplies include only non-medicated items, excluding epi-pens. Refer to 11/2006 memorandum to providers from the DDS Director of Health and Clinical Services, regarding recommended first aid kit contents.  
If unlocked medications are found in first aid supplies, rate SC 17 as "Not Met" for individual's who cannot self-medicate.  
Refer to DDS CLA Licensing Regulation: 11h
- 91. SC 20** Personal protection equipment (PPE) is readily available at the individual's service location.  
PPE shall include gloves, face shield or mask, eye protection, gown, a resuscitation device and other relevant PPE equipment items as described in agency's exposure control plan.  
Refer to DDS CLA Licensing Regulation: 11h

Report Filters:

Service: "CLA4+" Active Indicator? "Yes"

- ! **92. SC 21** Personal protection equipment (PPE) is readily available in vehicles used to transport the individual.  
PPE shall include gloves, face shield or mask, eye protection, gown, a resuscitation device and other relevant PPE equipment items as described in agency's exposure control plan.  
Refer to DDS CLA Licensing Regulation: 11h
- ! **93. SC 38** The individual's environment is free from potential hazards.  
The intent of this indicator is to determine if the individual's interior environment and property are free from potential safety hazards. For example, interiors, walkways and stairs are in good repair, garbage is properly contained or disposed of, the property is free of pests and pets have appropriate vaccinations and are not contraindicated for the individuals.  
There is safe storage of all materials consistent with individuals' needs. Consider individual specific safety needs, such as PICA, etc. For example, flammable items, poisonous items, cleaning products, etc.  
If immediate jeopardy situation refer to: J13 Pest Infestation, J15 Poisonous substances accessible, J16 flammable substances.
- ! **94. SC 28** The exterior and grounds of the individual's environment are safe.  
Exterior grounds should be clear of potential hazards and maintained in good condition. For example, refuse is properly contained or disposed of, the property is free of pests, egress doors and pathways are not blocked, pathways and driveways are maintained and free of debris and snow/ice during winter weather and pool areas are fenced and secured as appropriate. All exterior environments are well maintained. Ensure ornamental plantings do not pose a visual obstruction near traffic areas.  
For cleanliness concerns, rate SC 27a "Not Met".  
If immediate jeopardy situation refer to: J5 Obstructed means of egress.  
Refer to DDS CLA Licensing Regulation: 11d
- ! **95. SC 27a** The individual's environment is clean.  
This indicator refers to all interior and exterior cleanliness.  
For physical environmental conditions that require funding or a contracting process for remediation, use indicator SC50.  
Refer to DDS CLA Licensing Regulation: 11d, 11i
- ! **96. SC 27b** The individual's environment is structurally well-maintained.  
This indicator refers to both interior and exterior structural concerns.  
For potential safety concerns rate "SC 38" or "SC 28" "Not Met" as applicable. Dangerous situations caused by structural decline of the environment may indicate an immediate jeopardy situation; refer to Immediate Jeopardy Situation Reviewer Guidelines.  
For physical environmental conditions that require funding or a contracting process for remediation, use indicator SC 50.  
Refer to DDS CLA Licensing Regulations: 11d, and 11i
- ! **97. SC 50** There are no physical environmental conditions that require funding or a contracting process for remediation.  
Remediation may include a capital improvement project or other corrective method that requires a long-term solution. Issues may include modifications to a home to promote individual safety, accessibility and privacy (e.g., climate control, handrails, countertops, free movement, bathroom, kitchen or other renovations, etc.).  
Rate "Not Rated" unless documentation of funding process is available.  
Refer to DDS CLA Licensing Regulation: 11d
- ! **98. SC 27c** The individual's environment is adequately lighted, has a comfortable temperature and is free from unpleasant odors.  
For physical environmental conditions that require funding or a contracting process for remediation, use indicator SC50.  
If immediate jeopardy situation refer to: J8 No heat; J9 No electric; J10 No or insufficient water (or unsafe water supply).  
Refer to DDS CLA Licensing Regulation: 11d, 11i
- ! **99. SC 35** Furniture and furnishings are safe and in good repair.  
Interior and exterior furniture and furnishings do not produce potential safety hazards to individuals.  
For example: Rugs have non-skid backing. Furniture arrangement does not restrict easy navigation for individuals who use adaptive mobility equipment.  
Refer to DDS CLA Licensing Regulation: 11e



**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

- 100. SC 30** The location has sufficient toileting and/or bathing facilities and supplies to meet the individual's needs.

The intent of this indicator is to determine if the location has sufficient bathing/toileting facilities and supplies. Consider the individual's specific needs for safe access and use of the facilities.

For physical environmental conditions that require funding or a contracting process for remediation, use SC50.

Refer to DDS CLA Licensing Regulation: 11f
- 101. SC 25** There is sufficient storage space for clothes and personal belongings.

Individuals should have room to safely store their personal belongings, clothing, etc. Storage space may include individual storage areas, closets, bureaus, trunks, etc.

Refer to DDS CLA Licensing Regulation: 11i
- 102. SC 31** Personal hygiene supplies in the individual's environment are stored separately from others and in a sanitary manner.

Toothbrushes are stored in individual holders and nail clippers are not shared, etc. If more than one individual's supplies are kept in the same area, the supplies are labeled with the owner's name.
- 103. SC 32** Bathrooms, common areas, and personal living spaces afford privacy.

The intent of this indicator is to determine that the individual's environment meets their need for privacy, as appropriate. For example, doors on bathrooms and bedrooms, partitions and/or privacy screens in common areas, window coverings in bathrooms and bedrooms.

Refer to DDS CLA Licensing Regulation: 11f
- 104. SC 33** The individual's bedroom has a window or door that opens directly to the outside for ventilation.

Screened windows should be intact.

Refer to DDS CLA Licensing Regulation: 11c
- 105. SC 26** Kitchen and dining areas have appropriate equipment for the sanitary storage, preparation, and serving of food and an adequate supply of food.

Equipment includes but is not limited to: refrigerator, stove, other appliances, dishes, utensils, etc.

All burners on gas stoves are working properly.

If immediate jeopardy situation refer to: J12 Inadequate food supply.

Refer to DDS CLA Licensing Regulation: 11i

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

- 106. SC 34** Hot water temperature is maintained between 100 and 120 degrees Fahrenheit at water sources accessible to the individual.
- This indicator applies to sinks, bathtubs, bottled water dispensers with a hot water tap or other hot water source that an individual has access to.
- Water temperature must be maintained between 100 and 120 degrees Fahrenheit. For ICF settings water temperature must be maintained between 100 and 110 degrees Fahrenheit.
- Any support person who directly assists individuals during bathing must check the water temperature immediately before assisting the individual into the bath or shower. Refer to DDS Safety Alert; Hot Temperature Safety Awareness 12/27/2004.
- Hot and cold water dispensers present a serious burn hazard. DDS does not recommend use of such dispensers. If such units are present in any service, precautions must include a documented procedure for access to, education of and supervision of individuals using such units. Refer to DDS Safety Alert; Hot & Cold Water Unit Dispensers 6/9/2004.
- Hot tubs: Individuals must have a written doctor's order from their primary physician to use a hot tub. Individual's using a hot tub must have direct supervision by support staff. Support persons who assist individuals during hot tub use must check the water temperature immediately before use. Refer to DDS Policy I.P.R.E.001 Water Safety.
- If immediate jeopardy situation refer to: J11 Hot water temperature above 138 degrees Fahrenheit. If water temperature exceeds 138 degrees Fahrenheit at hot water sources that an individual can access this is an immediate jeopardy situation. The provider must develop an immediate corrective action plan to resolve the potential burn risk. A corrective action plan involves but is not limited to:
1. Install a thermostatic mixing valve or regulator that maintains water temperature between 100 and 120 degrees Fahrenheit. For ICF settings water temperature shall be maintained between 100 and 110 degrees Fahrenheit.
  2. Regularly measure water temperatures to ensure that the water temperature is maintained between 100 and 120 degrees Fahrenheit. For ICF settings water temperature shall be maintained between 100 and 110 degrees Fahrenheit.
  3. Assess each individual's capability to independently regulate water temperature and provide instruction to safely regulate hot water as needed.
  4. Document in the individual's record his or her ability to safely adjust water temperature.
  5. Provide constant within eyesight supervision of each individual, as needed, to prevent burn accidents.
- In CLAs and CRSs a thermostatic mixing valve is required. These devices are to be installed at the primary water-heating source (e.g., furnace, hot water heater). All new CLAs are required to have a thermostatic mixing valve installed as a condition of initial licensure. Refer to DDS Directive: Hot Water Anti-Scald Device Installation 8/25/2006.
- Refer to DDS CLA Licensing Regulation: 11d
- 107. SC 36** Any electrical outlet within six feet of an open water source is protected by a ground fault circuit interrupter (GFCI).
- Refer to DDS CLA Licensing Regulation (CLA3-): 11c
- Refer to DDS CLA Licensing Regulation (CLA4+): 11d
- 108. SC 37** Electrical sockets and extension cords are not overloaded.
- Electrical outlet adapters shall not be used in electrical wall sockets. Wall sockets can only be used for one plug each.
- Power strips and surge protectors are acceptable for use when plugged into a single socket.
- Refer to DDS CLA Licensing Regulation (CLA3-): 11c
- Refer to DDS CLA Licensing Regulation (CLA4+): 11d
- 109. SC 39** Electrical cords are not run under rugs.
- Refer to DDS CLA Licensing Regulation (CLA3-): 11c
- Refer to DDS CLA Licensing Regulation (CLA4+): 11d
- 110. SC 40** Electrical outlets and junction boxes have cover plates and no exposed wires.
- Refer to DDS CLA Licensing Regulation (CLA3-): 11c
- Refer to DDS CLA Licensing Regulation (CLA4+): 11d
- 111. SC 41** A means to wash and dry clothes is available.
- Clothes washing and drying appliances are available either on site or otherwise accessible; a laundromat, for example.
- Refer to DDS CLA Licensing Regulation: 11m
- 112. SC 42** Clothes dryers are properly vented to the outside or to an appropriate inside filter unit.
- Clothes dryer venting is installed and maintained according to manufacturer's specifications.
- Refer to DDS CLA Licensing Regulation: 11d

