NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Person Centered Review

Guidance Documentation
&
Reference Manual

March 12, 2018

PERSON CENTERED PROTOCOL OVERVIEW

This document serves as a resource tool to aid in the completion of the OPWDD Division of Quality Improvement Person Centered Review Protocol, effective 06/27/17. It should be used as a reference and will be helpful when access to the DQIA Protocol application is unavailable. It will also support further understanding of standards applicable to specific program/service types. This document also serves as a reference for how to use the Person-Centered Review Reference manual.

A. The Person Centered Review Guidance Documentation & Reference Manual is comprised of the following sections:

1. **Bookmarks Tab:** This feature on the left-hand side of the document should automatically display upon opening the PDF. Use this feature to quickly navigate through the sections of the manual. If the section has an arrow (>) before the text you may also click to expand the selection, which includes linked sub-lists of topics under the given section.
2. **Table of Contents:** A more detailed listing of the manual's contents and corresponding page numbers, clicking on the **blue text** in this section will also take you to that selected section of the document.
3. **Standard Text:** This section lists every standard included in the Person-Centered Review (PCR).
4. **Standard Guidance:** This section includes every standard included in the PCR plus:
    a. Review activities and review content determined to be necessary components of the person-centered review for each standard;
    b. the guidance for evaluation of each standard including reasoned decision making for whether the standard is Met or Not Met.
    c. There is also guidance to assist in the review of additional requirements for services for individuals who are Willowbrook class members.
5. **Standards and Regulatory References By Service Type**
    a. There is a table for each program/service type or grouped program/service types.
    b. The tables identify:

        - The standards applicable to the specified program/service type; and
        - the regulatory reference or quality indicator (QI) applicable to each of the standards reviewed for that specific program/service type.

B. Design of the Person Centered Review Protocol:

- Allows for the review of all services a person receives from all OPWDD provider agencies, as well as Care Coordination Services.
- Is used for both site based and community based non-ICF services and supports.
- Many standards are universal regardless of service type. Standards are "expectation-specific" not service specific.

- Reviews services holistically to ensure person centeredness and effectiveness in outcomes important to the individual's quality of life.

C. Implementation Sample:

1. FULL Person Centered Review (PCR) – Statewide sample pull:

- A sample provided by NYS DOH of approximately 400 individuals;
- A randomly selected statewide sample of approximately 1500 individuals.

2. PARTIAL Person Centered Review:

- **Routine Partials** (Required):
  - **Willowbrook Review (IRA)**: Annually required reviews for all Willowbrook Class Individuals in IRA's
    - Review standards applicable to MSC/Care Management and IRA.
  - **Willowbrook Case Management Review (ICF/NH):** Annually Required reviews for all class members living in Nursing Homes and 5% of class members in ICFs
    - Review standards applicable to Willowbrook Case Management service

- **As Needed Partials**:
  - **Complaints**
    - Surveyor reviews standards that relate to the breadth of the complaint.
  - **Monitoring**
    - Surveyor reviews standards being monitored for current compliance status due to factors that include, but are not limited to the following:

      - Previously identified issues or deficiencies affecting the individual's health, safety, welfare;
      - Concerns regarding the agency's ability to ensure an individual's health, safety, welfare;
      - Follow-up due to a reported incident or allegation;
      - Concerns regarding the agency's ability to address concerns competently;
      - Pattern of repeat deficiencies.
  - **Validation**
    - Surveyor reviews standards previously cited via Statement of Deficiencies (SOD) which may or may not have resulted in a 45 Day Letter;
    - Review includes assessment of compliance with the standards as well as verification that the Plan of Corrective Action (POCA) to address the deficiencies was effectively implemented.
  - **Supplemental**
    - As needed based on discovery during site reviews, when specific aspects of the quality of a person's services must be assessed. Surveyor will review any standard as pertinent to the scope of their review activities.

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STANDARD TEXT

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STANDARDS AND REGULATORY REFERENCES BY SERVICE TYPE

Standard Text

Standard No.	Standard Text	Decision
Section 1 SERVICE PLANNING		
1-1	The individual was provided written notice of their right to a person-centered planning process.	Met/Not Met
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met
1-8	The individual's service planning includes consideration of natural supports as well as paid supports.	Met/Not Met
1-9	The individual has made informed choice of residential setting and alternative options considered by the individual are recorded in his/her written plan.	Met/Not Met
1-10	Assessments needed by the individual or required by program regulation were completed to inform the individual's plan development.	Met/Not Met
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met
1-12	The individual's strengths and preferences are documented in the service plan.	Met/Not Met
1-13	The individual's identified needs for clinical and/or functional support are documented in the service plan.	Met/Not Met
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person-centered plan.	Met/Not Met
1-16	The individual's goals and priorities regarding meaningful relationships are identified in the person-centered plan.	Met/Not Met

Standard No.	Standard Text	Decision
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person-centered plan.	Met/Not Met
1-18	The individual's goals and priorities related to health concerns and medical needs are identified in the person-centered plan.	Met/Not Met
1-19	The individual's known food, medication, and/or environmental allergies and the corresponding precautions are identified in the person-centered plan.	Met/Not Met/NA
1-20	Individualized considerations and safeguards regarding fire safety are identified in the person-centered service plan.	Met/Not Met
1-21	The person-centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person-centered plan.	Met/Not Met
1-23	The individual's written plan documents each specific service and support to be provided to address his/her needs and achieve his/her identified desired outcomes, short term and long term goals.	Met/Not Met
1-24	The individual's written plan identifies the amount, frequency and duration of each HCBS waiver service he/she receives, as applicable.	Met/Not Met/NA
1-25	The person-centered plan identifies the provider(s) of the individual's supports and services.	Met/Not Met
1-26	The person-centered plan evidences that informed choice is made regarding self-direction; and if chosen, identifies the services that the individual elects to self-direct.	Met/Not Met
1-27	For FIDA-IDD, the Life Plan identifies the services the individual is responsible to schedule and the support needed to do so.	Met/Not Met
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met
1-29	The person-centered service plan is signed by the individual as indicator of written informed consent or approval.	Met/Not Met

Standard No.	Standard Text	Decision
1-30	The individual's person centered service plan is agreed to by services providers and/or members of the team as required.	Met/Not Met
1-31	The individual's FIDA-IDD Life Plan is authorized as required per the services in the plan.	Met/Not Met
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met
1-33	The person-centered service plan includes all relevant and applicable attachments.	Met/Not Met
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met
1-35	The Individual's written person centered service plan is reviewed with regular required frequency.	Met/Not Met
1-36	Review of the plan includes the individual's status/progress towards the achievement of his/her goals, priorities and outcomes.	Met/Not Met
1-37	The individual's person centered service plan is revised whenever changes are necessary and warranted and/or as directed/preferred by the individual.	Met/Not Met/NA
1-38	Revisions to the individual's written plan are documented in the form and format required.	Met/Not Met/NA
1-39	Decisions made by FIDA-IDD outside of IDT meeting, are recorded in the Comprehensive Participant Health Record and communicated to all IDT members within one (1) business day.	Met/Not Met
1-40	The SC/CM/CC competently assures person centered planning as evidenced by the individual's written plan for services and supports and interview.	Met/Not Met
1-41	CAS findings were reviewed with the individual within 30 days	Met/Not Met

Standard No.	Standard Text	Decision
Section 2 SERVICES & SUPPORTS REQUIREMENTS & DELIVERY - UNIVERSAL REQUIREMENTS		
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met

Standard No.	Standard Text	Decision
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met
2-8	The person is participating in activities in the most natural context.	Met/Not Met
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met/NA
2-15	The person is satisfied with the specific service.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2a CASE/SERVICE COORDINATION MGMT. SERVICE AND SUPPORTS DELIVERY		
2a-1	The individual was provided a choice of service/care manager/coordinator.	Met/Not Met
2a-2	An initial Level of Care determination (LCED) was completed indicating OPWDD determination that the individual is eligible for services (when individuals receive HCBS Waiver Services).	Met/Not Met/NA
2a-3	The level of care is reevaluated at least annually (within 365 days) as evidenced by a current LCED in the SC/CC record.	Met/Not Met/NA
2a-4	The service plan record contains a correctly completed Documentation of Choices form.	Met/Not Met/NA
2a-5	The Willowbrook class member's Notice of Rights is placed in the SC /CM/CC service record.	Met/Not Met
2a-6	The SC/CM/CC advocates/ensures that rights limitations occur only with required protections, justifications and approvals in place.	Met/Not Met/NA
2a-7	The individual has a signed Service Coordination Agreement, which is reviewed annually.	Met/Not Met
2a-8	The individual enrolled in FIDA-IDD is provided a set of guidelines and care responsibilities of the entire IDT.	Met/Not Met
2a-9	The individual and designees, as applicable are given required contact information.	Met/Not Met
2a-10	The individual can reach the service coordinator when needed in a timely manner.	Met/Not Met
2a-11	The SC/CM/CC solicits input from/among members of the person's "circle"/team as part of the review of the person's services and status as needed.	Met/Not Met
2a-12	Meetings for the review of the person centered service plan must be face to face as required by the service type.	Met/Not Met
2a-13	The individual who is a Willowbrook class member has an activity plan.	Met/Not Met
2a-14	The SC/CM/CC notes indicate that the service coordinator/case manager has contact with the individual in the frequency and manner required by service and when needed.	Met/Not Met
2a-15	The service coordinator/case manager meets with the individual in his/her home at least quarterly with a Willowbrook Class Member, annually with a non-class member, and when needed.	Met/Not Met
2a-16	A Service Coordination Observation Report (SCOR) was completed at least twice yearly for Willowbrook Class Members and as needed.	Met/Not Met

Standard No.	Standard Text	Decision
2a-17	If the SCOR identifies issues, the case notes in the individual's record evidence advocacy and resolution of the issue(s).	Met/Not Met/NA
2a-18	SC/CC/CC has taken action to affirm that all allegations of abuse and/or neglect were reported to appropriate parties and investigated as appropriate.	Met/Not Met
2a-19	If abuse was substantiated, SC/CM/CC advocates for the safety and protection of the individual.	Met/Not Met/NA
2a-20	The SC/CM/CC monitors that the individual is linked to and receiving the services he/she wants and that the services are helping the individual to attain his/her valued outcomes and life goals.	Met/Not Met
2a-21	The WCS Coordinator or WSC assists the QIDP, treatment coordinator and/or IDT members in linking to services and/or in support during crisis intervention, as needed.	Met/Not Met
2a-22	The SC/CM/CC monitors that the fire safety safeguard identified in the Person Centered Plan are in place/provided.	Met/Not Met
2a-23	The SC/CM/CC monitors that individuals receive the health care services identified in their service plan.	Met/Not Met
2a-24	Care/Case/Service Coordinator/Manager advocates for the rights and entitlements of the individual in the home, day and work environments and in all spheres of his/her life.	Met/Not Met
2a-25	The Care/Case/Service Coordinator/Manager ensures that procedural and substantive due process requirements are met.	Met/Not Met/NA
2a-26	The WCS Coordinator or WSC ensures active representation, either by the class member, the correspondent or Consumer Advisory Board (CAB)	Met/Not Met
2a-27	The person is satisfied with the coordination/case management services he/she receives.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2b: SELF DIRECTION		
QQ-2b	Does the individual Self-Direct by exercising Budget authority?	Yes/No
2b-1	The individual is supported to exercise budget authority over how his or her resources are budgeted and managed within the Personal Resources Account (PRA).	Met/Not Met

Standard No.	Standard Text	Decision
Section 2c: HCBS WAIVER FISCAL INTERMEDIARY SERVICES (FI)		
2c-1	The individual is supported by the Fiscal Intermediary (FI) to complete billing and payment for goods and services identified in his/her Self Direction budget when the individual exercises Budget Authority.	Met/Not Met
2c-2	The individual is supported by the Fiscal Intermediary (FI) to complete billing and payment for goods and services identified in his/her Self Direction budget and to provide additional staffing-related services when the individual exercises Budget and Employment Authority.	Met/Not Met
2c-3	The individual is provided a monthly expenditure report.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2d: HCBS WAIVER COMMUNITY TRANSITION SERVICES		
2d-1	There is a written summary of the specific Community Transition expenses paid on behalf of the individual by the FI, including the date and cost of each purchase or payment.	Met/Not Met
2d-2	There is evidence that the person is responsible for his/her own living expenses in the home.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2e: HCBS WAIVER SUPPORT BROKERAGE		
2e-1	The Support Broker assists the individual with developing a comprehensive self-direction budget within the person's Personal Resource Account (PRA) amount.	Met/Not Met
2e-2	There is a written support brokerage agreement describing the broker's responsibilities to assist the individual.	Met/Not Met
2e-3	Face-to-face planning meetings (Circle of Support meetings) occur 4 times per year. They may occur concurrently with the ISP review meetings.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2f: HCBS WAIVER INDIVIDUAL DIRECTED GOODS AND SERVICES		
2f-1	The Individual Directed Goods and Services (IDGS) a person receives address an identified need in a person's ISP, to promote his/her inclusion in the community, and/or increase the person's safety and independence in the home environment, and/or decrease the need for other Medicaid services.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2g: LIVE-IN CAREGIVER		
2g-1	The individual receiving Live-in Caregiver services resides in his/her own home or a leased residence where he/she is responsible for the residence.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2h: HCBS WAIVER SUPPORTED EMPLOYMENT (SE)		
2h-1	SEMP services are directed toward achieving sustained self-employment or competitive integrated employment in the general workforce, in a job that meets the individual's personal and career goals.	Met/Not Met
2h-2	Individuals receiving SEMP who are earning a wage must be compensated at or above the minimum wage.	Met/Not Met/NA
2h-3	Services provided without the individual present are documented and serve to benefit the individual in attaining his/her employment goals.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2i: HCBS WAIVER PATHWAY TO EMPLOYMENT (PE)		
2i-1	The individual receives pathway to employment services individually or simultaneously in a group of no more than 4 individuals.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2j: HBCS COMMUNITY PREVOCATIONAL SERVICES (PV)		
2j-1	Services delivered to the individual other than in the community do not exceed 2 hours per day.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2k: HCBS WAIVER SITE BASED PREVOCATIONAL SERVICES		
2k-1	When the individual's services include site-based prevocational services, the individual must have a demonstrated or assessed earning capacity relative to the prevocational task(s) involved, of less than 50 percent of the current State minimum wage, Federal minimum wage or prevailing wage, whichever is greatest, and be expected to have such an earning capacity while participating in the services.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2l: HCBS WAIVER INTENSIVE BEHAVIOR SERVICES (IB)		
2l-1	A functional behavioral assessment meeting content requirements is completed prior to development of the individual's behavior support plan.	Met/Not Met
2l-2	The individual has a behavior support plan (BSP) which meets content requirements.	Met/Not Met
2l-3	There is a written, signed agreement between service provider and the person regarding nature, duration and scope of IB services to be provided.	Met/Not Met
2l-4	Written informed consent is obtained prior to implementation of the BSP.	Met/Not Met
2l-5	Upon conclusion of IB services, an evaluation of the service outcomes in increasing skill development and decreasing challenging behaviors must be completed.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 2la: HCBS WAIVER INTENSIVE BEHAVIOR SERVICES (IB)		
QQ-2la	The individual's BSP includes restrictive/intrusive intervention(s) and/or rights limitation(s).	Yes/No
2la-1	The BSP describes the individual's behavior justifying the interventions and/or limitation(s).	Met/Not Met
2la-2	Previous strategies that have been tried and deemed ineffective are described with explanation regarding why use of less restrictive alternative would be insufficient/inappropriate.	Met/Not Met
2la-3	The plan describes specific use of interventions as a hierarchy starting with most positive/least intrusive to most restrictive.	Met/Not Met
2la-4	Interventions used/in the plan are only those permissible in IB services.	Met/Not Met
2la-5	There is a plan to fade/minimize/eliminate use of restrictive/limiting interventions.	Met/Not Met
2la-6	The individual's BSP describes documentation necessary for implementation of each intervention and mandated reporting if applicable.	Met/Not Met
2la-7	The BSP provides the schedule to review and analyze the use of restrictive/intrusive/limiting interventions, no less than every 60 days.	Met/Not Met
2la-8	The review results are documented.	Met/Not Met
2la-9	There is documentation that the individual is visually examined for injury and assessed for pain/discomfort following physical interventions.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2m: HCBS ADAPTIVE TECHNOLOGIES		
QQ-2m	The individual receives/received HCBS Waiver Adaptive Technology.	Yes/No
2m-1	The person's need for the adaptive device is documented in his/her ISP.	Met/Not Met
2m-2	The specific device is identified in the ISP.	Met/Not Met
2m-3	The adaptive device increases/maintains the individual's safety, independence and/or community integration.	Met/Not Met
2m-4	The individual receives on-going support needed to use the device, as identified in his/her ISP.	Met/Not Met/NA
2m-5	The effectiveness of the device is periodically reviewed/assessed.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 2n: HCBS ADAPTIVE TECHNOLOGIES		
QQ-2n	The individual receives/received HCBS Waiver Environmental Modifications (Emod).	Yes/No
2n-1	The person's need for the E-mod is documented in his/her ISP.	Met/Not Met
2n-2	The E-Mod enables the person to live safely in the home and/or improve/maintain independence.	Met/Not Met
2n-3	As appropriate, the E-Mod involved the professional consultation necessary for the E-Mod construction or use.	Met/Not Met/NA
2n-4	The E-Mod was provided with attention to requirements for building and fire safety codes as necessary.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 2o: HCBS WAIVER FAMILY EDUCATION & TRAINING (FE)		
2o-1	FET is identified in the individual's ISP under Waiver services, with effective date, frequency, duration, and valued outcomes.	Met/Not Met
2o-2	Documentation evidences that training was provided to the individual's family regarding the nature and impact of the person's disability and/or the service options.	Met/Not Met
2o-3	Training provided to the individual's family was at least two (2) hours duration and provided by someone other than the person's MSC.	Met/Not Met

Standard No.	Standard Text	Decision
Section 2p: DAY TRAINING		
2p-1	When the individual's services include vocational services, services must be in compliance with federal and state laws regarding labor wages and safety.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 2q: DAY TREATMENT		
2q-1	The individual is receiving active treatment.	Met/Not Met/NA
2q-2	Coordination with the individual's residential provider is evident.	Met/Not Met/NA
2q-3	When the individual's services include therapeutic prevocational services, he/she must be compensated in compliance with New York wage and hour laws.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 2r: PRIVATE SCHOOL		
2r-1	If the individual is engaged in pre-vocational training, it is in accordance with applicable federal and state labor and wage laws, including periodic review of pre-vocational task to deem if they require compensation.	Met/Not Met/NA
2r-2	When the individual's services include vocational services, compliance with federal and state laws regarding labor wages and safety is evidenced.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 2s: SPECIALTY HOSPITAL		
2s-1	The service plan (IPP) identifies whether the individual has a health care problem that requires more than three (3) hours of daily individualized care by health care staff.	Met/Not Met

Standard No.	Standard Text	Decision
Section 3: RIGHTS AND SUPPORTS OF RIGHTS		
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met
3-2	The individual is informed of rights as a FIDA-IDD member and availability of the FIDA-IDD Ombudsman.	Met/Not Met
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met
3-4	The individual is informed of their HCBS rights.	Met/Not Met
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met

Standard No.	Standard Text	Decision
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met
3-7	The individual is supported to express themselves through personal choices/decisions on style of dress and grooming preferences.	Met/Not Met
3-8	The individual is supported to participate in cultural/religious/associational practices, education, celebrations and experiences per their interests and preferences.	Met/Not Met
3-9	The individual is supported to have visitors of their choosing according their preferences.	Met/Not Met
3-10	The individual has privacy in his/her home, bedroom or other service environments and per their needs for support.	Met/Not Met
3-11	The individual is aware that he/she is not required to follow a particular schedule for waking up, going to bed, eating, leisure activities, etc.	Met/Not Met
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs.	Met/Not Met
3-13	The individual can choose to eat meals when they want to, even if mealtimes occur at routine or scheduled times.	Met/Not Met/NA
3-14	The individual has access/is supported to have access to food at any time and to store their own food and snack choices for their use at any time as desired, similar to people without disabilities.	Met/Not Met
3-15	The individual is supported to have independent access to the site/service setting with freedom to come and go as desired, similar to people without disabilities.	Met/Not Met
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met
3-17	The setting reflects the individual's needs and preferences including the presence of any necessary physical modifications, if applicable.	Met/Not Met
3-18	The individual has a lease or other written occupancy agreement that provides eviction protections and due process/appeals and specifies the circumstances when he/she could be required to relocate.	Met/Not Met
3-19	There is evidence that the individual and/or their representative knows/understands their right to due process/appeals and when he/she could be required to relocate.	Met/Not Met

Standard No.	Standard Text	Decision
3-20	The individual may view their service record upon request.	Met/Not Met
3-21	The individual controls their personal resources and decides how to spend their personal discretionary funds.	Met/Not Met
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met

Standard No.	Standard Text	Decision
Section 3a: RIGHTS LIMITATIONS (OTHER THAN BEHAVIOR SUPPORT)		
QQ-3a	The individual is subjected to restrictions or limitations to their rights not associated with a Behavior Support Plan.	Yes/No
3a-1	When interventions that restrict or modify the individual's rights are used (not part of a behavior support plan), the individual's service plan includes a description of the positive and less intrusive approaches that have been tried but have not been successful.	Met/Not Met
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights modification (clinical justification).	Met/Not Met
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.	Met/Not Met
3a-5	The individual has given informed consent to the rights limitations/restrictions in place.	Met/Not Met

Standard No.	Standard Text	Decision
Section 4: FULL ACCESS TO THE COMMUNITY		
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community.	Met/Not Met
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.	Met/Not Met
4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are meaningful to them for the period of time desired.	Met/Not Met

Standard No.	Standard Text	Decision
Section 5: RELATIONSHIPS		
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met

Standard No.	Standard Text	Decision
Section 6: LIVING ARRANGEMENTS		
6-1	The individual is satisfied with their living situation and does not express a desire (when questioned) to move to another living setting and/or with another roommate.	Met/Not Met
6-2	If the individual is NOT satisfied with living situation, there is evidence that the staff is proactively working to find an alternate arrangement based on the person's needs, choices and preferences in a timely manner.	Met/Not Met/NA
6-3	The individual's personal living spaces(s) reflect their individualized interest and tastes.	Met/Not Met

Standard No.	Standard Text	Decision
Section 7: SAFEGUARD PLANNING AND DELIVERY		
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met/NA
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met/NA
7-6	The individual's needs for support and assistance related to fire safety and evacuation are documented according to service/setting requirements.	Met/Not Met
7-7	The individual is provided the necessary supports and assistance related to fire safety and evacuation.	Met/Not Met
7-8	The individual is provided necessary supports necessary to facilitate financial stability and freedom from financial exploitation.	Met/Not Met

Standard No.	Standard Text	Decision
Section 8a: HEALTH SERVICES & SUPPORTS		
8a-1	A health assessment which identifies the individual's health care needs has been completed by a physician, PA, NP, or RN.	Met/Not Met
8a-2	The individual has someone chosen/delegated to support them in coordinating their health care.	Met/Not Met
8a-3	The individual's service plan identifies the services and supports necessary to access to and receive routine professional medical care and evaluation.	Met/Not Met

Standard No.	Standard Text	Decision
8a-4	The individual's routine health care providers are identified and known to the person and/or their supports.	Met/Not Met
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	Met/Not Met
8a-6	The individual receives routine medical exams/medical appointments per his/her health care professionals' recommendations.	Met/Not Met
8a-7	The individual receives diagnostic evaluation/testing per his/her health care professionals' recommendations and standard safe practice (e.g. Lab work, x-rays, scans, MRIs, etc.).	Met/Not Met
8a-8	The individual receives necessary dental exams and treatments.	Met/Not Met
8a-9	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender, and age.	Met/Not Met
8a-10	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met/NA
8a-11	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA
8a-12	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met
8a-13	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	Met/Not Met/NA
8a-14	The individual's emerging signs/symptoms are reported to a health care professional, and monitored and addressed appropriately.	Met/Not Met/NA
8a-15	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met/NA
8a-16	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA
8a-17	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA
8a-18	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA
8a-19	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met
8a-20	The individual exhibits a healthy lifestyle and/or receives support(s) to replace the unhealthy behaviors with healthier actions.	Met/Not Met
8a-21	The individual is provided choice in health care providers.	Met/Not Met

Standard No.	Standard Text	Decision
8a-22	The individual is supported to advocate and is included in informed decision-making related to medical care and treatment.	Met/Not Met
8a-23	Individuals have been given the opportunity to have advanced directives in place (DNR order, healthcare proxy, or living will).	Met/Not Met
8a-24	For those that have advanced directives, they are completed properly in accordance with the Healthcare Decisions Act.	Met/Not Met/NA
8a-25	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met
8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA
8a-27	The individual is given access to family planning resources and sexuality education and/or counseling if desired.	Met/Not Met/NA
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	Met/Not Met
8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall with the medical care that the individual receives.	Met/Not Met

Standard No.	Standard Text	Decision
Section 8b: HEALTH SERVICES & SUPPORTS - COMMUNITY BASED WAIVER SERVICES		
QQ-8b	The agency's waiver certification includes approval to provide delegated nursing services per the NPA expansion to selected community based HCBS services, and is providing such services to the individual in the course of community based waiver service delivery.	Yes/No
8b-1	A medical assessment which identifies the individual's health care needs has been completed by a physician, PA, NP, or RN.	Met/Not Met
8b-2	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met
8b-3	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA

Standard No.	Standard Text	Decision
8b-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met
8b-5	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	Met/Not Met/NA
8b-6	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met

Standard No.	Standard Text	Decision
Section 8c: HEALTH SERVICES & SUPPORTS - COMMUNITY BASED WAIVER SERVICES - Medication		
QQ-8c	Does the person receive support for medication administration during delivery of this service?	Yes/No
8c-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met
8c-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met
8c-3	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA
8c-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA
8c-5	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met

Standard No.	Standard Text	Decision
Section 8d: HEALTH SERVICES & SUPPORTS - DAY & RESPITE SERVICES		
QQ-8d	The individual receives supports related to health care, delivered by the site/program staff.	Yes/No
8d-1	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s) addressed during services at the site.	Met/Not Met/NA
8d-2	The individual receives the needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met
8d-3	The individual's service record/service plan is maintained to reflect current status of the individual's health needs being addressed.	Met/Not Met
8d-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met
8d-5	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 8e: HEALTH SERVICES & SUPPORTS - DAY & RESPITE SERVICES - Medication		
QQ-8e	Does the person receive support for medication administration during delivery of this service?	Yes/No
8e-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met/NA
8e-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA
8e-3	The individual receives medications and treatments safely as prescribed.	Met/Not Met/NA
8e-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 9: BEHAVIOR SUPPORTS		
QQ-9	The individual receives behavior supports/ the program/service includes implementation of a Behavior Support Plan.	Yes/No
9-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	Met/Not Met
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	Met/Not Met
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	Met/Not Met
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	Met/Not Met
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	Met/Not Met

Standard No.	Standard Text	Decision
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 9a: RIGHT LIMITATIONS, RESTRICTIONS, & INTRUSIVE INTERVENTIONS		
QQ-9a	RESTRICTIVE/INTRUSIVE INTERVENTIONS used and/or LIMITATIONS ON THE INDIVIDUAL'S RIGHTS are used to address behavior and/or part of the individual's Behavior Support Plan.	Yes/No
9a-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	Met/Not Met
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met

Standard No.	Standard Text	Decision
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 9b: MECHANICAL RESTRAINING DEVICES		
QQ-9b	MECHANICAL RESTRAINING DEVICES are used with the individual to address behavior and/or included in their BSP.	Yes/No
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	Met/Not Met
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA

Standard No.	Standard Text	Decision
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met
9b-11	The individual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred.	Met/Not Met
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 9c: PHYSICAL INTERVENTIONS		
QQ-9c	Physical Interventions are used with the individual and/or included in their Behavior Support Plan.	Yes/No
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA
9c-5	Repeated emergency use of physical interventions in a 30-day period or six-month period resulted in a comprehensive review.	Met/Not Met/NA
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met

Standard No.	Standard Text	Decision
Section 9d: TIME OUT		
QQ-9d	Time Out is used with the individual and/or included in the Behavior Support Plan.	Yes/No
9d-1	Time Out was used in accordance with the individual's Behavior Support Plan.	Met/Not Met
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met

Standard No.	Standard Text	Decision
Section 9e: BEHAVIOR MEDICATIONS - GENERAL		
QQ-9e	Medication is used as a behavior support.	Yes/No
9e-1	Medication to address the individual's challenging behavior or a symptom of a diagnosed co-occurring psychiatric disorder is administered only as a part of a BSP or Monitoring Plan which includes additional interventions.	Met/Not Met
9e-2	Written Informed Consent for use of medication by the individuals has been obtained and is current.	Met/Not Met
9e-3	When the plan includes the medication the Individual's service record includes a semi-annual medication regimen review that is used to evaluate the benefits/risk of continuation.	Met/Not Met
9e-4	The Individual's service record includes evidence that the prescriber was consulted regarding administration and continued effectiveness of the medication.	Met/Not Met
9e-5	The Individual's service record includes evidence that the use of medication is having a positive effect on his/her behavior or target symptoms.	Met/Not Met
9e-6	The Individual's service record includes evidence that the effectiveness of the medication has been re-evaluated at least semi-annually at the program plan review with required service attendees.	Met/Not Met
9e-7	Medications were administered in accordance with requirements.	Met/Not Met

Standard No.	Standard Text	Decision
Section 9f: PRN BEHAVIOR MEDICATIONS		
QQ-9f	The individual is either prescribed PRN MEDICATIONS for behavior or co-occurring symptoms AND/OR medications was ordered in an emergency situation.	Yes/No
9f-1	When prn medication is prescribed to address behavior or symptoms of a psychiatric disorder, this strategy is included in the Individual's Behavioral Support or Monitoring Plan.	Met/Not Met/NA
9f-2	The Individual's service record includes evidence of the display of the behavior(s) or symptom(s) for which the PRN medication is being prescribed in the past 12 months.	Met/Not Met/NA
9f-3	The Individual's Behavioral Support or Monitoring Plan provides instruction and guidance for administration of the PRN medication, consistent with the prescriber's order.	Met/Not Met/NA
9f-4	The Individual's service record must include a summary, in behavioral terms, of the results of the PRN medication administration.	Met/Not Met/NA
9f-5	The Individual's service record includes evidence that any adverse or unexpected side effects were reported to the PRN prescriber immediately and the planning team by the next business day.	Met/Not Met/NA
9f-6	Use of PRN Medications on more than four (4) separate days in a 14-day period resulted in consideration of a recommendation for incorporation into a regular drug regimen.	Met/Not Met/NA
9f-7	Lack of use of a PRN medication during a six-month period resulted in a review of the BSP and a recommendation to the prescriber.	Met/Not Met/NA
9f-8	Effectiveness of the medication ordered in an emergency is documented in the Individual's record.	Met/Not Met/NA
9f-9	Emergency use of medication in more than 4 instances in a 14-day period resulted in a comprehensive review.	Met/Not Met/NA
9f-10	Use of PRN medications in conjunction with a restrictive physical intervention technique were reported electronically to OPWDD.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 9g: MEDICATION MONITORING PLANS ONLY		
QQ-9g	The individual has a monitoring plan only, as medications are prescribed to treat only the co-occurring diagnosed psychiatric disorders as diagnosed by a physician, psychiatrist, or psychiatric nurse practitioner.	Yes/No
9g-1	The Individual's record identifies the symptoms he/she exhibits and each co-occurring psychiatric disorder diagnosis.	Met/Not Met
9g-2	The Individual's Monitoring Plan clearly identifies target symptoms associated with each medication prescribed for a psychiatric disorder.	Met/Not Met
9g-3	The Individual's Monitoring Plan includes the method to measure and document symptom reduction and functional improvement.	Met/Not Met
9g-4	The Individual's Monitoring Plan includes alternative interventions (other than medication).	Met/Not Met
9g-5	The individual's Monitoring Plan is developed by a qualified clinician.	Met/Not Met
9g-6	The effectiveness of the individual's Monitoring Plan in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met

Standard No.	Standard Text	Decision
Section 10a: INCIDENT MANAGEMENT- Reporting		
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 10b: INCIDENT MANAGEMENT- Reported in IRMA		
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met

Standard No.	Standard Text	Decision
Section 10c: INCIDENT MANAGEMENT- Not Reported in IRMA		
QQ-10c	There are Minor Notable Occurrence reported through the agency process but not entered into IRMA.	Yes/No
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met

Standard No.	Standard Text	Decision
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA

Standard No.	Standard Text	Decision
Section 11: Quality of Life Summary		
11-1	The person has the resources to obtain possessions and supplies necessary for comfortable daily living.	Met/Not Met
11-2	The individual is living as independently as able in the home/living environment they choose.	Met/Not Met
11-3	The person is maintaining/improving and/or developing meaningful relationship(s).	Met/Not Met
11-4	The person is employed, doing volunteer work or participating in other integrated meaningful activities, per their desires/life goals.	Met/Not Met
11-5	The person is maintaining their desired role in their community.	Met/Not Met
11-6	The individual is living safely/receiving supports to live safely in their home/living environment, according to informed choices and responsible consideration.	Met/Not Met
11-7	The person lives safely in their community per their informed choices.	Met/Not Met
11-8	The person is satisfied with the supports they receive intended to achieve their outcomes.	Met/Not Met
11-9	The person's service(s) in total, contribute to advancing toward or achieving their specified goals and personal outcomes.	Met/Not Met

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Standard Guidance

SECTION 1: SERVICE PLANNING

Standard No.	Standard Text	Decision
1-1	The individual was provided written notice of their right to a person-centered planning process.	**Met/Not Met**

Guidance

DISCUSSION:
The individual, (advocate, if needed); service/care coordinator/manager.

DOCUMENTATION REVIEW:
- Form and format of rights provision provided by the service coordination agency.

GUIDANCE:
- The service coordinator must give notice of the individual's right to a person-centered planning (PCP) process, in accordance with Part 636-1.2 and 636-1.3.
- The written notice must also include the right to object to services, per with Section 633.12.
- This written notice must be given to the person as well as, if applicable the person upon whom decision-making is conferred by state law (such as legal guardianship, durable power of attorney, parent of a minor, Consumer Advisory Board, etc.)
- For people who already have an ISP in place by November 1, 2015, the service coordinator may give written notice at the time of the person's next ISP review.
- For people who do NOT have an ISP in place on November 1, 2015, the service coordinator must give written notice prior to the initiation of the person-centered planning process and development of the plan.
- The written notice must be conveyed in plain language and in a manner that is accessible to and understood by the person.

SELECT "MET" IF:
- ✓ either the 1st or 2nd bullet PLUS the 3rd is evident:
- ✓ There is documentation that written notice of the person's right to a person-centered planning meeting, including the right to object to services was provided; or
- ✓ It is verified through discussion with the person and/or guardian, if applicable that the written notice was provided to them; AND
- ✓ The notice is written in plain language that is understandable to the person per report of person or documentation review

SELECT "NOT MET" IF:
- ✓ There is no evidence of a written notice of the right to a person-centered planning meeting and the right to object to services in the person's file
- ✓ It cannot be verified that the written notice was provided to the person or legal guardian, if applicable
- ✓ The written notice is written in complicated, inaccessible, and/or difficult to understand language.

Standard No.	Standard Text	Decision
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	**Met/Not Met**

Guidance

DISCUSSION:
The individual, (advocate, if needed), service/care/treatment coordinator/manager.

DOCUMENTATION REVIEW:
- Form and format of rights provision provided by the service coordination agency.

GUIDANCE:
- A person's full participation in his/her service planning includes having the support of people he/she trusts and values to be part of the process. Ensuring that the person feels comfortable and is supported by those attending their person-centered planning meetings is critical to creating an effective person-centered planning process.
- The person's circle of support should be chosen by the person either explicitly or based on understanding of the person's positive relationships and responses to people whether family, service provider or community member.
- Verify that these people are invited to participate in the process, as needed and as desired by the person.
- The person also has the right to decide who does NOT participate in the planning process, including staff members. There may be confidential or intimate issues that the person does not want to discuss in front of certain individuals, and those wishes must be respected.
- In order to facilitate the participation of people important to the individual, the agency should demonstrate flexibility in scheduling meeting times, locations, and modalities if needed.
- The person is best supported when chosen circle members can be physically or remotely present at the planning meeting, however this may not always be possible. Alternate ways to include circle members in the planning process may include pre- or post-meeting discussions.
- The exception to this is when decision-making authority is conferred upon another by another state law (such as a legal guardianship, durable power-of-attorney, Consumer Advisory Board, etc.). However, in these instances the person should still maintain significant decision-making authority whenever possible, especially pertaining to daily decisions and preferences. When decision making authority is legally designated to another, it typically applies to specific decisions and is not meant to encompass all aspects of a person's life.
- This applies to development of the entire person centered service plan, including specific services the individual receives (as applicable) and is required for all HCBS Waiver Habilitation Service Planning.

SELECT "MET":
- ✓ If bullet 1 and 2 or 3 and bullet 4 are evident
- ✓ The person has chosen who is in their circle of support, who they would like to attend their meetings/participate AND
- ✓ The person reports that they are supported to invite whomever they want to their person-centered planning meeting; OR
- ✓ There is evidence that people identified as important to the person are invited to the person-centered planning meeting; AND
- ✓ Documentation demonstrates that people invited by the person have had opportunities to participate in other ways if meeting attendance is not possible or insufficient; or there is clear evidence that the person has no preferences or requests regarding who participates.

SELECT "NOT MET" If any of the following are evident:

- ✓ The person reports that they are not allowed to choose who attends their meetings
- ✓ The person is unaware they can choose who participates;
- ✓ There is insufficient evidence to verify that the people important to the person were invited and accommodated as needed, to participate.

Standard No.	Standard Text	Decision
1-3	The individual's planning process/planning meetings include participation and input from required parties.	**Met/Not Met**

Guidance

DISCUSSION:

As needed: Individual; service coordinator, treatment coordinator, case manager; circle/team members

DOCUMENTATION REVIEW:

- Review the record for documentation identifying who participated in the planning meeting, e.g. sign in sheet, meeting minutes, service notes may indicate effort made by the coordinator of services.

GUIDANCE:

- Expectations for participation in service planning varies dependent on the service(s) the person receives and/or the service environments.
- In most cases, participation in the planning process may include:
  - The individual per their clear choice to participate;
  - As desired/needed for support a family member, advocate, guardian, friend;
  - The person responsible for coordination of services (e.g. service coordinator, care manager or coordinator, treatment coordinator, etc.) representative providers of services, based on services person receives
  - Medical/clinical staff as appropriate and necessary (e.g. RNs, psychologist, MD, Physical therapist, etc.
  - People requested by the individual who will assist the individual in decision making is addressed in the standard above.

- Direct participation of the individual, (their advocate if required) and the coordinator of services should be evident. If the individual receiving services does not participate in a planning meeting, there should be evidence of efforts to secure their participation and/or justification for having the planning meeting without the individual's direct presence (e.g. The individual's informed or clear choice, clinical contraindications, etc.) How their input, choices, and perspective are reflected in service planning should also be documented.

- For other circle/team members: participation and input may occur through attendance and participation at a planning meeting or by the party providing information and input before and/or after the meeting as appropriate. Service planning minutes or care/service coordination notes should reflect the input provided to the planning considerations and decision making.

- In all service environments, the staff member designated as the coordinator of services (e.g. MSC, Case Manager, Case Coordinator, Treatment Coordinator, Program coordinator), has the role of seeking, coordinating and incorporating input from required parties and providers into the service planning.

- Specialty Hospital regulations specify that the person's program plan be developed by the interdisciplinary team inclusive of the medical treatment and active programming providers and direct care staff.

- The Willowbrook Permanent Injunction requires that service planning for individuals who are class members, includes/invites the individual, correspondent, MHLS and CAB representative (to the extent he/she represents the individual.

- For individuals enrolled in FIDA, the Interdisciplinary team (IDT) includes the individual, the Care Manager, and the primary (and knowledgeable) providers of the individual's DD services. The IDT members are expected to actively provide input in-person or remotely.

SELECT "MET" If :

- ✓ There is documentation identifying required parties participated in the planning process through meeting participation or solicited/provided input before/after the meeting as needed; AND/OR
- ✓ If required parties did not participate or provide input, there is a reasonable documented explanation for their lack of participation (for individual or advocate); and
- ✓ There is documentation evidencing that parties expected to participate/provide input were invited and encouraged to do so.

SELECT "NOT MET" If any of the following are evident:

- ✓ Documentation of service planning and resultant service plans evidence lack of information from relevant required parties
- ✓ Documentation of service planning and resultant service plans evidence out of date information as evidence of insufficient input from relevant required parties
- ✓ There is insufficient evidence to verify that required parties participated/provided input in service/program planning
- ✓ There is insufficient evidence to demonstrate that required parties were invited and actively encouraged to participate as required.

Standard No.	Standard Text	Decision
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	**Met/Not Met**

Guidance

DISCUSSION:
Required: Individual;
As Needed: advocate/family, coordinator of services

DOCUMENTATION REVIEW:
Service notes may indicate efforts made by the coordinator of services.

GUIDANCE:

- Discuss meeting attendance/participation with the individual and/or family, when meetings are scheduled, where they are held, how this is determined. Discuss whether the times/locations work well with their needs. If physical accessibility needed, verify the accommodation is provided.
- Service planning meetings should not be scheduled solely on the basis of administrative convenience for agency staff, e.g. time and location. The person should have active input into where and when their meetings are held. An effort should be made to make/provide an environment conducive to the person's comfort and participation.
- Agencies and agency representative should be willing to accommodate the individual at reasonable times outside the agency's business hours, especially if needed to accommodate a work schedule and/or clinical/medical services/supports. The person should not routinely be expected to make a choice to miss work or miss the meeting.
- If problems in accommodation are noted, determine whether the agency has rigidly adhered to meeting scheduling rather than allowing, inviting or offering flexibility to participants.
- The needs of the person's desired circle, especially non-agency advocates such as family and friends should be considered. Meeting schedules should also be respectful to family members' employment or other responsibilities, as well as accessibility if applicable.
- This applies to service planning of the entire person centered service plan, but also to specific services components (as applicable) and is required for HCBS Waiver Habilitation Service Planning.

SELECT "MET" IF:

- ✓ The person reports/it is evident that person-centered planning meetings have been scheduled at the times and locations that are satisfactory
- ✓ The person reports/it is evident that the person can provide input regarding date, time and place
- ✓ There is evidence in the person's record that meetings have been scheduled around the person's needs and their needs for support.

SELECT "NOT MET" IF:

- ✓ The person reports that they are unable to attend their own meetings due to scheduling conflicts or because of the location of where the meeting was held.
- ✓ There is little to no evidence or documentation that the person-centered planning team has been sensitive to the scheduling needs of the person.
- ✓ There is evidence that the person has been unable to attend their own meetings, with little to no justification or explanation.

Standard No.	Standard Text	Decision
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	**Met/Not Met**

Guidance

DISCUSSION:

Required: individual as described below

As needed: family/advocate, coordinator/manager of services, circle/team members

DOCUMENTATION REVIEW:

- Any documents that provide evidence of this standard, e.g. Service plan, service planning minutes, service notes.

GUIDANCE:

- When the person DIRECTS the planning process, they are given the authority to focus discussions and decisions about their own life. The overall focus of this standard looks at whether the person-centered planning process is led by the person and/or the perspective of the person and verifies whether those included in the person's circle/team play an active role in assisting the person with service planning and decisions. This requires that the person is provided with the encouragement as needed to direct the planning process per their desire to do so, and to ensure information, discussion and decision making is guided towards her/his desired outcomes.
- Assistance with directing service planning and decision-making becomes especially critical when people have communication difficulties, require assistance in advocating for themselves, and require assistance in understanding options. Supporting a person to direct PCP may include access to alternative communication modalities or other language interpreters during discussion.
- A person who requires a high level of assistance due to cognitive disability, also needs to "direct" the person-centered planning process. This means that the process is implemented using the person's perspective, requiring the circle to keenly identify the person's interests, preferences and choices, and guiding discussion and making decisions accordingly.
- Examples of assisting the person in decision-making include: explaining the issues that need to be decided, discussing options, discussing advantages and disadvantages, answering the person's questions, encouraging the person to actively participate in discussions, and/or assisting the person to communicate his/her preferences. Assistance of the person with the service planning process might also include scheduling a pre-meeting with the person to discuss what topics, issues, outcomes, and services the person would like to address at their person-centered planning meeting so that the person doesn't come to the meeting nervous or overwhelmed. It is vitally important for people who are supporting the person to not immediately "pre-judge" or dismiss something that the person has requested as "unrealistic" or "unachievable". The person-centered planning process provides for ongoing learning opportunities to continually discover more about what is most important to the person.