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

- 113. SC 44**      Poisonous substances are correctly labeled and safely stored according to the needs of the individual.  
If immediate jeopardy situation refer to: J15 Poisonous substances accessible (as appropriate based on individuals).  
Refer to DDS CLA Licensing Regulation: 11d
- 114. SC 45**      Combustible and flammable substances are used and stored appropriately.  
Approved gasoline storage containers and approved propane storage containers are used. Oil-based paint, lighter fluid, and other substances are labeled and stored safely. Storage is permissible in a shed or garage if the substances are in limited quantities (i.e., five gallons or less of gasoline, no more than two gas grill propane tanks) and are stored in an area furthest from the residence. Attached storage areas must have a firewall adjacent to the residence.  
Applicable only to CLAs and CRSs, combustible and flammable substances are stored outside the individual's residence at least 10 feet away from the residence.  
If immediate jeopardy situation refer to: J16 Flammable substances in the home (gas, significant quantities of oil-based paint, etc.).  
Refer to DDS CLA Licensing Regulation: 11d    Hazard prevention
- 115. SC 43**      Basements are free of standing water.  
Refer to DDS CLA Licensing Regulation: 11d
- 116. SC 29**      The individual's environment is accessible, as needed, and promotes individual independence.  
The intent of this indicator is to determine if the setting is accessible to the individual. The setting has, as indicated by each individual's needs, ramps, automatic door openers, grab bars, tables, counters and appliances at appropriate height, ample space, etc. Bathing facilities meet the individual's needs. Any environment within the location where the individual receives service is accessible.  
For physical environmental conditions that require funding or a contracting process for remediation, use indicator SC50.
- 117. SC 49**      There is documentation that the safe condition and designed use of adaptive equipment and safety devices is monitored.  
Periodic monitoring and documentation of monitoring of the safe condition and designed use of adaptive equipment and safety devices should occur on a regular basis, in accordance with manufacturer's specifications, in order to ensure that the safety of the consumer and functionality of adaptive equipment and safety devices is evaluated. Note that this includes both the sample individual's adaptive equipment and safety devices and common adaptive equipment and safety devices.  
Seat/lap belts, wheelchairs, side rails, adaptive equipment, etc.  
For Bed and side rail safety: Bed safety audits must be completed at least annually. Refer to DDS Health Bulletin #98-4 R Bed and Side Rail Safety (Rev. 10/2000).  
There is documentation that all monitoring devices including but not limited to door alarms, listening devices or other sensors have been regularly checked and maintained in good operating condition. Refer to DDS Safety Alert, Individual Safety Monitoring Devices 4/4/2007.  
In OH-SL: If it is documented in the individual's IP that they are capable of independently monitoring his or her own adaptive equipment and safety devices, then rate "N/A".  
Refer to DDS CLA Licensing Regulation: 11e, 18a3A
- 118. SC 48**      Adaptive equipment and safety devices are in good condition and used as designed.  
The intent of this indicator is to ensure that both the sample individual's adaptive equipment and safety devices and common adaptive equipment and safety devices are being maintained and utilized as designed.  
Shower chair safety belts securely hold an individual and operate as designed. Grab bars are securely fastened, etc.  
If immediate jeopardy situation refer to: J2 Non-functioning adaptive equipment (wheelchair, braces, shower/tub/toilet chairs, bedrails, feeding pumps, etc.).  
Refer to DDS CLA Licensing Regulation: 11e, 18a3A
- 119. SC 46**      Vehicle adaptive equipment and vehicle safety devices are in good condition and used as designed.  
The intent of this indicator is to ensure that vehicle adaptive equipment and safety devices are used and maintained according to manufacturer's specifications, are functional and that they are utilized as designed. This includes manufacturer installed seat belts as well as wheelchair tie down & restraint systems, safety harnesses/vests, seatbelt clips, wheelchair lifts, etc.  
All adaptive equipment shall be secured so that it does not present a hazard while the vehicle is in use.  
The vehicle is clean and well maintained. There is no evidence of people smoking in vehicles.  
If immediate jeopardy situation refer to: J17 Vehicle safety equipment is in disrepair (seatbelts, wheelchair anchors, vehicle maintenance).

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**I 120. SC 47**

There is documentation that the safe condition and designed use of adaptive vehicle safety devices is monitored.

Periodic monitoring and documentation of the safe condition and designed use of vehicle adaptive equipment and safety devices should occur on a regular basis. This includes wheelchair tie down & restraint systems, safety harnesses/vests, seatbelt clips, wheelchair lifts, etc. This does not include non-adaptive vehicle seat belts.

Refer to DDS CLA Licensing Regulation: 18a2E

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**D Documentation**

**121. D 1** The individual's plan indicates he or she directed or participated in the planning process to the extent that he or she chose to participate.

The intent of this indicator is to ascertain if the individual has involvement in the planning process to his or her desire and capability. Family members sometimes participate along with the consumer. Individuals and their family members are encouraged to participate in the planning process to the greatest degree possible; they may or may not choose to participate in the process. Individuals and their family members are encouraged to communicate their needs and preferences and to choose from among support options and providers. Every effort will be made to schedule the planning meeting at times and locations that will facilitate participation by the individual and his or her family, guardian, advocate or other legal representative, as applicable.

If the individual chooses not to attend his or her planning meeting, a personal support team member will seek from the individual his or her feedback that will be used at the planning meeting to develop his or her Individual Plan. If the individual chooses not to attend his or her planning meeting, the plan is to be reviewed with the individual by a support team member, dated and documented on IP. 11 Signature Sheet, of the Individual Plan. If the individual's guardian is unable to attend the planning meeting, the provider has documentation on file to show that the plan was sent for review and approval of the plan.

The individual's plan documents how the individual was involved in directing his or her plan. As possible, the individual signs his or her plan. Individuals and the people who are important in their lives will receive the supports they need to be directly involved in the development and implementation of their Individual Plan including supports in their native language or primary mode of communication.

Refer to IP 9, Individual's Participation in the Planning Process. Refer to IP.11, IP Signature Sheet. Refer to Procedure No. I.C.1.PR.002b Subject: Planning and Support Team.

At Family Respite Centers, an individual's planning process is documented on DDS Family Respite Center forms. (DDS Family Respite Center Procedure Attachments B, F, G, H, I and L)

For individuals living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA4 (four or more individuals living in the home), DSO, GSE, SHE, SEI.

Refer to DDS CLA Licensing Regulation: 17d

**122. D 57** The individual's plan is on file at the service location, available for support staff to implement.

The individual's current Individual Plan must be on file at the service location within 30 days of plan development. The individual's IP may be at a provider location for support persons' use when the individual has mobile support services or an own home/family setting.

In the service types of DSO, GSE, SHE and SEI, if an individual lives in a private ICF/MR home, the plan used may be other than an Individual Plan. For example, IP short, IP transition, OPS, Person-centered Plan may be used.

If the individual's plan is not available at the service location, and service provider can show documentation of their attempts to obtain this information from DDS, the indicator will be rated "Not Met, DDS Responsible".

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**123. D 2**

The Individual Plan is developed and implemented on a timely basis.

The intent of this indicator is to determine if the team has developed, and provider has implemented the components of the IP they are responsible for in a timely manner. Time frames for implementation of the IP may be specified based on a person's specific needs, but not for the convenience of staff. If a goal has not been addressed, documentation as to why should be on file. All reviewers should review provider documentation including progress notes, data sheets, and in-service training records to determine if all of the services and supports were implemented in accord with the IP date.

Refer to Policy No. I.C.1.PO.002 Subject: Individual Planning: All individuals who receive DDS HCBS Waiver services, all children in Voluntary Services, all individuals who receive any DDS funded residential supports, including individualized home supports, and clients of the department who pay directly for residential habilitative services shall have an individual plan. For individuals who are enrolling in a HCBS waiver, the individual plan – short form, along with a Summary of Supports and Services, IP.6, may be used for the first 90 days of receipt of new HCBS Waiver services, 45 days in licensed settings, after which time an individual plan must be in place. At a minimum, individual plans will be reviewed and updated on a yearly basis. Individuals currently receiving HCBS waiver services who receive new residential or day supports and services or experience a major change in one or both of these services, must have a new IP.6 in place prior to a change in services. The individual plan shall be updated within 90 days of the change in waiver services except in licensed settings where an update is required within 45 days. Individuals who live in ICF/MR settings must have their individual plans updated within 30 days of a change in services.

Refer to "A Guide to Individual Planning – Individual Planning Timeframes - At a minimum, Individual Plans will be reviewed and updated on a yearly basis for persons enrolled in a waiver".

Reviewers should look to see that the Individual Plan has been updated annually, within the same month of the last year's plan. The current plan should be on file and ready for staff to implement within 30 days of the planning meeting.

Per procedure on extending an IP, if a plan needs to be extended beyond the last day of the month in which the IP was held in the previous year, the reviewer should look for documentation that team members were notified and agreed to continue the current plan until the team could meet. This should be documented on the front page of the current IP – on IP.1 Information Profile.

Refer to DDS Policy No. I.C.1.PR.002a: Refer to the IP Action Plan form for specific information on timelines for implementation of specific goals and strategies.

In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.

In the service types of DSO, GSE, SHE and SEI, if an individual lives in a private ICF/MR home, the plan used may be other than an Individual Plan. For example; IP short, IP transition, OPS, Person-centered Plan may be used.

**124. D 11a**

Demographic and personal information is maintained in the individual's record.

The IP Information Profile and other documented personal information are updated annually or when changes in the person's life occur. This information includes the individual's name, date of admission, date of birth, place of birth, social security number, department number, current family information, and personal characteristics including language, ethnicity, legal status and any other demographic information relevant to the individual.

In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.

Refer to DDS CLA Licensing Regulations: 16e, 16g, and 16i

**125. D 4**

The individual's preferences and personal goals are identified in his or her plan.

The individual's planning process includes the identification of personal goals, desired outcomes and personal preferences as reflected in IP.2: Personal Profile, IP.3: Future Vision, I.P. 5: Action Plan, IP.9: Individual's Participation in the Planning Process and IP.12: Periodic Review of Plan.

The individual's preferences can include relationships with family and friends, routines, community participation, ethnic, cultural, and religious identities, a vision for the future, etc.

In family settings (FAM), when there is #not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.

For consumers living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA, DSO, GSE, SHE, SEI.

Refer to DDS CLA Licensing Regulation: 17d, and 17f

**126. D 17**

The record indicates the individual is engaging in activities that reflect personal preferences.

Review the individual's documented personal preferences in his or her Individual Plan. Review documentation of preferred activities in which the individual participates.

Refer to DDS CLA Licensing Regulation: 17g

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**127. D 5a**

The individual's record contains necessary and current health, safety and programmatic assessments, screenings, evaluations, reports and/or profiles.

The intent of this indicator is to see that required medical, safety and programmatic assessments, screenings, evaluations, reports and profiles are up to date and current, medical appointments, and identification of routine health issues are current and documented in the individual's record. Medical appointments are to occur in the required time frames. Reference physician reports and consultant sheets for medical results and required follow-up.

Evidence found in IP.2: Personal Profile, IP.3: Future Vision, IP.4: Assessments, IP.5: Action Plan, and IP.6: Summary of Supports and Services. As part of the assessment review, the individual and his or her planning and support team shall complete and review the Level of Need (LON). If a significant need is identified in the LON it must be addressed in the IP.5 Action Plan. The individual's record, including assessments, shall include the status of current and needed healthcare. Reviewers should also look for needed and current Guidelines and Protocols in addition to the list above.

Refer to "A Guide to Individual Planning", Individual Planning Sections "Review Recent Assessments, Screenings, Evaluations and Reports" and the Assessments section of the Individual Plan, IP.4, should list the current assessments, screenings, evaluations, and reports that are available or needed by the individual. Any assessments or reviews identified as needed must be referenced in the Action Plan, IP.5 and should be done within three months. However, any issue or concern that poses an immediate risk must be addressed immediately.

Refer to DDS Health Standard #09-1, Routine Preventative Health Care and Attachment A, Minimum Preventative Care Guidelines. Refer to Health Standard #9-02 Guidelines for Deferred, Limited, or Declined Healthcare.

Documentation must be available to show what type of support the nurse is providing. If a nurse is provided through a Healthcare agency, the individual must sign a release so that copies of the agency's documentation of services provided is available in the home.

Self-Administration of Medication Assessments: All individuals are required to have a baseline assessment on file. The RN must identify on at least an annual basis that the assessment remains current. An updated assessment shall be completed whenever there is a change in the individual's self-administration abilities.

For Bed and side rail safety: Bed safety audits must be completed at least annually. Refer to DDS Health Bulletin #98-4 R Bed and Side Rail Safety (Rev. 10/2000).

Aquatic Activity Screening: Refer to DDS Policy I.P.R.E.001 Water Safety  
An individual's Bathing Guideline identifies the level of supervision needed and whether or not the individual can safely regulate water temperature. Refer to Safety Alert "Bathing and Personal care" issued 12/19/00, reissued 5/13/10.

The individual's plan shall consider the individual's need to participate in training for the detection and prevention of abuse and neglect, and to learn about economic supports (i.e. insurances, benefits, income). Includes individualized training on procedures to educate the individual about abuse and neglect detection and prevention if appropriate.

For day services, this indicator refers to assessments, etc., relevant to the day service circumstances.

In a family setting (FAM), (for medical appointments) documentation may be found in the family home for people who hire their own staff. The reviewer should ask the individual or personal representative if there have been any medical visits and if there is any documentation kept in these areas e.g. calendar. The reviewer should rate "met" when the family reports that they have had a medical appointment even if documentation is not available. Families often do not keep documentation of visits and do not send all information to their Case Manager; otherwise, documentation will be maintained in the case management record.

In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.

For DDS Family Respite Centers, refer to the Guest Profile and other respite documents identified in DDS procedures. Refer to DDS Family Respite Center forms (attachments B, C and D- physician's orders).

Refer to DDS CLA Licensing Regulation: 16d, 17e, 17k, 18a4A, 18a4B  
17k states the OPS planning process shall be conducted annually based on an annual assessment of the individuals functioning skills.

**128. D 9**

The individual's plan identifies behavioral issues and strategies, as applicable.