SELECT "MET" If at least 3 of the following are met:

- ✓ The person reports that he/she directs and/or receives support/assistance to direct/actively participate in the service planning activities.
- ✓ It is evident that people in the person's chosen circle/team have been assisting the person to direct/actively participate in the service planning activities.
- ✓ The person reports/it is evident that that the planning process focuses on his/her personal goals, interests, priorities of the person.
- ✓ The person reports/it is evident that their requests are acknowledged and acted upon.
- ✓ There is evidence that people who support the person and know the person well actively advocate for services and supports that promote the person's choices while conscientiously addressing the person's needs.

Note: this does not mean that issues that do not interest or are not priorities to the person must be ignored. How to best support the person's needs/issues related to their health, safety, and well-being should be discussed and determined with the person's perspective and with informed choice as capable.

SELECT "NOT MET" If any of the following are present AND the service plan is not truly reflective of the person's priorities and desired life:

- ✓ The person has reported that they receive insufficient assistance with directing/active participation in person centered planning, and are dissatisfied.
- ✓ The person or those that know the person well report that service planning decisions are made for the person by staff of the agency, with little or no individualized support.
- ✓ People who participate in the person's circle of support state that they have not been given opportunities to assist the person with service planning and the person needs such assistance to fully participate.
- ✓ There is little to no evidence that the person's requests, interests, priorities for services are acknowledged and acted upon.

Standard No.	Standard Text	Decision
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	**Met/Not Met**

Guidance

DISCUSSION:

Required: individual, coordinator/manager of services; As needed: family/advocate, circle/team members

DOCUMENTATION REVIEW:

As needed: Any documents that provide clarification if needed, e.g. Service plan, service planning minutes, and service notes.

GUIDANCE:

- A conflict of interest means that a member of the person-centered planning team has a competing interest with the interests of the person with a disability which a reasonable person would regard as making it difficult to properly perform their responsibilities to the person with disability. Conflicts of interest may include, but are not limited to, the same supervisory oversight of service coordinators as providers of other services, financial interests in the provision of services, and any personal or familial relationships of staff or service coordinators with the circle of support or individual. Agencies must develop policies that ensure conflicts of interest do not interfere in the person-centered planning process. (The agency p & p will be verified during the agency review.)
- Discuss with the person, their advocate, coordinator and agency staff whether there have been disagreements between the person and circle members. Discuss how the disagreement(s) are addressed.
- Conflicts of interest may occur from an administrative perspective, e.g. what agency is providing services and whether it is in the best interest of the person or the agency.

- Conflict of interest can also occur regarding services and activities standpoint, e.g. when the person expresses interest in increased independence and autonomy while the person's advocate insists on no changes.
- The person must be provided with a clear and accessible dispute resolution process when there are disagreements within the person-centered planning process. There should also be strategies for conflicts and disagreements between person-centered planning team members. If necessary, ask the coordinator/manager if guidelines, as well as strategies for handling disagreements among people who participate in the person-centered planning process exist. If needed, verify that the policy was effective specific to the individual's situation.
- The preferences and values of the person with ID/DD must be at the center of all strategies to address conflict of interests and conflicts in the planning process.

SELECT "MET" If any of the following are evident:

- ✓ The person reports that they are satisfied with how disagreements that arise at the meetings are handled.
- ✓ When disagreements are identified, there is a methodical and clear process of mediation and dispute resolution that is adhered to, with the person's best interests consistently in mind.
- ✓ The agency has a written policy and procedure regarding conflict-of-interest within person-centered planning, as well as a clearly identified dispute resolution process pertaining to disagreements between person-centered planning team members.
- ✓ There are no reported disagreements of conflicts.

SELECT "NOT MET" If any of the following are evident:

- ✓ The person reports difficulties, differences of opinion, and/or disagreements between team members that remain unresolved, and there is no evidence or documentation in the person's file that these conflicts have been addressed in any thoughtful, methodical, or comprehensive way.
- ✓ There is evidence that a person-centered planning team member has a conflict-of-interest that has not been resolved and has made it difficult for the team member to effectively participate in supporting the person.
- ✓ The individual's priority is not addressed due to a conflict of interest.

Standard No.	Standard Text	Decision
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	**Met/Not Met**

Guidance

DISCUSSION:

Required: individual, coordinator/manager of services regarding information provided, how it was provided, if the individual was able to ask questions and get clarification, and how.

Discuss as needed: family/advocate, circle/team members, supports.

DOCUMENTATION REVIEW:

- As needed: Any documents that provide clarification if needed, e.g. Service plan, service planning minutes, and service notes.

GUIDANCE:

- This standard looks at whether the person is provided information and experience necessary to lead/participate in person-centered planning and decision making. The person must receive information necessary to make informed choices and decisions. The person may need support to explore service options, and understand differences, advantages, disadvantages based on their personal goals. This education and knowledge is part of supporting the person to DIRECT the planning process, empowering their ability to make decisions about their own life. A person who requires a high level of assistance due to cognitive disability, should also have the opportunity to learn about service options. Experiencing options is often the most effective means to allow him/her to understand and respond to the environment and activities in the way he/she best communicates.
- This applies to service planning of the entire person centered service plan, but also to specific services components (as applicable) and is required for HCBS Waiver Habilitation Service Planning.

SELECT "MET" If any of the following are evident:

- ✓ The person reports/it is evident that they are provided the information needed to choose the services that are receiving, and assistance in understanding the information, if applicable.
- ✓ The person reports/it is evident that options were explained and the opportunity to visit, experience, learn more about the options was provided as needed/requested.
- ✓ The person's advocates, service coordinators, supports were responsive to her/his interests and preferences when providing information about service options.

SELECT "NOT MET" If any of the following are evident:

- ✓ The person reports that he/she received little to no information about service options and explanation of characteristics of the service options.
- ✓ There is no evidence that the person received information and explanation regarding service options, and explanation of characteristics of the service options.
- ✓ Service options discussed/provided do not correspond to known/documented interests and preferences of the individual.

Standard No.	Standard Text	Decision
1-8	The individual's service planning includes consideration of natural supports as well as paid supports.	**Met/Not Met**

Guidance

DISCUSSION:

Required: individual, coordinator/manager of services;
As needed: family/advocate, circle/team members, supports

DOCUMENTATION REVIEW:

- As needed: Any documents that provide clarification if needed, e.g. Service plan, service planning minutes, and service notes.

GUIDANCE:

- Natural supports can be an important part of each person's life. Beneficial natural supports are those that provide the individual a support system that promotes their independence and growth. The development of a person centered service plan includes consideration of supports that may best be provided by the person's natural supports. Natural supports may include family members, friends, neighbors, church members, fellow hobbyists, etc. For example, if the person needs support to pursue their interest in visiting the library to borrow books weekly. A neighbor/friend does the same. A Community Habilitation service to support the individual in finding and borrowing books at the library may not be necessary, as the neighbor is happy to and capable of providing the support, and the individual is happy to visit the library with the neighbor.

- Some individuals may already have people in their life they can "count on" other than paid staff. Other individuals may have a more limited circle of friends, family and acquaintances that show a willingness to support them in their interests and activities.

- In addition to identifying natural supports and the supports they provide in service planning, consideration should also be given to the appropriateness of exposing the individual to more activities and individuals with the possibility of identifying and/or expanding relationships and possible future natural supports to the person.

- Natural supports can be defined as personal associations and relationships which are developed in the community and enhance the life of people. These "natural supports" may include family member, advocates, friends, neighbors, community members, church and social club members.

- People considered as "natural support" should be either chosen by the individual or are considered important to the person and/or their family.

- An individual many not want to have an extensive natural support network. If this is the case, this choice should be respected and should not be forced upon the person, but rather offered from time to time as a potential option as people's decisions and choices change over time.

- An individual should be supported to consult/use their natural supports and/or to develop natural supports per their choice.

- Unpaid supports are voluntary, not mandated, and optional. They cannot be compelled or required to provide support (for example, if an unpaid caregiver is unable to continue providing support, they cannot be required or compelled via the written service plan to continue providing those identified

unpaid supports and services). However, identifying the person's preference for unpaid caregivers should be included as part of the planning and the written person-centered plan.

SELECT "MET" If any of the following are evident:

- ✓ The service plan identifies the supports provided by persons who are natural supports to the individual.
- ✓ Discussion and/or the service plan or service planning notes/minutes evidence a discussion/consideration of any of the following:
  - o Supports needed by the individual that could be provided by a natural support if obtained/agreed/ relationship is developed
  - o Parties involved in the person's life that may be able to support/assist the individual in some interests, requests, needs if determined to be able and willing to do so;
  - o Efforts that should be taken to enhance the person's relationships with others;
  - o The appropriateness of pursuing and arranging natural supports part of the person's individualized service plan.

SELECT "NOT MET" IF:

- ✓ There is no evidence of consideration of natural supports as part of the person's service planning and services/support providers.

Standard No.	Standard Text	Decision
1-9	The individual has made informed choice of residential setting and alternative options considered by the individual are recorded in his/her written plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: individual;
As needed: family/advocate, coordinator/manager of services; direct supports

DOCUMENTATION REVIEW:

- As needed: Any documents that provide clarification if needed, e.g. Service plan, service planning minutes, and service notes.

GUIDANCE:

- A person's home is the center of comfort and safety. As with any person, a person receiving services should decide the home setting and environment that they prefer and want, based on understanding the options for residential services and supports.
- The individual's person centered service plan must document the alternative housing options that the individual considered and that the individual chose the residence where he or she is living. It is important to note that options discussed should not be limited to those provided by a provider agency currently supporting the person, but must also include all options. The service plan must document that the individual's options including settings that are available to individuals without disabilities. While support options may be limited if a person has specialized needs or if the person or his/her circle of support has specific desires, the options available must be referenced in the planning process. This information must be included in the narrative section of the service plan or in a separate document that is attached to the service plan.

- State regulations require that this be documented if an individual resides in a certified residential setting. Federal regulations do not make a distinction of certified/non-certified for documentation in the person centered plan if the person receives HCBS Waiver Services.
- Residential options should:

- meet the individual's objectively assessed functional or medical needs;
- be based on the individual's resources for room and board;
- include settings that are available to individuals without disabilities; and
- include an option for a private unit if the residential setting is disability-specific.

- The documentation should include:
  - the alternative housing options that were considered (If the type of residential option being offered is not clear, include a description of the locations and the services that could have been provided to meet the individual's needs.); and
  - type of information provided to the individual about the options provided, including exposure to the actual setting if relevant;
  - Information that the residence was chosen by the individual from available options. (The documentation may be a note describing why the individual chose his/her current residential setting or a document signed by the individual stating that he or she is making an informed choice after being offered other options.)

- For individuals who currently reside in a certified residential setting, the coordinator/manager of services needs to ensure that the service plan includes documentation that the individual is satisfied with his/her current living arrangement. (Note: If not satisfied, there should be active planning to assist the individual to make a change. This may be included in the monthly service notes, habilitation providers' documentation or other related documentation. Satisfaction or response to dissatisfaction will be specifically reviewed in Section 6.)

SELECT "MET" If all of the following are evident:

- ✓ The person centered service plan identifies all of the following:
  - Housing options considered
  - The residence/residence type chosen by the individual and why
  - If the person lives in a certified residence, the individuals' satisfaction with current living arrangement
- ✓ Clear and comprehensive information was provided to the individual regarding home living options, to aid in decision making.

SELECT "NOT MET" If any of the following are evident:

- ✓ The service plan does not include information as described in the first bullet/sub-bullets above
- ✓ While the ISP may include appropriate documentation, there is evidence that the person was not provided adequate information to understand their option and make an informed decision.

Standard No.	Standard Text	Decision
1-10	Assessments needed by the individual or required by program regulation were completed to inform the individual's plan development.	**Met/Not Met**

Guidance

DISCUSSION:
As needed: Individual, family/advocate, coordinator/manager of services, service providers

DOCUMENTATION REVIEW:
- Required: Service plan, assessments, service notes, incident reports, prn/daily notes as appropriate to the service/setting

OBSERVATION:
In appropriate settings (e.g. certified residential and day settings)

GUIDANCE:
- Any assessments needed to identify the individual's needs for functional, clinical/medical support should be completed and identified in the person's service record. Assessments assist the coordinator of service to assure that the services and supports are appropriate and necessary. As part of the PCP process, the coordinator must complete or ensure that required or needed assessments are completed to assist in service and support planning and decisions.
- The coordinator is responsible to obtain a copy of the results of the assessment(s). The results of the assessment(s) should be shared with the individual and should be discussed with the individual at the next service planning/review meeting.
- Information from the assessment that is relevant to the development of the service plan must be summarized and described in the written plan. (E.g. in an ISP this may be included in the Profile and/or Safeguards Sections.)

- The surveyor should not "second guess" whether an assessment should have been completed if service planning and the resultant plan appears to be appropriate and meets the individual's needs. However, if there is clear evidence from survey activities that an assessment is necessary and has not completed, this should be identified as problematic. For example: Example 1) if during observation in the residence you noted that the individual had difficulty drinking without spilling and his service plan did not identify this issue and any decision making related to it. Example 2) Record review indicates that the person has had multiple falls in the past six months needing no more than first aid only. You are told that there is no request/plan to assess ambulation and/or environmental needs.
- Specialty Hospital services have more specific requirements regarding assessments:
  - Individuals must have had comprehensive assessment within 90 days prior to admission to the facility. [An accurate and current (within 90 days) IPP from a previous facility/DC meets this requirement.]
  - The assessment must identify both developmental disability and health care needs including the type and frequency and needed service outcomes requiring the admission to the specialty hospital.
  - The prior assessment requirement may be waived in an emergency admission, but a comprehensive assessment must be completed within 15 days of admission.

SELECT "MET" If any of the following are evident:

- ✓ Assessments, if needed are completed and relevant findings are identified in the service plan;
- ✓ Assessments that are needed, if not yet completed, have been identified and scheduled timely after identification of need;
- ✓ The coordinator, circle/team, and individual have sufficient information to identify and justify the person's service/support needs.

SELECT "NOT MET" If any of the following are evident:

- ✓ The individual, circle, team, coordinator do not have sufficient information to determine service/support needs of the individual
- ✓ Assessments have been completed but relevant information was not part of service planning and was not incorporated into the service plan.
- ✓ Needed assessments are not completed and action has not been taken to facilitate ensure completion of assessment(s) needed
- ✓ Survey findings clearly indicate the individual's need for further assessment of capabilities, needs and related supports (as referenced in the last paragraph in guidance above.)

Standard No.	Standard Text	Decision
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: Individual regarding what kind of life they want, their desired goals and outcomes; and whether they have shared this information with people who can support them to this end; Coordinator, service providers; people who know the person well.
As needed: Family/Advocate

DOCUMENTATION REVIEW:

Required: The person's written person-centered plan; supporting notes and documentation routinely reviewed in the survey process. If completed by provider and available, review documentation resulting from use of person centered planning tool such as CQL POMs documentation.

OBSERVATION:

As needed: If observation occurs as part of review of services (especially site based), further information regarding personal goals may be discovered naturally.

GUIDANCE:

- The person centered service plan should specify what it is intended to accomplish, the goals that will be achieved if the plan is successfully implemented. Documented goals and desired/valued outcomes identified for the person may be both formal goals and informal expectations, wishes, and hopes for the future. The basis for supporting the individual and providing services should be the person's identified goals and desired outcomes. The person-centered plan should flow from the information gathered about the person's hopes and interests for their future. Supports and services for the person should be based on the person's goals in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, consistent with the person's needs and desires. The person's service plans and goals and services that are part of the plan must consider the quality of life concepts most important to the person.
- The individual's service plan should clearly and comprehensively identify the person's goals and desired outcomes.

- An individual's desired outcomes should be personal and specific to the person, rather than generalized values that could be applied to anyone.
- Desired outcomes should evolve and change as the person grows and develops.
- Desired outcomes may describe short term life goals seen from the individual's perspective. The person's advocate, guardian, and/or family member may help the person state his/her valued outcome(s).
- They may also describe a long term life vision.
- Additional written plans such as HCBS Waiver Service Plans should document the desired outcomes relevant to the particular service and service activities.

SELECT "MET" IF any of the following are evident:

- ✓ Upon discussion with the person, and review of the person-centered planning process and meeting in section 1, there is evidence and documentation in the written plan that clearly identifies those goals and desired outcomes that are important to the person.
- ✓ The person reports that they are satisfied with the identified goals and desired outcomes in the written plan.
- ✓ Services and supports identified in the written plan support the person's goals and desired outcomes.

SELECT "NOT MET" IF any of the following are evident:

- ✓ The written plan lacks clearly specified, individualized goals and desired outcomes for the person.
- ✓ There is no clear connection between the person-centered planning discovery process and the written plan's goals and outcomes.
- ✓ The person reports that the written plan's identified goals and outcomes are not reflective of what is important to them.

Standard No.	Standard Text	Decision
1-12	The individual's strengths and preferences are documented in the service plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: Individual regarding what kind of life they want, preferences in life activities (routine and periodic), services and service locations, what they consider their skills and abilities.
Discuss also if this information has been sought or discussed with others.
Coordinator, service providers; people who know the person well.
As Needed: Family/Advocate

DOCUMENTATION REVIEW:

Required: The person's written person-centered plan; supporting notes and documentation routinely reviewed in the survey process. If completed by provider and available, review documentation resulting from use of person centered planning tool such as CQL POMs documentation.

OBSERVATION:

As needed: If observation occurs as part of review of services (especially site based), further information regarding strengths and preferences may be discovered naturally.

GUIDANCE:

- Supports and services should be developed in light of the individual's strengths, capabilities and preferences. Therefore this information should be recognized in the person centered plan.
- Service plans should document the individuals relevant strengths and preferences comprehensively;
- Service plans and service activities should not be intrusive or demeaning. Descriptions should be respectful of the person's when describing their characteristics, preferences and abilities.
- The written plan should identify and encourage the person's overall independence by focusing on the person's strengths in a positive way.
- Additional written plans such as HCBS Waiver Service Plans should document the strengths and preferences relevant to the particular service and service activities.

SELECT "MET" IF any of the following are evident:

- ✓ The written plan has documented the person's strengths and preferences in an individualized, positive and thoughtful way, and encourages the overall independence of the person by focusing on the person's capabilities (and not just clinical or functional needs).
- ✓ Documented preferences, strengths, and capabilities demonstrate the basis for decisions made in services and supports.
- ✓ The person reports that they are satisfied with how the written plan reflects their personal preferences and strengths.

SELECT "NOT MET" IF any of the following are evident:

- ✓ The written plan lacks any specific information regarding the person's strengths and personal preferences.
- ✓ The written plan does not appear to be individualized, or reflective of what you have learned about the person's capabilities, strengths, and preferences.
- ✓ The written plan is not written in positive, person-first language, or is mostly clinical and functional in nature.
- ✓ The person reports that they are dissatisfied with the written plan, and feels that it has not captured their personal preferences and does not focus on their strengths.

Standard No.	Standard Text	Decision
1-13	The individual's identified needs for clinical and/or functional support are documented in the service plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: Individual regarding what kind of life they want, what kinds of things they feel they need help with, any difficulties they have with independence, social activities, daily routine activities, mobility, health, etc.; Discuss whether this information has been sought or discussed with others.
Coordinator, service providers; people who know the person well.
As Needed: Family/Advocate

DOCUMENTATION REVIEW:

- Required: The person's written person-centered plan; supporting notes and documentation routinely reviewed in the survey process. If completed by provider and available, review documentation resulting from use of person centered planning tool such as CQL POMs documentation.

OBSERVATION:

As needed: If observation occurs as part of review of services (especially site based), further information regarding needs for support may be discovered naturally.

GUIDANCE:

- The plan should document those characteristics of the individual that need to be addressed through clinical and/or medical supports and service.
- The plan should also identify the amount and type of assistance or support a person needs because of limitations in performing daily activities.
- The plan should document mental, physical, and emotional needs and supports intended to assist the person to achieve the best possible health, restore lost capacity, or minimize further loss of functioning and independence.
- The person's needs should be identified in a comprehensive, individualized, and positive way as applicable.
- In addition to the need for direct intervention it may include identifying the person's needs for education, information and support for the person to make their own best possible choices about their clinical and healthcare needs.
- Written service plans (or attachment) should document needs for clinical and functional support accurately.

SELECT "MET" IF:

- ✓ The written plan for the most part, accurately and comprehensively documents the person's need for clinical supports and healthcare supports. Information lacking is inconsequential to ensure appropriate services.

SELECT "NOT MET" IF:

- ✓ The written plan lacks significant information regarding the person's need for clinical supports and healthcare supports based on information you have gathered from the person's record or interview.

Standard No.	Standard Text	Decision
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: Individual regarding what kind of life they want, their affiliations; their interest and involvement in religious/spiritual, church; cultural, religious or other life enhancing organizations they are involved with or would like to be more involved with; cultural or ethnic identity and desire to learn more about or maintain related customs, traditions, activities, or associations, etc.

Consider language/communication issues when planning to discuss with the individual and their supports. Discuss whether this information has been sought or discussed with others.

Coordinator, service providers; people who know the person well.

As Needed: Family/Advocate

DOCUMENTATION REVIEW:

- Required: The person's written person-centered plan; supporting notes and documentation routinely reviewed in the survey process. If completed by provider and available, review documentation resulting from use of person centered planning tool such as CQL POMs documentation.

OBSERVATION:

As needed: If observation occurs as part of review of services (especially site based) or visit to the person's residence, further information regarding interests in this area may be discovered naturally.

GUIDANCE:

- There should be overall sensitivity towards the person's cultural and religious beliefs, and the person-centered planning process and resulting plan should reflect this. Efforts must be made when developing the person centered service plan and identified supports/activities to both assist the individual to express their chosen and preferred identity, language, expressions of belief etc. Person centered plan must also ensure that their written plan identifies these preferences, identifies the supports that they may need regarding this area, and ensures services, service activities, and service schedules are respectful of these preferences. Additional written plans such as HCBS Waiver Service Plans should also document relevant information.

- Person-centered planning must be sensitive to the cultural and language differences either between the dominant community and the person, or between the person and the primary professionals involved with him or her. Open-mindedness and attention to successful communication are conducive to creating bridges and eliminating cultural barriers for a person who differs in some way from the normative/majority culture. The same skillful facilitation that supports a person who has a disability will also support a person with a disability who has cultural or language differences.
- Working with people who are culturally diverse requires not only objectivity but also a willingness to examine myths and stereotypes. A person with disabilities and language or cultural differences is at particular disadvantage and risk for unequal representation in traditional service planning and service provision. Cultural differences should not be overlooked in communication styles. Cultural differences can affect the communication of successful outcomes.
- The person-centered planning process must also provide meaningful access to participants and/or their representatives with limited English proficiency (LEP), to assistance including low literacy materials and interpreters.

SELECT "MET" IF any of the following are evident:

- ✓ DISCUSSION with the person indicates that their cultural and religious preferences and beliefs are respected and acknowledged as part of their person-centered planning meetings, and
- ✓ There is evidence that these preferences have been incorporated into their person-centered plan.
- ✓ If preferences are unknown the service planning considers if exposure to experiences pertinent to the individual's known background and/or heritage is appropriate and meaningful for inclusion in the service plan.
- ✓ Note: Some individuals may not have a particular/specific interest, in cultural, religious, or affiliation expression, even if provided the opportunity and experience. In this case the person centered service plan would likely lack any detailed information on this regard. As long as survey activities determine this is accurate, the standard is met.

SELECT "NOT MET" IF any of the following are evident:

- ✓ There is little to no documentation or evidence that the person-centered planning process and plan has been sensitive towards the person's cultural or religious beliefs despite indications that cultural and religious considerations are important to the person.
- ✓ The person (and/or their circle of support) reports that important cultural or religious beliefs are ignored, or overlooked as part of the person-centered planning meetings.

Standard No.	Standard Text	Decision
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: With individual, Coordinator, service providers; people who know the person well regarding community activities and interests outside his/her home. The purpose is to try to learn what the person wants to do in the community and what kind of community member they want to be, and how often they would like to these participate in these activities or go to certain places. This may also include creating and sustaining community based social networks, e.g. being a volunteer at the local library, being a "regular" at the local bank, diner, or gym.
As Needed: Family/Advocate

DOCUMENTATION REVIEW:

- Required: The person's written person-centered plan; supporting notes and documentation routinely reviewed in the survey process. If completed by provider and available, review documentation resulting from use of person centered planning tool such as CQL POMs documentation.

GUIDANCE:

- Written service plans must specify the varied community- based activities for which the person has expressed or demonstrated interest. This may include community activities intended to assist the person with functional skills, but should also include identification and planning for community integration based on individualized interests and priorities in leisure, recreation, associational memberships, and cultural interests. (Some examples include church membership, social activities and social groups, clubs of shared interests, shopping and purchasing desired or needed items, etc.) Service planning for community involvement should go beyond just basic functional, generic, and easily "billable" activities. However, it may also be appropriate to acknowledge what training and skills are needed for the person to be able to access their community interests with more independence.
- Service planning may include providing new experiences to an individual when it is unclear what the person prefers or it is acknowledged that the person has had limited opportunity and may benefit from exploration. This should be reflected in the service plan.
- It may at times be difficult to identify what truly interests a person, especially when communication abilities are limited and those supporting him/her must be attentive to subtle changes in affect, vocalization, animation and other behavioral signs. The circle/team must nevertheless make effort to determine interest.
- Some people may be happy to be out and about while others are homebodies. Person centered service planning should reflect the individual. For example, frequency of a certain preferred activity may change as a person's health changes, as he/she ages, or as interests broaden or narrow. However, for the homebody, efforts should be made to ensure this is a preference based on having meaningful opportunities and experiences vs. not having experiences important to the person. Adaptations to duration of activity may be part of consideration. The person centered plan community preferences should therefore reflect what is known already about the person's community preferences, but include supports to learn more when necessary.
- Support considerations may be simple or complex depending on the needs and interests of the person and their current abilities to navigate the community safely and responsibly. Consider that the plan has identified the community priorities, identified what supports (e.g. staff support, adherence to a written plan, transportation, financial, etc.) are necessary to make this happen for the person.
- Additional written plans such as HCBS Waiver Service Plans should document the specific priorities relevant to the particular service and service activities.
- Ensure service planning/plan DOES NOT limit or refuse to consider desired community participation because it may be difficult given staff levels, transportation, etc.
- *Note: review for service planning attentive to risk identification and remediation is specifically addressed elsewhere in this protocol. Therefore, focus here on the adequacy of service planning and identification in the service plan, of what the person wants and what they need to make it happen.*

SELECT "MET" IF any of the following are evident:

- ✓ The key to this standard being "MET" is that community preferences/activities are identified AND the strategies, related to the activities are in place for people and meaningful to them.
- ✓ The service plan accurately reflects community related interests and priorities that are important to the person, including desired frequency and supports needed for the person to engage in these activities. (For example, Sam would like to attend the senior center in Albany at least once per week on Saturday mornings to participate in playing checkers. Sam needs one-to-one staff support while at the senior center to ensure appropriate social interaction with other players); And/or:
- ✓ The service plan reflects related activities that will enhance the ability of the person to participate in community activities per his/her interests (such as training in using public transportation, training on becoming more independent with finances, discovery and research of new opportunities, etc.)
- ✓ Activities and interests documented in the plan specifically relate to the person's community integration goals and desired activities. The strategies/plan to support the individual or assist the individual to independently engage in the activities are documented in the service plan.

SELECT "NOT MET" if any of the following are evident:

- ✓ Meaningful community-related interests and/or need for and proposal for exposure is lacking in the service plan.
- ✓ The plan/supports to ensure the person's community opportunities is lacking in the service plan.
- ✓ Community-related activities are present in service plans, but they are not individualized to the person, and do not reflect what is meaningful or of interest to people.
- ✓ People report dissatisfaction with the plan's description and personal relevance of community interests and preferences.

Standard No.	Standard Text	Decision
1-16	The individual's goals and priorities regarding meaningful relationships are identified in the person centered plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: With individual, Coordinator, service providers; people who know the person well regarding the person's relationships. Identify family members, friends, romantic partner, co-workers, neighborhood and childhood chums, and others who the person either currently has a valuable relationship or desires/wants help with the developing/improving the relationship. Discuss also what type of support, and or skills to gain to maintain/enhance relationships the person needs. The purpose is to try to learn what the person wants and needs regarding relationships.
As Needed: Family/advocate

DOCUMENTATION REVIEW:

- Required: The person's written person-centered plan; supporting notes and documentation routinely reviewed in the survey process. If completed by provider and available, review documentation resulting from use of person centered planning tool such as CQL POMs documentation.

GUIDANCE:

- The person's priorities in this area should be identified in the person centered service plan as expressed/preferred by the individual. The supports/service needed to assist them in this area should also be documented in the service plan.
- Additional written plans such as HCBS Waiver Service Plans should document the specific priorities relevant to the particular service and service activities.

- Each person's preferences in this regard will be unique. Some people may be very involved with family members and/or friends, others may have had less opportunity, while to others it may not be important at all.
- The person's desire for relationships should be elicited/assessed in service planning, ensuring there is serious discussion of the person's desires and goals regarding relationships. The resultant plan must document the person's preferences/goals, the support needed and plan to ensure.
- There are different kinds of relationships and it is helpful to know what the person wants to assist them in determining how best to support them. It may be they want changes in a variety of ways; e.g. they want to meet and make a new friend who likes baseball games, or they want a best friend; or they have a significant other but need support/education in developing a sexual relationship with them; or they may want to start visitations with a sister who lives out of state; etc.
- Supporting relationship goals may require access to transportation, phones, cell phones, video chat capability, email, etc.
- Supporting relationship goals may include assisting the individual to develop social, communication and other skills.
- The person may be exactly where they want to be regarding this OPWDD value. If the person does not want to increase or change relationships, the service plan needs simply to document the current status and any supports, if needed to maintain this. However, this topic, as with all other life situations, should be reviewed during every service plan review.
- Unless clinically contraindicated, there should not be barriers in place to prevent the person from pursuing a sexual relationship.
- An intimate relationship may mean sexual or a close personal friendship with another person.
- Per their needs/want the person should receive assistance and education to learn about healthy relationships, and explore social occasions as a means to explore and develop relationships.

SELECT "MET" If all of the following are evident:

- ✓ The service plan documents the person's wishes and his/her circumstances regarding relationships.
- ✓ Supports/services are identified in the plan to align with the person's relationship goals and desires.
- ✓ The plan is responsive to the person's desires and the circle is responsive in determining how to facilitate vs. focusing on barriers to supporting.

SELECT "NOT MET" If any of the following are evident:

- ✓ The service plan does not include the person's wishes and his/her circumstances regarding relationships.
- ✓ Supports/services, as applicable, to support the person to achieve relationship goals are not identified in the plan and/or do not align with the person's relationship goals and desires.
- ✓ The plan is not responsive to the person's desires and the circle identifies barriers but not supports to help the person achieve relationship goals.

Standard No.	Standard Text	Decision
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: With individual, Coordinator, service providers; people who know the person well regarding the person's goals/dreams/preferences regarding life that is not part of activities of daily living. This includes interests in paid work/employment, volunteerism, education, skill enhancement, and hobby/recreation/leisure pursuits that contribute to the person's quality of life, purpose, and fulfillment. Discuss what the person typically does during the day when not doing routine daily life activities (e.g. domestic life, hygiene, meals, shopping for what they need); and how/if this fits into what they want. Discuss also what type of support, and or skills desired to gain, to maintain, or to enhance their priorities in this area.

As Needed: Family/Advocate

DOCUMENTATION REVIEW:

- Required: The person's written person-centered plan; supporting notes and documentation routinely reviewed in the survey process. If completed by provider and available, review documentation resulting from use of person centered planning tool such as CQL POMs documentation.

GUIDANCE:

- The person's preferences/priorities for employment or non-employment activities should be documented in the service plan as expressed or assessed.
- Additional written plans such as HCBS Waiver Service Plans should document the specific priorities relevant to the particular service and service activities.
- Determine if the individual has a job, is volunteering and/or participating in other meaningful activities, and if these activities align with his/her interests and life goals as indicated in the written plan. Determine if the activities are meaningful and were developed with their input and agreement. Determine whether their participation is individualized with the person's perspective instrumental in the activity's design.
- If employment is not desired by the person, or is he/she is not able to work, other meaningful day activities should be developed and offered per their assessed or known interests. This includes interests in paid volunteerism, education, skill enhancement, and hobby/recreation/leisure pursuits that contribute to the person's quality of life, purpose, and fulfillment.

SELECT "MET" If the following are evident:

- ✓ The service plan documents the person's wishes and his/her circumstances regarding meaningful work, volunteer and recreational activities.
- ✓ The plan is responsive to the person's desires as supports/services are identified in the plan that align with the person's goals and desires in this area.

SELECT "NOT MET" If any of the following are evident:

- ✓ The service plan does not include the person's wishes and his/her circumstances regarding meaningful work, volunteer and recreational activities.
- ✓ Supports/services, as applicable, to support the person to achieve goals in this area are not identified in the plan and/or do not align with the person's goals and desires in this area.
- ✓ The plan is not responsive to the person's desires and the circle identifies barriers but not supports to help the person achieve these goals.
- ✓

Standard No.	Standard Text	Decision
1-18	The individual's goals and priorities related to health concerns and medical needs are identified in the person centered plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: With individual, Coordinator, service providers; people who know the person well regarding the person's health and medical concerns and needs for support routinely and periodically.

As Needed: Family/Advocate

DOCUMENTATION REVIEW:

- Required: The person's written person-centered plan; supporting notes and documentation routinely reviewed in the survey process, assessments completed, medical information (e.g. physician appointment documentation, service notes, health assessments, etc.). If completed by provider and available, review documentation resulting from use of person centered planning tool such as CQL POMs documentation.

GUIDANCE:

- This standard is to assess whether the individual's health concerns and priorities have been identified and documented in the person-centered service plan as well as desired supports. This standard is meant to focus the health priorities from the person's perspective and per his/her informed decision making when applicable.
- Significant health care issues/concerns should be identified in service plan as they impact the person's quality of life. This may be related to specific diagnoses or to specific activities that impact the person's health.
- DISCUSSION and identification of health issues and supports may also include the routine health care activities that require support and monitoring; e.g. taking medication, diabetes care, needed equipment.
- Priorities related to health may also be maintaining health through a healthy lifestyle (e.g. dietary moderation, exercise, meditation, sleep habits) and related supports/education.
- The service plan must identify the strategy/supports to be provided to the individual to address the need(s). Parties responsible should be identified including natural supports.
- If the individual is a competent adult who will be independently ensuring their health/medical needs are met, the service plan should document this.
- An individual may make an informed decision not to address or receive support to address a medical condition. This condition must still be identified in the service plan, as well as efforts taken to inform/educate the individual, and circumstances regarding the informed decision.

SELECT "MET" If the following are evident:

- ✓ The service plan accurately documents the person's priorities related to his/her health and medical concerns.
- ✓ The plan is responsive to the person's health priorities as supports/services are identified in the plan that align with the person's goals and desires in this area.

SELECT "NOT MET" If any of the following are evident:

- ✓ The service plan does not document the person's priorities related to his/her health and medical concerns.
- ✓ The plan is responsive to the person's health priorities as supports/services are identified in the plan that align with the person's goals and desires in this area.

Standard No.	Standard Text	Decision
1-19	The individual's known food, medication, and/or environmental allergies and the corresponding precautions are identified in the person centered plan.	**Met/Not Met/NA**

Guidance

DISCUSSION:

Required: With individual, Coordinator, service providers; people who know the person well regarding the person's allergies and precautions needed/taken.
As Needed: Family/Advocate

DOCUMENTATION REVIEW:

- Required: The person's written person-centered plan; supporting notes and documentation routinely reviewed in the survey process, assessments completed, and medical information (e.g. physician appointment documentation, service notes, health assessments, etc.).

GUIDANCE:

- Review the service plan to verify that known allergies and related safeguards are documented in the service plan. Circumstances that put the person at risk for exposure to their known allergens are identified as appropriate. The key here is that information about real allergies to foods, medications, insect bites or environmental factors are included in the service plan or addenda and that the information is known to programs/persons who will be providing services to the individual.

SELECT "MET" IF:

✓ The person's allergies, exposure prevention, and response to exposure are accurately identified in the written service plan.

SELECT "NOT MET" IF:

✓ The person has known allergies which are not documented in the service plan.

SELECT "NA" IF:

✓ It is verified that the person has no known allergies.

Standard No.	Standard Text	Decision
1-20	Individualized considerations and safeguards regarding fire safety are identified in the person centered service plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: With individual, Coordinator, service providers; people who know the person well regarding the individualized safeguards need by individual: environmental, supervision, assistance and training, for example.

As Needed: Family/Advocate

DOCUMENTATION REVIEW:

- Required: The person's written person-centered plan; supporting notes and documentation routinely reviewed in the survey process, assessments completed, etc.

GUIDANCE:

- Service planning for the individual should include a discussion of what the person needs to ensure their safety in the event of a fire emergency and as needed, fire prevention.
- For individuals in Certified Residences and receiving Medicaid Service Coordination, supports that need to be in place to ensure an individual's safety in the event of a fire must be identified in the Safeguard Section of the ISP or attached to the ISP. (E.g. For individuals, who live in IRAs, the Individual's Plan of Protective Oversight may adequately address this requirement, if the content is appropriate.) This information should include the level and type of people assistance and/or supervision needed, any equipment that pertains directly to the individual (i.e. wheelchair, bed shaker or strobe light, but does not need to reference the home's alarm system).
- For individuals living independently, in family homes, or other non-certified environments, verify that the results of the fire safety discussion between the service coordinator and the individual/family/support person is summarized in the Safeguard Section of the ISP and includes any actions and supports that need to be in place to address identified fire safety needs.
- Supports/safeguards may include information on evacuation ability and/or or supports in place to ensure the person evacuates in an emergency, supervision requirements, adaptive equipment, environmental modifications, assurance that the environment includes smoke detectors, ability to make 911 notification and training needs the person may need/want, etc.
- Information should be written in such a way that service providers and other responsible persons know exactly what to do in an emergency to ensure the individual's safe evacuation.

SELECT "MET" IF:

- ✓ The person's fire safety needs are accurately identified in the written service plan.

SELECT "NOT MET" IF any of the following are evident:

- ✓ The person's fire safety needs are not identified in the service plan.
- ✓ The person's fire safety needs are not accurately identified in the service plan.
- ✓ The information in the service plan regarding fire safety needs is incomplete.

Standard No.	Standard Text	Decision
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	**Met/Not Met**

Guidance

DISCUSSION:

Required: with individual, coordinator, service providers; and people who know the person well regarding what kind of life the person wants, the activities they value, their pursuits, interests, and short and long term desires, the level of independence desired by the person, as well as level supports also considered as necessary. Discuss how decisions were made regarding what may appear to be "risky" aspects of the person's goals and/or the service plan, and how decisions were made regarding these areas.

As Needed: Family/Advocate

DOCUMENTATION REVIEW:

- Required: The person's written person-centered plan; supporting notes and documentation routinely reviewed in the survey process, assessments completed, etc.

OBSERVATION:

As appropriate to the review of the person's services, observation may provide additional information about the person, their interests, capabilities and vulnerabilities.

GUIDANCE:

- This standard examines whether an individual's expression of desired activities, goals, etc., that may create risk to his/her well-being is met with openness by the circle/team, and related issues/concerns are conscientiously and creatively discussed. The expectation is the issues are reviewed with the purpose to identify real threats to the person and how best to overcome and remediate to support the person to achieve the life they are requesting, rather than create barriers to his/her desired end. Actual documentation of risk factors and safeguards will be reviewed in the following standard.
- A critical aspect of the person-centered planning process means that the person is supported in taking actions associated with pursuing their goals and desired outcomes that may pose risks to their well-being.
- The person should be empowered to achieve their maximum level of personal choice and independence. It is therefore important that identified risk factors are specific, detailed and personal. Generalized risks and unsupported fears and "what-ifs" can prevent a person from being able to pursue what is important to them and are not conducive in allowing the person to live the best possible life.
- As part of the person centered planning process, strategies need to be developed to address health and safety, and risks for a person receiving supports. The goal of safeguard planning is not to eliminate all risk, but to find appropriate options that will assist individuals to manage the challenges and associated risks involved in their life choices including community participation. A true person-centered plan will enable individuals and their support teams (including MSCs and provider agency people) to identify potential risks and vulnerabilities (including behavioral and health considerations) and develop appropriate safeguards which helps lead individuals to outcomes or goals they consider to be meaningful and purposeful. The safeguard planning process should not result in overprotection which prevents individuals from leading lives they consider to be significant and productive.
- Supports and safeguards should be proportional to the risk to the person.

SELECT "MET" IFany of the following are evident:

- ✓ The individual and circle acknowledge risks to the person, and through conscientious discussion and appropriate, proportionate and individualized service planning support the person's preferences, priorities, and goals.
- ✓ The planning process includes agreement on strategies that support the person to/toward his/her desired outcome, even when identified to include risk.
- ✓ While no specific risks are apparent, and the person's priority interests and goals are addressed in service planning and plan.

SELECT "NOT MET" If any of the following are evident:

- ✓ Service planning and plan does not support or actively opposes the person's priority interests and goals because of real or perceived risk per the circle/team.
- ✓ Service planning and plan does not include the person's priority interests and goals, and evidence of meaningful discussion, considerations of safeguards to support the person are lacking.
- ✓ Service planning and plan addresses the person's priority interests and goals, but safeguard planning was disproportionate, to the actual risk resulting in decreased independence of the individual without justification.

Standard No.	Standard Text	Decision
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: with individual, coordinator, service providers; and people who know the person well regarding what kind of life the person wants, the activities they value, their pursuits, interests, and short and long term desires, the level of independence desired by the person, as well as level supports also considered as necessary. Discuss how decisions were made regarding what may appear to be risk factors related to the person's goals. Discuss also the service plan, and necessary and relevant protections, safeguards and supports in place to minimize the risk while encouraging the person toward desired outcomes.
As Needed: Family/Advocate

DOCUMENTATION REVIEW:

- Required: The person's written person-centered plan; supporting plans and attachments, supporting notes and documentation routinely reviewed in the survey process, assessments completed, services delivered, etc.

OBSERVATION:

As appropriate to the review of the person's services, observation may provide additional information about the person, their interests, capabilities, vulnerabilities and supports.

GUIDANCE:

- OPWDD/DQI has routinely expected the identification of the person's needed safeguards in the written service plan (e.g. ISP, Life Plan, program plan) and/or associated plans (and attachments) that are part of the overall service plan (e.g. IPOPs in IRAs, habilitation service plans, care plans, behavior support plans, etc.) This is not a duplicate of that expectation. It is a supplement.

- A critical aspect of the person-centered planning process means that the person is supported in taking actions associated with pursuing their goals and desired outcomes that may pose risks to their well-being. The identification/documentation of "the risk factors for the person and the measures in place to minimize risk" as considered in this regulation, is an identification of the issues specific to the person that must be addressed to reduce/eliminate obstacle's to the person's greater independence, autonomy and participation in their home, community, and relationships. If left unaddressed, the person would be limited in living the life they want.
- Therefore, the person-centered plan must include:
    - The risk factors, i.e. the person specific items or circumstances that are known to likely result in harm to the person (e.g. physical, emotional, financial), and/or reduce their successful management of daily life; and
    - The supports and measures in place and to be implemented to minimize the known risks for the person.
    - The supports and strategies to minimize known individual risks, may include "specific back-up plans and strategies". The requirement for back up strategies, demonstrates the intention that the person receive the supports needed to minimize risk even when unexpected situations arise. This is necessary to ensure the person's successful participation in their desired life activities and endeavors. Back-up plans are especially necessary in situations where staffing, transportation, or technological supports are not nimble. For example, if the person lives in their own apartment, misses their bus to dialysis, and this is the only public transportation modality they can independently manage, there should be an agreed upon and documented back-up strategy to ensure this is communicated and necessary medical care is accessed. If a person's Community Habilitation people fails to arrive for a specific service or support required by the person, what is the strategy in place to ensure the support is delivered.
    - The person should be empowered to achieve their maximum level of personal choice and independence. It is therefore important that identified risk factors are specific, detailed and personal. Generalized risks and unsupported fears and "what-ifs" can prevent a person from being able to pursue what is important to them and are not conducive in allowing the person to live the best possible life.

SELECT "MET" If both of the following are evident:

- ✓ The written plan clearly documents the necessary safeguards, risk factors, and back-up strategies necessary for the person to achieve their desired goals and outcomes. These identified risk factors are specific, justifiable, and contain sufficient detail.
- ✓ Documented risk factors, safeguards, and back-up strategies flow from the person's goals and desired outcomes that were identified through the person-centered planning process.