Behavioral issues and strategies shall be identified in IP.2: Personal Profile, LON and IP.4: Assessments and IP.5: Action Plan. The IP shall specify in which settings/supports the strategies are to be utilized.

In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.

For consumers living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA, DSO, GSE, SHE, SEI.

Refer to DDS CLA Licensing Regulation: 17f

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

- 129. D 10** The individual's plan identifies any supports that require coordination across settings.  
Refer to "A Guide to Individual Planning", Action Plan –IP.5. Settings include home, work and the community. Coordination of supports across settings may include specialized diets, medical concerns and adaptive equipment needs.  
For consumers living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA, DSO, GSE, SHE, SEI.  
Refer to DDS CLA Licensing Regulation: 17f
- 130. D 12** There is evidence that, if necessary, the individual is supported to obtain a legal representative to manage his or her finances.  
The need for a legal representative to manage the individual's finances may be identified in IP.5 Action Plan, IP.1 Information Profile, IP.2 Finances section and/or IP.9: Individual's Participation in the Planning Process. A legal representative may be a conservator.  
In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.  
For consumers living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA, DSO, GSE, SHE, SEI.
- 131. D 22** There is evidence that the individual has the support of a guardian or advocate as needed.  
The intent of this indicator is to determine that there is documentation identifying the individual's guardianship status. There shall be documentation that the individual's guardianship is reviewed by the Probate Court at least every three years. State law was amended in 2004 such that, for persons DDS determines to be "severe" or "profound", DDS need not submit a report for the 3-year review, unless specifically required by the Probate Court.  
There shall be evidence that the individual's team has addressed any identified need for an advocate, guardian or a change in guardianship.  
Refer to IP.9: Summary of Representation, Participation and Plan Monitoring under Choice and Decision-Making.  
In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.  
Refer to DDS CLA Licensing Regulation: 16f
- 132. D 28** The individual's record documents the support provided him or her to understand, obtain and maintain entitlements, benefits, and insurances.  
Refer to IP.1 -Information Profile to identify the individual's entitlements, benefits and insurances.  
Refer to DDS CLA Licensing Regulation: 16h
- 133. D 42** The individual's record documents that applications/redeterminations for Medicaid Title 19, DDS Waiver and other entitlements and benefits have been processed.  
The intent of this indicator is to ensure that the individual's redeterminations for Medicaid Title 19 and other entitlements and benefits have been processed and are on file in the individual's record and the HCBS Re-determination Form (IP.10) is present in the DDS Case management record and completed on an annual basis. An original HCBS Re-determination form with actual Case Manager signature must be maintained in the Case Management record.  
Refer to IP.1: Information Profile – Resource and Benefit information.  
Check to see if the individual is an HCBS Waiver recipient: CAMRIS; CDMMEN; status 1 field - if an individual is in the waiver, this field will display either "IFS" or "HCB". If the individual is in the waiver, in the individual's record look for: DDS Form 219 IFS or the IP.10 HCBS Re-determination form.
- 134. D 43b** After the IP development, providers obtain needed assessments, screenings, evaluations, reports and/or profiles and/or follow-up on recommendations.  
The intent of this indicator is to determine if providers have obtained needed assessments, screenings, evaluations, and reports in a timely manner. Refer to IP. 4 Assessments, Screenings, Evaluations and Reports, and the IP. 5 Action Plan to determine if these have been addressed within the timeframes specified in the individual's IP.
- 135. D 44** The individual's plan identifies health and safety issues and strategies.  
Refer to the Level of Need (LON) and IP.4: Assessments, Screenings, Evaluations, and Reports. Areas identified shall be addressed in IP.2: Personal Profile or IP.5: Action Plan.  
In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.  
For consumers living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA, DSO, GSE, SHE, SEI.  
Refer to DDS CLA Licensing Regulation: 17e



Report Filters:

Service: "CLA4+" Active Indicator? "Yes"

136. D 59 The individual's record documents the inspection, maintenance and monitoring of all Individual Safety Monitoring Devices.
- Review the Individual Plan for documentation of the need for Safety Monitoring Devices including, but not limited to: door alarms, listening devices and other sensors.
- Refer to DDS Safety Alert Issued April 4, 2007 regarding "Individual Safety Monitoring Devices". Review agency policy and procedures regarding Individual Safety Monitoring Devices. Documentation verifies that all Safety Monitoring Devices are regularly checked and maintained in good operating condition.
- Reviewers shall test safety monitoring devices to ensure proper working condition. If safety monitoring devices are not working properly, reviewers are to consider whether it is an immediate jeopardy situation and take proper action as described in the Jeopardy Guidelines.
137. D 33 The Individual Plan documents responsiveness to the individual's requests to make changes in supports and services or providers, if applicable.
- The intent of this indicator is to ensure that there is documentation available to show that the individual's team and/or provider has responded to the individual's requests to make changes in supports, services or providers.
- Evidence exists in the Individual Plan or Individual Progress Reviews that demonstrate that if the individual requested a change there was a response to this request. For example, implementation of the portability process, changes in service type, or amount of support is documented. The individual's Plan has been modified to reflect changes in the individual's life goals, circumstances or preferences.
- Refer to the individual's current IP, Individual Progress Reviews of the Plan.
- In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.
- For consumers living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA, DSO, GSE, SHE, SEI.
- Refer to Procedure No. I.C.1.PR.002b Subject: Planning and Support Team
- Refer to "A Guide to Individual Planning"
- Refer to DDS CLA Licensing Regulation: 17h
138. D 36 The Individual Plan identifies additional qualifications and training required for staff to adequately support the individual, if needed.
- The intent of this indicator is to ensure that there is documentation in the individual's IP.7: Provider Qualifications and Training section regarding support person training, specific to the individual's needs that are related to the support service being reviewed.
- IP.7 should reference staff qualifications and training specific to the individual, which may include but is not limited to the individual's health needs, behavioral support plans, ambulation protocols, allergy protocols, adaptive equipment, positioning, dietary / dining guidelines, etc.
- In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.
- For consumers living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA, DSO, GSE, SHE, SEI.
139. D 15 Individual Progress Reviews identify that the provision of needed supports and services is documented and progress is reviewed.
- The intent of this indicator is to determine if the services are being delivered to the individual as identified in the IP and that the provider maintains documentation of needed services and supports provided and progress made. Providers should maintain documentation on the specific personal outcomes and actions for which they are responsible, as outlined in IP. 5 Action Plan of the Individual Plan. This includes documentation of individual progress, data and/or anecdotal notes, as applicable.
- Service providers are required to submit a written six month Individual Progress Review to the Case Manager and other team members prior to the annual Plan and six months thereafter. Staff hired directly by the individual or family to provide self-directed supports will maintain ongoing documentation of the individual's progress on goals for which they are responsible.
- Refer to Procedure No. I.C.1.PR.002b Subject: Planning and Support Team. On an ongoing basis, the planning and support team will discuss any significant changes in the individual's life that warrant a revision of the Individual Plan. The planning and support team will identify the nature and minimum frequency of Plan reviews and shall meet to review and update the Individual Plan at least annually. A formal review of the Individual Plan may be requested at any time by a planning and support team member. In cases where more frequent meetings or progress reports are required by other state or federal regulations, the more stringent requirements shall prevail.
- Review provider specific plans including teaching strategies, nursing plans of care, protocols and guidelines. Attendance records may also be reviewed. If the person is not receiving the supports or services necessary, or if the individual is not making progress in his/her identified goals, the team should address the issue to ensure that the individual is receiving needed services.
- For consumers living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA, DSO, GSE, SHE, SEI.
- Refer to DDS CLA Licensing Regulation: 17h, 17j

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**140. D 18**

Individual Progress Reviews reflect progress on personal outcomes identified in the individual's plan.

The intent of this indicator is to ensure that the service provider reviews and documents progress on the specific personal outcomes and actions for which they are responsible, as outlined in the action steps IP. 5.

The provider should have documentation that a review has been made based on written, measurable, goals as identified in the Action Plan IP.5.

This indicator will be considered "Met" when the individual's record indicates that there is documentation that the provider has reviewed one or more personal outcomes noted in Action Plan IP.5 that the provider is responsible for.

In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.

For consumers living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA, DSO, GSE, SHE, SEI.

Refer to "A Guide to Individual Planning".

Refer to DDS CLA Licensing Regulation: 17h

**141. D 21**

The Individual Plan or Individual Progress reviews document the individual's satisfaction with supports and services.

The intent of this indicator is to ensure that there is documentation available regarding the individual's satisfaction with supports and services.

In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.

For consumers living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA, DSO, GSE, SHE, SEI.

**142. D 23**

The individual's record contains necessary notifications, including information shared with the individual and their representatives.

The intent of this indicator is to ensure that there is documentation available to show that the individual and his or her representatives have been properly notified as required.

Refer to IP. 1 Information Profile - Notifications and Reviews Section.

Refer to IP.6, Summary of Supports and Services.

In family settings (FAM), when there is not an agency providing supports, review Case Management Record only. When an agency is providing the FAM supports, review the agency's record for the individual.

For consumers living in private ICF/MR homes, this indicator is to be rated "Not Rated" for the following service types: CLA, DSO, GSE, SHE, SEI.

Refer to DDS CLA Licensing Regulation: 15a1

**143. D 26**

The individual's record contains necessary Human Rights Committee (HRC), Program Review Committee (PRC), and consent documents, as applicable.

The intent of this indicator is to ensure that there are applicable HRC, PRC and consents available in the individual's record as required.

Consents include those addressed during annual planning by the Case Manager. Consents include, as applicable (but not limited to): use of behavior modifying medication, use of restrictive programs and/or procedures, administration of medication, routine medical treatment, emergency medical treatment, medication disposal, photo release, release of confidential information and consent for pre-sedation for medical and dental procedures (as needed). There is evidence that the individual or his or her guardian controls access to personal information.

Initial consent is required for routine medical treatment and additional consent is required for non-routine invasive procedures, as needed.

If applicable, documentation of PRC and HRC reviews are on file, including documentation of follow-up to qualifications.

Refer to P&P I.E.PO.003 subject: Behavior Modifying Medications  
I.E.PR.003 subject: Behavior Modifying Medications (Attachment A) & See D1B, D2C&D  
I.E.PO.004 subject: Program Review Committee  
I.E. PR. 004 subject: Program Review Committee  
I.E. PR. 006 subject: Pre-Sedation for Medical/Dental Procedures

In a family setting (FAM), review the Case Management file only when there is not an agency providing the FAM supports. When an agency is providing the FAM supports, review the agency's records for the individual.

Note: PRC does NOT review psychotropic medications for individuals living with their families. PRC policy does apply if staff use restrictive programs with individuals living in their family homes.

Refer to DDS CLA Licensing Regulation: 15a1, 15b1, 15b2, 15b3B, 18a2A, 18a2B, 18a2C, 18a2D

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

- 144. D 27** The individual's record identifies that required procedures were followed if his or her rights were restricted.
- The intent of this indicator is to ensure that there is documentation available showing that required procedures were followed if the individual's rights were restricted.
- Refer to documents such as the Individual Plan, Behavioral Support Plan or DDS Incident Reports (DDS 255) to discover if the individual's rights have been restricted.
- Refer to relevant Policies and Procedures (e.g., restraint and/or aversive program methods). Restrictions may include buzzers installed on doors to restrict movement, and physical restraint or aversive program methods. Check for approval by PRC and/or HRC. Procedures are followed as designed and associated documentation is complete.
- In a family setting (FAM), review the Case Management file only when there is not an agency providing the FAM supports. When an agency is providing the FAM supports, review the agency's records for the individual.
- Refer to DDS Procedure I.E.PR.002 - Behavior Support Plans
- Refer to DDS CLA Licensing Regulation: 15a, 15b1, 15a4
- 145. D 27d** Approved behavioral techniques are used when an emergency restraint occurs.
- The intent of this indicator is to ensure that approved behavioral techniques are used when an emergency restraint occurs and proper documentation of the emergency restraint is available.
- Review records, including staff notes, the behavioral support plan, behavior data, DDS 255s to see if unapproved behavioral techniques or unauthorized restraint has been documented as having been used for the individual. Documentation of approved behavioral techniques includes proper notification of the use of emergency restraint, appropriate team notification and review of restraint, as required.
- Refer to list of DDS approved curriculum of restraints, PR.009 attachment I.
- Refer to DDS Procedure I.E.PR.002 - Behavior Support Plans
- Refer to DDS CLA Licensing Regulation: 15b1, 15b5
- 146. D 58** The individual has been informed of the complaint procedure to follow if he or she is not satisfied with his or her services and supports.
- The intent of this indicator is to ensure that there is documentation available to show that the individual and his or her representatives have been informed of the complaint procedure to follow if he or she is not satisfied with the services and supports being reviewed.
- Refer to agency policy and see if there is a documented complaint process. Documentation may include but is not limited to: consumer handbook, resident rights, agency policy, etc.
- Verify that the individual and/or guardian have signed an acknowledgement of the agency's grievance procedure.
- In a family setting (FAM), review the Case Management file only when there is not an agency providing the FAM supports. When an agency is providing the FAM supports, review the agency's records for the individual.
- 147. D 39** The individual's record contains documentation on DDS Form 255's for incidents of injury, restraint, unusual incidents and medication errors.
- The intent of this indicator is to determine that the provider is maintaining a copy of DDS 255's & 255m's at the service location. Review the individual's file to see if the DDS 255's & 255m's are on file for incidents involving injuries, unusual incidents, hospitalizations including ER & Walk-in visits, use of restraint and medication errors.
- Refer to DDS Procedure I.D.PR.009 Incident Reporting. This procedure delineates a standard process for reporting, documentation and follow-up.
- For Individuals who live in Own/Family Home and receive DDS funded services, refer to I.D.PR.009a.
- In a family setting (FAM), review the Case Management file only when there is not an agency providing the FAM supports. Documentation may be found in the family home for people who hire their own staff. The reviewer should ask the individual or personal representative if there is any documentation kept in these areas. Otherwise, documentation will be maintained in the case management record and with the FI record. When an agency is providing the FAM supports, review the agency's records for the individual.
- Refer to DDS CLA Licensing Regulation: 15a4B, 15a4D, 16a, 16b, 16c

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**I 148. D 40**

Individual's incidents and accidents are reported, investigated and followed-up as appropriate.

The intent of this indicator is to determine if the provider is routinely reporting all incidents and accidents using the DDS 255 Incident Report Forms and Critical Incident Follow-Up Form as necessary.

Verify that Follow-up is complete for all incidents and accidents that warrant follow up (e.g., follow-up may be by a nurse, team, clinician or other professional).

Discovery of accidents and incidents may occur in the course of reviewing documentation in general. For example, a provider log or nursing progress notes may indicate an occurrence of an incident or accident. If so, look for related incident and accident reports completed by the provider.

Refer to DDS Procedure I.D.PR.009 Incident Reporting. This procedure delineates a standard process for reporting, documentation and follow-up.

For Individuals who live in Own/Family Home and receive DDS funded services, refer to I.D.PR.009a.

In a family setting (FAM), review the Case Management file only when there is not an agency providing the FAM supports. Documentation may be found in the family home for people who hire their own staff. The reviewer should ask the individual or personal representative if there is any documentation kept in these areas. Otherwise, documentation will be maintained in the case management record and with the FI record. When an agency is providing the FAM supports, review the agency's records for the individual.

Refer to DDS CLA Licensing Regulation: 15a4B, and 15a4D

**I 149. D 54**

The individual has not experienced abuse or neglect.

The intent of this indicator is to determine if the individual has experienced substantiated abuse and/or neglect involving the service being reviewed.

The reviewer shall reference eCamris prior to the review to identify reports of abuse or neglect.

At the time of the review, the reviewer shall ask the provider to identify reports of abuse or neglect.

Rate "Not Met" if the individual has experienced substantiated abuse or neglect during the review period.

Rate "Not Rated" if an investigation is pending.

This indicator shall not be rated "N/A".

In a family setting (FAM), review the Case Management file only when there is not an agency providing the FAM supports. When an agency is providing the FAM supports, review the agency's records for the individual.