SELECT "NOT MET" If any of the following are evident:

- ✓ Risk factors, safeguards, and back-up strategies are not documented in the written person-centered plan.
- ✓ The written plan lacks sufficient information or detail pertaining to necessary safeguards, back-up strategies, and risk factors for the person,
- ✓ Documented risk factors, safeguards and/or back-up strategies are not person-specific. They are not consistent with the self-reported, other-reported and documented description of the person and their specific issues and considerations.
- ✓ Written safeguards, risk factors, and back-up strategies do not support or actively oppose the achievement of the person's desired outcomes and goals.

Standard No.	Standard Text	Decision
1-23	The individual's written plan documents each specific service and support to be provided to address his/her needs and achieve his/her identified desired outcomes, short term and long term goals.	**Met/Not Met**

Guidance

DISCUSSION:

Required: with individual, coordinator, service providers; and people who know the person well regarding what kind of life the person wants, the activities they value, their pursuits, interests, and short and long term desires, the level of independence desired by the person. Discuss also, supports and services needed and in place to assist the person to his/her desired outcomes, and the appropriateness of the services to meet the outcome/goals.
As Needed: Family/Advocate

DOCUMENTATION REVIEW:

Required: The person's written person-centered plan; supporting plans and attachments, supporting notes and documentation routinely reviewed in the survey process, assessments completed, services delivered, etc.

OBSERVATION:

As appropriate to the review of the person's services, observation may provide additional information about the services and supports needed by and/or provided to the individual.

GUIDANCE:

- The written person centered service plan must document the supports and services determined to be necessary to be provided based on individual's unique circumstances.
- There should be an evident connection of the services/supports to the person's goals, preferences, risks, needs, etc. you reviewed in previous standards. It should be clear how the person's prioritized aspirations and needs are being supported.
- The service plan should include services provided by OPWDD service providers.
- The service plan should also include services provided from other-than OPWDD providers, if any.
- Supports identified in the plan should include both paid AND unpaid supports, when applicable.
    - Note: Natural supports cannot be compelled or required to provide support. If unable to continue providing support, they cannot be required or compelled via the written service plan to continue providing those identified unpaid supports and services. The person and his/her circle would need to discuss and determine how to ensure the person would continue to receive the needed service/support from another provider, and amend the plan accordingly.
- Identified supports and services may address the following areas of the person's life:
    - Housing development or retention
    - Maintaining relationships with family and friends, developing new friendships
    - Employment changes or development or Vocational training
    - Community integration and independence
    - Medical and Behavioral health
    - Cultural understanding
    - Social activities

  - Recreational activities
  - Relationships
  - Language and health literacy
  - Functional and successful daily living
  - Other community living choices
- For individuals receiving HCBS Waiver Services, the service plan must identify each specific waiver service delivered to the individual.
- A true person-centered support plan must allow the person to live their life in the way that they choose, while supporting the individual to manage identified risks, agreed upon appropriate safeguards and the related services and supports (as reviewed above).
- Service plans should document the required information comprehensively. Attachments may provide supplemental information.

SELECT "MET" if all of the following are evident:

- ✓ The services and supports agreed upon, and determined necessary are identified in the written service plan.
- ✓ Services and supports identified in the written plan are reflective of the information gathered through the person-centered planning process
- ✓ Information gathered from your interview with the individual or someone who knows the person well matches the services and supports identified in the person's written plan with the preferences and needs of the person.
- ✓ Documentation of services and supports creates clarity between the person's priorities and the services.

SELECT "NOT MET" If any of the following are evident:

- ✓ The services and supports needed and received by the individual are not documented in the service plan.
- ✓ While the plan identifies the services, it is inaccurate and/or fails to identify significant services and supports necessary to the person.
- ✓ Many/most services/supports identified in the written plan do not reflect/relate to the priorities, strengths, goals, and desired outcomes gathered from the person-centered planning process.
- ✓ The person reports that the written plan does not reflect the services and supports that are important to the person.
- ✓ Services and supports identified in the written plan are not person-centered or individualized.
- ✓ It is unclear how the person's priorities and needs are being supported.

Standard No.	Standard Text	Decision
1-24	The individual's written plan identifies the amount, frequency and duration of each HCBS waiver service he/she receives, as applicable.	**Met/Not Met/NA**

Guidance

DISCUSSION:

Required: Discuss with the individual, the services they receive, how often and whether the time and frequency meet there needs. Discuss services with the coordinator, service providers; and people who know the person well, when and how often they are delivered.

As Needed: Family/Advocate

DOCUMENTATION REVIEW:

- Required: The person's written person-centered plan; supporting plans and attachments, supporting notes and documentation routinely reviewed in the survey process regarding services, service plans and services delivered.

GUIDANCE:

- If the individual receives HCBS waiver services the written service plan (ISP or Life Plan) must accurately record the name of the provider or agency (e.g., Sunshine Co. UCP, Southern DDSO) (addressed in a different standard), the type of service (e.g. community habilitation, supported employment, environmental modification), the frequency of the service (billing unit of service), the duration (e.g., on-going), and service effective date (e.g., 1/1/2010).

SELECT "MET" IF:

- ✓ The service plan identifies the type, frequency, duration and effective date of each HCBS wavier service the person receives.

SELECT "NOT MET" IF either of the following are evident:

- ✓ The service plan has significant omissions and errors in the identification of the type, frequency, duration and effective date of each HCBS wavier service the person receives.
- ✓ The service plan does not include one aspect of required the information consistently in the document (e.g. never identifies duration of all the person's waiver services).

Note: Minor errors, typos or limited omission of a required element do not need to be cited as 'Not met", however should be brought to the provider's attention for correction to reduce vulnerability and facilitate attention to detail.

SELECT "NA" IF:

- ✓ The person does not receive HCBS Waiver Services.

Standard No.	Standard Text	Decision
1-25	The person-centered plan identifies the provider(s) of the individual's supports and services.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

- Service Plan, Life Plan, Treatment Plan and associated documentation.

GUIDANCE:

- Individuals receiving service coordination and care management/coordination:
  - The written plan must identify the providers of both paid and unpaid supports identified in the person's plan. This means that specific person or persons, and/or provider agency or other entity providing services and supports must be documented.
  - Identifying a particular person by name may be applicable, for example:
    - In self-directed service situations, when the individual selects a particular person, not an agency employee to provide services/supports;
    - natural supports;
    - Specific medical or clinical providers.
- When a provider agency is responsible for the delivery of services, e.g. day habilitation; the particular person responsible to deliver the service does not need to be specified. However, the provider agency, and if site based location should be indicated.
- The identification of services and supports may include but are not limited to: OPWDD sponsored services, community medical and clinical service providers, other state or county sponsored services, and community members.
- Upon interview with the person, discussion of the person-centered planning process and review of the written person-centered plan, it should be clear who is identified as responsible to provide services to the person.
- Identification of the service provider should include the specific service or support as related to the person's preferences and needs.

Clinic Treatment:
• The Clinic Treatment plan must identify the name of the person responsible for treatment coordination.

SELECT "MET" IF:

- ✓ The written plan clearly identifies the providers of each services and supports for the person, including both paid and unpaid services and supports.

SELECT "NOT MET" IF either of the following is evident:

- ✓ The written plan does not identify the providers of supports and services, whether paid or unpaid.
- ✓ The written plan omits known providers of supports/services that you have become aware of through discussion and record review.

Standard No.	Standard Text	Decision
1-26	The person-centered plan evidences that informed choice is made regarding self-direction; and if chosen, identifies the services that the individual elects to self-direct.	**Met/Not Met**

Guidance

DISCUSSION:

Required: Discuss with the individual, coordinator/manager of services whether information on self-direction was provided, how it was provided, if the individual was able to ask questions and get clarification, etc. Through discussion with the person, their circle and advocates, supports and agency staff determine if the person is self-directing any services.

As needed: Family/Advocate, circle/team members

DOCUMENTATION REVIEW:

- As needed: Any documents that provide clarification if needed, e.g. Service plan, service planning minutes, and service notes.

GUIDANCE:

- The option to use self-direction must be made available to all individuals receiving HCBS.
- The individual must be provided sufficient information to make an informed decision about self-direction. He/she must be provided with information and explanation of self-direction, activities taken to self-direct services, and how the supports available to self-direct.
- The person-centered service plan must identify all the service(s) that the person chooses to self-direct. The services they choose to self-direct may be identified:
  - in the service plan;
  - in the individual's attached habilitation plan; HCBS Waiver Service Plans should document whether the particular service is self-directed; or
  - by attaching the following to the service plan: the individual's self-direction budget or the Memorandum of Understanding (MOU) for agency supported respite, community habilitation, or supported employment (SEMP).
- Self-direction is an individually-controlled method of selecting and using services and supports that allows the person maximum control over their HCBS and supports including the amount, duration, and scope of services and supports as well as choice of provider(s).
- Self-direction is a service delivery model where HCBS and supports are planned, budgeted, and directly controlled by the person receiving services. Self-direction should involve the person receiving HCBS and supports to the maximum extent possible and include the person's circle of support as applicable. Through self-direction, the person can maximize independence and control over needed HCBS and supports, including for example hiring and terminating service providers. Self-direction emphasizes the importance of allocating resources to enable the person to maximize their independence including by employing providers directly, designing an individualized, self-directed, community supported life, and using an accurate, fair, and flexible system for individual budget determinations.

SELECT "MET" IF:

- ✓ Apply to All: The individual was provided the opportunity and information to make an informed choice whether to self-direct services.
- ✓ Apply to an individual who has chosen to self-direct at least one service: Self-directed services are clearly identified as self-directed in the person-centered service plan.

SELECT "NOT MET" IF:

- ✓ Apply to All: The individual was not provided the opportunity and/or information to make an informed choice whether to self-direct services.
- ✓ Apply to an individual who has chosen to self-direct at least one service: The person is self-directing some or all of their services, but the service(s) are not identified as self-directed in the service plan.

Standard No.	Standard Text	Decision
1-27	For FIDA-IDD, the Life Plan identifies the services the individual is responsible to schedule and the support needed to do so.	**Met/Not Met**

Guidance

DISCUSSION:

Required: individual;
As needed: Family/Advocate, coordinator/manager of services; direct supports

DOCUMENTATION REVIEW:

- Required: Life Plan, Service Record and any documents that provide clarification if needed, e.g. Service plan, service planning minutes, and service notes.

GUIDANCE:

- To the extent that the participant is able, willing and agreeable to be responsible for scheduling their own appointments and services, the LP must clearly outline which services the Participant will be responsible for scheduling, how the Care Manager will support the Participant in these activities and what monitoring the Care Manager will do to ensure that necessary appointments, tests, etc. are obtained as called for in the LP.
- Verify that the Life Plan contains the type, frequency and provider of the service(s) that the individual is responsible for scheduling, if any. If the individual declines to schedule service appointments, then the LP should indicate this clearly. If the individual requires supports such as interpreters, accessible transportation, TTY or other services/equipment to enable him/her to complete this activity, this must also be clearly indicated in the LP.
- Verify that the actions by the care manager to support the person in scheduling are documented in the plan.
- Verify through interview that the individual/caregiver/advocate/designee agreed to schedule their services as indicated in the Life Plan, and that the necessary supports from the Care Manager were provided.

SELECT "MET" IF:

- ✓ The Life Plan documents accurately information about scheduling by the individual and support to be provided in this area.

SELECT "NOT MET" If any of the following are evident:

- ✓ The individual did not agree to schedule service appointments, but felt there was an expectation to do so;
- ✓ If the individual agreed to schedule service appointments, but appointments are scheduled for them without their input;
- ✓ If the Life Plan does not clearly indicate the individuals' agreement or declination and/or the level and type of support necessary.

Standard No.	Standard Text	Decision
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	**Met/Not Met**

Guidance

DISCUSSION:

Required: Discuss understanding of the plan with the individual and supports that know him/her best. Discuss preferred language and format for communication of the plan also as needed.

As needed: Other circle/team members

DOCUMENTATION REVIEW:

- Required: The written service plan and associated attachments.
- As needed: Any documents that provide clarification if needed, e.g. Service plan, service planning minutes, and service notes.

GUIDANCE:

- The plan should be written using clear, understandable language.
- The plan should be written/translated into the person's spoken and written language and that of the chosen members of their circle.
- A plan may be written in plain English, but if the person is blind, unable to read, or speaks another language, that is not considered accessible to the person. There are many possibilities that can help to make a written plan more understandable, and may include: having the plan written for the person in Braille, reading the written plan to the person with further explanation as needed, translating plan using American Sign Language (ASL), and using picture symbols when possible.
- The person, the people chosen by the person or required to participate in the person-centered planning process, and people responsible to implement the plan, should be able to understand the written plan.
- Based on your review of the written plan and discussion with appropriate parties, determine whether the plan was written in a manner suited to the understanding by the individual, their circle/team and service providers.

SELECT "MET" If most of the following is evident:

- ✓ Based on your understanding of the person and review of their written plan, the plan is generally understandable to the person, family/advocate as needed and the people responsible for implementing the plan, to the maximum extent possible.
- ✓ The person reports that he/she understands their person-centered plan, to the best of their ability, and is satisfied with how written information has been presented to them.
- ✓ There is evidence that the written plan has been provided to the person in plain language and has been made available to the person in the most accessible way suited to their needs (example: in native language, translated using American Sign Language, audio version, etc.).

SELECT "NOT MET" If any of the following are evident:

- ✓ The written plan uses complicated and clinical terminology.
- ✓ The person reports the plan is hard to understand and/or it is evident that they or their advocate do not understand the written plan.
- ✓ The written plan has not been provided to the person in an accessible way (example: plan is not written in Braille, not translated into their native language, or not written in plain language).

- ✓ The person reports requesting the written plan to be explained to them or translated into an understandable format, but there is no evidence that this has in fact occurred.

Standard No.	Standard Text	Decision
1-29	The person-centered service plan is signed by the individual as indicator of written informed consent or approval.	**Met/Not Met**

Guidance

DISCUSSION:

Required: Discuss with the individual aspects of their plan, what they think about the content of the plan, services and supports identified, service providers etc., if it aligns with their desired outcomes. Try to determine his/her level of understanding regarding their consent to the plan. Family/advocate and supports that know him/her best may also provide information regarding agreement to the service plan.

DOCUMENTATION REVIEW:

- Required: The written service plan and associated attachments.
- As needed: Any documents that provide clarification service planning minutes, and service notes.

GUIDANCE:

- Service Coordination through MSC or PCSS:
  - The written person-centered service plan should be finalized with the person's agreement that its content accurately reflects what had been discussed and decided.
  - As an indication of their agreement/consent, the plan should be signed by the person and/or someone upon whom state law confers decision making authority on behalf of the person.
  - Individuals must sign the ISP or an attestation stating that they agree to the ISP and to any attachments (i.e. habilitation plans, etc.).
  - Signature lines must not be left blank. If the person is unable or unwilling to sign, this should be noted on the signature line. If the person is a self-advocate and the advocate is not signing, "self-advocate" should be written on the line.
  - If attachments are subsequently added or changed, the individual must sign the ISP or attestation again to indicate acknowledgement of an agreement to the changes.
  - If the individual disagrees with a part of the plan that changed, e.g. a habilitation plan, he or she may choose not to sign. MSCs must then use an addendum to the ISP or the monthly service notes to document why the individual and evidence that the MSC will continue to advocate for the individual to acquire a habilitation plan that will be satisfactory to him/her.
  - It is the MSC's responsibility to ensure the signature from individual and/or legally appointed guardian are received. Conscientious activities and efforts must be implemented to obtain signatures and should be documented in service notes, as well as reasons why the signature was delayed.
  - Informed consent means the person has been provided an explanation and understands what the plan states, what services and supports are to be provided, the desired/expected outcomes; that they have the right to refuse/disagree and request changes. (standard 1-7)

- Care Management, e.g. FIDA-IDD:
  - The confirmation of the individual's approval may be through a signature page at the interdisciplinary team (IDT) meeting or sent to the person after the meeting to obtain an ink or electronic signature.

- The form should make it clear that the signature is an attestation that said member was involved in the IDT process, and not necessarily that they agreed with the ultimate care plan that was reached. The individual is provided information regarding their right to appeal to the plan as well.
- The individual may approve the Life Plan before or after any necessary Utilization Management process but the Care Manager must explain to the individual any changes in the final LP from the version drafted during the IDT meeting.
- It is the Care Manager's responsibility to ensure the signature(s) are received. Conscientious activities and efforts must be implemented to obtain signatures and should be documented in service notes.

SELECT "MET" IF:

- ✓ The written person-centered service plan has been signed (in a manner indicated above) by the person and/or someone who makes decisions on behalf of the person.

SELECT "NOT MET" If either are present:

- ✓ The written plan is not signed (as indicated above) by the individual and/or their legal representative, and there is no evidence in the person's record that there has been conscientious attempts to obtain their signature/approval of the plan.
- ✓ If the person has not consented to the plan, it is implemented, and there is no evidence in the person's file that they have been provided with due process and fair hearing requirements.

Standard No.	Standard Text	Decision
1-30	The individual's person centered service plan is agreed to by services providers and/or members of the team as required.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

- Required: The written service plan.
- As needed: Any documents that provide clarification.

GUIDANCE:

- Service Coordination through MSC or PCSS:
  - The service coordinator and service coordinator supervisor must sign the plan.
  - Providers of the Medicaid HCBS waiver supports and services identified in the written person-centered plan must sign the habilitation plans as they are responsible for implementing those provisions of the plan and are encouraged to sign the ISP. The habilitation plan is considered a component of the ISP, so signing the habilitation plan fulfills the requirement of signing the person-centered plan. This indicates their awareness and agreement to provide the supports and services identified in the person's plan.
  - While it is best practice to have other OPWDD service providers sign the service plan as an indicator that they acknowledge their responsibility to implement the plan, this requirement only applies, at this time, to service coordination and HCBS waiver providers.
  - It is the responsibility of the MSC to obtain the signatures of the providers or ensuring that providers' signatures are on an attached habilitation plan(s). It is not specified what agency staff is responsible to sign for Habilitation Services. Consider the role the person has in the oversight of the waiver service and/or development of the service plan.
  - Conscientious activities and efforts must be implemented to obtain signatures and should be documented in service notes.

- If MSCs do not receive signatures in a timely manner, they may distribute the ISP without the missing party's signature but must follow up to obtain the signature at a later date and document why the party did not sign in a timely manner.

- Care Management, e.g. FIDA-IDD:
  - Approval of the plan by Interdisciplinary Team (IDT) members (other than the individual) must be provided and documented by one of the following acceptable methods:
    - Verbal approval may be provided. The verbal approval and date given must be noted in the Life Plan;
    - Approval indicated by email or electronic signature;
    - Wet (ink) signature on a separate signature page in person;
    - Wet (ink) signature on the Life Plan.
  - IDT members include participating FIDA-IDD Plan members/providers including care management members, residential, day service, and HCBS waiver service providers.
  - When Utilization Management (UM) is required for any reason, a complete Life Plan will have 1) the Participant's signature and 2) the Primary Care Physician's signature and/or Utilization Management approval.
    - A note on UM (however UM is not being reviewed in this standard:
  - Before the initial LP is developed by the IDT, authorizations for items and services not subject to the continuity of care provisions must be made by the FIDA-IDD Plan through the utilization management (UM) process.
  - All Home and Community Based waiver services, ICF-IDD and day treatment services may be authorized by the Participant's duly convened IDT and are not subject to the FIDA-IDD Plan's UM process.
  - If an appropriately licensed physician does not participate in the IDT, any physician ordered services included in the Life Plan must be authorized by the FIDA-IDD Plan's UM process.
  - Other services subject to UM and medical necessity review are identified in the FIDA-IDD IDT Policy section VII.F.

SELECT "MET" IF:

- ✓ Service Coordination: Providers of service coordination, all HCBS services and supports identified in the person's plan have signed the written service plan as indicated above.
- ✓ Care Management, e.g. FIDA-IDD: IDT members as explained above have provided indication of approval in any approved method described above.

SELECT "NOT MET" IF:

- ✓ Service Coordination: Providers of service coordination, all HCBS services and supports identified in the person's plan have not signed the written service plan as indicated above, and there is no evidence in the person's record that there has been conscientious attempts to obtain their signature/approval of the plan.
- ✓ Care Management, e.g. FIDA-IDD: IDT members as explained above have not provided indication of approval in any approved method described above; and there is no evidence in the person's record that there has been conscientious attempts to obtain their signature/approval of the plan.

Standard No.	Standard Text	Decision
1-31	The individual's FIDA-IDD Life Plan is authorized as required per the services in the plan.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

- Required: Individual's Life Plan (LP); Comprehensive Participant Health Record
- As needed: Any documents that provide clarification.

GUIDANCE:

- The individual's Life Plan and services identified in it are considered authorized as follows:
  - Once a service or treatment has been agreed to by the IDT and/or FIDA-IDD Plan, and entered into the LP, that service or treatment is authorized until the LP is changed.
  - Compare the Life Plan to other documentation in the Comprehensive Participant Health Record to verify that the Primary Care Physician and/or other licensed professionals involved in development of the Life Plan have appropriately signed or otherwise indicated that the services outlined in the Life Plan are authorized.
  - The participation of the individual's Primary Care Physician in the IDT meeting or to review/approve the Life Plan, acts as service authorizations for all services included in the Life Plan that require a physician's order. This excludes services requiring a medical necessity review identified in the FIDA-IDD IDT Policy Section VII.F.
  - If the Primary Care Physician does not elect to participate in the IDT meeting or review/approve the LP, the LP's inclusion of some ordered services and care decisions included acts as service authorizations up to the extent allowed under the licensure of the professionals who agreed to participate in that IDT.
  - Between IDT meetings, the FIDA-IDD Plan must make any necessary service authorizations through its utilization management process. This may be due to the person's appeal or changing needs.

SELECT "MET" IF:

- ✓ There is evidence that the Life Plan and services within are authorized as indicated in the guidance above.

SELECT "NOT MET" IF:

- ✓ There is NOT evidence that the Life Plan and services within are authorized as indicated in the guidance above.

Standard No.	Standard Text	Decision
1-32	The person-centered plan is distributed to the individual and service providers.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Any documentation, per the agency's system that the plan was distributed. Verify that service providers have a copy of the plan when reviewing other services.

DISCUSSION:

- As needed: Verify that the individual and service providers were sent and received the individual's service plan.

GUIDANCE:

- There should be documentation/written evidence that the person-centered service plan has been distributed to all OPWDD service providers involved in implementing supports and services included in the person's plan. This ensures that everyone involved in implementation of the plan is aware of the contents in the plan and their role. This ensures continuity and consistency of supports and services for the person.
- If an HCBS Waiver Service Provider does not send the written Habilitation Service Plan to the service coordinator/care manager within required time frames (60 days initial, 30 days new), the HCBS service provider is responsible to distribute the plan to required parties.

SELECT "MET" IF:

✓ There is documentation/evidence that the plan has been distributed to all OPWDD service providers identified as responsible for implementing the supports and services contained in the person's plan.

SELECT "NOT MET" IF:

✓ It could not be verified that one or more OPWDD service providers responsible for implementation of the supports and services in the plan have been provided a copy of the person's plan**.**

Standard No.	Standard Text	Decision
1-33	The person-centered service plan includes all relevant and applicable attachments.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

- Required: Review of the person's service plan and attachments that ensure that all the required service plan documents are included.

GUIDANCE:

- This standard applies to the ISP as the person-centered plan. Attachments may vary dependent upon the individual's services and supports, and may include:
- All relevant habilitation plans for people receiving HCBS habilitation services;
- For residents of an Individualized Residential Alternative (IRA): The Individual Plan of Protective Oversight (IPOP);
- Service plans that are referenced as part of safeguards in the person centered plan such as a care plan or behavior support plan;
- All relevant documents that support modification to an individual's rights.

SELECT "MET" IF:

✓ All relevant attachments, as identified above, have been included as attachments to the written plan

SELECT "NOT MET" IF:

✓ All relevant attachments, as identified above, have not been included as attachments to the written plan.

Standard No.	Standard Text	Decision
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

As needed: Any documentation, per the agency's system that may evidence that the individual has been informed that they may request changes to his/her person centered plan.

DISCUSSION:

- Required: Verify that the individual understands that they may request a change to their plan and have the necessary contacts to make the request.

GUIDANCE:

- The person knows best what life they want to live and what components of the plan are or are not meaningful and effective. The person should know they can request changes/updates and be comfortable to make the request.
- Requests can be made verbally OR in writing by the person. The agency must respond to the request.
- Requests for a change may be made as part of service discussion and planning during routine interval reviews, but should not have to wait for the next scheduled review when the request or need occurs prior to a scheduled review.
- Discuss with the person if they have made a request, want to make a request, know how to make a request.
- Ask agency staff how a person could make a request. Inquire whether the agency has policies and procedures about HOW to request an update to a plan and whether it allows for the person to request a new meeting, even if it does not fall within scheduled review dates if circumstances, needs, and goals have changed significantly.

- FIDA-IDD Specific Guidance:
  - The Life Plan form must include language that clearly specifies:
  - The right of the Participant to appeal a LP;
  - That signing the LP does not preclude appeal;
  - Instructions for requesting an appeal; and
  - Contact information for the FIDA-IDD Ombudsman.

SELECT "MET" IF either of the following are evident:

- ✓ The person is aware that they can request updates to their plan or a new meeting if circumstances or needs and goals have changed since the last review.
- ✓ Agency policies and procedures are in place that describe the methods that the person can request updates to their plan.

SELECT "NOT MET" IF either of the following are evident:

- ✓ The person reports that they have never been informed that they could request an update or change to their plan.
- ✓ The agency lacks policies and procedures that allows and describes methods for individual requests for plan revision, and subsequent actions to be taken by the coordination agency.

Standard No.	Standard Text	Decision
1-35	The Individual's written person centered service plan is reviewed with regular required frequency.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review of the person's service plan and attachments, and any other documents that provide evidence of service review, such as service/care coordination notes, service notes and meeting minutes.

DISCUSSION:

- Required: Individual regarding participation in service plan reviews that occur routinely and/or as needed. Service/care coordinator or manager regarding reviews, review scheduling and as needed reviews.

GUIDANCE:

- Required reviews of the person-centered plan include:
  - At minimum, the service plan/ISP should be reviewed at least semi-annually, the Life Plan (FIDA-IDD) every six months;
  - As needed reviews:
  - When the capabilities, capacities, or preferences of the person have changed;
  - At the request of the person and/or people chosen by the person;
  - When it is determined that the plan (or portions of the plan) is/are ineffective;
- When it is determined that the plan requires review and revision due to changes and/or reassessment of the person's functional needs.
- Additional guidance for FIDA-IDD: When a Comprehensive Reassessment occurs, the IDT must be reconvened to review the plan within 30 days.

SELECT "MET" If the first bullet is met and the plan is reviewed per the remaining bullets as applicable:

- ✓ There is documentation that the plan has been reviewed at least semi-annually;
- ✓ when the needs, capabilities, or preferences of the person have significantly changed;
- ✓ at the request of the person or people chosen by the person;
- ✓ when it is determined that the plan does not adequately address the needs/outcomes of the person;
- ✓ there is evidence that that person's service plan was revised when revisions were needed.

SELECT "NOT MET" If any of the following are met:

- ✓ The plan has not been reviewed or revised based on the above criteria for "MET": at least semi-annually, when there have been significant changes, when the person's preferences have changed, or when the plan is no longer responsive to the person's needs and desired outcomes;
- ✓ The person reports that they have requested the plan be reviewed or revised due to one of the above factors and there is no evidence that this has occurred.

Standard No.	Standard Text	Decision
1-36	Review of the plan includes the individual's status/progress towards the achievement of his/her goals, priorities and outcomes.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review of the person's service plan and attachments, and any other documents that provide evidence of substantive review, such as service/care coordination notes, service notes and meeting minutes.

DISCUSSION:

- Required: Interview with the individual to evaluate if the services are delivered and effective in bringing them closer to their desired outcomes. Service/care/treatment coordinator or manager regarding activities and content of service plan reviews.

GUIDANCE

- This review applies to a review of the person's person centered service plan as a whole. Each specific service will be reviewed in Section 2. The review of the individual's service plan must include a review of the person's status regarding intended outcomes of the service plan, and effectiveness of the service and supports in the intended purpose. This review would require review/discussion of all services/support the person receives per the plan, to assure they are provided and assist the person in achieving his/her desired outcomes for quality of life, health and well-being. The person's status/progress/achievement and any obstacles to this, should be documented in the service plan as an update, service plan addendum, in service notes summarizing the meeting, and more meeting minutes supplementing the plan or notes.

- There is not a rigid expectation regarding how the person's status and effectiveness of services should be reviewed by the person, coordinator, and circle/team. It is important to remember that while all supports should be identified in the service plan, not all will be "formal" or rooted in OPWDD funded services. Therefore, there will be different types of information available to share and discuss in the review. Some of the supports provided through traditional services should have clear information to discuss (e.g. based on summarized data from behavior support, habilitation plan or clinic service documentation).

- Areas of discussion includes the required content of the service plan and each service or support included in the plan. This includes adequacy of formal services, effectiveness of safeguards, community experiences, relationship status, desired work/day activities, heath status and health service delivery, cultural and spiritual experiences, etc. Some supports may occur through access to opportunities and environments and what has been learned about the person and appropriateness/effectiveness of the plan, should be part of the review. The appropriateness of services, service providers, service modalities, frequency or type may be part of the review considerations.

- DISCUSSION with the individual, family/advocates, the MSC and provider agency and support staff should provide additional information. The service/care coordinator monitoring and contacts with the individual and service providers should contribute information necessary to review the progress/status/effectiveness and an awareness if the person's needs and outcomes were being met.

- The review of progress should be determined by the individual's progress towards desired outcomes in the plan, and the person's health safety and well-being. The perception of the individual is an important indicator of progress.

- As needed reviews will focus on the effectiveness of the service plan or portion of the plan related to the reason or need for the ad hoc review.

SELECT "MET" IF either of the following is evident:

- ✓ There is documentation demonstrating that reviews of the service plan include a conscientious review of the effectiveness of the plan/services/supports to achieve the individual's goals and outcomes of the plan.
- ✓ Service plan review ensures that review discussion and changes to the plan are focused on assisting the person toward their needed and desired outcomes.

SELECT "NOT MET" IF any of the following is evident:

- ✓ Documentation of the reviews of the service plan do not include a conscientious review of the effectiveness of the plan/services/supports to achieve the goals and outcomes of the plan.
- ✓ Service plan reviews do not ensure that any discussion and changes are focused on assisting the person toward their needed and desired outcomes.
- ✓ There is no documentation of the review of services.
- ✓ The person reports that the service plan or part of the service plan are not helpful in their achievement toward desired outcomes, he/she has expressed this to someone in their circle, but this has not been addressed or documented in the service plan reviews**.**

Standard No.	Standard Text	Decision
1-37	The individual's person centered service plan is revised whenever changes are necessary and warranted and/or as directed/preferred by the individual.	**Met/Not Met/NA**

Guidance

DOCUMENTATION REVIEW:

Required: Review of the person's service plan and attachments, and any documents that provides information that may indicate that revisions are needed or requested. This may include assessments, service notes, summaries, progress notes, medical reports, etc.

For FIDA-IDD: also Compare the Life Plan to other documentation in the Comprehensive Participant Health Record to verify that changes necessitating review of the Life Plan were documented and that the review has occurred.

DISCUSSION:

- Required: Interview with the individual regarding effectiveness of the services and whether they need/want revisions to the plan. Service/care/treatment coordinator or manager regarding activities and content of service plan reviews.

GUIDANCE:

- During reviews of the service plan, the person with the person's circle/team, will determine if revisions of the plan need to be made. These decisions may be made based on the individual's requests, assessment results, new needs, reduced need for services, and/or determination that current service(s) were ineffective.
- These decisions should be based on the review for progress/effectiveness, individual requests, changes in individual's status, assessment reports, etc.

- New problems or needs are added as they are identified, and goals attained and resolved problems should be retained for monitoring of continued status. The explanations or rationale for eliminating or relocating a resolved problem to maintenance care must be documented in the Life Plan for FIDA-IDD. Additional explanation may be included in MSC service notes or meeting minutes if documented for the service plan reviews.
- The service coordinator (for the ISP) and/or care manager for FIDA/IDD is responsible to revise the individualized service plan/life plan. If components of the service plan, such as a habilitation plan, behavior support plan, of protective oversight plan, require revision, the coordinator/manager must ensure that the necessary revisions are completed and attached to the service plan.

SELECT "MET" IF any of the following are evident:

- ✓ There is evidence that that the person's service plan or component was revised when determined to be needed.
- ✓ The plan has been revised when there have been significant changes, when the person's preferences have changed, or when the plan is no longer responsive to the person's needs and desired outcomes.
- ✓ The revision was completed and implemented within a reasonable time frame so that the person's needs and goals are addressed.

SELECT "NOT MET" If any of the following are evident:

- ✓ There is no evidence that plan has been revised when determined to be needed.
- ✓ The plan has not been revised as determined to be necessary during review.
- ✓ The plan has not been revised when the person's preferences have changed, or when the plan is no longer responsive to the person's needs and desired outcomes.
- ✓ The person reports that they have requested the plan be reviewed or revised due to one of the above factors and there is no evidence that this has occurred.

SELECT "NA" IF:

- ✓ Revisions to the plan were not necessary.

Standard No.	Standard Text	Decision
1-38	Revisions to the individual's written plan are documented in the form and format required.	**Met/Not Met/NA**

Guidance

DOCUMENTATION REVIEW:

- Required: Review of the person's service plan and attachments, as needed

GUIDANCE:

- ISP Revisions:
  - The ISP does not need to be rewritten and re-dated every time there is a change or need for revision. Changes may be made by using an addendum. The addendum must include the name of the person, the date of the ISP to which it applies, the date of the change, the new or changed information, and the signature of the service coordinator.
  - Addendums require only the signature of the service coordinator.
  - Addendums are filed with the current ISP and distributed to all appropriate parties.
  - A note must be written in the MSC record indicating the change was discussed with and agreed upon by the individual and/or advocate.
  - Changes to the ISP must be communicated to day treatment providers and HCBS Waiver habilitation service providers. If an addendum is used, copies are distributed.
  - Revision to the service plan may require changes to a portion of the plan that is an attachment.

- Life Plan Revisions (FIDA-IDD)
  - Revisions and updates to the Life Plan must be made directly to the service plan to preserve/document the history of care in order to track the effectiveness of interventions over time.
  - New or revisions to services/support should be documented in the Life Plan.
  - New issues should be added as they are identified
  - Resolved problems should be retained in the plan.
  - Rationale for removing/relocating a resolved problem to maintenance care should be documented in the life plan.

SELECT "MET" IF:

- ✓ Revisions to the Service Plan or Life Plan are documented and recorded as described above.

SELECT "NOT MET" If either of the following are met:

- ✓ Revisions to the Service Plan or Life Plan are not document as required.
- ✓ The appropriate content and/or inclusion in the service plan or addendum is not evident.

SELECT "NA" IF:

- ✓ Revisions to the plan were not necessary.

Standard No.	Standard Text	Decision
1-39	Decisions made by FIDA-IDD outside of IDT meeting, are recorded in the Comprehensive Participant Health Record and communicated to all IDT members within one (1) business day.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Comprehensive Participant Health Record (required); Service notes, Telephone logs, correspondence; emails (as needed)

DISCUSSION:

- Care Manager (Required); IDT members (as needed)

GUIDANCE:

- When decisions are made by the FIDA-IDD Plan outside of the IDT meetings, such decisions must be communicated to the Care Manager. The decisions must be recorded in the shared, accessible Comprehensive Participant Health Record and then must be communicated to all IDT members within one business day of the decision.
- Verify through interview that the care manager was informed of decisions outside the IDT within the required timeframe;
- Verify through document review that the decision was recorded as required.
- Verify through document review and interview that the decision was shared with IDT members within the required timeframe.

SELECT "MET" IF:

✓ Evidence reviewed supports that all decisions made outside the IDT were recorded and communicated in a timely manner.

SELECT "NOT MET" IF either of the following are evident:

✓ Evidence reviewed DOES NOT support that all decisions made outside the IDT were recorded in a timely manner;
✓ Evidence reviewed DOES NOT support that all decisions made outside the IDT were communicated in a timely manner.

Standard No.	Standard Text	Decision
1-40	The SC/CM/CC competently assures person centered planning as evidenced by the individual's written plan for services and supports and interview.	**Met/Not Met**

Guidance

GUIDANCE:

- This is a quality indicator. This standard requires the surveyor to use their survey activities and findings for the previous standards to determine whether, for the most part, the individual's service coordinator, case manager was competent to facilitate and ensure person centered planning and resultant plan.

- This determination should be based on discussions with the MSC or care manager and evidence that the written service plan truly is person centered based on what you have learned about the person.

SELECT MET IF:

✓ The individual service plan services and supports address the issues/preferences most important to the person.

SELECT NOT MET IF:

✓ The individual service plan and services and supports are not based on the issues/preference most important to the person.

Standard No.	Standard Text	Decision
1-41	CAS findings were reviewed with the individual within 30 days	**Met/Not Met**

Guidance

DISCUSSION:
Required: Individual (designee)
As Needed: Service coordinator, or care manager or care coordinator

DOCUMENTATION REVIEW:
- Service record- service notes, monthly notes

GUIDANCE:
- As discussed in person centered planning, the findings of the CAS (Comprehensive Assessment) must contribute to person centered planning discussion and decisions and the written plan. In order to prepare the individual for this, within 30 days of the completion of the CAS, the results/findings of the CAS should be explained/discussed with the individual (and/or actively involved family member). The service/care coordinator, responsible for person centered planning, should facilitate/ensure that this occurs. Review documentation such as MSC service notes, monthly notes, documentation by CAS assessors and/or discussion with the individual, to verify that this has occurred.

SELECT MET IF either of the following is evident:
- ✓ The CAS findings were discussed with the individual within a reasonable time frame following completion of the assessment.
- ✓ (Use judgment regarding time frame if greater than 30 days.)

SELECT NOT MET IF either of the following is evident:
- ✓ The CAS findings were not discussed with the individual.
- ✓ The CAS findings were discussed with the individual 60 days or more following completion of the assessment.

SECTION 2: SERVICES & SUPPORTS REQUIREMENTS & DELIVERY - UNIVERSAL REQUIREMENTS

Standard No.	Standard Text	Decision
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

- Required: Review the service record maintained by the service provider. In most cases the service record refers to one comprehensive record, unless otherwise indicated.

GUIDANCE:

- The information and documents that must be available in the individual's service record vary dependent on the service. A service record may be in an electronic or hard copy format.

- INFORMATION TO BE MAINTAINED IN SERVICE RECORDS IS AS FOLLOWS:
- Service Coordination (MSC and PCSS):
  - Documents that verify eligibility for services: e.g. disability information and redetermination of ICF/DD Level of Care eligibility;
  - Waiver enrollment documentation/forms if the person is enrolled in HCBS Wavier Services;
  - Statement that the person is self-advocating or name of the person advocate;
  - Any written professional evaluations;
  - Current ISP and appropriate attachments and revision documents;
  - Documents that demonstrate ongoing services activities needed by and on behalf of the person, e.g. service coordination notes.

- HCBS Waiver Services: The provider should maintain a record that includes the individual's service plan (ISP or Life Plan) and a copy of the HCBS Waiver Service Plan if applicable. While the provider must also maintain documentation related to service delivery, there is not firm requirement that they must be maintained in the same "case record". However, the documentation of service delivery, review and summarization must be available and accessible upon request.

- Day Training:
- The service/case record must be maintained and contain:
  - The person's current diagnosis;
  - Current documents related to the treatment/services provided to the person such as treatment/goal plans, service documentation and results/review of the services.

- Clinic Treatment:
  - Identification information about the individual receiving services, and his or her family/advocate if applicable;
  - Notation of services received outside of the clinic including identification of practitioner or responsible entity;

- Referral source;
- Date services/treatment to the person commenced;
- Name of the party responsible for treatment coordination;
- Diagnoses, as applicable, including those related to the person's developmental disability, other mental disabilities if present, and medical conditions;
- Reports of all known diagnostic examinations, assessments, laboratory procedures and specials studies, findings and conclusions performed at the clinic's recommendation within the last two years;
- Current individual written plan of services for all treatments being recommended and delivered by the clinic; and
- Treatment notes signed by the professional staff member or treatment coordinator making the note.

- Day Treatment:
  - Identification information about the individual receiving services, and his or her family/advocate if applicable;
  - Notation of services received outside of the clinic including identification of practitioner or responsible entity; o Referral source;
  - Date services/treatment to the person commenced;
  - Name of the party responsible for treatment coordination;
  - Diagnoses, as applicable, including those related to the person's developmental disability, other mental disabilities if present, and medical conditions;
  - Reports of all known diagnostic examinations, assessments, laboratory procedures and specials studies, findings and conclusions performed at the clinic's recommendation within the last year;
  - Comprehensive Functional Assessment (CFA);
  - Individual Program Plan;
    - Team meeting minutes;
    - The current individual written plan of services (treatment plans) for all services recommended and delivered by the day treatment facility; and
    - Treatment/service notes signed by the professional staff member or treatment coordinator making the note.

- Private School:
- All Private Schools:
  - Admission information;
  - Identifying information on the individual and his/her family;
  - Referral source;
  - Date services to the person commenced;
  - Name of staff member carrying overall responsibility for treatment and care;
  - Diagnoses, including psychiatric or mental retardation diagnoses;
  - Assessments, diagnostic examinations and evaluations, including findings and conclusions;
  - Reports of all periodic medical, dental, eye and hearing examinations, special studies such as X-rays, clinical laboratory tests, clinical psychological testing, electro-encephalograms, psychometric tests;
  - The current individual written plan of care, treatment and training (81.6[a][2]) or in integrated residential communities, the program narrative (27.3[f]);
  - Documentation of any referrals to another agency.

- Private Schools that are not Integrated Residential Communities
  - Progress notes written and signed by all staff members having significant participation in the program of treatment and care;
  - Summaries of case conferences, service review meetings and special consultations;
  - Closing summary of the course of treatment and care for individuals when discontinued; and
- In Private Schools Known as Integrated Residential Communities (IRC) the record should also include:
  - Program narrative, narrative description of individuals served in the setting (i.e. specific content of the narrative to reviewed in separate standard).

- Specialty Hospital:
  - Identifying information on the individual;
  - Admission information;
  - Current individual program plan;
  - Assessments, reassessments;
  - Progress notes and previous individual program plans;
  - Current service plans, description of treatments provided and medications administered;
  - Reports of illness or injury including the date and time of occurrence and action taken regarding each occurrence;
  - Summary of findings, progress and plans when the individual is discharged.

- Willowbrook Case Management (for individuals in ICFs and Nursing Homes:
  - Service Plan in whatever format maintained by the ICF or Nursing Home;
  - Monthly case notes;
  - Communications with the class member and correspondent when required;
  - Class Member notification of rights.

- FIDA-IDD:
- The FIDA-IDD organization must maintain a single, comprehensive “health” record. While the term “health” is used, the intent that the record includes:
  - Information regarding and as needed copies of service plans, treatment plans, goal plans;
  - Assessments;
  - Documentation of review of services.

SELECT "MET" IF:

- ✓ The individual’s service record is maintained and includes required and relevant information and documents as described above per service type/facility.

SELECT "NOT MET" IF any of the following is evident:

- ✓ The facility or service provider does not have a service record for the individual.
- ✓ The individual’s service record is does not include required and relevant information and documents as described above per service type/facility.

Note: Minor errors/omissions that do not significantly impact appropriate service planning, service delivery, continuity of care or due process may not require a ‘Not Met’. Compliance decisions require judgement by the surveyor/reviewer.

Standard No.	Standard Text	Decision
2-2	The service record contains the current service plan(s) required for the service/service setting.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review the service plan maintained by the service provider. Service plan, dependent on the service may also be known as ISP, Life Plan, treatment plan, program plan, care plan, habilitation service plan, etc.

GUIDANCE:

- Maintenance of a service plan by the provider agency may be electronic or hard copy.

- Regardless of the service, for purposes of this standard, a service plan is considered current if:
  - The plan is developed or revised in the past year and is an accurate portrait of the person and the services/treatments needed/wanted/provided. Allowances may be given for extension beyond 12 months as appropriate to the individual's circumstances; and/or
  - The plan was developed over one year ago; is an accurate portrait of the person and the services/treatments needed/wanted/provided; and there is documentation that the plan was reviewed and determined to continue to be accurate.

SELECT "MET" IF:

✓ The individual's service plan is current as described in guidance.

SELECT "NOT MET" IF:

✓ The individual's service plan is not current as described in guidance.

Standard No.	Standard Text	Decision
2-3	The individual's written service plan is developed within time frames required for the specific service.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review the service plan and service record maintained by the service provider. Service plan, dependent on the service may also be known as ISP, Life Plan, treatment plan, program plan, care plan, etc. Service notes may assist, if needed in determining timeline for plan development.

DISCUSSION:

- As needed: Speak with coordinator/manager, service provider and/or individual for clarification as needed regarding time frames. This is especially helpful when difficulty meeting time frames is identified to understand service provider processes and possible obstacles.

GUIDANCE:

Required time frames for development of the service plan vary dependent on the service. Maintenance of a service record may be electronic or hard copy.

- Service Coordination (MSC and PCSS):
  - Initial ISP: within sixty (60) days of HCBS or PCSS enrollment.
  - Ongoing: within forty-five (45) days of a review that results in a revision/rewrite of the ISP.

- HCBS Waiver Habilitation Services:
  - General – All Habilitation Services:
  - Initial: within sixty (60) days of start of the service.
  - Ongoing: revisions must be provided within thirty (30) days of a service plan review date or the date on which the habilitation service provider made a significant change.

- Special consideration for Pathway to Employment (PTE): unless an extension is granted for completion of the PTE plan, a Career/Vocational Plan must be developed within 12 months after the date the individual started receiving the service or the date by which the individual received 278 hours of the service, whichever circumstance occurs first. The pathway to employment provider shall give the career/vocational plan to the individual upon completion of the PTE service.

- Day Treatment:
  - Within 30 days of completion of the CFA.

- Specialty Hospital (SH):
  - Initial Service Plan: Persons admitted to a specialty hospital must have simultaneous assessment and treatment upon admission. This means that a person typically is admitted to the SH due to the nature of their identified health care needs. The facility must have a plan to provide at least initial services and treatment.

- Ongoing: Placement to a SH is intended to be short term to address the conditions requiring admission. Any changes to treatment and services necessary to the individual, to address their medical and developmental needs should be identified in the plan as the changes occur. At least quarterly, the interdisciplinary team must collectively review and evaluate each person's individual program plan. These reviews should identify necessary changes to the written plan. (NOTE: Compliance with frequency of reviews are reviewed elsewhere.)

- FIDA-IDD:
  - Initial: The Life Plan (LP) must be finalized sixty (60) days following completion of the initial assessment (the CSPA);
  - Ongoing: …and thirty (30) calendar days after the completion of a Comprehensive Reassessment (CR).

- All other Services:
  - The reviewer must determine whether service plans are developed and/or revised within timeframes to ensure that the individual receives services they need and agreed to, and that staff members supporting the individual have the information they need to provide the services.

SELECT "MET" IF:

- ✓ The individual's service plan is developed generally within expected time frames sufficient to ensure services are provided within the context of a written service plan. (Judgement should be used regarding slight delays, and conditions outside the control of the provider, e.g. the person was admitted to a service but then was hospitalized and temporarily not participating in services).

SELECT "NOT MET" IF any of the following are evident:

- ✓ The development or revision to the individual's service plan was not within expected time frames or not timely and the delay resulted in any of the following:
- ✓ The individual is not receiving services from the service provider,
- ✓ The individual is receiving services that do not align with his/her needs, preferences or intended outcomes for his/her participation in the service.
- ✓ The people working directly with the individual do not know what services and supports they should be providing because there is no written plan to instruct their actions.

Standard No.	Standard Text	Decision
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review the service plan and service record maintained by the service provider. Service plan, dependent on the service may also be known as ISP, Life Plan, treatment plan, program plan, care plan, habilitation service plan, etc.

DISCUSSION:

- As needed: Speak with coordinator/manager and/or service provider responsible for plan development.

GUIDANCE:

- Information required to be in the service plan may be unique to the service type and/or service setting. However, common content includes the individual's name and date of the plan; valued outcomes, needs, and/or concerns addressed in the plan; expected/intended outcome of service(s); a description of the services, supports, training and experiences that the individual is to receive and staff is to provide, sufficient for staff understanding of what they must do. These content areas are the key component necessary for competent service delivery.

- Service specific requirements for the written service plan are described below for your information, especially in cases where the plan is assessed to clearly lack structure and necessary information to ensure the individual receives the services he/she needs and wants; so, the surveyor can inform the provider.

- HCBS Waiver Services:
  - All HCBS Waiver Habilitation Services:
    - In general, the habilitation service plan must describe the responsibilities of the individual and the service provider necessary for delivery of the service and the achievement of the individual's goal. Review that the Habilitation plan includes required content. Every Habilitation Plan must include:
    - Identifying information including but not limited to the name of the habilitation provider, identification of the habilitation service, the review date;
    - The person's valued outcome(s) are derived from the ISP that directly relate to the habilitation service. The Habilitation service must relate to at least one of the individual's valued outcomes;
    - HCBS Waiver Service Plans should also identify strengths and preferences, needs/needs for support, cultural considerations, etc. relevant to the particular service and service activities, as applicable;
    - Actions to be taken in the delivery of the service to the individual that will support the person to reach the particular valued outcome(s) addressed in the plan. The strategies for service delivery may address skill acquisition/retention, staff support, or exploration of new experiences;
    - Specific enough description of actions to be taken so that habilitation staff know and understand what they must do to implement the person's Habilitation Plan;

- Safeguards that must be provided to the individual to ensure her/his health and safety while participating in the habilitation service. The safeguards may be described in the Habilitation Plan or in an attached document. The quality of the safeguards will be reviewed in Section 7.

- Pathway to Employment (PTE) specific requirements:
  - Service Delivery Plan: This is the plan for implementation of services to prepare the person to receive supported employment services certified by OPWDD or another state/federal program:
  - Lists the individual's objectives and the relevant activities that are necessary to achieve the individual's career/vocational and employment goals and to prepare the individual to receive supported employment services;
  - Describes the responsibilities of the individual necessary to facilitate successful service delivery of the service and to achieve his/her career and employment goals;
  - Describes the responsibilities of the service provider necessary to successfully deliver the service to achieve his/her career and employment goals.
  - Career/Vocational Plan: This plan is developed and provided to the individuals after implementation of the PTE Service Delivery plan has occurred. This plan identifies and is focused on the individual's career/vocational and employment goals, employment needs, talents, and natural supports. The information known about the person and the experience and progress made during PTE should inform this Career/Vocational Plan. The plan serves as the individual's detailed career/vocational plan for guiding his or her employment supports. This plan must:
  - Identify the individual's career/employment goals, needs, skills;
  - Include interviews, action steps, career development activities, community-based volunteer experiences, work experiences, and
  - Recommendations for future employment related services.
  - It must be submitted to OPWDD, shared with the New York State Education Department- Adult Career and Continuing Education Services (ACCES-VR) and
  - It must be given to the individual upon completion of the service.

- Day Training:
  - The service plan should include the needs/conditions to be addressed; objectives/intended benefits; and written plan describing the treatment/care/training to be provided to achieve the objective(s).

- Clinic Treatment:
  - An individual must have a written plan of services for all treatments delivered by the clinic. The plan of service must document the course of treatment and outcomes expected.

- Day Treatment: Day Treatment refers to an Individual Program Plan (IPP) and Treatment Plan. The IPP is the larger aggregation of service plan documentation, while Treatment Plans are a part of the IPP. For purposes of this standard, we are reviewing the Treatment Plan. (IPP components are included in review of 2-1)
  - Should describe the individualized activities, experiences, and services to be provided to the person to achieve his/her program objectives/outcome;
  - Plan should include outcomes: Written statements of the specific identifiable, observable changes in a person's behavior and/or status that are expected to occur within a specified period as the result of specified activities, therapies, or interventions.
  - Plans should contain methodology, written direction, interventions, and/or strategies for implementation.
  - Treatment plans may include specific medical prescriptions if needed for specific clinical interventions.

- Information should be described clearly so that all parties implementing the plan understand what to do.

- Private School:
  - Private Schools Not Integrated Residential Communities (IRC):
    - The individual written plan of care/treatment/training must specify the person's conditions, those to be addressed in the plan, the specific care/treatment/training to be provided, and the intended benefits.
  - In Private Schools Known as IRCs the record should also include:
    - The individual written service plan is sometimes called the Program narrative. The written plan must include: a description of the individual's strengths and needs; a description of the strategies that will be used to address each identified; how the individual's independence and autonomy and community involvement is facilitated or enhanced; and staff responsible for implementing the plan/components specified in the plan.

- Specialty Hospital:
  - The individual program plan must:
    - Provide description of the individual;
    - State the conditions requiring admission;
    - Include medical treatment to be provided for health-related problems/conditions; and active programming related to the conditions resulting from developmental disability(ies);
    - The goals and long- and short-term objectives established to attain or maintain the optimal medical, clinical and/or functional areas being addressed;
    - Service plans for each service;
    - The specific service plans must include written direction for all necessary services and when appropriate, medical prescriptions;
    - Anticipated outcomes of treatment and programs
    - Additional requirements are reviewed through other standards.
- FIDA-IDD:
- Life Plans (LP) refers to a comprehensive record of the person services to be delivered by the FIDA-IDD plan itself and providers within the FIDA-IDD provider network. Dependent on the person's services and service environments, it may include reference to the IRA or ICF services, Habilitation Services and Day Program services, etc. Elements of the Life Plan related to person centered planning were reviewed in Section 1. For purposes of this standard, review the content of the Life Plan will focus on service oriented content. The Life Plan must include:
  - Services needed to meet the desired outcomes: For each need identified, the LP must:
    - State the issue/problem/need;
    - Identify the intervention(s) to address the need;
    - Identify the measurable outcomes of the intervention
    - Expected timeframe expected to achieve the desired outcome;
    - Short and long term goals for all problems/needs;
    - How frequently specific services will be provided;
    - A schedule of preventive service needs;
    - Method and frequency of evaluating progress towards goals and documentation of progress toward the goals including success, barriers, or obstacles;
    - How technology will be used if applicable;

SELECT "MET" If both following are evident:

- ✓ The individual's service specific written service/treatment plan generally includes required information per the service; and
- ✓ The service/treatment plan is written with sufficient clarity to enable effective implementation to support the person to achieve the intended outcome(s).

SELECT "NOT MET" If any of the following is evident:

- ✓ The individual does not have a written service/treatment plan for the individual;
- ✓ The individual's service/treatment plan does not include much of the required and relevant information per the service type;
- ✓ The individual's service/treatment lacks sufficient information to facilitate competent and consistent implementation by staff members responsible.

Note: Minor errors/omissions that do not significantly impact appropriate service delivery may not require a 'Not Met'. Compliance decisions require judgement by the surveyor/reviewer.

Standard No.	Standard Text	Decision
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review the service plan and service delivery documentation, and as needed, other applicable information such as monthly notes, service plan reviews, etc.

DISCUSSION:

- Required: Individual: Discuss services with the individual. Verify from the individual's perspective that the individual receives services when and how the services are provided/are expected to be provided.
- As needed: Speak with the service providers and people responsible for service plan/service delivery. Speak with family if the family is the best source of verification that services are being delivered as expected in frequency and content.
- Note: Some services, such as Respite, do not require a specific plan for the delivery of that specific service. However, verify that the service, if identified in the ISP or Life Plan, is provided to the individual as described and needed/requested.

OBSERVATION:

Opportunities to witness the delivery of components of the service plan may occur during observation in site based service environments (and of any other services if deemed necessary).

GUIDANCE:

- The service/treatment plan identifies the services, treatment, training, supports that are to be delivered to the person. There should be evidence through review of service delivery data collection, service notes and/or summaries, observation or interview that those supports and/or services are being provided.
- Verify that services are delivered with the frequency required or needed. If the plan (or a service schedule) specifies the frequency for delivery of the service and/or specific activities in the plan, it should generally be delivered with that frequency. If the service plan does specify a frequency, verify that the service/strategies are implemented with sufficient frequency to meet intended outcomes.

- If service delivery is not occurring as often as necessary, determine the reason, e.g. individual cancellation or refusal, insufficient people to deliver; insufficient transportation or resources, etc.
- Verify that the specific services/supports/treatments in the plan are delivered as described in the plan. Strategies included in the plan are likely to have been determined to be the best approach known to successfully achieve the outcomes desired, and consistent implementation is necessary to benefit the individual. Ensure also that activities during service delivery relate to the plan. For example, if a community habilitation plan is directed to assist the person to learn to cook a simple meal, service notes should be related to the activities necessary to cook a meal, rather than for example, choosing a leisure activity or other, non-meal prep activity. Services delivered should relate to the intended outcomes/benefits of the service plan and/or goals included within.

Please Note: RESPITE ONLY: As no written plan is required for Respite services, review Respite service note documentation to verify that the individual is receiving respite services as described in the ISP.

SELECT "MET" If both of the following are evident:

- ✓ There is evidence that the individual's service specific written service/treatment plan is implemented with sufficient frequency per the plan and/or to meet the intended outcomes of the plan; and
- ✓ There is evidence that the service/treatment plan is implemented per the goals, strategies, activities described in the plan to assist the person to achieve the intended outcome(s).

SELECT "NOT MET" If any of the following is evident:

- ✓ The individual's service/treatment plan is not implemented with sufficient frequency per the plan and/or to meet the intended outcomes of the plan;
- ✓ Specific goals, strategies, activities described in the plan to best support the individual are not implemented;
- ✓ Services are delivered by people but do not relate to the written plan.
- ✓ The individual's service/treatment plan does not include much of the required and relevant information per the service type;
- ✓ The individual's service/treatment plan lacks sufficient information to facilitate competent and consistent implementation by people members responsible.

Note: Minor errors/omissions that do not significantly impact appropriate service delivery may not require a 'Not Met'. Compliance decisions require judgement by the surveyor/reviewer.

Standard No.	Standard Text	Decision
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review the service plan and service delivery documentation, and as needed, other applicable information such as monthly notes, service plan reviews, etc.

DISCUSSION:

- Required: Individual: Discuss the service plan with the individual, ask when and how the individual receives services and ask about the activities and experiences that occur during service provision. Verify from the individual's perspective that the service plans and activities are related to helping him/her to achieve goals, as intended.
- As needed: Speak with the service providers and people responsible for service plan/service delivery; Speak with family if the family is the best source of verification that services are being delivered to facilitate achievement of desired outcomes.

OBSERVATION:

Opportunities to witness the delivery of components of the service plan may occur during observation in site based service environments (and of any other services if deemed necessary).

GUIDANCE:

- This standard requires a determination that the service plan and service implementation clearly relate to and are intended to meet the individuals desired outcomes and the life the person needs and wants.

- In order for the individual to have the life he/she desires, the service plan and service delivery must be designed and provided in a manner that facilitates the individual's personal outcomes. This is to distinguish between services that simply meet OPWDD requirements and generally meet the needs of the person and a service plan and activities that clearly and assertively focus on the person's priorities to help the person live his/her desired life. The service delivery is based on the individual's voiced preferences and choices.

- It is understood that the connection between the service and desired outcome/life goals may be very close and apparent for some (e.g. SEMP services clearly related to person's desire to work in child care, or a behavior support strategies that facilitate successful community activities), but less direct and not obvious for others (e.g. Clinic services for strength and balance training so that the person feels more comfortable using public transportation to travel in the community independently). The individual and/or service providers, and the service plan should assist in making the connection. If the plan does not document a connection to the person's desired outcomes and/or the individuals involved cannot explain how the service fits with the person's desired outcomes, inquire further to ascertain why the services/supports are in place.

SELECT "MET" IF either of the following are evident:

- ✓ It is evident that the service plan and implemented activities and experiences clearly benefit the person toward their life goals and desired quality of life.
- ✓ The individual's service is designed to foster the achievement of personal outcomes/life priorities of greatest interest and import to the person, in a manner individualized for that person.

SELECT "NOT MET" If any of the following are evident:

- ✓ It is evident that the service plan and/or implemented activities and experiences are not focused on achievement of his/her life goals, outcomes and desired quality of life.
- ✓ Services are delivered and keep the person involved in activities, but the activities cannot be connected to the person's life goals, outcomes, and desired quality of life (even if the activities benefit the person).
- ✓ Services plans and/or services delivered not needed/wanted by the person.
- ✓ Services do not support the individual's personalized goals.

Standard No.	Standard Text	Decision
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review the service plan and service delivery documentation, and as needed, other applicable information such as monthly notes, service plan reviews, etc.

GUIDANCE:

- Standard 2-5 reviews delivery of services and Standard 2-6 reviews appropriateness per the person's desired outcome. This standard reviews that:
  - Service delivery documentation generally provides sufficient information to evaluate effectiveness of the service. In general that means information is provided about the service activities and treatment provided and the individual's response, performance, success, and/or need for assistance. In some cases the service/goal/treatment plan will specify what should be documented and how; and
  - Service delivery documentation meets content and format meets requirements of the specific service as it relates to quality of information.
    - The intent is not to ensure documentation required for billing, although regulatory references may include that information for continuity. Some of the information provides helpful information about service delivery, for example for some waiver habilitation services, staff to service recipient ratio must be identified. This allows you to understand the circumstances of service delivery.

- Service documentation may occur through use of data collection documents and/or narrative accounts of the service delivery and results. Documentation typically should be able to be attributed to the person making the notation. Narratives notes should be signed by the author. Documentation may be electronic or paper/hard copy. It is expected that service documentation occur as contemporaneously as possible with time of service delivery. While timeframes are not defined for some services, completion of summary notes within one month is best practice.

- Service Specific Information if applicable, otherwise use information above:
- HCBS Waiver Habilitation Services – General Expectations including Res Hab in residential settings:
  - Service Documentation may be:

- a Daily Narrative Note; or
- a daily checklist with a monthly summary note.
- Narrative notes must include the services provided, the individual's response. At least monthly the narrative note must also summarize the individual's response and any issues or concerns.

- Pathway to Employment (PTE):
  - PTE requires use of a checklist prescribed or approved by OPWDD for documentation of direct or indirect services. The Monthly Summary note is also required, which identifies the individual's response to service and any issues or problems.
  - For both Direct and Indirect service delivery, documentation must include start and stop times of service delivery, staff to participant ratio at the time and the allowable service(s) delivered.

- Supported Employment (SEMP): SEMP service delivery requires use of a checklist and the Monthly Summary note. The Monthly note must describe the actions taken by staff, individual's response, vocational progress, and issues/concerns if any.

- HCBS Waiver Intensive Behavior Services
  - Service delivery documented may be a direct, face-to-face or indirect service.
  - Staff must complete a narrative note for each day of service. This documentation should include a description of all the services provided for the day based on the Behavior Support Plan (BSP); and
  - At least a monthly summarization of the individual's response to the service. This summarization of the individual's response may be documented on a daily narrative note.

- HCBS Waiver Respite Services:
  - There must be an entry on a Respite Documentation Record for each day that Respite service is provided.

- Clinic Treatment:
  - There must be treatment notes evidencing delivery of clinic treatment services and signed by the professional staff or treatment coordinator making the note.

- Private Schools:
  - There must be progress notes regarding services delivered and signed by staff members participating in the person's services/treatment.
  - Private Schools known as an IRC: The IRC must be able to, following its own procedures, evidence appropriate interventions by the staff in accordance with the individual's program narrative.

- Day Training:
  - There must be progress notes regarding services delivered and signed by staff members participating in the person's services/treatment.

- Day Treatment:
  - Progress notes related to objectives/services/treatment must be completed and signed by the professional staff member or treatment coordinator making the note.

- Specialty Hospital:
  - There must be a record of treatments provided and progress notes regarding the interventions to be provided, describing the individual's response to services.

SELECT "MET" If both of the following are evident:

- ✓ Service documentation provides sufficient information about services delivered, individual's response and/or skill demonstration, and review effectiveness.
- ✓ If required, service documentation is in the format required by the service.

SELECT "NOT MET" If any of the following is evident:

- ✓ Service documentation does not provide sufficient information about one or more of the following: services delivered, individual's response and/or skill demonstration, and review effectiveness.
- ✓ Service documentation is not in the format required by the service, if required.

Standard No.	Standard Text	Decision
2-8	The person is participating in activities in the most natural context.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:
Required: Review the service plan and service delivery documentation, and as needed, other applicable information such as monthly notes, service plan reviews, etc.

DISCUSSION:
Required: Individual: Discuss the service plan with the individual and ask when and how the individual receives services.
As needed: Speak with the service providers and staff responsible for service plan/service delivery; Speak with family if the family is a source of information about service delivery.
Note: Some services, such as Respite, do not require a specific plan for the delivery of that specific service. However, verify that the service, if identified in the ISP or Life Plan, is provided to the individual as described and needed/requested.

OBSERVATION:
Opportunities to witness the delivery of components of the service plan may occur during observation in site based service environments (and of any other services if deemed necessary).

GUIDANCE:

- This standard addresses whether delivery of supports and services occur in a natural setting.
- Through interview with the individual and support staff, record review and observation, determine whether staff work to provide situations that are in real life settings or the most appropriate setting related to the outcome.
- Plan may specify settings and context for service delivery.
- Service documentation may provide specific information on service delivery including how and where.

- Examples of Natural Context include:
  - Hygiene and home life activities such as housekeeping and cooking occur in their home;
  - Recreation and sporting activities occur at the same time and same locations where community members participated;
  - Activities related to banking skills occur in a community bank;
  - Community safety is discussed and taught through supervised community experiences where street crossing and stranger danger are practiced and discussed;
  - Healthy choices discussion and teaching occurs while menu planning and grocery shopping; not just in a classroom or clinical setting;
  - Religious expression occurs through scheduled public services in the local place of worship vs. specially arranged services for the local individuals with disabilities.
- In order for services, supports and activities to occur in the most natural context, the individual's supports should be developed/designed to facilitate this; e.g. time of service delivery, staffing allocations, etc.

- It is understood that there may be occasions where activities supportive of the goals/outcome may occur in a practice setting that is not natural, however best practice is that is an exception and not a norm. Also activities in a non-natural context may be necessary due to factors beyond the control of the provider of supports (e.g. weather, health of person).

SELECT "MET" If the following is evident:

- ✓ The individual is routinely provided services and associated activities in the natural setting or context appropriate for the person.

SELECT "NOT MET" If any of the following is evident:

- ✓ The individual is not routinely provided services and participating in activities in their natural context or setting.
- ✓ The individual routinely needs to engage in service activities related to life skills in environments where the activities would not normally occur.

Standard No.	Standard Text	Decision
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:
Required: Review the service plan and service delivery documentation, and as needed, other applicable information such as monthly notes, service plan reviews, etc.

DISCUSSION:
- Required: Individual: Discuss with the individual, their services, when and how they receive them, etc.
- As needed: Speak with the service providers and people responsible for service plan/service delivery; Speak with family if they are a source of information about service delivery.

Note: Some services, such as Respite, do not require a specific plan for the delivery of that specific service. However, verify that the service, if identified in the ISP or Life Plan, is provided to the individual as described and needed/requested.

OBSERVATION:
Opportunities to witness the delivery of components of the service plan may occur during observation in site based service environments (and of any other services if deemed necessary).

GUIDANCE:
- This standard assesses whether the individual's services are delivered in the most integrated setting appropriate to the activity and the individual's preferences and needs.
- Integrated for the purposes of this standard, means any setting where individuals without disabilities are also participating in activities and/or daily life. This can mean a typical community location (e.g. retail store, theater, community park, YMCA fitness center) or agency facilities/programs/activities in which community members and/or non-disabled people routinely participate (e.g. agency operated fitness center open to and used by local community members, agency sponsored business frequented by community members, agency sponsored business where a disabled and non-disabled people work together for the same business oriented purpose).
- Integrated is not any setting or service location where the majority of people are disabled and the preponderance of non-disabled individuals are provider agency employees.
- Most integrated setting acknowledges that the appropriate type/level/setting for integration is dependent on: (1) the particular activities related to the service (e.g. a clinic treatment therapy session, or an outcome to increase ability to self-administer medications at home would not be an activity compatible with integration); and (2) the preferences, skills, strengths and vulnerabilities of the individual. However, ensure that there is not a pattern of using risks and vulnerabilities as a reason to exclude or minimize use of integrated settings. The provider should demonstrate efforts to support service delivery in integrated settings, through conscientious discussion of risk and strategies to minimize risks.
- This standard may overlap with 2-8's review of "natural context" as it can be seen by the examples that natural context at times can mean an integrated community setting.

- For each service reviewed, determine whether the activities related to service delivery are occurring in the most integrated setting appropriate to the intended outcome of the service and the individualized needs of the individual.

SELECT "MET" If the following is evident:

✓ The individual is routinely provided services and associated activities in the most integrated setting as individualized to the person and the service activities.

SELECT "NOT MET" If any of the following is evident:

✓ The individual is not routinely provided services and participating in activities in the most integrated setting appropriate for the person.

✓ The individual routinely needs to engage in activities related to life skills typically applied in the community, in environments where the activities would not normally occur.

Standard No.	Standard Text	Decision
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review the service plan and service delivery documentation, and as needed, other applicable information such as monthly notes, service plan reviews, etc.

DISCUSSION:

- Required: Individual: Discuss the service plan with the individual, ask when and how the individual receives services and ask about the activities and experiences that occur during service provision. Discuss whether initiative and independence encouraged or do people "do for" the individual and make the decisions.
- As needed: Speak with the service providers and people responsible for service plan/service delivery. Determine how decisions are made regarding how service delivery occurs and how they know what the individual wants/prefers. Speak with family if the family is a source of information about service delivery.
- Note: Some services, such as Respite, do not require a specific plan for the delivery of that specific service. However, verify that the service, if identified in the ISP or Life Plan, is provided to the individual as described and needed/requested.

OBSERVATION:

Opportunities to witness the delivery of components of the service plan may occur during observation in site based service environments (and of any other services if deemed necessary).

GUIDANCE:

- This standard requires that DQI people assess whether services are delivered in a manner that encourages the person's independence, decision making and choices, as well as to assist the person to develop skills to responsibly do so. This approach to service delivery, implemented supportively, results in a person's increased sense of dignity.

- The expectation is that on a consistent basis in the course of service delivery, the individual is given opportunities and supports as illustrated by the following examples:
  - The individual is encouraged to attempt/try to complete a tasks/portions of tasks and/or demonstrate a skill for him/herself rather than people “doing” or taking over.
  - The individual is encouraged/supported to make choices when opportunities exist, regarding the activities related to service implementation. E.g. Services include encouragement to walk 30 minutes a day in 2- 15 minute intervals. The individual is provided options for where to take the walks and when.
  - The individual is encouraged to fully participate with service planning scheduling (what support/goal/activity to work on when, activities to use to accomplish implementation, etc.). E.g. for a habilitation plan that includes varied activities related to increasing independence with family, the individual requests this week to work on learning face time on Tuesday when her friend gets home from work, placing a call on the weekend.
  - Encouragement and opportunities for independence autonomy occurs both during delivery of specific strategies in the written plan, but also informally as opportunities arise and as a matter of course when supporting the individual.
  - If individuals are not skillful at making decisions on how services are delivered, people should still provide opportunities for independence, choice and preferences, and attempt to let the individual take the “lead” through astute observations and input from others.

SELECT "MET" If the following is evident:

- ✓ The individual is routinely provided opportunities as part of service delivery and supported to increase/demonstrate independence, autonomy, initiative in a manner congruent with their strengths and skill development potential.

SELECT "NOT MET" If any of the following is evident:

- ✓ The individual is not or is infrequently provided opportunities as part of service delivery and supported to increase/demonstrate independence, autonomy, initiative in a manner congruent with their strengths and skill development potential.
- ✓ The service provider and/or people providing direct supports is controlling the manner in which services are implemented, planned, scheduled, organized, without regard to the person's expressed or observed preferences.

Standard No.	Standard Text	Decision
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:
Required: Review the service plan and service delivery documentation, and as needed, other applicable information such as monthly notes, service plan reviews, etc. Assessment of this standard requires consideration of what is documented as compared to what people tell you and what you observe.

DISCUSSION:

- Required: Individual: Discuss the service plan with the individual, ask when and how the individual receives services and ask about the activities and experiences that occur during service provision. Also ask if this is what they expected from the service/service plan.

- Required: Speak with people responsible for service plan/service delivery. Discuss the service plan, what their responsibility is to implement, what the individual is supposed to do, people's impression of the plan/service, etc. The intent is not necessarily to quiz people on every detail of the plan, but rather to determine if the people understands the intent of the service and service plan outcomes, their role in facilitating it, and their capacity to competently implement the plan.

- As needed: Speak with family/advocate if they are a source of information about service delivery.
- Program management people for clarification.

OBSERVATION:
Opportunities to witness the delivery of components of the service plan may occur during observation in site based service environments (and of any other services if deemed necessary). Observations, if completed should service to verify that people understand the plan, the person and implement services appropriately.

GUIDANCE:

- People responsible for implementation should be able to describe the plan, its general intent and activities conducted with the individual in the implementation of the service plan. people should be able to explain the plan as individualized to the person, not in generalities. It is okay for people to use the written plan as a reference when discussing it with you.
- Service documentation should evidence that the plan is implemented appropriately as an indicator of people's understanding. The documentation of service delivery will also demonstrate whether people understand the service and what should be documented.
- Observation of service implementation when possible, will provide information and verification of people's understanding of the plan and how to provide the services to the person in a manner congruent with the plan and the individual's needs.

- RESPITE:
  - Respite supports must understand their responsibilities in providing respite services to the individual, where to find information regarding the individual's needs for support and assistance necessary during the delivery of Respite services.

SELECT "MET" If: All of the following are present:

- ✓ During discussion, people are generally knowledgeable regarding the service plan and how to provide the service/supports to the individual in a manner appropriate for the person;
- ✓ Record review (and observation as applicable) evidence that people competently provide the service/support needed by the individual and per the written plan.

SELECT "NOT MET" If any of the following are present:

- ✓ During discussion, people do not know/cannot explain the service plan and how to provide the service/supports to the individual in a manner appropriate for the person;
- ✓ Record review (and observation as applicable) evidence that people provide the service/support incorrectly, inconsistently, not in a manner appropriate for the person, and/or not per the written plan.

Standard No.	Standard Text	Decision
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review the service plan and service delivery documentation, monthly notes if used, service plan reviews, meeting minutes if used, etc.

DISCUSSION:

- Required: Individual: Talk with the individual to evaluate if the service is effective in assisting him/her to learn, develop skills, do activities they are interested in, and bring them closer to their goals and desired outcomes.
- Service Provider: Discuss the actions taken to review the service(s) delivered and whether they result in the intended outcome. People delivering service: Discuss impressions on the effectiveness of the service they deliver to the individual, the individual's response and whether they think it is helping them to live his/her life in a meaningful, safe and functional manner.
- As needed: Speak with family/advocate if they are a source of information about the effectiveness of the service to meet the intended outcome/benefit.

OBSERVATION:

Opportunities to witness the delivery of components of the service plan may occur during observation in site based service environments (and of any other services if deemed necessary). These observations, may provide specific information regarding the service, the individual's and whether it may be effective in its intended outcome.

GUIDANCE:

- This standard requires that the specific service be reviewed to assess whether that particular service/treatment/service environment, results in meeting the person's need, goal and or desired outcome.
- This review is separate from 1-36 which requires review of effectiveness of the entire person centered service plan as a whole in assisting the person to live or achieve his/her desired life.

- The provider's review of the service should include discussion of the individual's documented responses or performance when the service is delivered, as well as discussion with the individual, family/advocates, and direct support staff. The perception of the individual is an important consideration.
- Effectiveness should be determined using the individual's status/progress towards desired goals/outcome described in the specific service. This may include individual progress, regression, maintenance of skills and functional ability, ensuring provision of a support, increasing opportunities for experiences, etc. as the plan is written.
- The review of the service effectiveness is dependent on characteristics of the service. For example:
    - A physical therapy clinic service may be to increase lower extremity strength. While very clinical measures may be used, effectiveness may also be evidenced by continued use of a walker and less frequent need for wheelchair use.
    - The effectiveness of residential habilitation service provided to assist an individual to gain or improve a life skill, require information on changes in the person's skill level
    - The effectiveness of a community habilitation service designed to provide the individual experiences with animals to determine the best match for volunteer activities, would likely include a review of the number and type of opportunities provided, characteristics and comparisons among the opportunities, and the individual's assessed responses, e.g. positive vs. unfavorable, glee vs. fear, etc. dependent on setting and type(s) of animals.
    - Behavior services as part of waiver service deliver have resulted in lower documented frequency of target behaviors and anecdotally, successful visits with grandma of increasing duration.
- The review of the specific service may occur at the same time of the review of the person-centered plan (if applicable) or as needed within the specific service environment/provider agency. When necessary the results of the separate review should be communicated to other service providers who need to know the information.
- Verify that the review is completed competently based on factual information regarding the individual's response to the service and whether he/she is benefiting from the service related to the reason the person is receiving it.
- Decisions and justification to continue services that do not appear to be effective, should be documented.

SELECT "MET" if at least two of the following are evident:

- ✓ There is evidence that the impact of the service to meet the outcomes expected has been assessed.
- ✓ There is consideration of the person's progress, achievements, gains, responses re: the outcome, and/or regression, disinterest, or barriers re: achievement of the outcome.
- ✓ Service/treatment documentation has been conscientiously and accurately reviewed to analyze the person's status relative to the intended outcome.

SELECT "NOT MET" if any of the following are evident:

- ✓ The impact of the service to meet the outcomes expected has not been assessed.
- ✓ There is no evidence that the person's progress, achievements, gains, responses, and/or regression, disinterest, or barriers re: achievement of the outcome have been discussed and considered.
- ✓ Service/treatment documentation has not been reviewed in consideration of service effectiveness.
- ✓ Service/treatment documentation has not been reviewed competently in consideration of service effectiveness.
- ✓ When the individual is determined not to have benefited from the service, the appropriateness of the plan and/or delivery strategies in the plan has not been considered.

Standard No.	Standard Text	Decision
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review the specific service plan and service delivery documentation, progress notes if used, monthly notes if used, service plan reviews, meeting minutes if used, etc.

GUIDANCE:

- Verify that the review of the service as discussed in 2-12 is documented.
- The person's status/progress/achievement and any obstacles to this, should be known by the service provider and persons responsible for oversight of the service/service delivery and documented.
- In general, the documentation should provide sufficient information, as relevant, to allow for a clear understanding of how the service impacted/benefited the person; how this was determined; whether the service is determined to be appropriate and effective; recommendations to continue, discontinue, revise, etc. Additional information may also be included, such as discoveries about the person and issues addressed or needing to be addressed.
- The documented review should accurately reflect the individual's status and effectiveness of the service based on the information gathered in your review of 2-12.
- The documentation should allow for continuity of service provision, information to support decisions on continuance or revision to the service, and contribute to a history of service experiences by the person.
- When the individual is determined not to have benefited from the service, the appropriateness of the plan and/or delivery strategies in the plan is considered.
- Review and documentation of the review may occur in varied ways. General Guidance and service specific requirements are described below:
    - When specific review frequency and format are not identified for a service type, the review and documentation of service effectiveness may occur by any of the following means:
        - Review of the person's status and the effectiveness regarding specific service types/goals/plans may occur as part of the review of the full service plan. The review of the specific service may be documented as an addendum, meeting minutes, or described in any format that provide sufficient information as indicated above. Frequency should be sufficient to allow for continuation of effective services, and not necessarily wait until an annual review.
        - Monthly progress notes or summaries.
        - Quarterly progress notes or summaries.
        - Other means that provides sufficient information and sufficient frequency to meet the person's needs.
    - Day Treatment: Review of each individual program plan should occur per agency policy, but with adequate frequency to ensure they are appropriate at least annually. Summaries/progress notes may be per goal/objective by the professional staff responsible for the service; or a summarization of all services in the program plan completed by the treatment coordinator.
    - Habilitation Services: Plans must be reviewed at least two (2) times annually. Documentation may occur as in #1 above. Review of effectiveness may also be evidenced in the narrative notes for the service.
    - Clinic Treatment: The written clinic treatment plan of service is reviewed with frequency specified for medical and/or dental treatment, and at least semi-annually by the clinician/practitioner or treatment coordinator.

- Specialty Hospital: Monthly reviews of the individual's response to the program plan must be completed by a member or members of the IDT. The IDT must review quarterly.

SELECT "MET" If both of the following are evident:

- ✓ There is evidence that review of services/service effectiveness was reviewed with the frequency required by the service type AND/OR if no frequency specified, frequently enough to identify issues and ensure appropriate service revision and delivery.
- ✓ Documentation evidences that a conscientious and accurate review of service effectiveness occurred.

SELECT "NOT MET" If any of the following are evident:

- ✓ There is no documentation evidencing that review of service/service effectiveness occurred.
- ✓ It could not be verified that services/service effectiveness was reviewed with frequency required.
- ✓ There are documented reviews, however they do not identify accurately the person's status, service effectiveness, and any issues evident from review of other documentation, observation or discussion.
- ✓ There are documented reviews, however they do not include sufficient information regarding the individual's status and service effectiveness.

Standard No.	Standard Text	Decision
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	**Met/Not Met/N/A**

Guidance

DOCUMENTATION REVIEW:

Required: Review the service plan and/or any supporting documentation that evidences that any changes to the service/program/treatment plan(s) related to the specific service are made.

INTERVIEW:

As needed for clarification, with individual and/or service provider.

GUIDANCE:

- Verify that any changes to the service plan, treatment plan, habilitation plan, or a specific "goal" plan have been made as determined to be necessary during the provider's review of services and/or based on your findings in the review of 2-12 and 2-13.
- Revision may apply to an entire individualized program plan, clinic treatment plan, habilitation service plan etc. or a portion of it.
- Revision to specific plans should ensure that a person responsible to implement/provide the service understands what to do/what has changed. Form and format may be according to agency procedures.

SELECT "MET" IF any of the following are evident:

- ✓ There is evidence that that the person's plan/service was revised when determined to be needed;
- ✓ The plan/service has been revised when there is evidence that it is ineffective and/or not achieving the intended outcome;
- ✓ The plan/service has been revised when the person's needs/preferences/conditions have changed;
- ✓ The revision was completed and implemented within a reasonable time frame so that the person's needs and goals are addressed.

SELECT "NOT MET" IF any of the following are evident:

- ✓ There is no evidence that plan/service has been revised when determined to be needed.
- ✓ The plan/service has not been revised as determined to be necessary during review.
- ✓ The plan/service has not been revised when the person's needs/preferences/conditions have changed;
- ✓ The plan/service is ineffective and has not been revised;
- ✓ The person reports that they have requested the plan/service be revised and there is no evidence that this has occurred.

SELECT "NA" IF:

- ✓ Revisions to the plan/service were not necessary.

Standard No.	Standard Text	Decision
2-15	The person is satisfied with the specific service.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:

Required: Review the service plan and/or any supporting documentation that evidences that any information regarding the person's satisfaction. This may also include documentation of service delivery and the person's response, as well as the service/care coordination/management documentation.

INTERVIEW:

Required: with individual, service provider, direct supports, and coordinator/case manager as applicable.

GUIDANCE:

- Based on interview with the person, family and MSC determine whether the person and advocate are pleased with the service/support received and whether they agree that they are meeting their intended purpose. This standard is based upon the individual's perception. It may or may not be an accurate assessment based on your review of the service. In residential settings such as IRAs, CRs, Apartments, and FC homes, this includes residential habilitation services.

SELECT "MET" If any of the following are evident:

- ✓ The person is satisfied with the service.
- ✓ The person reports that he/she benefits from the services/it meets their need for support/it provides the help they want.

SELECT "NOT MET" If any of the following are evident:

- ✓ The person is dissatisfied with the service.
- ✓ The person reports that he/she does not benefit from the service and the service does not help them.
- ✓ The person reports they do not want the service.

SECTION 2a: CASE/SERVICE COORDINATION/MGMT. SERVICE AND SUPPORTS DELIVERY

Standard No.	Standard Text	Decision
2a-1	The individual was provided a choice of service/care manager/coordinator.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:
As Needed: Service delivery notes (e.g. MSC notes, care management notes) and/or the service plan may evidence activities related to coordination options discussed and choice within the agency and other agencies.

INTERVIEW:
Required: With individual; As Needed: Service coordinator/care manager.

GUIDANCE:

- Section 1 includes a standard that the person has made informed choices of services/providers at a time when coordination services are already in place. This serves as additional verification that the individual was provided options regarding the service coordinator or care manager supporting the person.
- MSC and PCSS Services: Individuals should be made aware of provider agencies in their area that provide coordination services and choose the one that they believe will be the best fit for them, within available options. The Service Coordination Agreement explains a person's right to change vendors. The MSC must ensure the individual is aware of his or her right to choose a different vendor. Likewise, individuals may determine that they want to continue receiving the service from the same agency but find they need/want to work with another coordinator.
- FIDA-IDD Care Management: Individuals will typically be assigned a care manager. However, individuals may determine that they would prefer to work with another care manager within the agency and should be provided the option to do so when available.
- Recognize that the options available in the area or within the agency may be limited. An agency is not expected to provide the person with a change in coordinator/manager if there are no available options for change.

SELECT "MET" If any of the following are evident:

- ✓ The person has been informed that he/she may have a choice of coordinator/manager;
- ✓ The person has been informed of other agencies providing the service;
- ✓ If applicable, the person's request for a change in vendor (MSC) ore change in service coordinator/care manager has been adequately addressed by the agency.

SELECT "NOT MET" If at least two of the following are evident:

- ✓ The person has not been informed that he/she may have a choice of coordinator/manager;
- ✓ The person has not been informed of other providers of the service (MSC);
- ✓ The person reports that he/she has requested information regarding the above and it has not been provided;
- ✓ The person reports that he/she has requested a change in coordinator/manager and it has not been addressed by the agency.

Note: this does not mean a change has had to occur if not available, but does mean that the agency should take action to improve satisfaction with current provider, until a change can be made.

Standard No.	Standard Text	Decision
2a-2	An initial Level of Care determination (LCED) was completed indicating OPWDD determination that the individual is eligible for services (when individuals receive HCBS Waiver Services).	**Met/Not Met/NA**

Guidance

DOCUMENTATION REVIEW:
Required: MSC/PCSS service record.

GUIDANCE:

- It is the service coordinator's responsibility to ensure the timely completion of the Level of Care eligibility process and the LCED form.
- The initial process requires the local office of OPWDD (DDSOO) to make a determination that the individual seeking enrollment in the waiver has a developmental disability. The reviewer should see documentation in the MSC record that the DDSO has determined that the individual is eligible for services.
- The initial LCED form requires the signature of a review physician and the DDSOO Director/designee.
- The effective date of the initial LCED can precede the signature date of the DDSOO Director/designee, but it can be no earlier than the date the physician reviewed/ signed the LCED form.
- An appropriate completed LCED form is one which has all required portions completed and all required signatures and date of signatures.

SELECT "MET" If the following is evident:

- ✓ The person has received HCBS Wavier services for less than a year and there is an appropriately completed LCED form is in the service record.

SELECT "NOT MET" If any of the following are evident:

- ✓ The person has received HCBS Wavier services for less than a year and:
- ✓ An LCED form is in the service record but incompletely or inaccurately; or
- ✓ There is no LCED form.

SELECT "NA" If either of the following are evident:

- ✓ The person has received an HBCS Service for over 1 year;
- ✓ The person does not receive any HCBS Waiver service.

Standard No.	Standard Text	Decision
2a-3	The level of care is reevaluated at least annually (within 365 days) as evidenced by a current LCED in the SC/CC record.	**Met/Not Met/NA**

Guidance

DOCUMENTATION REVIEW:
Required: MSC/PCSS service record.

GUIDANCE:
- It is the service coordinator's responsibility to ensure the timely completion of the LCED redetermination process.
- The annual LCED redetermination must be reviewed and approved by a Qualified Intellectual Disabilities Professional (QIDP) who is familiar with the participant's functional level, or a physician (or physician's assistant or nurse practitioner if so authorized by a physician).
    - QIDP approval/signature is sufficient except residents of Community Residences subject to Part 671.4 which explicitly requires the signature of a physician's assistant/nurse practitioner on the LCED (671.4 (5)(b)(1)(ii).
- The redetermination must be completed and signed within 365 days of the previous LCED authorization.
- The definition of a QIDP contained in 42 CFR Part 483.

SELECT "MET" If the following is evident:
- ✓ The person has received HCBS Wavier services for a year or more and there is an appropriately completed LCED evidencing review and approval by a qualified person within 365 days of previous determination.

SELECT "NOT MET" If any of the following are evident:
- ✓ The person has received HCBS Wavier services for a year or more and:
- ✓ An LCED form is in the service record but does not have adequate documentation of review and authorized approval within required time frame; or
- ✓ There is no documentation of redetermination via LCED form.

SELECT "NA" If either of the following are evident:
- ✓ The person has been receiving HBCS Service(s) for less than 365 days;
- ✓ The person does not receive any HCBS Waiver service.

Standard No.	Standard Text	Decision
2a-4	The service plan record contains a correctly completed Documentation of Choices form.	**Met/Not Met/NA**

Guidance

DOCUMENTATION REVIEW:
Required: MSC service record.