Refer to DDS CLA Licensing Regulation: 15a4a, 15a4C

Refer to DDS Policy and Procedure:

I.F. PO.001: Abuse and Neglect

I.F. PR.001: Abuse and Neglect, Allegations: Reporting and Intake Processes

I.F. PR.003: Abuse and Neglect, Investigation: Assignment, Tracking, Review, Completion

I.F. PO.004: Abuse and Neglect: Recommendations and Prevention Activities

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**I 150. D 46**

The individual's record shows policies and procedures were followed, and follow-up to Abuse and Neglect concerns regarding the individual, including notification to families.

The intent of this indicator is to verify that policies and procedures were followed if there was a report of abuse or neglect, including documentation detailing follow-up and notification to families and guardians.

Refer to DDS Policy and Procedure I.F.PO.001, Abuse and Neglect.

Refer to DDS Procedure I.F.PR.002, Abuse and Neglect/Notification.

The individual's record verifies that all allegations of abuse or neglect were made within required time frames ("report, or cause a report to be made to Office of Protection and Advocacy [OPA] as soon as is practically possible upon noticing or learning of the suspected abuse or neglect"/DMR OPA Interagency Agreement) and to appropriate agencies: OPA if the individual is between 18-59 years of age; Department of Children and Families (DCF) if the individual is under 18 years of age; Department of Social Services (DSS) if the individual is 60 years of age or over; and Department of Public Health (DPH) if a medical facility or provider is licensed by the DPH.

Documentation verifies an investigation was completed, with a subsequent determination. If abuse or neglect was substantiated, and recommendations were a result of that determination, documentation verifies implementation of the recommendations. If recommendation(s) were not implemented, documentation reflects rationale for no implementation.

If the individual is between 18-59 years of age, Protective Services, or Immediate Protective Services, may be warranted and imposed by the OPA. Protective Services are actions intended to prevent abuse or neglect, and include, but are not limited to: the provision of medical care for physical and mental health needs; the provision of support services in the facility (if applicable), including the time limited placement of department staff in such facility; the relocation of a person with mental retardation to a facility able to offer such care; assistance in personal hygiene; food; clothing; adequately heated and ventilated shelter; protection from health and safety hazards; protection from maltreatment, the result of which includes, but is not limited to, malnutrition, deprivation of necessities or physical punishment; and transportation necessary to secure any of the above-stated services. Documentation verifies the development and submission to the OPA of a Protective Service Plan within fifteen calendar days from receipt of the investigation report. The commencement of Immediate Protective Services shall occur prior to receipt of the completed investigation report.

Subsequent to the initial provision of protective services, the individual's record contains evidence of review of the plan, including meeting with the individual at least once every six months, to determine whether continuation or modification of the services is warranted. The review of the protective service plan also verifies implementation across all applicable settings.

In a family setting (FAM), review the Case Management file only when there is not an agency providing the FAM supports. When an agency is providing the FAM supports, review the agency's records for the individual.

Refer to DDS CLA Licensing Regulation: 15a4A, 15a4C, 15a4D

**151. D 7b**

Support providers carry out all health related orders as determined by health care professionals.

Documentation shall reflect that the individual's support team and health care provider(s) have considered and implemented all health related orders and recommendations. This applies to medical treatment, special dietary requirements, occupational therapy, physical therapy, and other therapeutic services.

Refer to IP.4 – Assessments, Screenings, Evaluations and Reports. Refer to DDS Health Standard #09-1, Routine Preventative Health Care and Attachment A, Minimum Preventative Care Guidelines.

For review purposes, D7b does not apply to medication administration or dental orders.

In a family setting (FAM), documentation may be found in the family home for people who hire their own staff. The reviewer should ask the individual or personal representative if there have been any medical visits and if there is any documentation kept in these areas e.g. calendar. The reviewer should rate "met" when the family reports that they have had a medical appointment even if documentation is not available. Families often do not keep documentation of visits and do not send all information to their Case Manager; otherwise, documentation will be maintained in the case management record.

When an agency is providing the FAM supports, review the agency's records for the individual.

Refer to DDS CLA Licensing Regulation: 18a3A, 18a4B, 18c2

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

- 152. D 8** There is evidence the individual experiences prompt treatment, management and follow-up services for his or her health issues upon identification.
- The intent of this indicator is to verify the individual has experienced timely treatment and ongoing care for non-routine and unexpected health issues. If a non-routine, significant and unexpected health issue is identified (e.g., a fall, an unexpected seizure), there is documentation that initial treatment is prompt, recommendations for further treatment are acted on, and designated follow-up occurs in a timely manner.
- Refer to IP.4 – Assessments, Screenings, Evaluations and Reports and other forms of documentation, e.g. progress notes, logbooks, etc. If nursing oversight is being provided, any changes in health status should be reflected in nursing documentation in the individual's medical record.
- Refer to applicable DDS Medical Advisories and Health Standards.
- In a family setting (FAM), documentation may be found in the family home for people who hire their own staff. The reviewer should ask the individual or personal representative if there have been any medical visits and if there is any documentation kept in these areas e.g. calendar. The reviewer should rate "met" when the family reports that they have had a medical appointment even if documentation is not available. Families often do not keep documentation of visits and do not send all information to their Case Manager; otherwise, documentation will be maintained in the case management record.
- When an agency is providing the FAM supports, review the agency's records for the individual.
- Refer to DDS CLA Licensing Regulation: 18a3A, 18a4A, and 18a4B
- 153. D 6** There is evidence that the individual has the needed support to manage his or her medication.
- Documentation shall identify the support the individual requires to manage his or her medications. Depending upon the individual's assessed need, the support of medication management can be part of a daily routine or an individual teaching plan.
- Refer to physician's orders, medication administration record (MAR), Self-Administration of Medication Assessment and IP as applicable.
- Self-Administration of Medication Assessments: All individuals are required to have a baseline assessment on file. The RN must identify on at least an annual basis that the assessment remains current. An updated assessment shall be completed whenever there is a change in the individual's self-administration abilities.
- 154. D 27c** Behavior modifying medications are managed consistent with the physician's treatment plan.
- Review the physician's treatment plan and related documentation for consistent implementation (e.g., how often blood work is done, how often TD screens are completed, other treatment directives, monitoring of side effects). Compare physician's orders with the individual's treatment plans.
- Verify that TD screenings and blood work are completed as recommended, psychiatrist appointments are attended as designated, medications are reviewed and changes are documented and current, the medication administration record (MAR) is checked for behavior medication administration and the monitoring of side effects, and behavior support plans are consistent with the physician's treatment plan.
- In DSO, GSE, SHE: Check the physician's orders and medication administration record (MAR) for behavior medication administration. Related documentation that is not the responsibility of the day service provider (bloodwork, TD screens, etc.) may not be required to be in the record.
- Refer to DDS CLA Licensing Regulation: 15b2, 18a1
- 155. D 32** The individual's record documents monitoring of medications and side effects.
- The intent of this indicator is to determine if the individual's record documents that provider licensed personnel are monitoring the individual's medications and side effects. Check the individual's medication administration record (MAR) to ensure that his or her medications are administered as prescribed.
- If the Self-Medication Administration Assessment identifies the individual is independent in self-administering medication and receives nursing oversight, the individual's progress reviews shall identify that a registered nurse monitors the administration of medication, including any adverse side effects. For self-administering individual's who live in their own home with no nursing support, rate "N/A".
- Refer to DDS CLA Licensing Regulation: 18a1

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

- 156. D 29** The individual's personal finances are protected through systematic record keeping.
- The intent of this indicator is to ensure that individual's personal monies are maintained and accounted for.
- Refer to provider policies and procedures for management of client funds. Refer to DDS Procedures for Handling Client Monies. Refer to IP.1 and IP Personal Profile, to determine the individual's capability in managing his/her finances and the level of assistance needed. Ensure that individual is receiving earned and unearned income (DSS personal needs allowance).
- Refer to I.F.ADV.001, The Use of Client's Personal Funds for Transportation to and from or while at a DDS Funded Day Program; I.F. ADV.003, The Use of Client's Personal Funds for Donations to Their Support Provider; and I.F. ADV. 004, Use of Consumer Funds to Procure Prescription and Nonprescription Medications and Outpatient Services
- In OHSL, CRS, CLA, CTH and RC, this refers to the individual's personal finances at home as well as bank accounts (checking accounts, savings accounts, etc). Review cash on hand balance sheets, cash on hand, check registers, checking account statements, saving statements, paystubs, bills and receipts. Ensure adequate documentation of all income and expenses. Ensure that expenses benefit the personal needs of the individual.
- In DSO, GSE and SHE, this applies to funds maintained at the program site. Review balance sheets and cash on hand.
- In RES, refer to DDS Family Respite Center form, Attachment J, Personal Spending Sheet.
- If the IP clearly states that the individual or family is responsible for managing the individual's finances and the provider is not responsible, rate "N/A".
- Refer to DDS CLA Licensing Regulation: 19a1, 19a3
- 157. D 30** The individual's personal finances are protected through periodic financial record audits.
- The intent of this indicator is to determine if the provider is protecting the individual's personal finances (e.g., ledger, checking and savings accounts, etc.) by conducting periodic financial record audits. Internal provider audits should be completed by an individual who does not regularly handle the individual's finances. Review completed audits and ensure audit recommendations are implemented. Refer to provider policies and procedures regarding systems for auditing individual's personal finances.
- For public services, refer to DDS Procedure I.F.PR.007, Personal Funds Financial Management.
- Refer to DDS I.F. Directives and Advisories: Adv.001 – Use of client personal funds for transportation. Adv.003 – Use of clients' personal funds for donation to the support provider. Adv.004 – Use of clients' funds to procure prescription & non-prescription medications and outpatient services.
- If the IP clearly states that the individual or family is responsible for managing the individual's finances and the provider is not responsible, rate "N/A".
- Refer to DDS CLA Licensing Regulation: 19a1
- 158. D 31** The individual has money to buy necessary personal items and participate in community activities.
- The intent of this indicator is to determine if the individual has access to financial resources to purchase needed personal items and participate in community activities. Review balance sheets, receipts and individual's leisure record to ensure opportunities for participating in community activities are provided and needed personal items are purchased.
- Refer to DDS CLA Licensing Regulation: 19a1
- 159. D 41** The individual's personal finances, including assets, and personal property are being managed and monitored responsibly.
- The intent of this indicator is to determine if the individual's property and assets are monitored responsibly. Refer to provider policies and procedures for management of client assets and property. Refer to IP, Personal Profile, to determine the individual's capability in managing his/her finances and the level of assistance needed. Refer to asset/account statements. Ensure that all monies are secured. Ensure that individual is receiving earned and unearned income (DSS personal needs allowance), maintaining balances within third party funding asset limits and paying bills in a timely manner. Ensure that expenses benefit the personal needs of the individual. In CLAs, refer to individual's personal property inventory and determine if personal property observed through course of review is included in inventory. Determine if inventories are updated as needed when purchases are made.
- For public services, refer to DDS Procedure I.F.PR.007, Personal Funds Financial Management.
- Refer to DDS I.F. Directives and Advisories: Adv.001 – Use of client personal funds for transportation. Adv.003 – Use of clients' personal funds for donation to the support provider. Adv.004 – Use of clients' funds to procure prescription & non-prescription medications and outpatient services.
- If the IP clearly states that the individual or family is responsible for managing the individual's finances and the provider is not responsible, rate "N/A".
- Refer to DDS CLA Licensing Regulation: 15a3, 19a1, 19a2, 19a4
- 160. D 47** There is evidence that emergency plans as required by policy and procedures are in place.
- The emergency plan addresses the supports each individual requires to evacuate safely (e.g., independently evacuates, needs verbal or physical assistance), identifies individuals' ambulation capability and level of supervision needed, medical needs, the support person/staff levels and responsibilities, and any physical environment or fire safety accommodations (fire doors, sprinklers, egress doors, smoke detectors, fire extinguishers, etc).
- Refer to DDS Fire Safety and Emergency Guidelines.
- Refer to DDS CLA Licensing Regulation: 12a

**Report Filters:**

**Service: "CLA4+" Active Indicator? "Yes"**

**161. D 35**

Support person training regarding the individual's health, safety, and plan is documented.

The intent of this indicator is to determine if the support person interviewed for the review is trained in all areas necessary to support the individual. Refer to the individual's IP to determine training needs including additional training/qualifications identified in IP-7. There is documentation that the support person is trained within 30 days of hire and prior to working alone regarding the individual's health, safety and programmatic support needs including the IP, LON and DDS Aquatic Safety Screening. This may include training on the individual's behavior support plan, dietary needs, OT/PT protocols, nurse delegated tasks, etc. Individual-specific training will occur at least annually and whenever there are changes in the individual's health, safety and plan.

Additionally, in all services in which there is a public or private provider agency delivering services, there is documentation that the support person is trained in the following areas:

Within 30 days of hire and prior to working alone:  
Active DDS Safety Alerts

(Training will occur on an ongoing basis as new Active DDS Safety Alerts are issued)

Within 30 days of hire, prior to working alone, and every calendar year between March 1 – May 1  
Water Safety Policy and Procedure

Within 30 days of hire, prior to working alone and, annually thereafter:  
Blood borne Pathogens  
Water Safety Policy and Procedure (within 30 days of hire and every calendar year between March 1 – May 1)  
Emergency Procedures including the Red Book/Emergency Relocation Plan  
DDS Fire Safety

Within 30 days of hire, prior to working alone, and every two years thereafter:  
Provider Policies and Procedures  
Dysphagia  
Communicable Disease Control  
Hazardous Materials Handling  
Signs and Symptoms of Disease and Illness  
Basic Health and Behavioral Needs

Within 30 days of hire, prior to working alone, and at a frequency determined by the provider:  
HIPAA and confidentiality

Within six months of hire and every two years thereafter:  
Individual Program Planning Process  
First Aid (note: Where certification exceeds this timeframe, for example Red Cross, this shall be considered met.)  
Behavioral Emergency Techniques (note: the retraining requirements of the DDS-approved curriculum must be implemented to be considered met, for example PMT).

Additionally, in CLAs:

Within 30 days of hire and prior to working alone, and every two years thereafter:  
Routines of the residence

Refer to provider staff development policies and procedures to determine if any additional provider-mandated training is completed as required.

When providers utilize the "train the trainer" model for training staff, there should be documentation on file to show that the subject matter expert – topic specialist (for example, OT, PT) trained a staff person or the nurse to train others.

Refer to:  
DDS Policy II-D-PO-5, "Staff Training"  
DDS Procedure I.PR.E.001, "Water Safety Procedure"  
CLA Licensing regulation, 17a-227-14  
DDS Health Standard 07-01, "Dysphagia"  
DDS Safety Alerts  
DDS "Fire Safety Prevention, Safety Training and Awareness"  
Department of Labor (OSHA) Standard

**162. D 37**

There is documentation that at least one support staff on duty per shift is currently trained in cardiopulmonary resuscitation (CPR).

The intent of this indicator is to determine if there is one support person per shift currently trained in CPR. Refer to the weekly support person schedule and sample the shift prior to the review, the shift on which the review is conducted and the shift after the review (for a total 24 hour period). Then, refer to CPR training documentation to ensure that at least one support person per shift is currently CPR trained.

Activity schedules should take into account the availability of CPR certified support staff both at the service location and in the community including transportation.