GUIDANCE:

- The "Documentation of Choices" form specifies that:
  - Choice was offered between waiver services and institutional care (ICF) and the choice made;
  - Choice of whether to receive MSC services was provided and choice made;
  - Choices of services were provided and choices made were informed choices.
- Review the Documentation of Choices form in the MSC service record. Verify that it is filled out completely, signed and dated by all required parties (individual as able, Service Coordinator, OPWDD representative (typically from the DDRO), and Advocate as appropriate).

SELECT "MET" IF:

- ✓ The Documentation of Choices form is completed, signed and dated as appropriate.

SELECT "NOT MET" If any of the following are evident.

- ✓ There is no Documentation of Choices form.
- ✓ The Documentation of Choices form in incomplete, lacking necessary information.
- ✓ The Documentation of Choices is not signed and dated by the SC, the OPWDD representative, and the individual and Advocate as appropriate to the person's circumstances.

Standard No.	Standard Text	Decision
2a-5	The Willowbrook class member's Notice of Rights is placed in the SC /CM/CC service record.	**Met/Not Met**

Guidance

DOCUMENTATION REVIEW:
Required: MSC service record.

GUIDANCE:
- Individuals who are Willowbrook class members must receive the Notice of Rights for Willowbrook class members.
- The Permanent Injunction requires that all providers maintain the "Notice of Rights" statement in each Class Member's record.
  - It must be in Section 1 of MSC records;
  - For other services it is only specified that the Notice of Rights is prominently displayed in the WB class member's records: residential, day and Willowbrook case services;
  - The requirement also states the rights should be printed on sturdy purple paper stock.

SELECT "MET" If either the 1st or 2nd bullet PLUS the 3rd immediately above is evident:
- ✓ The Willowbrook Class Member Notice of Rights is in the individual's service record and easily identified in the record.

SELECT "NOT MET" IF:
- ✓ There is no evidence of a written Notice of Rights in the person's service record.

Standard No.	Standard Text	Decision
2a-6	The SC/CM/CC advocates/ensures that rights limitations occur only with required protections, justifications and approvals in place.	**Met/Not Met/NA**

Guidance

DISCUSSION:
Required: Individual and service coordinator regarding rights limitations; As Needed: Direct supports, provider agency staff

DOCUMENTATION REVIEW:
Required: ISP and/or service plan by any other name; supplemental plans/attachments such as Behavior Support Plans (BSP) or safeguard documents

OBSERVATION:
Observation, when required or necessary, may result in identifying limitations/restrictions that are in place, to inform your f/u with the coordinator.

GUIDANCE:

- The service coordinator, care or case manager should be alert to formal or informal limitation of the individual's rights when they complete routine activities, and observation, record review and discussion with the individual and their supports.
- If rights are limited, the MSC must ensure that there is a current justification, consent, approval, written plans when required and required documentation as applicable per 636-1.4 and 633.16.
- The service coordinator, care manager, case manager ensures that behavior support planning has occurred when limitations are in place to address the individual's behavior when it is the justification for the behavior.
- If the service coordinator, care manager, case manager is aware of rights limitations occurring without appropriate regulatory protections, the must ardently and consistently advocates for appropriate protective actions. If advocacy with parties or providers limiting rights do not bring results intended, the coordinator/manager must continue to advocate, for example broadening parties involved in the advocacy, ensuring support and advice from supervisors, assisting and empowering the individuals including assistance to file grievances and insist on due process.
- Written plans and/or documentation required when rights are limited should be part of/an attachment of the person's individualized service plan.
- Information about rights and rights limitations can be found in Sections 3 and 9-9g. You likely will not be able to answer this standard until those sections are reviewed if applicable.

SELECT "MET" If either of the following are evident as stated:

- ✓ The individual is subject to any limitation, restriction or modification of rights and there is evidence that they are needed/clinically justified, and written plans, approvals and protections are in place as required by regulatory requirements; OR
- ✓ The individual is subject to any limitation, restriction or modification of rights, requirements regarding implementation of restrictions are not met, however there is evidence that the service coordinator/ care manager has consistently and vigorously advocated for the individual and appropriate actions to ensure rights are only limited through appropriate mechanisms.

SELECT "NOT MET" If the following is evident:

- ✓ The MSC is aware of that the person is subject to rights limitations, restrictions, modifications, appropriate justification, approvals, and protections are not evident, and there is no evidence of advocacy by the coordinator/manager on behalf of the individual.

SELECT "NA" IF:

- ✓ The individual is not subject to any rights limitations.

Standard No.	Standard Text	Decision
2a-7	The individual has a signed Service Coordination Agreement, which is reviewed annually.	**Met/Not Met**

Guidance

DISCUSSION:
As Needed: Individual; service coordinator

DOCUMENTATION REVIEW:
- Required: Service Coordination Agreement

OBSERVATION:
Observation, when required, may result in identifying limitations/restrictions that are in place, to inform your f/u with the coordinator.

GUIDANCE:
- The service coordinator and individual should discuss and agree upon and understand their responsibilities as outlined in the agreement when Medicaid Service Coordination services are provided and received...
- A copy of the Basic Agreement should be given to the person, family/ advocate.
- A copy of the Basic Agreement must be placed in the first section of the Service Coordination Record.
- For individuals newly enrolled in MSC, the Agreement should be completed before an individual first begins receiving service coordination services but at least within 60 days of a person's enrollment in the MSC.

SELECT "MET" IF:
- ✓ A signed and current Service Coordination Agreement is in the individual's record.

SELECT "NOT MET" IF either of the following is evident:
- ✓ There is no signed Service Coordination Agreement in the person's record.
- ✓ There is a signed Service Coordination Agreement but the most recent needed annual review is overdue.

Standard No.	Standard Text	Decision
2a-8	The individual enrolled in FIDA-IDD is provided a set of guidelines and care responsibilities of the entire IDT.	**Met/Not Met**

Guidance

INTERVIEW:
Required: Individual (or designee)
As needed: Care Manager

DOCUMENTATION REVIEW:
Required: Participant/FIDA-IDD Agency agreement, Service record

GUIDANCE:

- Verify that a set of guidelines and care responsibilities for the entire IDT has been established and actually exists in a written form.
- Verify that the service agreement between the participant/guardian/caregiver/designee and the FIDA-IDD plan/provider agency documents, attests, affirms, or authenticates that the individual received the set of guidelines and/ or care responsibilities for the entire IDT.
- This affirmation may be included in the service agreement between the FIDA-IDD Plan or attached as a separate simultaneously dated document.
- Acceptable proof that the participant was provided a set of the IDT's guidelines and care responsibilities include signed copy of the guidelines, a signed receipt for a written copy of the guidelines, or verification by the individual, advocate, caregiver or designee through interview that the written guidelines were given/and received.

SELECT "MET" IF:

- ✓ Documentation clearly indicates that the guidelines/care responsibilities for the entire IDT was provided to the individual.

SELECT "NOT MET" If either condition below is evident:

- ✓ A set of guidelines/care responsibilities for the entire IDT was NOT established;
- ✓ Interview with the participant and/ or documentation review indicates the guidelines/care responsibilities for the IDT team HAS NOT been provided to the individual.

Standard No.	Standard Text	Decision
2a-9	The individual and designees, as applicable are given required contact information.	**Met/Not Met**

Guidance

DISCUSSION:
Required: Individual – Discuss if he/she knows how to/has contact information.
As Needed: Service coordinator

DOCUMENTATION REVIEW:
Service record

GUIDANCE:

- Medicaid Service Coordination and PCSS
  - The individual (or designee) must be given a phone number at which the MSC or substitute can be reached after hours/24 hours in the event of an emergency.
  - The number must be current and answered by a person, not a recording or answering machine.
  - The agency may use whatever form or format it chooses to provide the phone number.
  - Review for evidence that the number was provided to the individual (and/or designee). This may be documented in service coordination notes or the mechanism used by the agency.

- FIDA-IDD:
  - Individuals (and their designees who are current IDT members) must be given current contact information for all members of his/her IDT.

- The provider must ensure that when contact numbers change, the individual is provided updated information.

SELECT "MET" IF:
- ✓ There is evidence that the individual (designee) was provided the current contact information.

SELECT "NOT MET" If either of the following is evident:
- ✓ There is no evidence that the individual (designee) was provided contact information.
- ✓ The individual was provided contact information but did not receive updates if changes occurred.

Standard No.	Standard Text	Decision
2a-10	The individual can reach the service coordinator when needed in a timely manner.	**Met/Not Met**

Guidance

DISCUSSION:
Required: Individual (designee)
As Needed: Service coordinator (SC), people that know the individual best

DOCUMENTATION REVIEW:
Service notes

GUIDANCE:

- Through discussions with the individual determine if they have needed to contact their service coordinator, if they were able to talk to them when needed. If the individual had to leave a message for their service coordinator, try to assess whether the service coordinator get back to them within a reasonable time frame. While the individual's perspective of "timely" is important, assess based the reason the individual was trying to reach the SC, and urgency of the reason.
- Discuss whether the person feels comfortable/welcomed reaching out to the SC when needed.
- If the person has had to call after business hours, were they able to talk to a person, even if it was not their own SC.
- Service notes should document communications made by the individual to the SC and may provide information regarding these exchanges and timeliness.
- If there are concerns with timely communication between the individual and SC, the person's other service providers may have input regarding the individual's ability to get in touch with the SC.

SELECT "MET" IF:

- ✓ The individual (designee) is able to make contact with the SC within reasonable time frames when needed.

SELECT "NOT MET" If either of the following are present:

- ✓ The individual (designee) is dissatisfied with ability to contact the SC in a timely manner and there is additional evidence that timely contact is problematic.
- ✓ The individual (designee) is dissatisfied with ability to contact the SC in a timely manner and no evidence that timely contact has occurred when needed.

SELECT "NA" IF:

- ✓ Based upon information gathered, the individual has not had the need to call/reach out to the SC or cannot recall if they ever had the need to do so.

Standard No.	Standard Text	Decision
2a-11	The SC/CM/CC solicits input from/among members of the person's "circle"/team as part of the review of the person's services and status as needed.	**Met/Not Met**

Guidance

DISCUSSION:
Required: Individual (designee), Service coordinator, service providers, and other team/circle members and people that know the person best

DOCUMENTATION REVIEW:
Service record, case notes

GUIDANCE:

- Section 1 review participation of appropriate team member in formal service planning. This standard reviews that the SC/CM/CC maintains and facilitates effective communication with/among the individual, their advocate(s), service providers, and other circle/team members.
- Maintaining effective communication among involved parties facilitates timely identification of changes to the person's status, needs, satisfaction, choices, accomplishments, etc. This enables the service coordinator or care/case manager to more effectively assist and advocate for the individual as needed.
- Talk with the SC/CM/CC and review service notes/monthly notes with the intent to identify how the SC/CM/CC engages with key service providers, supports and the individual in a way that allows them to maintain understanding of "how things are going" for the individual. Consider whether the SC/CM/CC communicates with the involved parties sufficiently and with appropriate frequency necessary to keep informed. Communication strategies and frequencies may vary depending on the person, ability to self-advocate (or have advocacy by family/designee), and individualized concerns and need for support.
- In addition to gathering information about the person, the SC/CM/CC must also communicate effectively to inform service providers and other significant circle member of the individual's status or changes.
- To the degree necessary discuss with service providers, the type and level of interaction they have with the SC/CM/CC and other service providers.

SELECT "MET" If at least 2 of the following are evident:

- ✓ The SC/CM/CC is aware/can describe of what is going on with the person, sufficient to be responsive to changing needs, ineffective services, or new requests, as evidence that the SC/CM/CC ensures sufficient communication to ensure that they.
- ✓ SC/CM/CC service delivery documentation evidences communication with providers delivering services (and other circle members as needed) regarding the individual and their services/supports.
- ✓ The SC/CM/CC provides significant updates regarding the individual as needed to service providers and other applicable circle members.
- ✓ The individual's services, supports, living and service environments are appropriate for the person at the time of review, with no need for significant changes. This outcome will be sufficient to determine that the degree and mechanisms for communication are adequate.

SELECT "NOT MET" If any of the following are evident:

- ✓ The SC/CM/CC is not aware or cannot describe the person's status, i.e. what is going on with the person and whether their life is stable or undergoing change.
- ✓ The SC/CM/CC is not aware of changes in the status resulting in ineffective response to changing needs.

- ✓ Service providers and other significant circle members report that the SC/CM/CC does not contact/communicate with them.
- ✓ SC/CM/CC service documentation lacks evidence of any communication with providers delivering services to the individual.

Standard No.	Standard Text	Decision
2a-12	Meetings for the review of the person centered service plan must be face to face as required by the service type.	**Met/Not Met**

Guidance

DISCUSSION: Required: Individual (designee)
As Needed: Service coordinator

DOCUMENTATION REVIEW: Service record: ISP, ISP sign-in, service notes, monthly notes

GUIDANCE:

- Medicaid Service Coordination:
  - Face to face applies to the individual and SC being present in the same location.
  - The minimum requirement is that at least one review annually is a face-to-face meeting. (This not preclude a face-to-face meeting at other reviews of the ISP, depending on the choice of the individual, the significance of changes in the individual's life and the professional judgment of the MSC.)
  - Documentation of the service plan review meeting should indicate that both parties met in person.

- Plan of Care Support Services: Each ISP review meeting must be a face to face meeting

- Willowbrook Case Management/Coordination: It is expected that relevant parties which include the WB case manager/coordinator attend the planning meeting in person (ICF or Nursing Home).

SELECT "MET" IF:

- ✓ Documentation evidences that the SC/CM/CC and individual met in person/face to face for at least service plan review meeting annually.

SELECT "NOT MET" IF either of the following are evident:

- ✓ There is no evidence that the SC/CM/CC and individual met in person/face to face for at least one service plan review meeting annually.
- ✓ The SC/CM/CC and individual did not meet in person/face to face for at least service plan review meeting annually.

Standard No.	Standard Text	Decision
2a-13	The individual who is a Willowbrook class member has an activity plan.	**Met/Not Met**

Guidance

DISCUSSION:
As Needed: Individual (designee), Service coordinator

DOCUMENTATION REVIEW:
Service record- Activity Plan

GUIDANCE:

- All Willowbrook Class Members must have an Activity plan completed within 60 days of a person's enrollment into the MSC program.
- The MSC Activity Plan should describe certain short-term service coordination activities that are most important to the person. Usually, these activities are related to the person centered valued outcomes. The Activity Plan identifies the parties who are responsible for carrying out these activities. A start date should be entered for each activity included in the plan. When an activity is completed, the "task is done" box should be checked.
- The Activity Plan should be attached to the person's ISP.
- The Activity Plan must be reviewed and updated at least every six months.
- This review of the Activity Plan should be documented in the service coordination notes.
- New activities the individual would like completed may be added at any time.

SELECT "MET" If all of the following is evident:

- ✓ An Activity Plan has been developed and is in the MSC record;
- ✓ The Activity Plan generally meets content requirements;
- ✓ The Activity Plan has been reviewed every six months, and revised if needed;
- ✓ The Activity Plan content is generally adequate.

SELECT "NOT MET" If any of the following are evident:

- ✓ An Activity Plan is not in place;
- ✓ The Activity Plan is not reviewed every six months;
- ✓ The Activity Plan content is largely inadequate or not individualized.

Standard No.	Standard Text	Decision
2a-14	The SC/CM/CC notes indicate that the service coordinator/case manager has contact with the individual in the frequency and manner required by service and when needed.	**Met/Not Met**

Guidance

DISCUSSION:
Required: Individual (designee)
As Needed: Service coordinator, or care manager or care coordinator

DOCUMENTATION REVIEW:
Service record- service notes, monthly notes

GUIDANCE:
• Through review activities verify that face to face contact occurs as required.
• If the needs of the individual warrant more face-to-face meetings than the required minimum, the SC/CM/CC should meet with the individual more frequently. It is their responsibility to use his/her professional judgment, in consultation with the individual and others as appropriate to determine when more frequent meetings are needed. The assessment of whether a face-to-face meeting is needed should be on-going and based on the unique circumstances and needs of the person. The individual's safety and well-being should be the most important factor when deciding when and how often to meet in person.
• The in-person visits and what occurred should be documented in service notes.
• Be alert for circumstances or agency practices that limit the frequency of contacts and do not allow for an individualized approach.
• Medicaid Service Coordination (non- Willowbrook Class Member)
o Face-to-face meetings between the individual and SC must occur a minimum of 3x a year.

• Medicaid Service Coordination (Willowbrook Class Member)
o Face-to-face meetings between the individual and SC must occur 1x every calendar month

• Plan of Care Support Services
o Face-to-face meetings must occur 2x/year during the ISP reviews.

• FIDA-IDD: The care managers must contact the individual as frequently as outlined in the Life Plan but at least through one telephone contact per month.

• Willowbrook Case Management/Coordination (ICF or Nursing Home): Face-to-face meetings between the individual and SC must occur 1x every calendar month.

SELECT "MET" If the following are evident:
✓ Contacts occur in the minimum frequency required.
✓ Contacts occur in the manner required (e.g. face-to-face or phone).
✓ If necessary based on the individual's circumstances, additional contacts are planned routinely and/or as needed.

SELECT "NOT MET" If any of the following are present:
- ✓ The number of contacts do not meet the minimum frequency required.
- ✓ Contacts do not occur in the manner required (e.g. face-to-face or phone).
- ✓ If necessary based on the individual's circumstances, additional contacts do not occur, despite the individual's request.

Standard No.	Standard Text	Decision
2a-15	The service coordinator/case manager meets with the individual in his/her home at least quarterly with a Willowbrook Class Member, annually with a non-class member, and when needed.	**Met/Not Met**

Guidance

DISCUSSION:
Required:
Individual (designee)
As Needed: Service coordinator

DOCUMENTATION REVIEW:
Service record- service notes, monthly notes

GUIDANCE:
- Through review activities verify that in home visits occur as required.
- If the needs of the individual warrant more frequent in home visits than the required minimum, the SC/CM/CC should meet with the individual more frequently.
  It is their responsibility to use his/her professional judgment, in consultation with the individual and others as appropriate to determine when more residential visits are needed. The individual's safety and well-being should be the most important factor when deciding when and how often to visit the person in their home.
- The in home visits and what occurred should be documented in service notes.
- The visit to the individual's home allows the service coordinator to identify potential hazardous conditions in the home, as well as cleanliness or maintenance problems.
- Be alert for circumstances or agency practices that limit the frequency of contacts and do not allow for an individualized approach.
- Medicaid Service Coordination (non- Willowbrook Class Member)
  - The SC must meet face-to-face with the individual in his/her home at least one time a year.
- Medicaid Service Coordination (Willowbrook Class Member)
  - For Willowbrook Class members, a face-to-face service meeting in the person's home is required at least once during each three-month quarter of a calendar year.
  - A calendar year is divided into four, three month quarters:

- 2nd quarter – April through June
- 3rd quarter – July through September
- 4th quarter – October through December

• FIDA-IDD (Willowbrook Class Member): There is only a requirement for in-home face-to-face if the individual is a Willowbrook Class Member. The care managers must contact conduct a visit in the home at as frequently as identified in the Life Plan but at least one time every three month quarter of the calendar year. See above.

• Willowbrook Case Management/Coordination (ICF or Nursing Home): For Willowbrook Class members, a face-to-face service meeting in the person's home is required at least once during each three-month quarter of a calendar year. See above.

SELECT "MET" If either of the following are evident:
✓ In home face to face visits occur in the minimum frequency required.
✓ If necessary based on the individual's circumstances, additional in home face to face visits are planned routinely and/or as needed.

SELECT "NOT MET" If either of the following are evident:
✓ The number of in home visits do not meet the minimum frequency required
✓ If necessary based on the individual's circumstances, additional in home face to face visits do not occur, despite the individual's request.

Standard No.	Standard Text	Decision
2a-16	A Service Coordination Observation Report (SCOR) was completed at least twice yearly for Willowbrook Class Members and as needed.	**Met/Not Met**

Guidance

DISCUSSION:
As Needed:
Service coordinator, individual, residential staff or family care provider

DOCUMENTATION REVIEW:
- Service Coordination Observation Report (SCOR)

GUIDANCE:
- The Service Coordination Observation Report (SCOR) is a document used by the service coordinator to review and document health, safety, and environmental issues in OPWDD certified residences. Its use is mandatory for use for Willowbrook Class Member's in certified residences.

SELECT "MET" IF both of the following are evident:
- ✓ There is evidence that a SCOR is completed 2x/calendar year minimum (non-consecutive quarters).
- ✓ At least 1x/year the SCOR is completed together with the CAB.

SELECT "NOT MET" If any of the following are evident:
- ✓ There is no evidence that a SCOR has been completed.
- ✓ The SCOR is not completed with required frequency.
- ✓ A SCOR is not completed together with the CAB at least one time in the calendar year.

Standard No.	Standard Text	Decision
2a-17	If the SCOR identifies issues, the case notes in the individual's record evidence advocacy and resolution of the issue(s).	**Met/Not Met/NA**

Guidance

DISCUSSION:
As Needed: Service coordinator, residential staff or family care provider

DOCUMENTATION REVIEW:
Required: Service Coordination Observation Report (SCOR), service/case notes, monthly notes, correspondence as needed

GUIDANCE:
- If a SCOR identifies issues that need correcting, the SC/CM is required to advocate that the issues are addressed with the involved parties. Advocacy efforts and resolution of the issue(s) must be documented in the service/case notes.

SELECT "MET" IF:
- ✓ There is documentation to demonstrate SC/CM advocacy for resolution of issues identified on the SCOR.

SELECT "NOT MET" IF:
- ✓ There is no evidence that the SC/CM advocated for resolution of issues identified on the SCOR.

SELECT "NA" IF:
- ✓ There are not issues or concerns identified on the SCOR.

Standard No.	Standard Text	Decision
2a-18	SC/CM/CC has taken action to affirm that all allegations of abuse and/or neglect were reported to appropriate parties and investigated as appropriate.	**Met/Not Met**

Guidance

DISCUSSION:
As Needed: Individual (designee), Service coordinator

DOCUMENTATION REVIEW:
- Required: Service record- e.g. Service notes, monthly notes, correspondence as needed

GUIDANCE:
- 2a-20 and 2a-21 deal directly with the actions of the SC/CM/CC to advocate for the safety of the individual. These standards are not a review of the SC/CM/CC agency's incident management process.
- 2a-20 reviews advocacy that acts of abuse and/or neglect are reported and investigated. The SC/CM/CC must be alert to evidence of abuse, neglect or intimidation and ensures that allegations are reported.
- The SC/CM/CC must advocate/ensure that any allegation of abuse/neglect they are aware of is reported within the agency of origin and to the JC when appropriate. In some situations, e.g. when individuals live in and the abuse occurred in the community, the SC/CM/CC may be the person to report the event.
- The SC/CM/CC must also advocate/ensure/monitor that appropriate parties are notified such as law enforcement, family, Willowbrook CAB and the Justice Center if they discover these parties were not notified as needed.
- If an individual is a Willowbrook Class Member living in a Nursing Home, the Willowbrook SC/CM must advocate that any allegations identified by the Nursing Home are reported internally, to OPWDD, and the Justice Center when required.
- General situations when a SC/CM/CC will be aware of alleged abuse:
    - If the person is receiving services from an OPWDD authorized or certified program and if the alleged abuse occurs while under the auspices of the program, the SC/CM/CC will be/should be notified by the provider.
    - The SC/CM/CC may also become aware of or observe potential abuse in the course of performing his/her duties.
- The SC/CM/CC should verify that the program/agency is conducting an investigation into the circumstances.
- Service notes must include a description of the allegation/adverse event involving the individual and a description of the SC/CM/CC's actions on behalf of the person.
    - In the best case scenario, the SC/CM/CC is made aware of the event and through contact with the agency of record, verifies that the event was reported and is being investigated, and again when the investigation is complete. Notes should reflect this.
    - At other times the SC/CM/CC may need to consistently advocate and monitor that appropriate actions are taken to report and investigate. Notes should reflect all actions taken.

SELECT "MET" If either of the following are evident:

- ✓ There is documentation to demonstrate that the SC/CM ensured/verified that allegations of abuse/neglect they are aware of, are reported as required and investigated.
- ✓ There is documentation to demonstrate that the SC/CM advocated to the degree necessary, to ensure allegations of abuse/neglect have been reported and investigated.

SELECT "NOT MET" If either of the following are evident:

- ✓ There is no documentation to show that the SC/CM ensured/verified that allegations of abuse/neglect they are aware of, are reported as required and investigated.
- ✓ There is no documentation to demonstrate that the SC/CM advocated to the degree necessary, to ensure allegations of abuse/neglect have been reported and investigated.

SELECT "NA" IF:

- ✓ There have been no reported allegations of abuse or neglect on behalf of the individual.

Standard No.	Standard Text	Decision
2a-19	If abuse was substantiated, SC/CM/CC advocates for the safety and protection of the individual.	**Met/Not Met/NA**

Guidance

DISCUSSION:
As Needed: Individual (designee), Service coordinator

DOCUMENTATION REVIEW:

- Required: Service record- e.g. Service notes, monthly notes, correspondence as needed

GUIDANCE:

- 2a-20 and 2a-21 deal directly with the actions of the SC/CM/CC to advocate for the safety of the individual. These standards are not a review of the SC/CM/CC agency's incident management process.
- 2a-21 reviews that the SC/CM/CC advocates for and ensures the identification and implementation of appropriate actions for the protection of the individual are taken for any allegation of abuse/neglect they are aware of.
- Service notes must include a verification of protections implemented, description of the SC/CM/CC's actions and advocacy on behalf of the person if needed, and resolution of advocacy efforts.
- The SC/CM/CC should be alert to an unusual number of adverse events, which may reflect issues that need to be addressed to ensure the safety and protection of the individual.

SELECT "MET" If either of the following are evident:

- ✓ There is documentation to demonstrate that the SC/CM ensured/verified that protections are in place as needed by the individual.
- ✓ There is documentation to demonstrate that the SC/CM advocated to the degree necessary, for the identification and implementation of protections needed.

SELECT "NOT MET" If either of the following are evident:

- ✓ There is no documentation to demonstrate that the SC/CM ensured/verified that protections are in place as needed by the individual.
- ✓ There is no documentation to demonstrate that the SC/CM advocated to the degree necessary, for the identification and implementation of protections needed.

SELECT "NA" IF:

- ✓ There have been no reported allegations of abuse or neglect on behalf of the individual.

Standard No.	Standard Text	Decision
2a-20	The SC/CM/CC monitors that the individual is linked to and receiving the services he/she wants and that the services are helping the individual to attain his/her valued outcomes and life goals.	**Met/Not Met**

Guidance

DISCUSSION:

Required: Individual (designee), Service coordinator, service providers, direct supports

DOCUMENTATION REVIEW:

- Service record including person centered service plan, communication, service/case notes

GUIDANCE:

- This standard assesses that the SC/CM/CC is active in monitoring that the services the person needs to achieve their goals and meet their needs are accessed and being provided.
- Interview the SC/CM/CC, asking them to explain what actions they take to ensure the individual is receiving the services wanted/requested/identified in the service plan.
- Review the SC/CM/CC notes to verify that examples of these explained actions are completed and documented.
- When reviewing notes look for documentation of SC/CM/CC contacts and advocacy with the service providers regarding status of delivery of services and with the individual/advocate regarding delivery of services.
- Interview the individual receiving services and/or the family member/advocate (if applicable). Ask if the individual is receiving the services they should be receiving and want. Ask whether the SC/CM/CC talks to him/her about services and whether the SC/CM/CC acts if the individual expresses concerns about the services.
- Verify through record review, interview of the SC/CM/CC and interview of the individual, and advocate if appropriate, that the services the individual is receiving is helping the person to attain his/her valued outcomes and/or life goals. Be alert to whether services and valued outcomes are static with no change or progress for several years.

- Be alert to whether an unmet need for services is preventing the individual from progressing toward attainment of valued outcomes
- Since SC/CM/CC review activities will occur relatively concurrently with observation and documentation review of site based services, note whether the valued outcomes are being addressed and the individual is receiving the services requested and identified in the service plan. (Does not apply to Willowbrook Case Management in ICF and Nursing Home)
- Additional Guidance for Willowbrook Case Management/Coordination (ICF, Nursing Home):
    - The WCS or WSC also advocates for the individual to ensure:
- Programs and services which create personal independence and self-fulfillment;
- Services to support the class member as he/she ages within his/her residence and day program, or other appropriate settings;
- The class member's participation as a member of his/her community;
- Individual End of Life planning.
    - Case notes, the individual service plans or interview with the Willowbrook SC should indicate that the above are discussed and included in the individual's plan of services if and when appropriate.
    - Please note that the Willowbrook SC does not write the plan but should advocate for changes when needed. Case notes should document advocacy efforts and resolution.

SELECT "MET" IF both of the following are met:

- ✓ It is verified that the SC/CM/CC is taking appropriate actions to identify that services the person needs are accessed, and being delivered and are effective in meeting the person's needs and outcomes.
- ✓ It is verified that when needed, the SC/CM/CC advocates that services in the person centered plan are provided, and/or that the individual is linked to new services/supports when necessary.

SELECT "NOT MET" If any of the following are present:

- ✓ There is no documentation to evidence that the SC/CM/CC is taking appropriate actions to identify that services the person needs are accessed, and being delivered and are effective in meeting the person's needs and outcomes.
- ✓ There is no documentation to evidence that when needed, the SC/CM/CC advocates that services in the person centered plan are provided, and/or that the individual is linked to new services/supports when necessary.

Standard No.	Standard Text	Decision
2a-21	The WCS Coordinator or WSC assists the QIDP, treatment coordinator and/or IDT members in linking to services and/or in support during crisis intervention, as needed.	**Met/Not Met**

Guidance

DISCUSSION:
Required: SC/CM/CC
As Needed: Individual (designee), IDT members

DOCUMENTATION REVIEW:
- Service record

GUIDANCE:
- The SC/CM/CC should work cooperatively with other parties responsible for coordination of the individual's services routine and crisis. This is especially relevant in service environments that have specific positions also fulfilling coordination roles such as ICF and Nursing Homes.
  - In the ICF, the QIDP or the individual's treatment coordinator directs the activities of the IDT during times that new services are being sought or during a time of crisis for support of the individual and/or family. However, look for evidence that the SC/CM/CC has offered and provided assistance, when and if needed.
  - As needed and requested by the nursing home IDT or treatment coordinator, the SC/CM/CC should also assist in service linkage, especially regarding linkages to services in the community.
- Activities completed by the SC/CM/CC in this regard must be documented in service/case notes

SELECT "MET" If either is evident:
- ✓ If/as needed, the SC/CM/CC is assist others supporting the individual in a coordination role.
- ✓ The person's services appear appropriate with no additional action for service linkage.

SELECT "NOT MET" If any of the following are evident:
- ✓ Although needed due to need or inaction of the QIDP, IDT, treatment coordinator etc., there is no evidence that the SC/CM/CC provided assistance.
- ✓ The person's services are not appropriate or an urgent situation is not addressed and the SC/CM/CC has not offered or provided assistance to the primary coordinator of the services.

Standard No.	Standard Text	Decision
2a-22	The SC/CM/CC monitors that the fire safety safeguard identified in the Person Centered Plan are in place/provided.	**Met/Not Met**

Guidance

DISCUSSION:
Required: Individual (designee), direct supports
As Needed: Service coordinator, provider agency staff

DOCUMENTATION REVIEW:
- Required: Service record including person centered service plan, communication, service/case notes
- As Needed and Appropriate: Fire Safety information in certified residence

OBSERVATION:
While visiting/reviewing site based services, be alert to anything that may verify that the fire safety needs are addressed especially in reference to special needed devices such as strobes or bed shakers.

GUIDANCE:
- Inclusion of fire safety needs in the person centered plan is reviewed in Section1. This standard verifies that the SC/CM/CC monitors the supports.
- Verify through interview and review of the service plan and service notes that the SC follows up with the person, family and/or residential providers if applicable, to be sure that actions and recommendations from the fire safety assessment are implemented and appropriate.
- Using the information obtained from interview, discussion with the MSC, review of documentation, and observation if appropriate, verify that the fire safeguards (personnel, environmental modifications, equipment, etc.) identified in the ISP are in place and being implemented. This serves to support that the SC is adequately monitoring and ensuring fire safety needs are met.
- In discussion with the individual, especially those living in non-certified environments address topics to determine if they know what to do in a fire, how to evacuate, and whether anyone has talked to them about fire safety and evacuation.
- If possible, verify through interview, and observation and documentation review that each individual's fire safety needs are being met. (I.e. If a residential site review is occurring, verify that the person can and is being appropriately assisted in fire evacuation.)
- *NOTE: Service Coordinators are not required to routinely read fire drill reports or be present for fire drills. However, if the Service Coordinator determines that the person is in imminent danger due to lack of a current fire safety assessment or actions needed for fire protection, the Service Coordinator should contact his/her supervisor, as well as the individual responsible for fire safety at the residential site.*
- *NOTE: If the reviewer determines that an individual is in immediate danger due to lack of a current assessment or inadequate fire safety protections, call the appropriate Area Director immediately.*

SELECT "MET" If both of the following are evident:
- ✓ There is evidence that the individual's fire safety needs are being met.
- ✓ There is evidence that the SC monitors that fire safety needs of the individual are being met.

SELECT "NOT MET" If any of the following are present:

- ✓ The individual's fire safety needs are not being met.
- ✓ There is no evidence SC monitoring that fire safety needs of the individual are being met.
- ✓ There is evidence that the SC has not advocated to ensure the individual's fire safety needs are met when there is a fire safety need that must be addressed.

Standard No.	Standard Text	Decision
2a-23	The SC/CM/CC monitors that individuals receive the health care services identified in their service plan.	**Met/Not Met**

Guidance

DISCUSSION:
Required: Individual (designee), direct supports
As Needed: Service coordinator, provider agency staff

DOCUMENTATION REVIEW:

- Required: Service record including person centered service plan, communication, service/case notes, supporting documentation in record as needed (e.g. assessments, medical reports)
- As Needed and Appropriate: When individuals live in certified residential setting, review of health care records must be conducted.

OBSERVATION:
While visiting/reviewing site based services, be alert to anything related to health needs and support of same (e.g. dietary guidelines, special treatments or medical appointments).

GUIDANCE:

- Inclusion of health care needs in the person centered plan is reviewed in Section1. This standard verifies that the SC/CM/CC monitors the supports.
- The SC/CM/CC is responsible for monitoring an individual's healthcare services in an ongoing, timely and proactive manner.
- The SC/CM/CC should monitor that if an individual has an identified health need, he/she is receiving appropriate supports related to routine care and monitoring of the issue, scheduling and attending medical appointments, identifying illness and the need for medical assessment, etc.
- If the individual is a competent adult who has chosen not to obtain the identified health care service as indicated in the service plan, the service notes should indicate that the SC/CM/CC is continuing to advocate with the person and has offered to help to obtain the service. If the individual wants and needs assistance, the SC/CM/CC should monitor that medical appointments (both routine and PRN) are occurring and that medical recommendations are being acted upon. The service notes should reflect the monitoring and follow-up to healthcare related concerns.
- Discuss with the individual, family, and supports, topics including whether they go to doctor appointments, if they like their doctors, and attempt to determine their understanding of their health and needs for support for health care, scheduling and getting to appointment, understanding what happens at appointment, help they need day to day, etc.

- Note: The SC/CM/CC notes may not reflect all of the monitoring and follow-up of health care related concerns for individuals that live in certified settings where a health care professional (registered RN) would be responsible for the follow-up and documentation of these issues. In these cases, the SC/CM/CC may note that the residential RN is following up on health care concerns. This would be acceptable as long as adequate health care follow-up is being provided.
- Additional consideration for FIDA/IDT: The Care manager and the IDT members must work collaboratively to ensure timely access to services and either directly deliver or confirm delivery of services.

SELECT "MET" If all of the following are met:

- ✓ There is evidence that the individual's health and health care needs are being met.
- ✓ There is evidence that the SC monitors that health and health care needs of the individual are being met.
- ✓ As needed, the SC advocates so that that health and health care needs of the individual are met.

SELECT "NOT MET" If any of the following are evident:

- ✓ The individual's health and health care needs are not being met.
- ✓ There is no evidence SC monitoring that health and health care needs of the individual are being met.
- ✓ There is evidence that the SC has not advocated to ensure the individual's health and health care needs are met when there is a need that must be addressed.

Standard No.	Standard Text	Decision
2a-24	Care/Case/Service Coordinator/Manager advocates for the rights and entitlements of the individual in the home, day and work environments and in all spheres of his/her life.	**Met/Not Met**

Guidance

DISCUSSION:
Required: Individual (designee), Service coordinator,
As Needed: Provider agency staff, Direct supports

DOCUMENTATION REVIEW:
- Required: Service record including person centered service plan, communication, service/case notes

GUIDANCE:
- Review for Willowbrook class members only
- Look for evidence in service notes and/or through discussion of issues in the person's life, that the SC/CM/CC is alert to limitations to rights and entitlements. Willowbrook entitlements include:
  - Plans to address personal safety needs
  - A safe physical environment
  - Adequate staffing to provide supports and services
  - Active treatment which promotes independence
  - Appropriate services, based on individuals' personal strengths, needs and goals
  - Individualized strategies for community inclusion. For individuals in nursing homes, individual strategies for community inclusion should include, as applicable, discharge strategies and identification of services and supports needed by the individual to return to and be maintained in his/her community.
  - Acquisition of informed consent
  - Adequate staff coverage in the event of hospitalization
  - Individualized strategies for money management
  - Appropriate supports as the WB class member ages

SELECT "MET" If any of the following is evident:
- ✓ There is evidence that the SC/CM/CC advocates for the rights and entitlements of the Willowbrook class member as described above.
- ✓ Based on the PCR findings, the person's entitlements as a WBCM are generally provided/assured.

SELECT "NOT MET" If any of the following are present:
- ✓ The person is not provided entitlements due as a WBCM and there is no evidence that the SC/CM/CC advocates that this is addressed.

Standard No.	Standard Text	Decision
2a-25	The Care/Case/Service Coordinator/Manager ensures that procedural and substantive due process requirements are met.	**Met/Not Met/NA**

Guidance

DISCUSSION:
Required: Individual (designee), Service coordinator,
As Needed: provider agency staff, direct supports

DOCUMENTATION REVIEW:
- Required: Service record including person centered service plan, communication, service/case notes

GUIDANCE:
- In the event that it is determined that an individual no longer requires and/or is no longer eligible for services, and/or a change in residence is needed, the SC/CM/CC must ensure that all due process is met.
- Due process requires that the individual be appropriately informed of the proposed change, the mechanism for objections to the changes, and that mechanisms for due process are implemented when chosen by the individual.
- For Willowbrook class member, the WB CAB must be notified per paragraph 15 of the Willowbrook Injunction.
- There should be evidence in the service record of the SC/CM/CC advocacy regarding the above.

SELECT "MET" If any of the following are evident:
- ✓ A change in the individual's services or service setting is/was proposed by the service provider and the individual was afforded due process.
- ✓ A change in the individual's services or service setting is/was proposed by the service provider and the SC/CM/CC conscientiously advocated to ensure the individual was afforded due process.

SELECT "NOT MET" If any of the following are evident:
- ✓ A change in the individual's services or service setting is/was proposed by the service provider but the individual was not afforded due process.
- ✓ A change in the individual's services or service setting is/was proposed by the service provider but, the SC/CM/CC did not advocate to ensure the individual was afforded due process.

SELECT "NA" IF:
- ✓ There was no situation requiring assurance that the individual was afforded due process.

Standard No.	Standard Text	Decision
2a-26	The WCS Coordinator or WSC ensures active representation, either by the class member, the correspondent or Consumer Advisory Board (CAB)	**Met/Not Met**

Guidance

DISCUSSION:
Required: Individual (designee), Service coordinator, Willowbrook CAB
As Needed: Provider agency staff, Direct supports

DOCUMENTATION REVIEW:
- Required: Service record including person centered service plan, communication, service/case notes

GUIDANCE:
- Review for individuals who are Willowbrook class members.
- According to Appendix H of the Permanent Injunction, Active representation is generally defined as participating with the team in planning and evaluating the Class Member's plan of care and/or visits between the correspondent and the Class Member at least annually. Phone calls or simply signing consents does not qualify as active representation.
- Determine if the SC/CM/CC has made reasonable efforts to ensure "active representation" by a correspondent, CAB or correspondent and CAB. Co-representation is often requested by an aging parent, or one who lives at a distance, hindering full participation.
- In gauging the effort by the SC/CM/CC, consider the nature and type of efforts currently required and those made in the past and the outcome of such efforts; e.g. phone calls made, letters sent, reasonable notice for meetings, encouraging attendance by scheduling meetings to accommodate the representative, etc. If relevant parties were unable to attend, determine whether the Case Manager ensured the necessary information, and issues and concerns were represented at the meetings and efforts made to get representative the information following the meeting.
- Quarterly reports to OPWDD re: active representation and caseload information should be made by the SC/CM/CC.

SELECT "MET" If any of the following are evident:
- ✓ The individual is determined to be actively represented by himself/herself or family, guardian, advocate, or assigned CAB.
- ✓ The SC/CM/CC takes action to facilitate active representation through communication and accommodations to facilitate participation.

SELECT "NOT MET" If any of the following are evident:
- ✓ The individual is determined not to be actively represented by himself/herself or family, guardian, advocate, or assigned CAB.
- ✓ The SC/CM/CC does not take action to facilitate active representation.

Standard No.	Standard Text	Decision
2a-27	The person is satisfied with the coordination/case management services he/she receives.	**Met/Not Met**

Guidance

DISCUSSION:
Required: Individual (designee), Service coordinator, Willowbrook CAB
As Needed: provider agency staff, direct supports

DOCUMENTATION REVIEW:
- Required: Service record including communication documentation and service/case notes

GUIDANCE:
- Based on interview with the person, family and SC/CM/CC determine whether the person and advocate are pleased with the SC/CM/CC services and supports arranged and provided and whether they agree that they are meeting their needs for service linkage, coordination and advocacy.
- The evaluation of this standard is based upon the individual's perception whether or not it is an accurate assessment of the effectiveness and quality of service coordination or care/case management service.

SELECT "MET" IF:
- The individual (designee) reports satisfaction with the supports provided by the SC/CM/CC.

SELECT "NOT MET" IF:
- The individual (designee) reports dissatisfaction with the supports provided by the SC/CM/CC.

SECTION 2b: SELF DIRECTION

Qualifier Question: Does the individual Self-Direct by exercising Budget authority?	**Yes**	**No**

Standard No.	Standard Text	Decision
2b-1	The individual is supported to exercise budget authority over how his or her resources are budgeted and managed within the Personal Resources Account (PRA).	**Met/Not Met**

Guidance

INTERVIEW:
Individual receiving services, Support Broker or Fiscal Intermediary, Service Coordinator as needed, Other Circle of Support members, if needed

DOCUMENTATION REVIEW:

- Personal Resource Account, ISP, Brokerage Agreement

GUIDANCE

- Interview the individual receiving services and review the PRA, ISP, and Support Brokerage agreement to determine if the individual is sufficiently supported to exercise budget authority over how his/her resources are budgeted and managed within the Personal Resources Account (PRA).

- Ask if the individual feels he/she is receiving sufficient supports for budgeting and managing expenses.
- If yes, do records support the individual's perspective? If no, determine if the individual, service coordinator, support broker, and/or other members of his/her circle of support are working with the individual to address his/her concerns.

SELECT "MET"IF :

- ✓ When interview(s) and a review of person-centered planning records present sufficient evidence that the individual is supported to exercise budget authority over how his/her resources are budgeted and managed within the Personal Resources Account (PRA).

SELECT "NOT MET" IF:

- ✓ When interview(s) and a review of person-centered planning records do not present sufficient evidence that the individual is supported to exercise budget authority over how his/her resources are budgeted and managed within the Personal Resources Account (PRA).

SECTION 2c: HCBS WAIVER FISCAL INTERMEDIARY SERVICES (FI)

Standard No.	Standard Text	Decision
2c-1	The individual is supported by the Fiscal Intermediary (FI) to complete billing and payment for goods and services identified in his/her Self Direction budget when the individual exercises Budget Authority.	**Met/Not Met**

Guidance

INTERVIEW:
Individual receiving services, Fiscal Intermediary

DOCUMENTATION REVIEW:
• ISP, FI documentation

GUIDANCE

- There are currently two levels of FI services available to individuals receiving services. These involve (level one) budget authority and (level three) budget and employment authority. (Level 2 is not yet available.) In order to bill for level one FI services, the FI must perform the following duties:
  - Billing and payment of approved goods and services on behalf of the participant: a. Receive, verify, and process requests for payment for all goods and services shown in the approved budget; b. Promptly notify participant or designee of any requests for payment for services that have not been identified
    in the participant's approved service plan and budget; c. Confirm credentialing of contractors and vendors; d. Bill Medicaid (eMedNY) and/or OPWDD for services, supports, and goods on behalf of the individual who has a self-direction budget.
  - Fiscal accounting and reporting: a. Establish and maintain a separate account for each participant; b. Track disbursements and balances of participant funds for those services that are included in the self-directed budget; c. Send monthly expenditure reports to the participant by the end of the following month [See also standard 2c-3, below]; d. Report inconsistencies between the approved service plan and the budget to OPWDD.
  - Ensure Medicaid and corporate compliance: a. Review all service documentation that supports billing to eMedNY and OPWDD for accuracy, completeness, and compliance with applicable requirements; b. Maintain current copies of the ISP and self-directed service plans and budgets and hold
    for a period of six years from the date the care, services, or supplies were furnished or billed, whichever is later; c. Maintain all components of the individual service record and documents supporting billing for a period of six years from the date the care, services, or supplies were furnished or billed,
    whichever is later; d. Provide expenditure reports and service documentation to OPWDD and other authorized state agencies as required and as requested.
  - General administrative supports: a. Conduct any necessary meetings regarding the budget and FI duties; b. Report and investigate incidents related to IDGS, Community Transition Services, Live-in Caregiver, Support Broker, and Housing Subsidies/100% state-funded services, as required; c. Not bill the participant for expenses associated with the FI agency administrative overhead; d. Teach the participant the importance of proper documentation of staff work hours, expenditures, and provision of services, including how to review a service record, mileage reimbursement form, monthly summary note, invoice, and any other claim for payment to ensure that documentation is complete and accurate; e. Inform the participant of situations (such a hospitalization) which will cause the participant to lose eligibility) for FI services or other Medicaid funded services that are in budget.

SELECT "MET" IF:

- ✓ When there is evidence that the individual is supported by the Fiscal Intermediary (FI) to complete billing and payment for goods and services identified in his/her Self Direction budget when the individual exercises Budget Authority.

SELECT "NOT MET" IF:

- ✓ When there is evidence that the individual is not sufficiently supported by the Fiscal Intermediary (FI) to complete billing and payment for goods and services identified in his/her Self Direction budget when the individual exercises Budget Authority. Not Met findings may include, but not be limited to, lapses in required FI documentation and lapses in FI oversight that could affect the individual's eligibility services.

Standard No.	Standard Text	Decision
2c-2	The individual is supported by the Fiscal Intermediary (FI) to complete billing and payment for goods and services identified in his/her Self Direction budget and to provide additional staffing-related services when the individual exercises Budget and Employment Authority.	**Met/Not Met**

Guidance

INTERVIEW:

Individual receiving services, Fiscal Intermediary

DOCUMENTATION REVIEW:

ISP, FI documentation (This may include an MOU between the individual and FI)

GUIDANCE:

- There are currently two levels of FI services available to individuals receiving services. These involve (level one) budget authority and (level three) budget and employment authority. (Level 2 is not yet available.)

- In order to bill for level three, the FI must perform all duties identified in level one (see standard 2c-1, above) and the following duties:
  - Verify staff citizenship status and complete required background checks: CBC, DMV, Central Registry, etc.
  - Help the participant manage staff by: a. Maintaining staff background records; b. Processing time sheets and service records; c. Processing payroll, withholdings, federal, state, and local taxes, and making tax payments to appropriate tax authorities (such as FICA, Workers Comp, unemployment, etc.); d. Ensuring timely staff payments.
  - Participate in annual and/or semi-annual ISP meetings to discuss issues related to self-directed staffing and/or supports and budget expenditures.
  - Participate in Circle of Support (COS)/Planning Team meetings as a budget resource, as needed or as requested
  - Incident Management: reporting/investigating related to self-hired staff, as required.
  - Maintain communication with OPWDD regarding participant and services.
  - Provide training to the participant on his/her employer responsibilities by: a. Providing the participant with orientation and support in hiring staff (including assistance with job descriptions), staff management, performance evaluations, staff conflict resolution; b. Reviewing with participant

the FI's employment and conduct policies that would apply to self-hired staff; c. Addressing relevant co-management practices which relate to agency vs. participant responsibilities; d. Discussing use of overtime with participant, e.g., budget consequences.

- Help the participant manage staff by: a. Implementing hiring and discharge decisions for self-directed staff; b. Providing enrollment/employment package for all new self-directed staff; c. Providing to self-hired staff all OPWDD-approved basic agency mandatory trainings (e.g., incident reporting); d. Providing other trainings for self-hired staff as agreed upon with participant; e. Scheduling back up staffing, if agreed upon with participant; f. Assisting the participant with budget management; g. Collecting and verifying time sheets/service records.

Note: All Fiscal Intermediary services provided on behalf of a participant by an agency must be separate and distinct from Brokerage Services provided on behalf of such participant.

SELECT "MET" IF:

- ✓ When there is evidence that the individual is supported by the Fiscal Intermediary (FI) to complete billing and payment for goods and services identified in his/her Self Direction budget and to provide additional staffing related services when the individual exercises Budget Authority and Employment Authority.

SELECT "NOT MET" IF:

- ✓ When there is evidence that the individual is not sufficiently supported by the Fiscal Intermediary (FI) to complete billing and payment for goods and services identified in his/her Self Direction budget and to provide additional staffing related services when the individual exercises Budget Authority and Employment Authority. Not Met findings may include, but not be limited to, omissions in staff background check activities, lapses in required FI documentation and lapses in FI oversight that could affect the individual's eligibility services and well-being.

Standard No.	Standard Text	Decision
2c-3	The individual is provided a monthly expenditure report.	**Met/Not Met**

Guidance

INTERVIEW:
Individual receiving services, Fiscal Intermediary

DOCUMENTATION REVIEW:
Monthly expenditure reports

Review expenditure monthly reports and verify, by interviewing the individual, that the reports were provided to the individual every month, as required.

SELECT "MET" IF:
- ✓ The individual has been provided required monthly expenditure reports in a timely manner, as required.

SELECT "NOT MET" IF:
- ✓ The individual has not been provided required monthly expenditure reports in a timely manner, as required.

Note: This specific requirement is included in standards 2c-1 and 2c-2. If failure to provide the individual with expenditure reports is the only omission in the FI services, cite the lack of expenditure reports (or lack of timely reports) under this standard (2c-3) only.

SECTION 2d: HCBS WAIVER COMMUNITY TRANSITION SERVICES (FI)

Standard No.	Standard Text	Decision
2d-1	There is a written summary of the specific Community Transition expenses paid on behalf of the individual by the FI, including the date and cost of each purchase or payment.	**Met/Not Met**

Guidance

INTERVIEW:
Fiscal Intermediary, if needed

DOCUMENTATION REVIEW:
Summary of CTS expenses

SELECT "MET" IF:
- ✓ There is a summary of expenses paid on behalf of the individual along with supporting receipts/documents.

SELECT "NOT MET" IF:
- ✓ There is no summary of expenses paid on behalf of the individual along with supporting receipts/documents.

Standard No.	Standard Text	Decision
2d-2	There is evidence that the person is responsible for his/her own living expenses in the home.	**Met/Not Met**

Guidance

INTERVIEW:
Individual receiving services, Service Coordinator, if needed, Fiscal Intermediary, if needed

DOCUMENTATION REVIEW:
ISP, Documentation that shows the individual owns or rents his or her home and is responsible for the residence (e.g., deed, lease, etc.),

Allowable CTS expenses are expenses for items an individual needs to set up his or her own household.

SELECT "MET" IF:
- ✓ There is evidence that the individual receiving services owns or rents his or her home and is responsible for the residence.

SELECT "NOT MET" IF:
- ✓ There is no evidence that the individual receiving services owns or rents his or her home and is responsible for the residence.

SECTION 2e: HCBS WAIVER SUPPORT BROKERAGE (FI)

Standard No.	Standard Text	Decision
2e-1	The Support Broker assists the individual with developing a comprehensive self-direction budget within the person's Personal Resource Account (PRA) amount.	**Met/Not Met**

Guidance

INTERVIEW:
Individual receiving services, if needed; Support Broker or Fiscal Intermediary, if needed; Service Coordinator, if needed

DOCUMENTATION REVIEW:
Personal Resource; Account, ISP, if needed; Brokerage Agreement, if needed

SELECT "MET" IF:
- ✓ There is evidence that the Support Broker assisted the individual with developing a comprehensive self-direction budget within the individual's Personal Resource Account (PRA) amount.

SELECT "NOT MET" IF:
- ✓ There is no evidence that that the Support Broker assisted the individual with developing a sufficiently comprehensive self-direction budget within the individual's Personal Resource Account (PRA) amount.

Standard No.	Standard Text	Decision
2e-2	There is a written support brokerage agreement describing the broker's responsibilities to assist the individual.	**Met/Not Met**

Guidance

INTERVIEW:
Individual receiving services, if needed; Support Broker or Fiscal Intermediary, if needed; Service Coordinator, if needed

DOCUMENTATION REVIEW:
Brokerage Agreement

SELECT "MET" IF:
- ✓ There is a written support brokerage agreement describing the broker's responsibilities to assist the individual.

SELECT "NOT MET" IF:
- ✓ There is no written support brokerage agreement describing the broker's responsibilities to assist the individual or when the agreement lacks sufficient details in accordance with ADM 2015-06.

Standard No.	Standard Text	Decision
2e-3	Face-to-face planning meetings (Circle of Support meetings) occur 4 times per year. They may occur concurrently with the ISP review meetings.	**Met/Not Met**

Guidance

INTERVIEW:
Individual receiving services, if needed; Support Broker or Fiscal Intermediary, if needed; Service Coordinator, if needed

DOCUMENTATION REVIEW:
Documentation of Circle of Support meetings; ISP reviews

SELECT "MET" IF:
- ✓ There is documentation to show that Circle of Support meetings occurred 4 times during the year, as required.

SELECT "NOT MET" IF:
- ✓ There is no documentation to show that Circle of Support meetings occurred 4 times during the year, as required.

SECTION 2f: HCBS WAIVER INDIVIDUAL DIRECTED GOODS AND SERVICES (FI)

Standard No.	Standard Text	Decision
2f-1	The Individual Directed Goods and Services (IDGS) a person receives address an identified need in a person's ISP, to promote his/her inclusion in the community, and/or increase the person's safety and independence in the home environment, and/or decrease the need for other Medicaid services.	**Met/Not Met**

Guidance

INTERVIEW:
Individual receiving services, if needed; Service Coordinator, if needed; Fiscal Intermediary, if needed

DOCUMENTATION REVIEW:
ISP

SELECT "MET" IF:
- ✓ Documentation is sufficient to determine that the IDGS a person receives address an identified need in a person's ISP, to promote his/her inclusion in the community, and/or increase the person's safety and independence in the home environment, and/or decrease the need for other Medicaid services.

SELECT "NOT MET" IF:
- ✓ Documentation is not sufficient to determine that the IDGS a person receives address an identified need in a person's ISP, to promote his/her inclusion in the community, and/or increase the person's safety and independence in the home environment, and/or decrease the need for other Medicaid services.

SECTION 2g: HCBS WAIVER LIVE-IN CAREGIVER (FI)

Standard No.	Standard Text	Decision
2g-1	The individual receiving Live-in Caregiver services resides in his/her own home or a leased residence where he/she is responsible for the residence.	**Met/Not Met**

Guidance

INTERVIEW:
Individual receiving services; Service Coordinator, if needed; Fiscal Intermediary, if needed

DOCUMENTATION REVIEW:
ISP; Documentation that shows the individual owns or rents his or her home and is responsible for the residence (e.g., deed, lease, etc.);

Live-In Caregiver is a companionship service including “fellowship and protection,” rather than care or treatment. The LIC is reimbursed for room and board expenses associated with providing the service in accordance with a required written agreement.

SELECT "MET" IF:
- ✓ There is evidence that the individual receiving services owns or rents his or her home and is responsible for the residence.

SELECT "NOT MET" IF:
- ✓ There is no evidence that the individual receiving services owns or rents his or her home and is responsible for the residence.

SECTION 2h: HCBS WAIVER SUPPORTED EMPLOYMENT (SE)

Standard No.	Standard Text	Decision
2h-1	SEMP services are directed toward achieving sustained self-employment or competitive integrated employment in the general workforce, in a job that meets the individual's personal and career goals.	**Met/Not Met**

Guidance

INTERVIEW:
Individual receiving services; SEMP staff; Service coordinator, if needed

DOCUMENTATION REVIEW:
SEMP service delivery plan; ISP
Interview the individual to verify that the SEMP services are directed toward attaining integrated employment or self-employment in accordance with the individual's personal and career goals. The services must be person-centered and not simply based on employment opportunities currently available in the community.

SELECT "MET" IF:
- ✓ SEMP services are directed toward attaining integrated employment or self-employment in accordance with the individual's personal and career goals.

SELECT "NOT MET" IF:
- ✓ SEMP services are not directed toward attaining integrated employment or self-employment in accordance with the individual's personal and career goals.

Standard No.	Standard Text	Decision
2h-2	Individuals receiving SEMP who are earning a wage must be compensated at or above the minimum wage.	**Met/Not Met/NA**

Guidance

INTERVIEW:
SEMP staff

DOCUMENTATION REVIEW:
ISP; Records pertaining to pay
Determine that – if the individual is employed – that the individual is compensated at or above the Federal and State minimum wages, as required. Individuals who receive Extended SEMP are typically employed and must be compensated appropriately. Individuals receiving Intensive SEMP may or may not be employed.

SELECT "MET" IF:
- ✓ The individual has been employed during the last year and has been compensated at or above the Federal and State minimum wages, as required.

SELECT "NOT MET" IF:
- ✓ The individual has been employed during the last year but has not been compensated at or above the Federal and State minimum wages, as required.

SELECT "NA" IF:
- ✓ The individual is self-employed or was not employed during the last year.

Standard No.	Standard Text	Decision
2h-3	Services provided without the individual present are documented and serve to benefit the individual in attaining his/her employment goals.	**Met/Not Met**

Guidance

INTERVIEW:
Individual receiving services, if needed; SEMP staff, if needed; Service Coordinator, if needed

DOCUMENTATION REVIEW:
SEMP service delivery plan; ISP, if needed
SEMP includes a variety of services and activities provided directly or on behalf of an individual in accordance with outcomes identified in the individual's SEMP service delivery plan and ISP. All services must be documented in accordance with 635-10.5(af)(8)(ii) and (iii).

SELECT "MET" IF:
- ✓ The services provided without the individual present, are documented and serve to benefit the individual in attaining employment goals, as required.

SELECT "NOT MET" IF:
- ✓ The services provided without the individual present, are not documented, or do not serve to benefit the individual in attaining employment goals, as required.

SECTION 2i: HCBS WAIVER PATHWAY TO EMPLOYMENT (PE)

Standard No.	Standard Text	Decision
2i-1	The individual receives pathway to employment services individually or simultaneously in a group of no more than 4 individuals.	**Met/Not Met**

Guidance

INTERVIEW:
Pathway to Employment staff;

DOCUMENTATION REVIEW:
Pathway to employment service documentation

OBSERVATION:
Observe group services, if needed

Pathway to Employment is a person-centered employment planning and support service that may be provided in individual or small group sessions.

SELECT "MET" IF:
- ✓ The person's services are delivered in appropriately sized small groups.

SELECT "NOT MET" IF:
- ✓ The person's services are often delivered in groups larger than 4 (excluding job readiness training).

SECTION 2j: HBCS COMMUNITY PREVOCATIONAL SERVICES (PV)

Standard No.	Standard Text	Decision
2j-1	Services delivered to the individual other than in the community do not exceed 2 hours per day.	**Met/Not Met**

Guidance

INTERVIEW:
Prevocational services staff

OBSERVATION:
Observe service delivery, if needed

Community prevocational services are intended to be conducted in integrated community settings; however, it is recognized that there are certain very limited circumstances in which use of agency-based settings may be appropriate in accordance with 635-10.4(l)(3).

SELECT "MET" IF:
- ✓ Prevoc services are delivered predominantly off-site/community based. Time spent in a site for these prevoc services is time limited as described in the regulation.

SELECT "NOT MET" IF:
- ✓ Services delivery occurs most frequently in a site versus the community.

SECTION 2k: HCBS WAIVER SITE BASED PREVOCATIONAL SERVICES

Standard No.	Standard Text	Decision
2k-1	When the individual's services include site-based prevocational services, the individual must have a demonstrated or assessed earning capacity relative to the prevocational task(s) involved, of less than 50 percent of the current State minimum wage, Federal minimum wage or prevailing wage, whichever is greatest, and be expected to have such an earning capacity while participating in the services.	**Met/Not Met**

Guidance

INTERVIEW:
Prevocational services staff; Service coordinator, if needed

DOCUMENTATION REVIEW:
Prevocational services documentation; ISP

OBSERVATION:
Observe site based prevocational tasks, when needed

SELECT "MET" IF:

- ✓ There is evidence to show that the individual has a demonstrated or assessed earning capacity relative to the prevocational task(s) involved, of less than 50 percent of the current State minimum wage, Federal minimum wage or prevailing wage, whichever is greatest, and be expected to have such an earning capacity.

SELECT "NOT MET" IF:

- ✓ There is no evidence that the individual has a demonstrated or assessed earning capacity relative to the prevocational task(s) involved, of less than 50 percent of the current State minimum wage, Federal minimum wage or prevailing wage, whichever is greatest.

SECTION 2l: HCBS WAIVER INTENSIVE BEHAVIOR SERVICES (IB)

Standard No.	Standard Text	Decision
2l-1	A functional behavioral assessment meeting content requirements is completed prior to development of the individual's behavior support plan.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed: Licensed Psychologist or Licensed Clinical Social Worker (LCSW), Behavior Intervention Specialist (BIS) who wrote the Functional Behavioral Assessment (FBA).

DOCUMENTATION REVIEW:
Mandatory: FBA, Behavioral Support Plan (BSP), Person Centered Plan (ISP or other name)

- The content requirements of the FBA, to be completed before the development of the BSP, are:
- description of the challenging behavior in observable and measurable terms;
- identification and consideration of the antecedents for the behavior(s);
- identification of the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior;
- identification of the likely reason or purpose for the challenging behavior;
- identification of the general conditions or probable consequences that may maintain the behavior;
- inclusion of an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s);
- inclusion of an evaluation of preferred reinforcers;
- consideration of multiple sources of data including, but not limited to:
    - information gathered through direct observations of the individual;
    - information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and,
    - a review of available clinical, medical, behavioral, or other data from the individual's record and other sources;
    - that the FBA not be based solely on an individual's documented history of challenging behaviors; and
    - that it provides a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.

SELECT "MET" If both are present:
- ✓ FBA generally includes required content, addressing known behaviors to be address. If information is lacking, it does not negatively impact meeting the person's support needs and the development of an appropriate Behavior Support Plan.
- ✓ The FBA is completed before the development of the BSP

SELECT "NOT MET" If any of the following are present:

- ✓ An FBA is not completed
- ✓ The FBA is not completed before the BSP was developed
- ✓ The FBA is lacking content specific to individualized analysis of the person's behavior and the circumstances influencing his/her specific behaviors to be addressed.

Standard No.	Standard Text	Decision
2l-2	The individual has a behavior support plan (BSP) which meets content requirements.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed: Licensed Psychologist or Licensed Clinical Social Worker (LCSW), Behavior Intervention Specialist (BIS) who wrote the Functional Behavioral Assessment (FBA). Documentation Review: Mandatory: FBA, Behavioral Support Plan (BSP), Person Centered Plan (ISP or other name)

GUIDELINES:

- Development of the BSP must:
  - be done in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan;
  - be developed from information in the functional behavioral assessment (FBA) of the target behavior(s);

- The BSP should include:
  - a concrete, specific description of the challenging behavior(s) targeted for intervention; Since the BSP containing restrictive/intrusive interventions is being used in non-certified settings, the behavior it addresses should be described as it would occur in those settings.
  - a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports;
  - a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success;
  - the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others;
  - a method for collection of positive and negative behavioral data with which treatment progress may be evaluated; and
  - a schedule to review the effectiveness of the interventions included in the behavior support plan, for the purposes of IB Services, the schedule of reviews no less frequently than every 60 days, to include examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors;

Note: Development of BSPs must be by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques. For the purposes of delivering IB Services, a staff member who is a BIS must always operate under the clinical supervision of a Licensed Psychologist or an LCSW. Assurance that agencies have appropriately qualified personnel is included in the Agency Review. If this is problematic report to agency via use of the Agency Review Protocol.

SELECT "MET" IF:

- ✓ The written Behavior Support Plan includes required components written with sufficient clarity to ensure proper implementation.

SELECT "NOT MET" If either is evident:

- ✓ The written Behavior Support Plan lacks required components; and/or
- ✓ The BSP, though inclusive of required components, lacks sufficient clarity to ensure proper implementation.

Standard No.	Standard Text	Decision
2l-3	There is a written, signed agreement between service provider and the person regarding nature, duration and scope of IB services to be provided.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory: Individual or Parent/Caregiver or family care provider, Agency staff responsible for the authorization or supervision of IB services

DOCUMENTATION REVIEW:

Mandatory: Written and signed agreement described.

Examine the written, signed agreement to verify that it describes the nature, duration and scope of IB service provision. Interview the signers of it to verify their understanding of the agreement.

SELECT "MET" If all are present:

- ✓ Nature, duration and scope are included in the written agreement.
- ✓ The agreement is signed by the provider and the individual (or caregiver)
- ✓ Interview verifies agreement with the IB services.

SELECT "NOT MET" If any of the following are not present:

- ✓ There is no IB services written agreement between the required parties.
- ✓ The written agreement exists but it doesn't include descriptions of the nature or duration or scope of IB service provision to the person.
- ✓ The written agreement is not signed by the required parties.

Standard No.	Standard Text	Decision
2l-4	Written informed consent is obtained prior to implementation of the BSP.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• BIS or licensed qualified professional who wrote the BSP
• Person supported and/or family/advocate who provided WIC

DOCUMENTATION REVIEW:
Mandatory:
• Any BSP for BI services. (WIC is required for all BSP for BI services; not just for those BSP's which contain restrictive or intrusive interventions.)
• WIC documentation

There should be documentation that written informed consent was obtained prior to implementing a BSP for BI services. Written informed consent must be documented with the consenting party's signature and their relationship to the person and a date. For BI services, the requirement for written informed consent is not limited to plans containing restrictive/intrusive interventions. The consent-giver has the right to revoke approval of the BSP at any time, and request that a revised BSP be developed in accordance with the requirements of this ADM # 2013-03. Guidance regarding parties who may provide informed consent is found in regulatory references below, but when appropriate should first be sought from the individual.
• 633.16(g)(6) - Hierarchy of parties appropriate to provide consent
• 633.16(g)(7) – Determination of an individual's capacity to give informed consent
• 633.16(g)(8) – Informed Consent Committee

SELECT "MET" IF:
- ✓ WIC was obtained from the appropriate person prior to the implementation of the BSP for BI services.

SELECT "NOT MET" IF:
- ✓ WIC was not obtained from the appropriate person prior to the implementation of the BSP for BI services.

Standard No.	Standard Text	Decision
2l-5	Upon conclusion of IB services, an evaluation of the service outcomes in increasing skill development and decreasing challenging behaviors must be completed.	**Met/Not Met/NA**

Guidance

INTERVIEW:
As Needed:
Individual or Parent/Caregiver or family care provider
Agency staff responsible for the CAANS-DD tool, post-treatment assessment

DOCUMENTATION REVIEW:
Mandatory:
• Individual & Family Satisfaction Survey
• CAANS-DD tool, post-treatment assessment
• Evaluation of service outcomes by agency documentation

GUIDANCE:
- In order to improve the quality of the IB Services program, feedback on the outcomes for the individual is needed. Family Care provider or Parent/Caregiver input via the Family Satisfaction Survey, although optional, should be effectively sought by the agency providing the BI services. Their feedback is integral to the agency's effectiveness in service provision.
- It is mandatory that the agency perform the CAANS-DD tool and perform an evaluation of the service outcomes realized by the individual, so that it can improve on service provision whenever and wherever needed.

SELECT "MET" If all are present:
- ✓ Agency performed and documented the CAANS-DD tool, post-treatment assessment.
- ✓ Agency conducted and documented an evaluation of service outcomes.
- ✓ The agency requested an Individual & Family Satisfaction survey for BI services from the individual/family, and if obtained retains the information (for use in quality improvement activities).

SELECT "NOT MET" If:
- ✓ Any of the requirements for 'Met' above are not present.

SELECT "NA" If:
- ✓ Intensive Behavior Services are still being delivered, i.e. have not concluded.

SECTION 2la: HCBS WAIVER INTENSIVE BEHAVIOR SERVICES (IB)

Qualifier Question: The individual's BSP includes restrictive/intrusive intervention(s) and/or rights limitation(s).	**Yes**	**No**

Standard No.	Standard Text	Decision
2la-1	The BSP describes the individual's behavior justifying the interventions and/or limitation(s).	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
Licensed Psychologist or Licensed Clinical Social Worker (LCSW), or Behavior Intervention Specialist (BIS) who wrote the BSP containing restrictive/intrusive intervention(s) and/or rights

DOCUMENTATION REVIEW:
Mandatory:
BSP containing restrictive/intrusive intervention(s) and/or rights limitation(s).
As Needed:
Person-centered plan (ISP or other name)

Verify that the person's behavior is described so that the necessity for the restriction/intrusion/limitation for that behavior is clear. The FBA information should inform this description in the BSP. Since the BSP containing restrictive/intrusive interventions is being used in non-certified settings, the behavior it addresses should be described as it would occur in those settings. I.e., If a behavior presents with certain antecedents in the person's home and different antecedents in the community, the description of its presentation in the different settings should be clear in the FBA and BSP.

SELECT "MET" IF:
- ✓ The restrictions on rights or restrictive/intrusive intervention described in the BSP are clearly justified by the challenging behavior(s) described in the plan

SELECT "NOT MET" If either are present:
- ✓ Description of the challenging behavior, in the BSP, is not sufficient to justify the use of rights restrictions in the BSP.
- ✓ The challenging behavior and resultant rights restriction, as written in the BSP, is not based in the information from the FBA.

Standard No.	Standard Text	Decision
2la-2	Previous strategies that have been tried and deemed ineffective are described with explanation regarding why use of less restrictive alternative would be insufficient/inappropriate.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Qualified professional who wrote the FBA
• Qualified professional who wrote the BSP

DOCUMENTATION REVIEW:
Mandatory:
BSP containing restrictive/intrusive interventions and/or limitation
As Needed: FBA

This applies to BSPs with restrictive, intrusive or right limiting interventions. This should include a description of all positive, less intrusive and/or other restrictive or intrusive approaches that have been tried but have not been successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights. An explanation of why the less intrusive alternatives are insufficient to maintain or ensure the health or safety or personal rights of the Individual (or others) should be included.

SELECT "MET" IF both of the following are evident:
- ✓ The BSP includes a description of positive, less intrusive interventions which have been tried but were unsuccessful prior to the inclusion of the restrictions in the BSP.
- ✓ There is an explanation as to why the less intrusive interventions are/were inadequate to maintain or ensure the health, safety or personal rights of the person or others.

SELECT "NOT MET" IF:
- ✓ Explanation regarding the inadequacy or ineffectiveness of less intrusive/restrictive strategies is lacking.

Standard No.	Standard Text	Decision
2la-3	The plan describes specific use of interventions as a hierarchy starting with most positive/least intrusive to most restrictive.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed: Qualified professional who wrote the FBA, Qualified professional who wrote the BSP

DOCUMENTATION REVIEW:
Mandatory:
• FBA
• BSP

Preferred methods, to be used first, are positive approaches, strategies and supports designed to teach and reward replacement behaviors. An established hierarchy may be appropriate for positive/teaching strategies, preventive and diffusive strategies, as well as reactive interventions. The plan should clearly describe:
• teaching and reward strategies to routinely implement, as proactive prevention of challenging behaviors;
• what strategies to implement, initially when a target behavior presents, and;
• conditions which signal the need to advance to other strategies.
In all cases, a hierarchy of approaches, strategies and supports should begin with the least restrictive, limiting or intrusive and progress to more restrictive, limiting or intrusive approaches, strategies and supports only when lesser interventions prove ineffective. OPWDD stresses that the least restrictive intervention or least intrusive methods be used at all times. Interventions or intrusive methods must be used only when the lesser interventions or methods prove ineffective and the BSP allows for more restrictive or intrusive methods be used. The setting in which the plan is being used may influence the hierarchy and this should be described. E.g.. A person who is known to run away from support staff or care provider when he is anxious may be in greater danger to himself and others in a shopping mall than when he is at home. The hierarchy should be designed to be used in the settings and environments that the person is supported. When BSPs are being utilized in more than one service setting, the IB Services provider must consult and coordinate with these other service settings in order to develop an appropriately integrated plan and prevent conflicting or inappropriate strategies.

SELECT "MET" IF:
- ✓ The BSP contains a hierarchy of proactive approaches, initial interventions and clear behavioral indicators to move to more (allowed by plan) restrictive interventions for specific challenging behaviors specific to the support settings in which the plan is to be used.

SELECT "NOT MET" If any of the following are evident:
- ✓ No hierarchy of strategies, supports, approaches from least to most restrictive are included in the plan.
- ✓ Interventions are listed but not in order of the least to the most restrictive.
- ✓ A hierarchy of strategies are listed, but there are no clear descriptions of behavioral indicators to guide staff as to if and when to advance to more restrictive interventions.
- ✓ The BSP is expected to be used in more than one service setting requiring hierarchal strategies unique to each or some, but the strategies and/or hierarchies to be used are not customized accordingly.

Standard No.	Standard Text	Decision
2la-4	Interventions used/in the plan are only those permissible in IB services.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Individual
• Parent/Caregiver
• Community Hab staff
• Family Care provider
• Qualified professional who wrote the BSP and/or FBA

DOCUMENTATION REVIEW:
Mandatory:
• FBA
• BSP
• Documentation of collected behavior data
• RIA
As Needed:
• IRMA

ADM # 2013-03 specifies that there is no allowable inclusion of or use of 'time-out' (the placement of a person alone in a room from which his or her normal ability to leave is prevented by a staff's or care provider's direct and continuous physical action, or placement of a person in a secured room or area from which he or she cannot leave at will) in a BSP for IB Services. Planned use of restrictive physical techniques can only be included in the BSP for implementation by trained hourly Community Hab staff if specific authorization by OPWDD has been obtained. Emergency use of restrictive physical interventions by trained Community Hab staff or Family Care Providers, to prevent serious harm, is allowed with the same reporting requirements of Part 624 as emergent use of these when under the auspice of OPWDD. Parents/Caregivers may only be taught those specific protective interventions identified in the BSP created for the person for whom they provide care, as they cannot be certified at any level of the OPWDD training curriculum. Parents/Caregivers and Family Care providers must not be trained in restrictive physical interventions or use of exclusionary time-out as IB Services.

SELECT "MET" IF all of the following are evident:
- ✓ BSP contains only allowed interventions.
- ✓ There is no use of time-out allowed in the BSP.
- ✓ If a restrictive physical intervention is included in the plan, it is only directed for use by trained Community Hab staff with specific OPWDD authorization.
- ✓ If emergency techniques are used, it was in order to prevent or minimize injury, using the least restrictive technique, only for the duration of the incident, and implemented by trained Community Hab staff or Family Care providers

SELECT "NOT MET" IF either of the following are evident:

- ✓ BSP contains 'time-out'.
- ✓ BSP contains restrictive physical interventions for use by provider staff (other than trained Community Hab staff and Family Care Providers).

Standard No.	Standard Text	Decision
2la-5	There is a plan to fade/minimize/eliminate use of restrictive/limiting interventions.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

• Support staff, Individual, Family Care Provider, Family/Care giver

• Qualified professional who wrote and/or monitors the BSP

DOCUMENTATION REVIEW:

Mandatory:

BSP with restrictive/intrusive interventions and/or limitation

This applies to BSPs with restrictive, intrusive or right limiting interventions. The BSP must include a plan to fade, minimize eliminate or transition restrictions and limitations is required for every type of restriction or limitation included in the plan to modify or control behavior. This aspect of the BSP should identify reasonable criteria and circumstances and approaches to reducing, transitioning or eliminating each restriction/limitation. These criteria must be based on documentation expected per the plan. Fading should also take into account prudent monitoring and safeguarding in this process.

SELECT "MET" IF:

- ✓ The BSP includes realistic, achievable fading plan criteria for staff, and if appropriate, the person, to know in order to potentially liberalize the restrictive interventions, as the plan's implementation supports the person's success toward positive coping in his/her life.

SELECT "NOT MET" If any of the following are evident:

- ✓ No plan to fade the restrictions are included in the BSP.
- ✓ A fading plan exists in the BSP but its criteria are unrealistic and minimize the likelihood that the person can achieve incremental fading of the restrictions in the plan.
- ✓ A fading plan for every restrictive intervention is not present. (i.e. there is a fading plan for some, but not for all, restrictive interventions.)

Standard No.	Standard Text	Decision
2la-6	The individual's BSP describes documentation necessary for implementation of each intervention and mandated reporting if applicable.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Support staff, Individual, Family Care Provider, Family/Care giver
• Qualified professional who wrote and/or monitors the BSP

DOCUMENTATION REVIEW:
Mandatory:
• BSP containing restrictive/intrusive interventions and/or limitation
• Documentation records of interventions/limitations employed

This applies to BSPs with restrictive, intrusive or right limiting interventions. The BSP should clearly describe what needs to be documented for each intervention and limitation, the format for this documentation and the frequency of the documentation.

SELECT "MET" IF:
- ✓ The BSP clearly describes how, what and how often staff should be documenting their implementation of restrictions and limitations imposed on the person based on the criteria of the BSP.

SELECT "NOT MET" IF:
- ✓ The BSP does not clearly describe how, what and how often staff should be documenting their implementation of restrictions and limitations imposed on the person based on the criteria of the BSP.

Standard No.	Standard Text	Decision
2la-7	The BSP provides the schedule to review and analyze the use of restrictive/intrusive/limiting interventions, no less than every 60 days.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Support staff, Individual, Family Care Provider, Family/Care giver
• Qualified professional who wrote and/or monitors the BSP

DOCUMENTATION REVIEW:
Mandatory:
• BSP containing restrictive/intrusive interventions and/or limitation
• Documentation of the periodic review and its conclusion

This review and analysis of implementation of behavior related restrictive/intrusive interventions and/or limitation must occur at least every sixty days for IB Services BSP's. It can be done more frequently, if required by the Behavioral Support Plan. The results of this review must be documented. The information should be sufficient to determine if and when the Behavioral Support Plan should be revised. Assess this standard both for inclusion of review schedule in the BSP as well as completion of the review.

SELECT "MET" If all are evident:
- ✓ The BSP includes a schedule to review the effectiveness of interventions (both positive and reactive) on, at least, an every sixty days basis.
- ✓ The effectiveness review schedule is included in the BSP and it includes the expectation to review for frequency, duration or intensity of challenging behaviors.

SELECT "NOT MET" If any are evident:
- ✓ The BSP doesn't contain such a schedule to review effectiveness of interventions of the BSP.
- ✓ An effectiveness review schedule is included in the BSP, but it is either not set at a specific interval of time or it is less often than every sixty days.
- ✓ The effectiveness review schedule is included in the BSP but it doesn't include expectation to review for frequency, duration or intensity of challenging behaviors.

Standard No.	Standard Text	Decision
2la-8	The review results are documented.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- Support staff, Individual, Family Care Provider, Family/Care giver
- Qualified professional who wrote and/or monitors the BSP

DOCUMENTATION REVIEW:

Mandatory:

- BSP containing restrictive/intrusive interventions and/or limitation
- Documentation records of interventions/limitations employed
- Documentation records of the results of the periodic reviews performed.

SELECT "MET" IF both of the following are evident:

- ✓ Results of the, at least, every 60 day reviews of the implementation of the restrictive/intrusive interventions is documented with any conclusions to the effectiveness of the interventions and progress of the person included.
- ✓ Any revisions to the plan as a result of the review are documented in the review notes and the plan is revised accordingly.

SELECT "NOT MET" IF either of the following are evident:

- ✓ There is no documentation of the periodic reviews and their outcome.
- ✓ Plan revisions are not documented and/or are not incorporated into the plan.

Standard No.	Standard Text	Decision
2la-9	There is documentation that the individual is visually examined for injury and assessed for pain/discomfort following physical interventions.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Support staff, Individual, Family Care Provider, Family/Care giver
• Any involved health care staff, e.g.. agency RN

DOCUMENTATION REVIEW:
Mandatory:
• BSP containing physical intervention techniques
• Program notes, communication log, etc.
• RIA review for person before visit, to include body check for possible injury
As Needed:
• IRMA review for person before visit
• Medical or clinical notes regarding person's health status

Verify that the person was assessed for injury as required and that the following occurred:
• Body check inspections and the findings of the inspection is documented in RIA;
• If an injury is suspected, that appropriate medical care is provided;

NOTE: Any injury which meets the definition of a reportable or significant incident or minor notable occurrence should be reported in accordance with Part 624. If injuries are noted verify that they were reported as part of your incident review.

SELECT "MET" If first bullet is present and if indicated, second bullet is present:
- ✓ Body check inspection for injuries was performed after any type of physical intervention technique was applied by qualified community hab staff (or emergently by Family Care provider or Community Hab staff)
- ✓ If medical care was indicated as a result of the body inspection, this was given to person.

SELECT "NOT MET" IF:
- ✓ Evidence reveals that a body check inspection for injuries was not performed after any physical intervention technique applied by staff.
- ✓ Evidence reveals that medical care indicated for an injury experienced during a physical intervention was not provided.

NOTE: this may require DQI staff to also identify concerns under Health Services and Incident Management.

SECTION 2m: HCBS ADAPTIVE TECHNOLOGIES

Qualifier Question: The individual receives/received HCBS Waiver Adaptive Technology.	**Yes**	**No**

Standard No.	Standard Text	Decision
2m-1	The person's need for the adaptive device is documented in his/her ISP.	**Met/Not Met**

Guidance

INTERVIEW:
Service Coordinator, if needed

DOCUMENTATION REVIEW:
ISP

Note: Within the category of adaptive technology, the unit of service consists of one approved communication or adaptive piece of equipment as specified in the person's individualized service plan. A person may, based on need, receive more than one unit of service.

SELECT "MET" IF:
- ✓ The AT is identified in the individual's ISP.

SELECT "NOT MET" IF:
- ✓ The AT is not identified in the individual's ISP.

Standard No.	Standard Text	Decision
2m-2	The specific device is identified in the ISP.	**Met/Not Met**

Guidance

INTERVIEW:
Service Coordinator, if needed

DOCUMENTATION REVIEW:
ISP

Allowable adaptive technologies include, but are not limited to (i) Communication aids and devices, including: (a) personal emergency response systems which are electronic devices that enable high-risk individuals to secure help in the event of an emergency. They also include portable “help” buttons to allow for mobility; (b) direct selection, alpha-numeric, scanning, and encoding communicators; (c) speech amplifiers; (d) electronic speech aids/devices; and (e) voice, light or motion activated electronic devices; (ii) Adaptive aids and devices, including: (a) standing boards/frames; (b) adaptive switches/devices; (c) meal preparation aids/devices/appliances; (d) specially adapted locks; (e) motorized wheelchairs; and (f) guide dogs and similar trained animals; and other adaptive aids and devices needed in accordance with the ISP that would not otherwise be covered by the State Medicaid Plan.

Within the category of adaptive technology, the unit of service consists of one approved communication or adaptive piece of equipment as specified in the person's individualized service plan. A person may, based on need, receive more than one unit of service.

SELECT "MET" IF:
- ✓ The specific device is identified in the individual’s ISP.

SELECT "NOT MET" IF:
- ✓ The specific device is not identified in the individual’s ISP.

Standard No.	Standard Text	Decision
2m-3	The adaptive device increases/maintains the individual's safety, independence and/or community integration.	**Met/Not Met**

Guidance

INTERVIEW:
Service Coordinator, if needed; staff and supports, as appropriate; Individual and/or advocate

DOCUMENTATION REVIEW:
ISP; Other records documenting response to services

OBSERVATION:
Observe the AT if at a certified residence

Discuss the AT with the individual and/or observe use of the device, if possible. Is the device appropriate to increase or maintain the individual's safety, independence, or community integration? Does the individual feel it is appropriate for any of those purposes? Follow up with residential staff or the service coordinator if it is not evident that the device is useful for meeting intended purposes.

SELECT "MET" IF:
- ✓ The device increases/maintains the individual's ability to function in a home and community-based setting with independence and safety, or presents potential to do so.

SELECT "NOT MET" IF:
- ✓ There is no evidence that the device increases/maintains the individual's ability to function in a home and community-based setting with independence and safety, and presents no potential to do so.

Standard No.	Standard Text	Decision
2m-4	The individual receives on-going support needed to use the device, as identified in his/her ISP.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Service Coordinator, if needed; staff and supports, if needed; Individual and/or advocate

DOCUMENTATION REVIEW:
ISP; Other records documenting response to services
Clinical services, such as physical, occupational, or speech therapy services – or other on-going services - may be necessary to support an individual's use of an AT device.

SELECT "MET" IF:
- ✓ An individual needs and receives on-going supports to use an AT device as intended.

SELECT "NOT MET" IF:
- ✓ An individual has difficulty using an AT, but is not provided with initial or ongoing supports to use the device.

SELECT "NA" IF:
- ✓ No ongoing support is needed.

Standard No.	Standard Text	Decision
2m-5	The effectiveness of the device is periodically reviewed/assessed.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Service Coordinator, if needed; staff and supports if needed; Individual and/or advocate, if needed

DOCUMENTATION REVIEW:
ISP or reviews; Other records documenting response to services

Clinical services, such as physical, occupational, or speech therapy services – or other on-going services - may be necessary to help an individual make the best use of an AT device. Even if specialized services are not needed for that purpose, there should be some process to periodically review the benefits of continued use of an AT device. Review the ISP and other documentation, and interview appropriate parties as needed, to determine if the service coordinator and planning team monitor use of the adaptive device in the context that it was originally recommended to increase or maintain the individual's safety, independence and/or community integration.

SELECT "MET" IF:
- ✓ There is a process to periodically review the benefits of continued use of an AT device and take any action needed in accordance with that review. Observations, interviews, and/or records may reveal informal and effective processes for doing this.

SELECT "NOT MET" IF:
- ✓ There is no effective formal or informal process to periodically review the benefits of an AT device. This is especially problematic if the device cannot be found or fell out of use without explanation.

SELECT "NA" IF:
- ✓ There is evidence that the individual no longer needs the AT device.

SECTION 2n: HCBS WAIVER ENVIRONMENTAL MODIFICATIONS (EM)

Qualifier Question: The individual receives/received HCBS Waiver Environmental Modifications (Emod).	**Yes**	**No**

Standard No.	Standard Text	Decision
2n-1	The person's need for the E-mod is documented in his/her ISP.	**Met/Not Met**

Guidance

INTERVIEW:
Service Coordinator, if needed

DOCUMENTATION REVIEW :
ISP

SELECT "MET" IF:
- ✓ The E-Mod is identified in the individual's ISP.

SELECT "NOT MET" IF:
- ✓ The E-Mod is not identified in the individual's ISP.

Standard No.	Standard Text	Decision
2n-2	The E-Mod enables the person to live safely in the home and/or improve/maintain independence.	**Met/Not Met**

Guidance

INTERVIEW:
Service Coordinator, if needed; staff and supports if needed; Individual and/or advocate, if needed

DOCUMENTATION REVIEW:
ISP

OBSERVATION:
- Observe the modification if at a certified residence
- Allowable modifications include, but are not limited to:

1. Modifications to allow access to or in the home, including: (i) ramps; (ii) lifts of a hydraulic, manual or electrical nature for porch, stairs and/or bathroom; (iii) widen doorways/hallways; (iv) hand railings/grab bars; and (v) automatic or manual door openers/door bells which are required as part of a residential habilitation service plan.
2. Bathroom/kitchen modifications, additions or adjustments when necessary to allow accessibility or improved functioning including: (i) roll-in showers; (ii) sinks/tubs; (iii) water faucet controls; (iv) plumbing adaptations (cut-outs, toilet/sink adaptations); (v) turnaround space changes/adaptations; (vi) worktables/work surfaces adaptations; and (vii) cabinetry/shelving adaptations.
3. Other adaptations, including: (i) medically necessary heating/cooling adaptations as required as part of a residential habilitation services plan or medical treatment. (Any such adaptations, used to solely improve a persons living environment, are to be included as part of room and board costs); (ii) electrical wiring to accommodate other adaptations or equipment installation; (iii) specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the person's welfare; and (iv) other appropriate environmental modifications, adaptations, or repairs necessary to make the living arrangement accessible or accommodating of the person's fire safety evacuation needs.
4. Modifications that address an individual's sensory deficits such as Braille identification systems, tactile orientation systems, bed-shaker alarm devices, and strobe-light smoke detection and alarm systems.