Refer to DDS CLA Licensing Regulation: 14d



Report Filters:

Service: "CLA4+" Active Indicator? "Yes"

- I 163. D 38 There is documentation that only licensed personnel or certified unlicensed personnel administer medications to the individual.
- Certified unlicensed personnel may administer medications in any facility in which fifteen or fewer individuals reside, during recreational activities outside the facility, or at a day program location. The intent of this indicator is to determine that only licensed or certified unlicensed personnel have administered medications.
- A list of support personnel certified to administer medications and copies of medication cards should be on file. Verify that the documentation shows that the support persons on duty have valid medication certification. Sample one month of the medication administration record (MAR) for the initials of support persons who have administered medication. Documentation must reflect that unlicensed support persons who administered medication are currently certified to administer medication. You may also ask the support person to show his or her medication card. Personnel not on the certification list, or support persons without medication cards should not be administering medication and initialing the medication administration record (MAR).
- Determine that certified unlicensed personnel comply with all training requirements as specified in DDS Medical Advisory #99-3. There is evidence that support persons have completed competency based training requirements which are a prerequisite to medication certification (e.g., New Employee Training [NET] Part 1 and NET Part 2 or an equivalent training program), and have had this task delegated by the supervising RN, as evidenced by current Checklists A and B. Review documentation of annual medication administration observation by RN (Checklist B). Subsequent to the initial worksite observation, the supervising nurse shall observe each certified unlicensed personnel administer medications at least once annually at the employee's usual worksite. This annual observation shall be done one year prior to the certificate expiration date (plus or minus four weeks). Documentation of the supervising nurse's observation shall be maintained as per agency policy. The department advises use of Checklist B as the documentation tool. Such documentation shall be made available upon request.
- Check for a copy of nurses' licenses on file.
- If the individual self-medicates, rate "N/A". (Verify that a current Self-Medication Assessment is on file that verifies that the individual is capable of self-medicating)
- Refer to DDS CLA Licensing Regulation: 18a1
- I 164. D 55 The support person has documented training regarding individual rights.
- The intent of this indicator is to determine that the support person who is interviewed for this review has documentation of training in human rights. Refer to provider policies and procedures regarding the frequency of this training.
- In a family setting (FAM), when there is not an agency providing the FAM supports, review the Fiscal Intermediary record. When an agency is providing the FAM supports, review the agency's records.
- I 165. D 56 The support person has documented training regarding abuse and neglect reporting and prevention.
- Review the training record of the support person interviewed for this QSR to determine that annual Abuse and Neglect reporting and prevention is documented.
- Refer to DDS Policy and Procedure:  
I.F. PO.001: Abuse and Neglect  
I.F. PR.001: Abuse and Neglect, Allegations: Reporting and Intake Processes  
I.F. PO.004: Abuse and Neglect: Recommendations and Prevention Activities
- In a family setting (FAM), when there is not an agency providing the FAM supports, review the Fiscal Intermediary record. When an agency is providing the FAM supports, review the agency's records.
- Refer to DDS CLA Licensing Regulation: 14c3
- I 166. D 60 The support person has current, documented training regarding signs and symptoms of disease and illness.
- The intent of this indicator is to determine that the support person who is interviewed for this review has documentation of training regarding the signs and symptoms of disease and illness. This training will include an overview of observable physical signs of illness and disease and the agency's reporting and recording procedures. Training is required within 30 days of hire, prior to working alone and within at least every 3 years thereafter.
- I 167. D 61 The support person has current, documented training regarding communicable disease control.
- The intent of this indicator is to determine that the support person who is interviewed for this review has documentation of training regarding communicable disease control. This training will include universal precautions, bloodborne pathogens, safe food handling, preparation and storage, and sanitary cleaning practices. Specific OSHA bloodborne pathogens training is required within 30 days of hire and annually thereafter. Communicable disease control training is required with 30 days of hire, prior to working alone and within at least 3 years thereafter.
- Refer to OSHA federal requirements/standards. Federal Register: Department of Labor (Occupational Safety and Health Administration); Title 29 of Federal Regulations Part 1910.1030 pages 64175 thru 64182 "Occupational Exposure to Bloodborne Pathogens."
- I 168. D 62 The support person has current, documented training regarding first aid for accidents.
- The intent of this indicator is to determine that the support person who is interviewed for this review has documentation of training regarding first aid for accidents. This training will include an overview of first aid. Training is required within six months of hire and within three years thereafter. Where certification exceeds this timeframe, for example Red Cross, this shall be considered met.
- I 169. D 63 The support person has current, documented training regarding individual's basic health and behavioral needs.
- The intent of this indicator is to determine that the support person who is interviewed for this review has documentation of training related to the basic health and behavioral needs of this individual. Training is required with 30 days of hire, prior to working alone and within three years thereafter.

Report Filters:

Service: "CLA4+" Active Indicator? "Yes"

- I 170. D 64 The support person has current, documented training regarding behavioral emergency techniques.  
The intent of this indicator is to determine that the support person interviewed for this review has documentation of training regarding behavioral emergency techniques. The training shall be comprehensive in instructing staff in desired responses to behavioral events. Techniques covered should emphasize support as needed as well as least restrictive intervention. Training is required within six months of hire and within every two years thereafter. The retraining requirements of DDS-approved curriculum must be implemented to be considered met, for example PMT.  
Refer to: DDS Approved Training Curriculum in the Use of Aversive and Physical Restraint Procedures
- I 171. D 65 The support person has current, documented training regarding emergency procedures.  
The intent of this indicator is to determine that the support person interviewed for this review has documentation of training regarding emergency procedures. This training shall include training in the Special Operations/Emergency Relocation Plan, Fire Safety and Evacuation Plan for the home. This training will address the needs of the individual in the event of a life threatening emergency and potential relocation. Training is required within 30 days of hire, prior to working alone and annually thereafter.
- I 172. D 66 Support providers implement appropriate nursing process based on the individual's needs.  
The intent of this indicator is to ensure that services are provided as necessary to maintain the optimal level of health for the individual. Under the oversight of the RN, these services shall include the coordination, assessment and provision of health services. There shall be procedures in place for the identification, reporting and assessment of signs and symptoms of illness, changes in condition and injury.  
There shall be a system in place for support staff to access RN on call services twenty-four hours per day and a system of documenting all nursing interventions and care including telephone conversations.  
There shall be documentation that support staff have implemented the plan identified by the RN. Selected tasks may be delegated by the RN to support staff. However, those tasks which require planning, assessment, evaluation or judgment cannot be delegated. The RN retains the responsibility and accountability for the delegated task. Activities which meet or assist the individual in meeting basic human needs and activities of daily living are not routinely considered nursing tasks.  
Refer to: LON, IP Personal Profile and Action Plan, annual nursing assessment and health plan of care, log/progress notes, nursing notes and nursing quarterly reviews.  
Refer to: DDS Nursing Standard 97.1 Nurse Delegation to Unlicensed Staff, DDS Nursing Standard NS# 09.1 Nursing Process
- I 173. D 67 Support providers implement appropriate nursing review of the individual's health, based on the individual's needs.  
The intent of this indicator is to ensure that nursing process and assessment occur as identified in DDS Nursing Standard, Nursing Process #NS 09.1. At the time of admission, a RN initial assessment shall occur within a 24-hour period, or as determined by the RN, but no later than two working days. A transfer from one home to another within the same agency is considered an admission to the new home and RN initial assessment shall occur. In the event that the primary RN is the same for both locations, the RN will document that the assessment and health plan of care remain current.  
At the time of readmission from either a hospital, acute or long-term care facility, the RN or RN On-Call must be immediately notified when the person is readmitted so orders can be reviewed and direction for care provided until assessment is completed. The RN must document reassessment of the individual's health care status/needs either within 24 hours prior to discharge or within 2 working days following discharge. The RN shall review physician's orders and review/update the nursing plan of care upon readmission.  
At least annually, in conjunction with the individual's Individual Plan, the RN shall develop a health plan of care to promote, maintain or restore an individual's health, prevent illness and affect habilitation.  
The health plan of care shall be reviewed at least quarterly or, whenever there is a change in the person's needs or health status.  
Refer to: DDS Nursing Standard, Nursing Process #NS 09.1, DDS Nursing Standard, 96.3 Nursing Documentation
- I 174. D 68 There is documentation that all support staff are currently trained in cardiopulmonary resuscitation (CPR).  
The intent of this indicator is to ensure that all support staff working in the home are currently trained in CPR. Copies of CPR certification cards shall be maintained on file in the home.  
Refer to DDS approved CPR curricula. Approved curricula includes; American Heart Association, American Red Cross, American Safety and Health Institute, Emergency Care and Safety Institute.

## **SETTINGS QUESTIONS TO BE ADDED TO THE ASSESSMENT**

Questions to be asked of persons who reside in a setting other than a private home or apartment.

1. Were you given choices regarding where to live?
2. Do you have a lease or similar agreement?
3. Are you able to come and go as you please?
4. Are you able to have visitors at any time?
5. Are you able to control your own schedule? (i.e. eating, sleeping, visiting)
6. Are you able to furnish and decorate your room as you choose?
7. Do you have Wi-Fi access or access to a computer, I-pad or similar device?
8. Do you have privacy in your living area?
9. Are you able to choose when, what and where you eat?
10. If you have services in your home, were you able to choose who provided those services?