SELECT "MET" IF:
- ✓ Modifications benefit the individual to live more safely and/or independently in their home as described in examples above.

SELECT "NOT MET" IF:
- ✓ Modifications clearly do not fit into the purpose and intent of e-modifications.

Standard No.	Standard Text	Decision
2n-3	As appropriate, the E-Mod involved the professional consultation necessary for the E-Mod construction or use.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Service Coordinator, if needed; staff or supports, if needed

DOCUMENTATION REVIEW:
ISP

OBSERVATION:
Observe the modification if at a certified residence

SELECT "MET" IF:
- ✓ Professional consultation was needed and obtained and the modification is safe, accessible, and useful to the individual receiving services.

SELECT "NOT MET" IF:
- ✓ Professional consultation was obtained and the modifications is not safe, accessible, or useful to the individual receiving services.

SELECT "NA" IF:
- ✓ When no professional staff consultation was needed.

Standard No.	Standard Text	Decision
2n-4	The E-Mod was provided with attention to requirements for building and fire safety codes as necessary.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Service Coordinator, if needed; staff or supports, if needed

DOCUMENTATION REVIEW: ISP

OBSERVATION:
Observe the modification if at a certified residence

SELECT "MET" IF:
- ✓ The contract identified a requirement to meet codes and regulations in accordance with 635-10.5(f)(2) and the modification met the requirement(s), or when the contract noted that no such requirement exists.

SELECT "NOT MET" IF:
- ✓ The contract identified a requirement to meet codes and regulations in accordance with 635-10.5(f)(2) and the modification did not meet those requirement(s).

Select "NA" IF:
- ✓ The modification was not a type to which building or fire code applies or is affected.

SECTION 2o: HCBS WAIVER FAMILY EDUCATION & TRAINING (FE)

Standard No.	Standard Text	Decision
2o-1	FET is identified in the individual's ISP under Waiver services, with effective date, frequency, duration, and valued outcomes.	**Met/Not Met**

Guidance

INTERVIEW:
Family Education and Training Service Provider; Service coordinator, when needed

DOCUMENTATION REVIEW:
ISP; Records where required information is documented

SELECT "MET" IF:
- ✓ FET is identified in the individual's ISP under Waiver services, with effective date, frequency, duration, and valued outcomes.

SELECT "NOT MET" IF:
- ✓ FET is not identified in the individual's ISP under Waiver services, with effective date, frequency, duration, and valued outcomes.

Standard No.	Standard Text	Decision
2o-2	Documentation evidences that training was provided to the individual's family regarding the nature and impact of the person's disability and/or the service options.	**Met/Not Met**

Guidance

INTERVIEW:
Family Education and Training Service Provider; Individual and family member, if needed; Service coordinator, if needed

DOCUMENTATION REVIEW:
Records where required information is documented

SELECT "MET" IF:
- ✓ FET services are related to the disabilities, the nature of disabilities, and options for supports, services, future planning.

SELECT "NOT MET" IF:
- ✓ FET services are related to the disabilities, the nature of disabilities, and options for supports, services, future planning.

Standard No.	Standard Text	Decision
2o-3	Training provided to the individual's family was at least two (2) hours duration and provided by someone other than the person's MSC.	**Met/Not Met**

Guidance

INTERVIEW:
Family Education and Training Service Provider; Service coordinator, if needed; Individual and family member, if needed

DOCUMENTATION REVIEW:
Records where required information is documented

SELECT "MET" IF:
- ✓ FET provided is of sufficient duration and provided by qualified staff.

SELECT "NOT MET" IF:
- ✓ FET provided is not provided appropriately per the standard.

SECTION 2p: DAY TRAINING		
Standard No.	**Standard Text**	**Decision**
2p-1	When the individual's services include vocational services, services must be in compliance with federal and state laws regarding labor wages and safety.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Day Training manager or designee

DOCUMENTATION REVIEW:
Required certificate; Record of payment, where applicable

SELECT "MET" IF:
- ✓ The person's services support vocational training activities, he/she is compensated appropriately per the facility's labor certificate, and the work environment and equipment appears to be appropriate and safe.

SELECT "NOT MET" IF:
- ✓ The above statement cannot be affirmed.

SELECT "NA"IF:
- ✓ The individuals who do not receive vocational training or vocational services as part of their day training service plans.

NOTE : This standard is Not Applicable to HCBS waiver prevocational services – see section 2k of this survey instrument.

SECTION 2q: DAY TREATMENT		
Standard No.	**Standard Text**	**Decision**
2q-1	The individual is receiving active treatment.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Staff providing direct support services; Individual's treatment coordinator; Individual receiving services

DOCUMENTATION REVIEW:
Comprehensive Functional Assessment (CFA); Individual Program Plan (IPP); Program implementation data

OBSERVATION:
Observe for implementation of active treatment
Review the CFA, IPP, and data to determine if the individual receives an integrated, individually tailored plan of activities, interventions, and therapies directed toward achieving individual specific outcomes.
Review the following considerations:
• Does the individual require active treatment?
• The program plan is directed toward acquisition of the behaviors and skills necessary for a person to function with as much self-determination and independence as possible and prevention or deceleration of regression or loss of current optimal functional status
• The plan is implemented as intended
• The individual is benefitting from the services (If not, the plan is modified in a timely manner.)
• The plan is updated in accordance with the individual's needs. (Was the plan modified in response to an ongoing change in the individual's condition or adaptive behavior?)

SELECT "MET" IF:
- ✓ The individual receives an integrated, individually tailored plan of activities, interventions, and therapies directed toward achieving individual specific outcomes and the plan is updated in accordance with the individual's needs.

SELECT "NOT MET" IF:
- ✓ The individual dos not receive an integrated, individually tailored plan of activities, interventions, and therapies directed toward achieving individual specific outcomes or the plan is not updated in accordance with the individual's needs.

SELECT "NA" IF:
- ✓ The individuals admitted to the facility for less than thirty days at the time of the survey.

Standard No.	Standard Text	Decision
2q-2	Coordination with the individual's residential provider is evident.	**Met/Not Met/NA**

Guidance

INTERVIEW : Individual's treatment coordinator, if needed; Staff responsible for coordinating services at the residence (e.g., QIDP), if needed

DOCUMENTATION REVIEW : IPP review records

SELECT "MET" IF:

- ✓ There is evidence the residential coordinator is invited to or participates in IPP reviews and interviews confirm sufficient communication by the day treatment provider.

SELECT "NOT MET" IF :

- ✓ There is no evidence the residential coordinator is invited to or participates in IPP reviews and interviews confirm a lack of appropriate communication by the day treatment provider.

Standard No.	Standard Text	Decision
2q-3	When the individual's services include therapeutic prevocational services, he/she must be compensated in compliance with New York wage and hour laws.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Individual's treatment coordinator, if needed; Day Treatment program management staff, if needed

DOCUMENTATION REVIEW:
IPP review records; Record of payment, where applicable

OBSERVATION:
Observe therapeutic prevocational services, if needed

SELECT "MET" IF:

- ✓ The individual receives therapeutic prevocational services meaning the activities address needs and do not simply have a vocational purpose; and the individual is compensated as required if the therapeutic activity results in a saleable product or economic benefit.

SELECT "NOT MET" IF:

- ✓ The individual participates in (pre)vocational activities with no identified therapeutic purpose; and/or
- ✓ The individual should be compensated for work activities in the day treatment site, but is not compensated.

SELECT "NA" IF:

- ✓ The individual does not participate in prevocational services in the Day Treatment.

SECTION 2r: PRIVATE SCHOOL		
Standard No.	**Standard Text**	**Decision**
2r-1	If the individual is engaged in pre-vocational training, it is in accordance with applicable federal and state labor and wage laws, including periodic review of pre-vocational task to deem if they require compensation.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Staff with oversight of prevocational services performed at the facility; Individual receiving services.

DOCUMENTATION REVIEW:
Service planning and review records; Record of payment, where applicable.

OBSERVATION:
Observe work environment.

SELECT "MET" IF:
When the individual performs prevocational tasks and the activity(ies):

- ✓ Are part of his/her plan of services;
- ✓ Are appropriately reviewed for appropriateness;
- ✓ Are provided in a manner that provides for the individual's safety and welfare;
- ✓ Compensation or lack of compensation is appropriate reviewed/addressed

SELECT "NOT MET" IF:

- ✓ The individual performs prevocational tasks as part of his or her plan of services at the private residential school and requirements as indicated above are not met.

SELECT "NA" IF:

- ✓ The individual does not perform prevocational tasks as part of his or her plan of services at the private residential school and/or the private school is an Integrated Residential Community.

Standard No.	Standard Text	Decision
2r-2	When the individual's services include vocational services, compliance with federal and state laws regarding labor wages and safety is evidenced.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Staff with oversight of vocational services performed at the facility; Individual receiving services

DOCUMENTATION REVIEW:
Employment Records; Record of payment, where applicable

OBSERVATION:
Observe work environment

SELECT "MET" IF all of the following are evident
The individual does perform vocational tasks as part of his or her plan of services at the private residential school and:
- ✓ Work conditions are safe and adequate;
- ✓ The individual's work activities (dates, times, description, oversight, etc.) and payments are adequately recorded per 25.6(a)-(e).

SELECT "NOT MET" IF any of the following are evident:
The individual does perform vocational tasks as part of Private School Services and:
- ✓ They are not part of his or her plan of services;
- ✓ Work environment is not safe and appropriate;
- ✓ There is not adequate documentation of work l's work activities and payment.

SELECT "NA" IF:
- ✓ The individual does not perform prevocational tasks as part of his or her plan of services at the private residential school and/or the private school is an Integrated Residential Community.

SECTION 2s: SPECIALTY HOSPITAL

Standard No.	Standard Text	Decision
2s-1	The service plan identifies whether the Individual has a health care problem that requires more than 3 hours of daily individualized care by health care staff.	**Met/Not Met**

Guidance

INTERVIEW:
Treatment coordinator or program administration/management staff; Direct support staff

DOCUMENTATION REVIEW:
Comprehensive Assessments; Individual Program Plans (IPPs)

OBSERVATION:
If needed
Subdivisions 680.5(c) and (d) require that, at the time of admission, there is a comprehensive assessment which shows that the individual receiving services requires more than 3 hours of daily individualized attention from health care staff. The assessment must have been completed within 90 days before the admission, or within 15 days following admission in the case of an emergency placement.
The glossary in 690.13 defines "health care staff" as staff including, but not limited to, physicians, dentists, registered nurses, licensed practical nurses, or direct care staff performing services under the supervision of any of these parties. Respiratory therapists are also considered health care staff.

Paragraph 680.6(h)(4) requires an updated assessment within six months following admission if the hospital stay is expected to last beyond six months' time. Section 680.6 addresses the content and review of the IPP. Each individual residing at the specialty hospital must have an IPP that is collectively evaluated by the interdisciplinary on a quarterly basis, and the IPP must state the conditions requiring admission to the specialty hospital.

SELECT "MET" IF:
- ✓ An individual admitted during the previous six months; has a comprehensive assessment indicating the individual requires more than three (3) hours of support from health care staff; or
- ✓ Any longer term residents when assessments, reassessments, and/or IPP reviews, together with a review of activity schedules, staff interviews, and surveyor observations, present evidence that an individual continues to require three or more hours of daily individualized care by health care staff. In these cases, the IPP must state the conditions requiring the individual's admission and continued stay at the specialty hospital, and the course of treatment implemented to address those conditions and related needs.

SELECT "NOT MET" IF:
- ✓ There is no documentation to show that an individual residing at the facility requires three or more hours of daily individualized care by health care staff.

SECTION 3: Rights & Supports of Rights		
Standard No.	**Standard Text**	**Decision**
3-1	The individual is informed of their rights according to Part 633.4	**Met/Not Met**

Guidance

DISCUSSION:

As Needed:

• Individual and/or family/advocate if written evidence is unavailable or unclear

• Direct supports and/or service/care coordinator/manager

DOCUMENTATION REVIEW:

Mandatory:

• If available, documentation of 633.4 rights being given to the person and/or family or advocate (e.g. copy of signed rights or service notes indication they were provided and explained)

GUIDANCE:

- There must be documentation of the agency having given the person supported and/or his family/advocate as needed, a notification of his rights as delineated by 633.4. It is not necessary that the person or family/advocate sign receipt of having received this information but DISCUSSION: should support that this was received by them. While it is the responsibility of all service providers to ensure that the individual is aware of their rights, allow for some flexibility when the individual receives more than one service from an agency one which includes Medicaid Service Coordination (MSC). It is acceptable if the MSC takes on this responsibility. For other service providers, this responsibility will fall to others in the agency.
  (See standard below to evaluate if the information on rights was provided in a manner understandable and accessible to the person.)

SELECT "MET" If any of the first three bullets and the fourth bullet is present:

- ✓ There is written, dated acknowledgement by the individual (and/or their representative) of the receipt of the notice of rights per 633.4 in the service record; or
- ✓ There is documentation in the service record indicating that the individual (and/or their representative) was informed of their rights guaranteed by Part 633.4; or
- ✓ Based on discussion with the individual and others it is apparent that they were informed of their rights and responsibilities per 633.4

NOTE: For the above three criteria: In the case of a person receiving Service or Care coordination and other OPWDD services, evidence of that the person's coordinator provided the information is sufficient so long as it is evident that they explained it's applicability to all OPWDD services.

- ✓ The notice of 633.4 rights notice provided to the individual is an accurate representation of the rights and responsibilities afforded to individuals receiving OPWDD services and supports.

SELECT "NOT MET" If any of the following is present:

- ✓ No written evidence exists of the person and/or family/advocate has been informed of their rights per 633.4.

- ✓ Individual and/or family/advocate denies ever having been informed of above rights and there is no written evidence which supports that they were informed.
- ✓ Information provided on rights and responsibilities is inaccurate and/or not current.

Standard No.	Standard Text	Decision
3-2	The individual is informed of rights as a FIDA-IDD member and availability of the FIDA-IDD Ombudsman.	**Met/Not Met**

Guidance

DISCUSSION:

As Needed:

• Individual and/or family/advocate if written evidence is unavailable or unclear

• Direct supports and/or service/care coordinator/manager

DOCUMENTATION REVIEW:

Mandatory: If available:

• Copy of FIDA member rights information given to the person (family/advocate); and

• Documentation that the information was provided to the individual

GUIDANCE:

- Participants must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, functional status, and language needs.

SELECT "MET" If any of the first three bullets and the fourth bullet is evident:

- ✓ There is written, dated acknowledgement by the individual (and/or their representative) of the receipt of the notice of rights as a FIDA member in the service record; or
- ✓ There is documentation in the service record indicating that the individual (and/or their representative) was informed of their rights as a FIDA member; or
- ✓ Based on discussion with the individual and others it is apparent that they were informed of their rights as a FIDA member.

  AND
- ✓ The notice of FIDA member rights notice provided to the individual is an accurate representation of the rights afforded to individuals who are FIDA members.

SELECT "NOT MET" If any of the following is evident:

- ✓ No written evidence exists that the person and/or family/advocate has been informed of their FIDA rights
- ✓ Individual and/or family/advocate denies ever having been informed of the rights and there is no written evidence which supports that they were informed.
- ✓ Information provided on their FIDA member rights is inaccurate and/or not current.

Standard No.	Standard Text	Decision
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	**Met/Not Met**

Guidance

DISCUSSION:

As Needed:

• Individual and/or family/advocate if written evidence is unavailable or unclear
• Direct supports and/or service/care coordinator/manager

DOCUMENTATION REVIEW:

Mandatory: If available:

• Copy of right-to-object information given to the person (family/advocate); and
• Documentation that the information was provided to the individual

GUIDANCE:

- For individuals receiving OPWDD facilities and services there must be evidence that the individual has been advised/notified of his/her right to object to services, object to changes in services, and the procedures for making the objections.
- It is not necessary that the person or family/advocate sign receipt of having received this information but interview and/or other documentation in the service record should support that this was provided to them by the provider agency and/or at least by the MSC for an agency providing multiple services. In situations when a person has an MSC the MSC record should include this information on when and how it was provided.
- The individual, and advocate if appropriate, initially and when any changes occur, must be told that he/she can express complaints, concerns or objections, including requesting a change of service providers, and the process to do so.
- Services refers to the entire service plan (e.g. the ISP, the IPP, and the Treatment Plan) or any part of it (e.g. the Behavior Site Plan, a safeguarding strategy or restriction, medication provided).
- This right includes being informed that they cannot be discharged from services without being provided with the opportunity to object to the discharge.

SELECT "MET" If either is evident:

- ✓ There is evidence in the service record that the agency and/or program coordinator or MSC or MSC vendor informed the individual of his/her right-to-object guaranteed by Part 633.12 initially and whenever the individual needs or requests such information, OR

- ✓ Individual and/or family/advocate affirm that they have received information about the right-to-object to services provided to the individual and changes in services, what this means, and the process to do so. (If the person and/or family/advocate is unable to affirm due to communication, cognitive or other barriers, and the written evidence demonstrates that they had been informed, this may still be 'Met'. In this case, interview staff and/or program coordinator or MSC for more information.)

SELECT "NOT MET" If any of the following is evident:

- ✓ No written evidence readily exists of the person and/or family/advocate has been informed of their 633.12 right-to-object.
- ✓ Individual and/or family/advocate denies ever having been informed of their 633.12 right-to-object and there is no evidence which supports that they were informed.

Standard No.	Standard Text	Decision
3-4	The individual is informed of their HCBS rights.	**Met/Not Met**

Guidance

DISCUSSION:

As Needed:

• Individual and/or family/advocate if written evidence is unavailable or unclear

• Direct supports and/or service/care coordinator/manager

DOCUMENTATION REVIEW:

Mandatory: If available:

• Copy of rights related specifically to receipt of HCBS services and service environments given to the person (family/advocate);

Documentation that the information was provided to the individual

GUIDANCE:

- HCBS rights included in review of this standard are:
  - Each individual has privacy in his or her sleeping or living unit.
  - Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
  - The individual sharing a unit has a choice of roommates in that setting.
  - The individual has freedom to furnish and decorate his or her sleeping or living unit within the lease or other agreement.
  - Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
  - Each individual is able to have visitors of his or her choosing at any time.
- The right to have, and be protected by, a lease or other written occupancy agreement that provides eviction protections and due process/appeals and specifies the circumstances when he/she could be required to relocate.
- The right to due process/appeals to include:

- under what conditions he/she could be required to relocate; and
- how to request a change in living arrangement, home or roommate
- The right to informed consent and a person-centered planning process if safety needs dictate any modification of these rights. Such modification meets the eight requirements as dictated in ADM 2014-04 regarding rights modifications to HCBS rights.

SELECT "MET" If either is evident:

- ✓ There is written documentation that the agency and/or program coordinator (or MSC) informed the individual of his/her rights as guaranteed by HCBS requirements as outlined by CMS 441.301, NYCRR Part 636 and directed in ADM 2014-04.
- ✓ Individual and/or family/advocate affirm that they have received and explanation of the rights related to receiving HCBS services in their current service settings. (If the person and/or family/advocate is unable to affirm due to communication, cognitive or other barriers, and the written evidence demonstrates that they had been informed, this may still be 'Met'. In this case, interview staff and/or program coordinator for more information.)

SELECT "NOT MET" If any of the following is evident:

- ✓ No written evidence readily exists of the person and/or family/advocate has been informed of their HCBS rights.
- ✓ Individual and/or family/advocate denies ever having been informed of their HCBS rights and there is no written evidence which supports that they were informed.

Standard No.	Standard Text	Decision
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory: Individual and/or family/advocate
As Needed: Staff and/or program coordinator

DOCUMENTATION REVIEW:
Mandatory: documentation of rights information provided to the individual and/or his family/advocate

GUIDANCE:

- Written Information provided to individuals regarding any/all of their rights must be conveyed in plain language and in a manner that is accessible to and understood by the person, and/or their family/advocate to facilitate comprehension. E.g. Interpreted into a language other than English, low literacy versions, avoiding complicated language, technical terms, acronyms, etc. Pictorial depictions may be helpful with individuals without reading skills.
- Verbal communication with individuals should also be provided using plain/simple language with attention to the needs of the person and ensuring their understanding
- Other communication methods necessary should be employed including sign language, braille, use of language interpreters for verbal explanations, etc.

SELECT "MET" If either are evident:

- ✓ There is a documentation that written notice of the person's rights was provided in an understandable manner;
  or
- ✓ It is verified through interview with the person and/or guardian, if applicable, that the rights information was provided to them in an understandable manner. They are comfortable in their understanding of the content.

SELECT "NOT MET" If any of the following is evident:

- ✓ There is no evidence of a written notice of the person's rights and the right to object to services in the person's file
- ✓ It cannot be verified that the written notice was provided to the person or legal guardian, if applicable
- ✓ The written notice of rights is conveyed in complicated, inaccessible, and/or difficult to understand language or manner.
- ✓ It is written in a language of which the recipient is not literate and does not understand.
- ✓ The written notice is written in complicated, inaccessible, and/or difficult to understand language by the person and/or family/advocate.

Standard No.	Standard Text	Decision
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory: Individual and/or family/advocate

DOCUMENTATION REVIEW:
As Needed: Routine documentation review may provide information that supports, or refutes, that individuals know/do not know how to make an anonymous complaint.

GUIDANCE:

- Discussion is the primary means of verifying if a person knows how to make an anonymous complaint. If the person, or their family/advocate if necessary, cannot say how they would lodge a concern without having to be identified as the one complaining, then the process may not exist for them in a practical way. But if the person or family/advocate has difficulty understanding what is meant by anonymous and they can describe how they have in the past, or would in the future, effectively voiced a complaint without having to identify themselves, then this standard may still be met. The surveyor may have to ask probing, open-ended questions to verify the ability a person/family/advocate has to effectively complain without being identified and without fear of retribution for complaining.

SELECT "MET" If either is evident:

- ✓ The person and/or their family/advocate can tell you who they would contact to make an anonymous complaint and/or how they would go about doing it.
- ✓ The person and/or their family/advocate cannot tell you this process but there is documentation in their record which shows evidence of them successfully making anonymous complaints. (e.g. person is unable but family member called the agency hotline, state hotline or JC regarding a complaint, which was resolved in a positive manner for the person.)

SELECT "NOT MET" If:

- ✓ Neither of the above conditions under 'Met' exist.

Standard No.	Standard Text	Decision
3-7	The individual is supported to express themselves through personal choices/decisions on style of dress and grooming preferences.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory: Individual regarding preferences and who makes style decisions, or family/advocate
As Needed: Staff and/or program coordinator and/or service/care coordinator/manager

DOCUMENTATION REVIEW:
As Needed: Person centered plan (ISP or other name)

OBSERVATION:
Mandatory: to verify that person appears to be expressing his/her personal style per this standard

GUIDANCE:

- The purpose of this standard is to ensure that persons have the right to self-expression of personal style via clothing choices (color, maker, style, etc.), hair style (length, color, facial hair, etc.) and grooming (timing of bathing, grooming products, etc.). Staff are responsible to support the person to make their own decisions regarding personal style and not impose their own style values on the person supported.
- If the person is supported at a private school, ensure that this standard is being met, in light of school dress code or other conforming rules, based on student life in school. There may be an allowable dress code for life in school but it should not require conformance and thwart personal expression of style when not in school. IMPORTANT NOTE - When evaluating this standard:
- For all services: When there is an appropriate, documented rights modification that restricts a person's access to this right, clinical justification and appropriate documentation of the conditions and protections related to the rights restriction compliant with 633.4 and/or 633.16 if part of a Behavior Support Plan satisfies the standard as being 'Met'.

SELECT "MET" If the first two bullets are present, or if the third bullet is evident:

- ✓ The person is wearing clothing that expresses their own personal fashion choices and style, and/or the person can point to particular aspects of clothing or personal grooming and explain why they like these, and/or the person reports that staff helped them to find specific items that matched their preferences when shopping or getting dressed.

AND:

- ✓ The person's grooming habits are healthy, are satisfactory to the person and are not impacting their social acceptance. The person or their family/advocate reports that personal grooming habits are chosen by the person as an individual.

OR:

- ✓ Rights modifications criteria or required elements of a BSP are met.
- ✓ If a private school's dress code is in effect at school, it doesn't extend to the person's life outside of class time.

SELECT "NOT MET" If any of the following are evident:

- ✓ The person is wearing clothes which don't fit him/her and this is not their choice.
- ✓ The person expresses that they would like a choice of what they wear or how they wear their hair (etc.) and they don't have this choice.
- ✓ The person's grooming needs are not addressed and it is negatively impacting his/her social acceptance.

Standard No.	Standard Text	Decision
3-8	The individual is supported to participate in cultural/religious/associational practices, education, celebrations and experiences per their interests and preferences.	**Met/Not Met**

Guidance

DISCUSSION:

• Mandatory: Individual and/or family/advocate, Direct supports
• As Needed: program coordinator and/or service/care coordinator/manager

DOCUMENTATION REVIEW:

Mandatory: Person centered plan (ISP or other name), Service notes, daily or prn notes as applicable, Activity logs or similar documentation as applicable

OBSERVATION:

As Needed: If opportunity arises and observation is needed to verify this standard

GUIDANCE:

- Discussion with the person supported (or family, advocate, if person unable) is mandatory to validate this standard which identifies the degree to which support staff foster the person to participate in communities of their choice. These communities are those which the person identifies with and feels included in. Faith based, ethnic, gender identity, educational, civic, and vocational are some examples of these types of groups which persons may want to participate in. It is the role and expectation of staff to assist the person to become aware of these community groups, discover their interest or not, and support inclusion in them if desired. Staff are required to leave aside any personal bias about these groups the person identifies with when supporting the person. Any concerns about health or safety of the person's participation is to be addressed via a strengths/risks assessment process and is not to be pre-judged by staff. Discussion must include what staff are doing to assist the person to learn about the existence of the diverse community groups with which he/she may identify. It is inadequate to accept that the person is not interested in community inclusion in any type of group if there is no evidence that the person is supported to discover or explore such options. E.g. An exploratory step is taken when a woman is supported to visit ethnic grocery stores which sell products from her country of origin and in which the sales staff speak her native language.

SELECT "MET" IF:

- ✓ There is evidence that the person is supported by staff to discover, explore and participate in any community based groups based on faith, culture, ethnicity, gender identity, etc. to the degree and amount the person prefers

SELECT "NOT MET" If:

- ✓ There is no evidence that support staff are actively supporting the person to discover, explore or participate in community based groups of the person's choosing.

Standard No.	Standard Text	Decision
3-9	The individual is supported to have visitors of their choosing according their preferences.	**Met/Not Met**

Guidance

INTERVIEW:

• Mandatory:
o Individual and/or family/advocate
o Direct supports
• As Needed:
o program coordinator and/or service/care coordinator/manager

DOCUMENTATION REVIEW:

Mandatory:
• Person centered plan (ISP or other name)
• Service notes, daily or prn notes as applicable
• Activity logs or similar documentation as applicable

OBSERVATION:

As Needed: If opportunity arises and observation is needed to verify this standard

GUIDANCE:

- The person should have the opportunity to develop close, private, and personal relationships without unnecessary barriers or obstacle. The person should be aware that they may invite people of their choosing to visit them and be assisted to do so. The person should also be aware that they may visit with others in the community. Even if the person expresses little to no interest in having visitors, the person should understand that it is his/her right. Visitors should have access to all appropriate areas of the facility when visiting and should not be denied entry to common areas and/or the person's room (unless there is a compliant modification of this right on behalf of the person supported.) The facility may require visitors to sign in and/or notify the facility administrator that they are in the site or complete other procedures to ensure the safety and welfare of residents and staff. However, procedures should not unnecessarily restrict visitors for the convenience of staff and/or to restrict the person from freedom of association with those they choose. Visitation overnight must be allowable, subject to limits in lease or other agreement that prevent visitation from being stretched into legal occupancy. Some individuals may not express or may not be capable of expressing interest in visitation by family, friends, workmates, and others. However, residential staff is expected to support all individuals to maintain and/or develop social relationships to the degree desired by the person. This obligation is continuous and should not be stopped based on an individual's past responses. Staff can remind individuals that they may invite people to the support setting and that they will assist them in any way possible. They may also use certain events as an opportunity to suggest to the person how to engage a friend in the event (e.g., Saturday is your birthday and you said you wanted a BBQ. What do you think about inviting Sally to join the party?) For individuals who cannot or will not express their desire or interest, staff should be observant of their reaction to family members and other people. If they and others in their circle agree that the person may benefit from visits with people the individuals seems to enjoy, they should provide the supports to

facilitate such locations, including visits in the residence. It is understood that in a shared living and day activity site situation, the needs of other residents or participants must also be respected, but there should be an effort to communicate and coordinate between the affected parties, rather than having blanket house, or program, rules restricting when and how a person can receive visitors.

- A person who attends day hab and/or certified prevoc settings should also be supported to have visitors at these sites. It may take some coordination with staff, to have a place to accommodate visitors and protect privacy of others, but there should be no blanket rules against visitors for staff convenience.
- IMPORTANT NOTE - When evaluating this standard: When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. The rights modification must have been considered as part of the Habilitation/Person-centered planning process; and if related to an assessed behavioral need, documented in a Behavior Support Plan in accordance with all of the requirements of 633.16. If the modification is for any reason, it must:
    - Identify the specific individualized assessed need;
    - Document the positive interventions and supports used prior to the modification;
    - Document the less intrusive methods of meeting the need that had been tried but did not work;
    - Include a clear description of the condition that is directly proportional to the assessed need;
    - Include regular collection and review of data to measure the ongoing effectiveness of the modification;
    - Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;
    - Includes the informed consent of the Individual;
    - Includes an assurance that interventions and supports will cause no harm to the Individual.

SELECT "MET" If at least two of the following are evident:

- ✓ There is evidence that people visit the person in his/her home and/or day hab and/or certified prevoc site.
- ✓ The person reports that he/she can have visitors whenever he/she chooses.
- ✓ The person receives encouragement and support from residential or day setting staff to have visitors (e.g., assistance in scheduling visits).
- ✓ This right has been modified in compliance with the criteria to modify rights as noted above

SELECT "NOT MET" If any of the following are evident:

- ✓ There are blanket rules/visiting hours restricting the person from having visitors of their choosing at any time.
- ✓ The person does not receive any support or assistance to have visitors.
- ✓ The person isn't aware of his/her right to have visitors.
- ✓ The person reports wanting people to visit and having been denied the opportunity.
- ✓ There are rights restrictions in place to limit visitors, and these do not include the required elements to modify rights.

Standard No.	Standard Text	Decision
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support.	**Met/Not Met**

Guidance

DISCUSSION:

• Mandatory:
o Individual and/or family/advocate
o Direct Supports
• As Needed:
o program coordinator and/or service/care coordinator/manager

DOCUMENTATION REVIEW:

Mandatory:
• Person centered plan (ISP or other name)
• List of safeguards (IPOP or other name)

OBSERVATION:

Mandatory: Time observing may evidence practices related to privacy and privacy accommodations in bedrooms, bathrooms, access to private calls, etc.

GUIDANCE:

- The privacy of an individual should be respected in all aspects of life. Preservation of the person's right to privacy is a basic human dignity. The residence and staff must ensure that the person's need for privacy is respected and protected. This includes being able to have private conversations, having a say in who has access to their personal information, possessions and living space, as well as having privacy in medication administration, bathing, grooming, and dressing. Staff need to support persons to have the opportunity to privately speak on the telephone, open and read mail, email, text and visit with others.

(i) IMPORTANT NOTE - When evaluating this standard: When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. The rights modification must have been considered as part of the person-centered planning process; and if related to an assessed behavioral need, documented in a Behavior Support Plan in accordance with all of the requirements of 633.16. If the modification is for any reason, it must:

1. Identify the specific individualized assessed need;
2. Document the positive interventions and supports used prior to the modification;
3. Document the less intrusive methods of meeting the need that had been tried but did not work;
4. Include a clear description of the condition that is directly proportional to the assessed need;
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
6. Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;

7. Includes the informed consent of the Individual;
8. Includes an assurance that interventions and supports will cause no harm to the Individual.

SELECT "MET" If all are present:

- ✓ Staff knock and wait for and receive permission to enter their bedroom or bathroom while the Individual is in one of these rooms.
- ✓ Individuals can lock their bedroom and bathroom door. Assistance is provided in private when needed by the person.
- ✓ The person has access to, and is supported to, make private phone calls and/or send private e-mails/text messages when it is convenient to him/her.
- ✓ Staff refrain from discussing personal issues and/or personal information about the person with, or in front of, others who have no need and/or right to know it.
- ✓ The person has the opportunity to take medications and receive treatments privately.
- ✓ Individuals report that staff support them to communicate, in private, in the manner noted above.
- ✓ Staff support, assist, and remind the person to facilitate their privacy.
- ✓ If necessary, this right has been modified in compliance with the criteria to modify rights as noted above.

SELECT "NOT MET" If any of the following are present:

- ✓ Discussion with the person and/or family/advocate or observations demonstrate that the person's right to privacy is not being protected as noted in what makes this standard 'Met' or other by evidence gathered by surveyor.
- ✓ There are blanket house rules which control a person's privacy and means to communicate with others as they prefer (e.g. no phone calls after 9 p.m., staff are present with a person who is emailing to monitor content, staff screen mail received by the persons who live there, etc.)
- ✓ Required rights modifications criteria or required elements of a BSP are not met.

Standard No.	Standard Text	Decision
3-11	The individual is aware that he/she is not required to follow a particular schedule for waking up, going to bed, eating, leisure activities, etc.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory: Individual and/or family/advocate
As Needed: Direct supports and/or program coordinator

OBSERVATION:

As Needed: to verify that there are no posted group or individual schedules

GUIDANCE:

- A person's awareness about their right to follow their own schedule may depend on how much they know about their rights to independently choose, and be supported to implement, their preferred choice of activities and times. It is the agency's responsibility to inform the person of and to exercise these

rights. When interviewing a family member/advocate, remember to encourage them to answer from the person's point of view. To go beyond a 'yes/no' response which may, or may not, be based on an informed choice, consider the following probes to verify this standard:

- Is the person aware that they don't have to follow a structured and regimented house schedule (such as, wake up at 5am, eat at 6pm, shower at 7pm, bed by 9pm, etc.)? If a person prefers to follow a routine, as long as it is his or her informed choice and not coerced, it is acceptable to meet this standard.
- Does the house have a shower schedule, a dining schedule, a laundry schedule that the person is told they must follow and does the person know that he has the right to create and follow his own schedule for these activities?
- Is the person's routine individualized and different from others in the setting or does everyone follow the same schedule for all activities?
- Does the person have access to in-house activities such as watching TV, radio, and other leisure activities that interest him/her? Is he/she able to access those activities when he/she chooses? (Or does everyone have to go to bed by 10pm, or watch the same TV shows as his/her housemates, regardless of choice, for example?)
- Is the person encouraged, taught, and provided the opportunity to plan his/her own daily activities, including mealtimes, community events, and other activities on a regular basis? This may also apply to weekly and monthly routines.

SELECT "MET" If all are evident:

- ✓ Evidence demonstrates that the person is not made to follow a schedule based on group, house rules and/or staff/FCP convenience.
- ✓ The timing of the person's daily activities is based on his informed choice, preferences and needs.

SELECT "NOT MET" If any are evident:

- ✓ Discussion with the person and/or family/advocate or observations demonstrate that the person's right to his/her own schedule of activities is not of his/her own informed choice, preferences or needs.
- ✓ There exists a house or group schedule which the person is expected to follow, not based on his/her individual choice.

Standard No.	Standard Text	Decision
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory: Individual and/or family/advocate
As Needed: Direct supports and/or program coordinator

DOCUMENTATION REVIEW:
Mandatory:
• Person centered plan (ISP or other name)
• List of safeguards (IPOP or other name)

OBSERVATION:

Mandatory:

• Interaction between persons and staff

• Support received to make and keep his/her own schedule of activities

GUIDANCE:

- Providers are expected to encourage and support persons to freely choose and control their own schedules and activities (e.g. when to eat, when to sleep, what to watch on TV, preferred community activities, etc.) in the same manner as people without disabilities do. The staff must ensure that sufficient support is available based upon persons' priorities and their plans and activity preferences. Preventing a person from receiving any service in their person-centered plan is a direct violation of the person-centered plan and HCBS requirements.
- Spontaneity in choice of activities should be encouraged and supported whenever possible. A person learns both that they can enjoy spur of the moment activities and experience disappointment when a lack of planning makes participation in an activity not possible. Agency staff/FCP can support the person to learn how to exercise greater control over his/her own schedule when they also work to develop natural supports such as family members and friends to aid in accessing activities.
- In non-residential settings, this right is manifest in the ability of the person to request scheduling changes while support is given to them to understand that in volunteer and employment settings, the amount of scheduling flexibility available to them is determined by the scheduling needs of the volunteer site (e.g. nursing home, animal shelter) and the employer (grocery store, restaurant). Assisting a person to weigh the cost/benefit of dictating one's own schedule with his/her ultimate goal of meaningful activity and/or work as offered by the wide-world of establishments, is an informed decision making opportunity for the person. The provider must provide individuals with the opportunity to participate in negotiating his/her work schedule, break/lunch times and leave with his/her employer to the same extent as individuals not receiving Medicaid funded HCBS. He/she should be supported to request scheduling changes as provided to him by staff supports (e.g. to ask not to be picked up for work 2 hours early just because of staff convenience) and other negotiable service options (e.g. to be supported to learn to take mass transit for even greater independence, etc.) In a day service setting, the setting provides opportunities for regular meaningful non-work activities in integrated community settings for the period of time desired by the individual and afford opportunities for individual schedules that focus on the needs and desires of an individual and an opportunity for individual growth.
- This standard speaks to the requirement that the site staff and family care providers "optimize" individual initiative in making life choices of daily living by persons supported. Attention here is paid to what staff are doing to promote personal choice and decision making skills by persons they support. This is active support, not passively waiting to see what a person will do. E.g. the person-centered plan identifies that the person likes to go outside and walk after he gets home and needs a support person to accompany him in the neighborhood. Evaluate, through record review, DISCUSSION: and observation if this preferred activity is occurring based on the person's preferred frequency.

IMPORTANT NOTE - When evaluating this standard:

- When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. The rights modification must have been considered as part of the person-centered planning process; and if related to an assessed behavioral need, documented in a Behavior Support Plan in accordance with all of the requirements of 633.16. If the modification is for any reason, it must:
  1. Identify the specific individualized assessed need;
  2. Document the positive interventions and supports used prior to the modification;

3. Document the less intrusive methods of meeting the need that had been tried but did not work;
4. Include a clear description of the condition that is directly proportional to the assessed need;
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
6. Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;
7. Includes the informed consent of the Individual;
8. Includes an assurance that interventions and supports will cause no harm to the Individual.

SELECT "MET" If all of the following are evident:

- ✓ The person and/or family/advocate if needed, reports that he/she has been informed of, encouraged and supported to follow their own schedule of daily activities, based on what he/she prefers.
- ✓ The person's schedule (if one exists and it doesn't have to be written down in order to exist) is individualized and person-centered.
- ✓ The person's priorities are being supported through his/her schedule.
- ✓ If necessary, this right has been modified in compliance with the criteria to modify rights as noted above.

SELECT "NOT MET" If any of the following are evident:

- ✓ The person's schedule is regimented and reflects little to no meaningful decision-making by the person.
- ✓ The person's schedule is based on what others in the home want and need; as opposed to what he/she prefers to do with his/her time.
- ✓ Subtle or explicit coercion occurs to influence the person's choice of activities.
- ✓ Blanket or house rules exist which govern the person's schedule of leisure, dining, bathing, resting, grooming, etc.
- ✓ The person and/or family/advocate if needed, reports dissatisfaction with the opportunity he/she has to make and keep his/her own schedule or to make changes to it.
- ✓ Rights modifications criteria or required elements of a BSP are not met, if modification to this right has occurred or is occurring.

Standard No.	Standard Text	Decision
3-13	The individual can choose to eat meals when they want to, even if mealtimes occur at routine or scheduled times.	**Met/Not Met/NA**

Guidance

DISCUSSION:

Mandatory: Individual and/or family/advocate

As Needed: Direct supports and/or program coordinator

DOCUMENTATION REVIEW:

• As Needed:

o Person centered plan (ISP or other name)

o List of safeguards (IPOP or other name)

o Behavioral Support Plan

o Prescriber's diet order
o Documentation of HCBS rights modifications criteria

OBSERVATION:
As Needed: Person preparing to dine or dining

GUIDANCE:

- Residentially, people must have 24 hours a day access to food unless there is an appropriate rights modification in place. This requirement can be met in a variety of ways, including by giving individuals control in selecting the foods that they eat, storing food in their rooms, eating in their rooms, and deciding when to eat. Minimal options, such as the choice of a snack bar or crackers, will not meet the requirements. A person should not be presented with narrow meal and snack options, decided by someone else, without input from the person. Food options should not be unreasonably limited. CMS notes that requirement would not be satisfied by choice between a granola bar or pitcher of water and crackers. The requirement does not pertain to providing full dining services or meal preparation 24 hours a day, but rather applies to access to food at all times.

- In non-residential settings, the service setting must allow for individuals to have a meal/ snacks at the time and place of their choosing. For instance, the service setting should afford individuals full access to a dining area with comfortable seating and opportunity to converse with others during break or meal times and afford dignity to the diners (i.e., individuals are treated age-appropriately and not required to wear bibs.) The day service setting should provide for an alternative meal and/or private dining if requested by the individual. Individuals should have access to food at any time consistent with individuals in similar and/or the same setting who are not receiving Medicaid-funded services and supports. In the volunteer setting, if regimented break/snack/meal times are part of the operations of the setting, the person has been informed that this is part of the conditions of his/her volunteer work and he/she consents to this. In the Private School setting, the adherence to scheduled meal times during the classroom day, is expected.

- A person who resides at a Private School setting has the same right to flexible meal and snack times, after the classroom day is over, as anyone else who lives in HCBS waiver settings (which is the same as those who do not live in HCBS waiver settings.)

- Any modification or restriction to a person's food choices or choice of mealtimes must be supported by a specific assessed need and justified in the person-centered service plan or behavior support plan. When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. The rights modification must have been considered as part of the Person-centered planning process; and if related to an assessed behavioral need, documented in a Behavior Support Plan in accordance with all of the requirements of 633.16. If the modification is for any reason, it must:

    1. Identify the specific individualized assessed need;
    2. Document the positive interventions and supports used prior to the modification;
    3. Document the less intrusive methods of meeting the need that had been tried but did not work;
    4. Include a clear description of the condition that is directly proportional to the assessed need;
    5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
    6. Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;

7. Includes the informed consent of the Individual;
8. Includes an assurance that interventions and supports will cause no harm to the Individual.

- It is also recognized that in some cases, others in the program might be impacted by the modifications needed for a particular person. For example, if someone's individualized assessed needs indicate that a modification is necessary that the person cannot have access to food at any time, there might be a need to have pantries and the refrigerator locked as there is clear evidence that an individual needing modifications will seek out food and that other positive approaches to safeguarding have not been successful. This type of modification affects everyone in the immediate service setting. In these cases, there must be arrangements made so that other individuals can have the right to access to food at any time. These arrangements might include the ability to ask staff/FCP to open the pantry at any time, and/or the person having a special area in the pantry, or locker at day setting, or in their own room for storage of their own food. The expectation is that reasonable approaches are taken to support the people who are impacted by the restriction that is in place to maintain the level of control that is appropriate for them, through mitigating activities that are person-centered.

- Consider the following probes when verifying this standard:
  - Is the person able to have a meal at the time and place that he/she prefers?
  - Is the person able to request an alternative meal if they so choose? Is the person able to decide what they eat?
  - How is the person able to get food even when it is not mealtime? Are food and snacks accessible and available at any time?
  - Are cabinets, refrigerators, and the pantry unlocked, and is the person is able to access the food?
  - If the person prefers to eat alone, is that honored?
  - Is the person able to choose where and with whom they eat? Does the person have assigned seating with no choice?
  - If choice or access regarding food and eating are altered in any way, is the specific assessed need identified in a person-centered plan/behavior support plan?
  - Is the person able to shop for food, assist with grocery shopping and/or help pick the food they like to eat?
  - Is the person able and supported to keep your own food in your bedroom, or locker at day setting, if they choose?

SELECT "MET" If at least two of the following are present:

- ✓ The person reports being able to eat their meals and snacks when they choose, if they do not wish to have their meal at the scheduled time in the residential or day service setting. In the community setting, the person has agreed to the meal/break times of the volunteer site or employer.
- ✓ During observation of meal times, individuals are not coerced to come to the table or dining area.
- ✓ During discussions and/or documentation review, it is evident that there is flexibility provided for meals to accommodate individual schedules and preferences in the residential and day service setting. In vocational settings, this has been agreed to by the individual before choosing it as a vocational site or employer.
- ✓ If necessary, this right has been modified in compliance with the criteria to modify rights as noted above.

SELECT "NOT MET" If any of the following are present:

- ✓ During observation, people appear to be coerced to eat at routine meal, break or snack times.
- ✓ A person reports that they have requested to have their meal in their room or in another area, or at another time and staff/FCP does not honor the request (and there is no valid rights modification documentation and there is no prior agreement by the person in the community vocational setting.)
- ✓ There is documentation/written evidence that indicate that there is no choice/flexibility to alter one's meal/snack/break time schedule in the residential or day service setting. In the vocational setting, the person was unaware of regimented break/meal times as a condition of participation or employment.
- ✓ There is a 'blanket or house rule' that meals and meal/snack/break times are regimented in the residential or day service setting, in the name of 'family-style dining'.
- ✓ Rights modifications criteria or required elements of a BSP are not met if a modification to this right has occurred or is occurring.

Select "NA" IF:

- ✓ No meals/mealtimes occur for the individual during their receipt of the service or in the service setting.

Standard No.	Standard Text	Decision
3-14	The individual has access/is supported to have access to food at any time and to store their own food and snack choices for their use at any time as desired, similar to people without disabilities.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory: Individual and/or family/advocate
As Needed: Direct supports and/or program coordinator

DOCUMENTATION REVIEW:

• Mandatory: Person centered plan (ISP or other name)
• As Needed:
o List of safeguards (IPOP or other name)
o Behavioral Support Plan
o Prescriber's diet order
o Documentation of HCBS rights modifications criteria

OBSERVATION:

Mandatory:
• Person accessing food at any time as opportunity arises, and/ or
• evidence of their access to and/or the presence of a secure, personal storage area for their own food

GUIDANCE:

- Residentially, people must have 24 hours a day access to food unless there is an appropriate rights modification in place. This requirement can be met in a variety of ways, including by giving individuals control in selecting the foods that they eat, storing food in their rooms, eating in their rooms, and deciding when to eat. Minimal options, such as the choice of a snack bar or crackers, will not meet the requirements. A person should not be presented with

narrow meal and snack options, decided by someone else, without input from the person. Food options should not be unreasonably limited. CMS notes that requirement would not be satisfied by choice between a granola bar or pitcher of water and crackers. The requirement does not pertain to providing full dining services or meal preparation 24 hours a day, but rather applies to access to food at all times.

- In non-residential settings, the service setting must allow for individuals to have a meal/ snacks at the time and place of their choosing. For instance, the service setting should afford individuals full access to a dining area with comfortable seating and opportunity to converse with others during break or meal times and afford dignity to the diners (i.e., individuals are treated age-appropriately and not required to wear bibs.) The day service setting should provide for an alternative meal and/or private dining if requested by the individual. Individuals should have access to food at any time consistent with individuals in similar and/or the same setting who are not receiving Medicaid-funded services and supports. In the volunteer setting, if regimented break/snack/meal times are part of the operations of the setting, the person has been informed that this is part of the conditions of his/her volunteer work and he/she consents to this.

- In the Private School setting, the adherence to scheduled meal times during the classroom day, is expected. A person who resides at a Private School setting has the same right to flexible meal and snack times, after the classroom day is over, as anyone else who lives in HCBS waiver settings (which is the same as those who do not live in HCBS waiver settings.)

- Any modification or restriction to a person's food choices or choice of mealtimes must be supported by a specific assessed need and justified in the person-centered service plan or behavior support plan. When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. The rights modification must person-centered planning process; and if related to an assessed behavioral need, documented in a Behavior Support Plan in accordance with all of the requirements of 633.16. If the modification is for any reason, it must:

    1. Identify the specific individualized assessed need;
    2. Document the positive interventions and supports used prior to the modification;
    3. Document the less intrusive methods of meeting the need that had been tried but did not work;
    4. Include a clear description of the condition that is directly proportional to the assessed need;
    5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
    6. Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;
    7. Includes the informed consent of the Individual;
    8. Includes an assurance that interventions and supports will cause no harm to the Individual.

- It is also recognized that in some cases, others in the program might be impacted by the modifications needed for a particular person. For example, if someone's individualized assessed needs indicate that a modification is necessary that the person cannot have access to food at any time, there might be a need to have pantries and the refrigerator locked as there is clear evidence that an individual needing modifications will seek out food and that other positive approaches to safeguarding have not been successful. This type of modification affects everyone in the immediate service setting. In these cases, there must be arrangements made so that other individuals can have the right to access to food at any time. These arrangements might include

the ability to ask staff to open the pantry at any time, and/or the person having a locked pantry, or locker at day setting, or in their own room for storage of their own food. The expectation is that reasonable approaches are taken to support the people who are impacted by the restriction that is in place to maintain the level of control that is appropriate for them, through mitigating activities that are person-centered.

- Consider the following probes when verifying this standard:
  - Is the person able to have a meal at the time and place that he/she prefers?
  - Is the person able to request an alternative meal if they so choose? Is the person able to decide what they eat?
  - How is the person able to get food even when it is not mealtime? Are food and snacks accessible and available at any time?
  - Are cabinets, refrigerators, and the pantry unlocked, and is the person is able to access the food?
  - If the person prefers to eat alone, is that honored?
  - Is the person able to choose where and with whom they eat? Does the person have assigned seating with no choice?
  - If choice or access regarding food and eating are altered in any way, is the specific assessed need identified in a person-centered plan/behavior support plan?
  - Is the person able to shop for food, assist with grocery shopping and/or help pick the food they like to eat? *Are you able and supported to keep your own food in your bedroom, or locker at day setting, if you choose?

SELECT "MET" If all of the following are present:

- ✓ The person has access to food 24-7, either through storing the food in their room, or their locker during the day and/or getting food from the refrigerator, pantry, and/or asking for food at any time or there is an appropriate rights modification in place through the person-centered planning process that includes all the required elements.
- ✓ The provider staff makes clear that access to food 24-7 is the person's right, and supports their access to it, unless there is a necessary and compliant rights modification.
- ✓ The provider staff supports the person to budget, purchase, and store food that they choose so that it is available to the person at any time, unless there is a necessary and compliant rights modification.
- ✓ If it applies, the community vocational setting provided, and the person understood and agreed to, information about its rules about storing and accessing food at any time during their volunteer or paid work there.

SELECT "NOT MET" If any of the following are present:

- ✓ The person does not have access to food 24-7 in a residential setting or hours of operation in a day service setting.
- ✓ The person is not supported to purchase/store food (and they would like to do so.)
- ✓ If it applies, the community vocational setting did not provide, and/or the agency staff didn't support the person to understand and agree to, information about the vocational settings' rules about storing and accessing food at any time during their volunteer or paid work there.
- ✓ There are blanket rules/policies or operational practices in place that are obstacles/barriers to this right.
- ✓ The person has a rights modification but it does not contain the required elements.

Standard No.	Standard Text	Decision
3-15	The individual is supported to have independent access to the site/service setting with freedom to come and go as desired, similar to people without disabilities.	**Met/Not Met**

Guidance

DISCUSSION:
• Mandatory: Individual and/or family/advocate
• As Needed: Direct supports and/or program coordinator

DOCUMENTATION REVIEW:
• Mandatory: Person centered plan (ISP or other name)
• As Needed:
o List of safeguards (IPOP or other name)
o Behavioral Support Plan
o Documentation of HCBS rights modifications criteria

OBSERVATION:
As Needed: Person using their key, or other means of independent access, to come and go from the setting.

GUIDANCE:

- In the residential setting, the person should have access to their home with as much independence as possible as determined by the person, their skills, and individualized needs for environmental, adaptive, and human supports. Environmental modifications, the use of technology, and personal assistance from staff are all ways that a person can have greater control over and more independent access of their home. Some people may need specialized training and encouragement to feel comfortable fully accessing and utilizing their residence key or other means to enter their home and to use their right to come and go as they desire. The agency is responsible to provide this support.

- In Private Schools, the ability to come and go freely during the classroom day is not subject to the expectations of this standard. If the person lives at the private school, then the requirements of this standard apply to his right to come and go freely just as they would be living in any other waiver residential setting, i.e., the same as those who don't live in waiver settings.

- In the day setting, the person should have this same right. The day service setting should allow individuals the freedom to move about inside and outside of the setting as opposed to one restricted room or area within the setting. When the setting is located in the community/building among other residential buildings, private businesses, retail businesses, restaurants, doctor's offices, etc. it is an opportunity to facilitate integration with the greater community for persons supported, which is their right.

- Discussion with the person or his family/advocate should address:

    - if he/she has a key, or other means of independent access to the front door of the site
    - if he/she would like to have a key or other means of independent access to the front door of the site
    - if he/she is allowed to come home when he wants to when he is away from the residence or day service setting site.
    - if he/she can leave the residence or day service setting site when he wants to.
    - if he/she doesn't, then who decides when he is able to leave the residence, or day service setting, for an event or activity and come back again.

- When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. In HCBS waiver settings, the rights modification must have been considered as part of the person-centered planning process; and if related to an assessed behavioral need, documented in a Behavior Support Plan in accordance with all of the requirements of 633.16. If the modification is for any reason, it must:

    1. Identify the specific individualized assessed need;
    2. Document the positive interventions and supports used prior to the modification;
    3. Document the less intrusive methods of meeting the need that had been tried but did not work;
    4. Include a clear description of the condition that is directly proportional to the assessed need;
    5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
    6. Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;
    7. Includes the informed consent of the Individual;
    8. Includes an assurance that interventions and supports will cause no harm to the Individual.

SELECT "MET" If any of the following are present:

- ✓ The person has a key, or other independent means, to unlock the door of the day service site or residence and they are allowed to come and go whenever he/she chooses.
- ✓ The person has been fully informed of his/her right to have a key or other independent means to unlock the door of the day service site or residence and they are allowed to come and go whenever he/she chooses, but they prefer not to exercise these rights at this time.
- ✓ There is an appropriate rights modification in place that includes all required elements regarding the person having a key, or other independent means and the right to come and go freely.

SELECT "NOT MET" IF:

- ✓ None of the above conditions in 'Met' are present.

Standard No.	Standard Text	Decision
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory: Individual and/or family/advocate
As Needed: Direct supports and/or program coordinator

DOCUMENTATION REVIEW:
• Mandatory: Person centered plan (ISP or other name)
• As Needed:
o List of safeguards (IPOP or other name)
o Behavioral Support Plan
o Documentation of HCBS rights modifications criteria

OBSERVATION:
• Mandatory: observe the program site to determine if it appears to meet the person's needs for movement and independence
• As Needed: Person accessing all typical shared areas of their home and/or day service setting without unnecessary barriers or blanket rules to the contrary

GUIDANCE:
- Typical shared spaces include, but are not limited to, a kitchen with cooking facilities and refrigerator; dining area; laundry; and comfortable seating in shared areas, when they choose. The setting must be physically accessible, including access to bathrooms and break rooms. Appliances, equipment, and tables/desks and chairs must be at a convenient height and location, with no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting individuals' mobility in the setting. If obstructions are present, are there environmental adaptations such as a stair lift or elevator to ameliorate the obstructions. The person should have access to all typical spaces in the home and/or service setting, with as much independence as possible as determined by the person, their skills, and individualized needs for environmental, adaptive, and human supports. Environmental modifications, the use of technology, and personal assistance from staff are all ways that a person can have greater control over, and more independent access of, their environment. Some people may need specialized training and encouragement to feel comfortable fully accessing and utilizing their home and/or service settings and its features. An agency is responsible to provide this support. However, a program may also have arbitrary 'house or program rules', locked areas, and other practices that prevent a person's increased access to their own environment. If that is the case, this standard is 'Not Met'. In Private Schools, the ability to access all spaces in the school building during the classroom day is not subject to the expectations of this standard. If the person lives at the private school, then the requirements of this standard apply to his right to access all typical spaces in the home freely, just as they would be living in any other waiver residential setting, i.e., the same as those who don't live in waiver settings.

- Consider the following positive conditions to determine if the person is being supported to increase his/her independence to move about their home and/or service setting:
    - there is no shared area in the setting she is not allowed to go/be in;
    - there is nowhere in the setting she cannot get in (e.g., cannot accommodate ambulation equipment or is locked);
    - there is nowhere in the setting that is locked and if it is, the person knows what to do to access it without undue effort;
    - Person can use appliances and equipment like the microwave, telephone, and washer/dryer, per her preference and abilities;
    - Person can use the kitchen and laundry room alone/without staff, per her preference and abilities;
    - If they don't know how to use appliances and leisure or recreational equipment, they are being taught how to use them by staff to do so to the maximum of her ability and interest;
    - Person gets around the setting with undue effort; can open the doors and turn on lights;
    - If person can identify anything that would make it easier for them to get around her home or service setting, they know how to ask for help to attain it and is reasonably assured the help will occur;
    - There are no places in the house or service setting that only staff/FCP can use without justification;
    - There are no things in the house or service setting that only staff/FCP can use without justification? (E.g. bathrooms, appliances, TV, phones, etc.);
    - There are no things that the person is prevented from doing in their home or service setting due to rules, practices, regulations or staff/FCP enforcement (includes coercion.)

SELECT "MET" If all of the first four bullets are present or if the fifth bullet is present:

- ✓ The person reports that he/she has full access to his/her home and/or service setting and can access common areas when he/she so chooses.
- ✓ There are no barriers/obstacles to the person being able to access common areas of the home and/or service setting when he/she so chooses. (e.g., no locked doors, obstructions, etc.) If there are such barriers due to a rights modification in place for someone else, the person's right to full access are accommodated through another appropriate method.
- ✓ There are no blanket rules limiting access to typical areas of the home and/or service setting.
- ✓ The person is supported to use typical spaces and common areas of the home and/or service setting based on his/her desired schedule.

OR:

- ✓ Out of necessity for health and safety, this right has been modified in compliance with the criteria to modify rights as noted above

SELECT "NOT MET" If either below are not present:

- ✓ Any of the first four bullets under 'Met' are not present
- ✓ Rights modifications criteria or required elements of a BSP are not present or are not met.

Standard No.	Standard Text	Decision
3-17	The setting reflects the individual's needs and preferences including the presence of any necessary physical modifications, if applicable.	**Met/Not Met**

Guidance

DISCUSSION:

• Mandatory: Individual and/or family/advocate
• As Needed: Direct supports and/or program coordinator

DOCUMENTATION REVIEW:

• Mandatory: Person centered plan (ISP or other name)
• As Needed:
o List of safeguards (IPOP or other name)
o Behavioral Support Plan
o Documentation of HCBS rights modifications criteria

OBSERVATION:

• Mandatory: observe the program site setting to determine if it appears to meet the person's needs and preferences including environmental modifications to better support their comfort, preferences, schedule and safety
• As Needed: Person benefitting from the adaptions, design, set-up, furniture, or other preferred environmental supports

GUIDANCE:

- Modifications should improve the access and safety of the setting for the person and should allow the person to live in their home, or other setting, with a greater level of comfort, accessibility, and safety. The agency is responsible to train persons supported about the proper use of their modifications and technology. Staff should also be trained in how to use the modification/technology and how to assist the person, if needed, in appropriate use.
- Consider the following positive conditions to determine if the person is being supported in his environment by adaptions and supports to increase his/her ability to use his environment:
  - o There are no places in the setting or house that the person is not able to safely access or that cannot accommodate his/her needs, i.e., the setting is wheelchair accessible, grab bars are present where needed
  - o The person is able to comfortably use all of the amenities of his/her home or setting that he/she would like to use. This includes the kitchen, washer/dryer, phone, microwave, television, stereo, computer, etc.
  - o The person doesn't know how to use these appliances and equipment, he/she is being taught how to use them by staff, per his/her preference
  - o if there is anything that would make it easier for the person to use all of the resources in his/her house, or setting, he/she knows how to request help and has a reasonable expectation of the help being provided.
  - o If the person uses technology in the setting, he/she is able to use it, or if he/she needs help with it, help is offered to him/her by staff
  - o If there are any modifications that have been made to the home or setting for the person's benefit and use, they are maintained and kept in good repair

- He/she has all of the necessary adaptive equipment/environmental modifications needed to foster independence
- There is nothing that the person has difficulty doing or cannot do because of lack of modifications or adaptations
- If there are any modifications or technology used, it is maintained. If the person can't use the modification or technology independently, staff/FCP is trained and available to assist with its use.

SELECT "MET" If both of the following are present:

- ✓ The person has all needed adaptive equipment and environmental modifications necessary to facilitate access within the home, service setting
- ✓ The adaptive equipment and environmental modifications for his/her benefit are in good working order.

SELECT "NOT MET" If any of the following are present:

- ✓ The person is not able to safely access areas of the service setting or home due to the lack of expected modifications.
- ✓ The person lacks necessary training, modifications, or adaptive equipment needed to facilitate access in the service setting, home, use of the resources
- ✓ The person reports that the service setting and/or home do not reflect his/her needs and preferences.
- ✓ The adaptive equipment and environmental modifications for his/her benefit are not in good working order.

Standard No.	Standard Text	Decision
3-18	The individual has a lease or other written occupancy agreement that provides eviction protections and due process/appeals and specifies the circumstances when he/she could be required to relocate.	**Met/Not Met**

Guidance

DISCUSSION:

• Mandatory: Individual and/or family/advocate
• As Needed: Direct supports and/or program coordinator

DOCUMENTATION REVIEW:

• Mandatory: Written Residency/Occupancy Agreement
• As Needed: Notice of Rights per 633.12 if the criteria of this standard are incorporated within it

GUIDANCE:

- ✓ The intent is that in order for a residence to be considered Home and Community-Based, the resident has a lease or written residency/occupancy agreement that provides protections that address eviction processes and appeals comparable to those provided under the jurisdictions of landlord-tenant law. It is the agency and residential setting's responsibility to ensure that residents are fully informed of their rights, including when eviction or involuntary discharge is necessary. There should be written evidence of an occupancy agreement or another comparable written agreement with the agency, in the person's file. This agreement should address the circumstances under which the person could be required to relocate that the due process/appeals provides to them.

- ✓ The occupancy agreement could be incorporated into the 633.12 Notice of Rights issued by the agency to the person or his family/advocate at the time she moved into the residence. It must be written in plain, understandable language to the person and/or his family/advocate; it must meet all of the conditions above and needs to be reviewed annually with the person or family/advocate. It must be signed by the person or his family/advocate, if she is unable to sign.

SELECT "MET" If the following is present:

- ✓ There is evidence of a written occupancy agreement that specifies due process and appeals regarding the person's residential setting and circumstances, under which he/she could be required to relocate. This can be a written residential/occupancy agreement that outlines 633.12 Notice of Rights and specifies the circumstances upon which the person would be required to relocate and the due process/appeals provided in these circumstances. This document can be combined with a Notice of Rights as long as the occupancy agreement section specifies protections/appeals from eviction and circumstances upon which the person could be required to relocate.

SELECT "NOT MET" IF:

- ✓ There is no evidence of a written occupancy agreement that includes due process/appeals and specifies circumstances where the person could be required to relocate and the due process/appeals available.

Standard No.	Standard Text	Decision
3-19	There is evidence that the individual and/or their representative knows/understands their right to due process/appeals and when he/she could be required to relocate.	**Met/Not Met**

Guidance

DISCUSSION:

• Mandatory: Individual and/or family/advocate
• As Needed: Direct supports and/or program coordinator

DOCUMENTATION REVIEW:

• Mandatory: Written Residency/Occupancy Agreement
• As Needed: Notice of Rights per 633.12 if the criteria of this standard are incorporated within it

GUIDANCE:

As per the standard above, there should be written evidence of an occupancy agreement or another comparable written agreement with the agency, in the person's file. Beyond written documentation, this standard verifies if the person, or his family/advocate if necessary, understand this agreement and its protection of the person's rights to due process if he is required to relocate. It is important to interview the individual and/or his representative to determine if he/she has awareness of these rights. Consider the following positive conditions to determine if the person or his family/advocate if necessary understand their rights to due process:

- o The person (or family/advocate) confirms that they have been made aware of the right of the person to protections if the agency ever asked or required him to move out or move to another residence.
- o The person or his family/advocate confirm that they have paperwork which lists his rights to live in this home.

- o The person or his family/advocate can explain the due process rights and appeals process regarding tenancy.

SELECT "MET" If any of the following is present:

- ✓ There is evidence that the person and/or their proxy/advocate was informed of, and understands these rights (e.g., signatures on the document; the person has a copy.)
- ✓ The person or their proxy, if necessary, can explain what their due process/appeals rights are should they be asked to relocate.
- ✓ The person and/or their representative can describe the process that will occur when someone is asked to relocate from the residence.

SELECT "NOT MET" If either of the following are present:

- ✓ There is an occupancy agreement but no evidence of the person and/or family/advocate having been informed of it
- ✓ The person (or family/advocate if necessary) report not having been informed of or do not understand their right to due process/appeals regarding tenancy.

Standard No.	Standard Text	Decision
3-20	The individual may view their service record upon request.	**Met/Not Met**

Guidance

DISCUSSION:

• Mandatory: Individual and/or family/advocate
• As Needed: Direct supports and/or program coordinator

DOCUMENTATION REVIEW:

As Needed: Any documentation that may be maintained that may document requests and/or accommodations to view record (e.g. case coordination notes, general daily service notes, health/medical notes, etc.)

GUIDANCE:

- In all services and settings, persons supported, or their family/advocate if appropriate, may view their service records. This right is guaranteed to all. If the request is refused, 633.4(a)(10) describes the process which must be followed to allow the requestor to appeal the declination.
  FIDA IDD Only

SELECT "MET" If any of the following is present:

- ✓ When the person or other qualified party has requested to view the person's service record, they were allowed to do so.
- ✓ For FIDA-IDD the requests to review or receive copies of the service record are accommodated.
- ✓ The request was made and declined by provider but due process per 633.4(a)(10) was correctly followed.

SELECT "NOT MET" IF:

- ✓ The person or other qualified party has requested to view the person's service record, they were not allowed to do so, as requested, and due process per 633.4(a)(10) was not followed by the provider.

Standard No.	Standard Text	Decision
3-21	The individual controls their personal resources and decides how to spend their personal discretionary funds.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory: Individual and/or family/advocate
As Needed: Direct supports and/or program coordinator

DOCUMENTATION REVIEW:
Mandatory:
• Person centered plan (ISP or other name)
• Personal allowance records
• Money management assessment

OBSERVATION:
As Needed: If opportunity arises and observation is needed to verify this standard

GUIDANCE:

- Both DISCUSSION : of the person, and/or family/advocate as appropriate, and review of personal allowance records in comparison with the person centered plan are integral to verifying this standard, in all service settings. Surveyor verification is best served by asking open-ended questions about how the person accesses and spends his/her money. Issues to ask about include, but are not limited to: who decides how much, where, how and on what he/she spends their money; does he/she want and receive help deciding how to spend money; where his/her paycheck goes, if they receive one, etc. Verify that staff/FCP are only giving minimal amount of support needed by the person and per their money management skills assessment. If the person can handle a certain amount of money themselves, see that the staff don't trespass that right based on the setting they're supporting the person in.

  IMPORTANT NOTE - When evaluating this standard:
- When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. The rights modification must have been considered as part of the person-centered planning process; and if related to an assessed behavioral need, documented in a Behavior Support Plan in accordance with all of the requirements of 633.16. If the modification is for any reason, it must:

  1. Identify the specific individualized assessed need;
  2. Document the positive interventions and supports used prior to the modification;
  3. Document the less intrusive methods of meeting the need that had been tried but did not work;
  4. Include a clear description of the condition that is directly proportional to the assessed need;

5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
6. Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;
7. Includes the informed consent of the Individual;
8. Includes an assurance that interventions and supports will cause no harm to the Individual.

SELECT "MET" If at least two of the first three bullets are present or the fourth bullet is present:

- ✓ the person receives support to spend his/her personal allowance on activities and personal interests which are meaningful to him/her
- ✓ the person reports having access to his/her personal funds when needed to engage in preferred activities and make purchases of his/her choice
- ✓ agency staff/FCP assist and support the person to make informed choices about their purchases and provide money management support and training as desired by the person

OR

- ✓ This right has been modified in compliance with the criteria to modify rights as noted above

SELECT "NOT MET" If any of the following is present:

- ✓ there is evidence (interview, record review) that the person doesn't receive sufficient support to exercise his/her right to spend personal allowance on activities and/or items of interest to him/her
- ✓ unnecessary or unreasonable barriers or restrictions on the person's ability to spend his/her personal allowance without an appropriate rights modification that clearly documents all required elements for such restriction.

Standard No.	Standard Text	Decision
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory: Individual and/or family/advocate

As Needed: Discussion with agency staff/FCP only is not a means to verify this standard but they should be able to describe what they do to support individuals to advocate for themselves.

DOCUMENTATION REVIEW:

Mandatory: Person centered plan (ISP or other name)

As Needed: Any documentation that may contain reference to examples of situations in which service providers worked with the person to advocate for themselves or to increase their self-advocacy skills. This would be imperative when the person cannot communicate his/her experience of staff actions and there is no objective other person (i.e. not provider staff) to interview and observation is not enough to verify.

OBSERVATION:

As Needed: If discussion doesn't fully verify that staff have worked with the person to advocate for themselves or to increase their self-advocacy skills. Observation of their interactions may help determine if this standard is or is not met.

GUIDANCE:

- Discussion with the person and/or his family/advocate as appropriate, is the primary means of verifying if a person has been supported by provider staff to advocate for themselves and/or to increase their advocacy skills. If a person relies on an advocate or family member to report his/her point of view to the surveyor, in regard to staff empowering individuals to self-advocate, the surveyor may have to ask probing, open-ended questions to verify that the family/advocate can give examples of staff actions to support him/her to advocate for their rights. If the person or family/advocate has difficulty understanding what is meant by advocacy or rights but they can describe how, in the past, staff have supported them to advocate for their rights, then this standard may still be met. Use documentation to reinforce DISCUSSION: and observation. It is the responsibility of all providers to train DSP staff and FCPs to support persons to self-advocate. Staff should be able to describe their training, knowledge and implementation of their skills in this required area of the DSP core competencies.

SELECT "MET" If the following is present:

- ✓ DISCUSSION: with the person, or his/her family/advocate if appropriate, confirms that staff/FCP support and advocate for their rights per requirement. Observation and/or documentation, as needed, supports this conclusion.

SELECT "NOT MET" If any of the following is/are present:

- ✓ Person and/or family/advocate, as appropriate, report that staff/FCP do not support them to advocate for themselves when making decisions/choices, making their wants/needs known and when exercising their rights.
- ✓ Observation of staff/FCP interaction indicates a lack of support for self-advocacy by the person. (E.g. a person is unhappy with a situation and expresses it but staff just tell them to learn to accept it without exploring opportunities they may have to improve it via communication, exploration of options, etc.)

Standard No.	Standard Text	Decision
3-23	The individual is not subjected to coercion (includes subtle coercion).	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory: Individual and/or family/advocate

As Needed: Discussion with agency staff only is not a means to verify this standard but they should be able to describe what they know about coercion and what they do to prevent it.

DOCUMENTATION REVIEW:

Mandatory: Person centered plan (ISP or other name)

As Needed: Any documentation that may contain reference to examples of situations in which providers worked with the person to make decisions freely; i.e., not based on what they think staff want them to do for fear of losing something else in the 'deal'. This would be imperative when the person cannot communicate his/her experience of staff/provider actions and there is no objective other person (i.e. not service providers) to interview and observation is not enough to verify.

OBSERVATION:

As Needed: If discussion doesn't fully verify that direct supports have worked with the person to make decisions freely without fear of retribution or loss of other rights, observation of their interactions may help determine if this standard is, or is not, met.

GUIDANCE:

- Discussion with the person and/or his family/advocate as appropriate, is the primary means of verifying if service providers treat them respectfully without the use of coercive means when making a choice. Examples of coercion:
  - a person is told that they need to eat dinner with and where his house-mates are, or the only option he'll have otherwise is a cold sandwich when they get time to make it
  - a person is told he needs to do a group activity today or if not, he will not be transported to his favorite store to shop tomorrow
  - a person is told that the staff/FCP will call his parent if he doesn't do what the staff/FCP is asking
  - a person is told that he is hurting the feelings of the staff member by not wanting to do what the staff wants him to do.

- If a person relies on an advocate or family member to report his/her point of view to the surveyor, regarding the possible use of coercion, the surveyor may have to ask probing, open-ended questions to verify that the family/advocate can give examples of what may or may not be coercive actions. If the person or family/advocate has difficulty understanding what is meant by coercion but they can describe how, in the past, staff have supported them to make their own free choices, and does not try to leverage power over them to do what staff want, then this standard may still be 'Met'. Use documentation to reinforce interview and observation. It is the responsibility of all providers to train DSP staff and FCP to support persons to make informed, free choices. The staff should be able to describe their training, knowledge and implementation of their skills in this required area of the DSP core competencies.

SELECT "MET" If the following is present:

- ✓ Discussion with the person, or his/her family/advocate if appropriate, confirms that the person is supported to make their own choice freely without coercion. Observation and/or documentation, as needed, supports this conclusion.

SELECT "NOT MET" If any of the following is/are present:

- ✓ Person and/or family/advocate, as appropriate, report that the person is not supported by staff/provider to decide freely when making decisions/choice but instead, use 'quid pro quo' to deal with the person's wishes and/or needs.
- ✓ Observation of interactions indicate they use techniques such as withdrawal of support, threats of negative consequences even if relatively innocuous, if the person does not do what the staff/FCP wants them to.

Standard No.	Standard Text	Decision
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory: Individual and/or family/advocate; (Interview with agency staff only is not a means to verify this standard.)

DOCUMENTATION REVIEW:
As Needed: Any documentation that may contain reference to examples of situations in which provider staff either respected and/or advocated for the rights of the person. This would be imperative when the person cannot communicate his/her experience of staff actions and there is no objective other person (i.e. not provider staff) to interview and observation is not enough to verify.

OBSERVATION:
Mandatory:
• If discussion doesn't fully verify respect of a person's rights, observation of their interactions may help determine if this standard is or is not met.
• To see if operational factors at the service setting or site reflect institutional conditions which violate HCBS rights of the person.

GUIDANCE:

- Discussion with the person and/or his family/advocate as appropriate, is the primary means of verifying if a person believes that their rights are respected by staff/FCP. These rights are inclusive of those protected by 633.4 and HCBS requirements and civil rights. If a person relies on an advocate or family member to report his/her point of view to the surveyor in regard to respect of his/her rights, the surveyor may have to ask probing, open-ended questions to verify that the family/advocate can give examples of staff/provider respect of the person's dignity and rights and advocacy for his/her rights. If the person or family/advocate has difficulty understanding what is meant by 'rights' but they can describe how, in the past, staff have supported and advocated for their rights, then this standard may still be met. Use documentation to reinforce discussion and observation.

SELECT "MET" If the following is present:

- ✓ Discussion with the person or his/her family/advocate if needed, confirms that staff/the provider supports and advocates for his/her rights per 633.4 and HCBS requirement. Observation and/or documentation, as needed, supports this conclusion.

SELECT "NOT MET" If any of the following is/are present:

- ✓ Person and/or family/advocate, as appropriate, report that staff/the provider do not respect their rights per 633.4 and HCBS requirement.
- ✓ Observation of interactions indicates a lack of respect for the rights of persons supported (e.g. coercion to sit at the dining table for meals, staff refusal of individual requests without justification, ignorance of overt preferences of person, rigid adherence to group schedule, etc.)
- ✓ Site or service setting operational factors reveal institutional conditions which negate the person's rights per HCBS (e.g. 'house rules', inaccessibility to typical areas of the site, segregation from community access, lack of control over personal schedule and/or money, breaches of guaranteed privacy, etc.)

SECTION 3a: Rights Limitations (Other than Behavior Support)			
Qualifier Question: The individual is subjected to restrictions or limitations to their rights not associated with a Behavior Support Plan (e.g. HCBS Rights Limitations)		**Yes**	**No**
Standard No.	**Standard Text**	**Decision**	
3a-1	When interventions that restrict or modify the individual's rights are used (not part of a behavior support plan), the individual's service plan includes a description of the positive and less intrusive approaches that have been tried but have not been successful.	**Met/Not Met**	

Guidance

INTERVIEW:

As Needed: Program coordinator, service/care coordinator/manager; FCP, Provider agency staff including direct support, managerial and/or clinical associated with providing safeguards and supports; Individual and/or family/advocate

DOCUMENTATION REVIEW:

- Mandatory as appropriate to the service type: Person centered plan (ISP or other name); Individualized Plan of Protection/Safeguards; Any associated documentation describing the history of less intrusive measures which were unsuccessful to include clinical assessments, etc.
  (Note: If a person has a restriction/limitation in place because of a behavioral concern, he/she should already have a behavior support plan in place that addresses this required element. If the person requires any limitations to rights expected in HCBS settings due to identified behaviors, the BSP would also be the appropriate place to provide the required documentation. If there is a BSP, review for requirements for restrictions/limitations reflected in the BSP or related to identified behaviors, in that section.)
- In the event that any of the person's rights are limited or modified for a person because of health or safety concerns (such as using a bed rail because of a seizure disorder), it may not be necessary or appropriate to develop a behavior support plan. However, the requirements in #'s 1-8, below, still apply and need to be documented. In those instances, the information regarding limitation/restriction may fit appropriately into an individualized Plan of Protective oversight (IPOP), habilitation plan, or safeguard section of the ISP. Note: If the IPOP is selected by the provider as the document source for required information, ensure that the information is documented in a manner and/or location that does not confuse the provider's/staff's ability to identify current strategies to be implemented. All documents that describe how to provide supports, if more than one is considered necessary by the provider, should align with each other and with the most current and correct information on how to support the person. It is also acceptable to use one master document and refer to additional documents that provide the instruction, so long as the referenced document(s) is easily accessible.
- When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. The rights modification must have been considered as part of the Habilitation/Person-centered planning process; If the modification is for any reason, it must:

  1. Identify the specific individualized assessed need;
  2. Document the positive interventions and supports used prior to the modification;
  3. Document the less intrusive methods of meeting the need that had been tried but did not work;

4. Include a clear description of the condition that is directly proportional to the assessed need;
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
6. Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;
7. Includes the informed consent of the Individual;
8. Includes an assurance that interventions and supports will cause no harm to the Individual.

SELECT "MET" IF:

✓ Review of the service plan and/or any associated attachments demonstrate that positive or less intrusive measures in the past have been attempted but insufficient to support the person and subsequently, the current modification to the right has been made.

SELECT "NOT MET" IF:

✓ There is no record of positive or less intrusive measures employed in the past to prior to the currently implemented rights modification.

Standard No.	Standard Text	Decision
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights modification (clinical justification).	**Met/Not Met**

Guidance

INTERVIEW:

As Needed: Program coordinator, service/care coordinator/manager; FCP, Provider agency staff including direct support, managerial and/or clinical associated with providing safeguards and supports; Individual and/or family/advocate as

DOCUMENTATION REVIEW :

Mandatory as appropriate to service type: Person centered plan (ISP or other name); Individualized Plan of Protection (IPOP or other name); Any associated documentation describing the history of less intrusive measures which were unsuccessful to include clinical assessments, etc.

GUIDANCE :

- (Note: If a person has a restriction/limitation in place because of a behavioral concern, he/she should already have a behavior support plan in place that addresses this required element. If the person requires any limitations to rights expected in HCBS settings due to identified behaviors, the BSP would also be the appropriate place to provide the required documentation.)
- In the event that any of the person's rights are limited or modified for a person because of health or safety concerns (such as using a bed rail because of a seizure disorder), it may not be necessary or appropriate to develop a behavior support plan. However, the requirements in #'s 1-8, below, still apply and need to be documented. In those instances, the information regarding limitation/restriction may fit appropriately into an Individualized Plan of Protection (IPOP), habilitation plan, or safeguard section of the ISP Note: If the IPOP is selected by the provider as the document source for required information, ensure that the information is documented in a manner and/or location that does not confuse the provider's/staff's ability to identify current strategies to be implemented. All documents that describe how to provide supports, if more than one is considered necessary by the provider,

should align with each other and with the most current and correct information on how to support the person. It is also acceptable to use one master document and refer to additional documents that provide the instruction, so long as the referenced document(s) is easily accessible. When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. The rights modification must have been considered as part of the Habilitation/Person-centered planning process; If the modification is for any reason, it must:

- Identify the specific individualized assessed need;
- Document the positive interventions and supports used prior to the modification;
- Document the less intrusive methods of meeting the need that had been tried but did not work;
- Include a clear description of the condition that is directly proportional to the assessed need;
- Include regular collection and review of data to measure the ongoing effectiveness of the modification;
- Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;
- Includes the informed consent of the Individual;
- Includes an assurance that interventions and supports will cause no harm to the Individual.

SELECT "MET" If the following is present:

- ✓ Review of the service plan or associated attachments or include a description of the person's individualized assessed need and/or behavior that justifies rights restriction or rights modification (clinical justification).

SELECT "NOT MET" If the following is present:

- ✓ Description of the person's individualized assessed need and/or behavior that justifies rights restriction or rights modification (clinical justification) is not documented in the person's written plan.

Standard No.	Standard Text	Decision
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed: Program coordinator, service/care coordinator/manager; FCP, Provider agency staff including direct support, managerial and/or clinical associated with providing safeguards and supports; Individual and/or family/advocate

DOCUMENTATION REVIEW:
Mandatory as appropriate to service type: Person centered plan (ISP or other name); Individualized Plan of Protection (IPOP or other name); Any associated documentation describing the time limits to be respected for reassessment of need for the rights modification.

GUIDANCE:

- (Note: If a person has a restriction/limitation in place because of a behavioral concern, he/she should already have a behavior support plan in place that addresses this required element. If the person requires any limitations to rights expected in HCBS settings due to identified behaviors, the BSP would also be the appropriate place to provide the required documentation.)
- In the event that any of the person's rights are limited or modified for a person because of health or safety concerns (such as using a bed rail because of a seizure disorder), it may not be necessary or appropriate to develop a behavior support plan. However, the requirements in #'s 1-8, below, still apply and need to be documented. In those instances, the information regarding limitation/restriction may fit appropriately into an individualized Plan of Protective oversight (IPOP), habilitation plan, or safeguard section of the ISP. Note: If the IPOP is selected by the provider as the document source for required information, ensure that the information is documented in a manner and/or location that does not confuse the provider's/staff's ability to identify current strategies to be implemented. All documents that describe how to provide supports, if more than one is considered necessary by the provider, should align with each other and with the most current and correct information on how to support the person. It is also acceptable to use one master document and refer to additional documents that provide the instruction, so long as the referenced document(s) is easily accessible.
- When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. The rights modification must have been considered as part of the Habilitation/Person-centered planning process; If the modification is for any reason, it must:
    - Identify the specific individualized assessed need;
    - Document the positive interventions and supports used prior to the modification;
    - Document the less intrusive methods of meeting the need that had been tried but did not work;
    - Include a clear description of the condition that is directly proportional to the assessed need;

- Include regular collection and review of data to measure the ongoing effectiveness of the modification;
- Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;
- Includes the informed consent of the Individual.
- Includes an assurance that interventions and supports will cause no harm to the Individual.

SELECT "MET" IF:

✓ Review of ISP, IPOP and/or any associated documentation, assessments include a description of the time frame of periodic review of the restriction and/or time frame for the restriction.

SELECT "NOT MET" IF:

✓ There is no record of a description of the time frame of periodic review of the restriction and/or time frame for the restriction.

Standard No.	Standard Text	Decision
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed: Program coordinator, service/care coordinator/manager; FCP, Provider agency staff including direct support, managerial and/or clinical associated with providing safeguards and supports; Individual and/or family/advocate

DOCUMENTATION REVIEW:

Mandatory: as appropriate to service type: Person centered plan (ISP or other name); Individualized Plan of Protection (IPOP or other name); Any associated documentation to include clinical assessments, etc., which may describe ways in which the plan could be designed to limit the need for the rights modification a person who has recently moved to a new home has fallen in the middle of the night. After less invasive measures have been tried, has a bed alarm installed. PT assessment guides night shift staff how to reorient the person to her new surroundings, teaching her to call staff and allow longer periods for the alarm to be off, etc.)

GUIDANCE:

(Note: If a person has a restriction/limitation in place because of a behavioral concern, he/she should already have a behavior support plan in place that addresses this required element. If the person requires any limitations to rights expected in HCBS settings due to identified behaviors, the BSP would also be the appropriate place to provide the required documentation.)

- In the event that any of the person's rights are limited or modified for a person because of health or safety concerns (such as using a bed rail because of a seizure disorder), it may not be necessary or appropriate to develop a behavior support plan. However, the requirements in #'s 1-8, below, still apply and need to be documented. In those instances, the information regarding limitation/restriction may fit appropriately into an individualized Plan of

Protective oversight (IPOP), habilitation plan, or safeguard section of the ISP. Note: If the IPOP is selected by the provider as the document source for required information, ensure that the information is documented in a manner and/or location that does not confuse the provider's/staff's ability to identify current strategies to be implemented. All documents that describe how to provide supports, if more than one is considered necessary by the provider, should align with each other and with the most current and correct information on how to support the person. It is also acceptable to use one master document and refer to additional documents that provide the instruction, so long as the referenced document(s) is easily accessible.

- When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. The rights modification must have been considered as part of the Habilitation/Person-centered planning process; If the modification is for any reason, it must:
- Identify the specific individualized assessed need;
    1. Document the positive interventions and supports used prior to the modification;
    2. Document the less intrusive methods of meeting the need that had been tried but did not work;
    3. Include a clear description of the condition that is directly proportional to the assessed need;
    4. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
    5. Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;
    6. Includes the informed consent of the Individual;
    7. Includes an assurance that interventions and supports will cause no harm to the Individual.

SELECT "MET" If all of the following are present:

- ✓ The written plan to address/eliminate the need for limitation includes description regarding: actions and supports to provide the person; what to do to assure interventions cause no harm, and the documentation/data collection necessary

SELECT "NOT MET" IF either of the following is/are present:

- ✓ There is no written plan to address/eliminate the need for the limitation/restriction, located in a document such as an IPOP, Hab plan, or other service plan.
- ✓ There is a plan but it lacks description of one or both of the following: actions and supports to provide the person; actions to ensure interventions cause no harm, and/or the documentation/data collection necessary.

Standard No.	Standard Text	Decision
3a-5	The individual has given informed consent to the rights limitations/restrictions in place.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed: Individual and/or family/advocate; Program coordinator, service/care coordinator/manager; FCP, Provider agency staff including direct support, managerial and/or clinical associated with providing safeguards and supports.

DOCUMENTATION REVIEW :

Mandatory as appropriate to service type: Person centered plan (ISP or other name); Individualized Plan of Protection (IPOP or other name); Documentation of informed consent of the rights modifications signed by the person or family/advocate as needed

GUIDANCE :

(Note: If a person has a restriction/limitation in place because of a behavioral concern, he/she should already have a behavior support plan in place that addresses this required element. If the person requires any limitations to rights expected in HCBS settings due to identified behaviors, the BSP would also be the appropriate place to provide the required documentation.)

- In the event that any of the person's rights are limited or modified for a person because of health or safety concerns (such as using a bed rail because of a seizure disorder), it may not be necessary or appropriate to develop a behavior support plan. However, the requirements in #'s 1-8, below, still apply and need to be documented. In those instances, the information regarding limitation/restriction may fit appropriately into an individualized Plan of Protective oversight (IPOP), habilitation plan, or safeguard section of the ISP Note: If the IPOP is selected by the provider as the document source for required information, ensure that the information is documented in a manner and/or location that does not confuse the provider's/staff's ability to identify current strategies to be implemented. All documents that describe how to provide supports, if more than one is considered necessary by the provider, should align with each other and with the most current and correct information on how to support the person. It is also acceptable to use one master document and refer to additional documents that provide the instruction, so long as the referenced document(s) is easily accessible.

- When there is an appropriate, documented rights modification that restricts a person's access to their rights, compliance with the following criteria satisfies the standard as being 'Met'. The rights modification must have been considered as part of the Habilitation/Person-centered planning process; If the modification is for any reason, it must:
- Identify the specific individualized assessed need;

1. Document the positive interventions and supports used prior to the modification;
2. Document the less intrusive methods of meeting the need that had been tried but did not work;
3. Include a clear description of the condition that is directly proportional to the assessed need;
4. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
5. Include established time limits for periodic review to determine if the modification is still necessary or can be terminated;
6. Include the informed consent of the Individual;
7. Include an assurance that interventions and supports will cause no harm to the Individual.

SELECT "MET" IF:

- ✓ There is documentation of the informed consent of the person, or their family/advocate if needed, to the existing plan to modify access to rights (which, correctly, is not addressed in a BSP or MMP.)

SELECT "NOT MET" IF:

- ✓ A plan of modification to rights of the person exists (which, correctly, is not part of a BSP or MMP) and there is no documentation of informed consent by the person, or their family/advocate if needed, to the plan.

SECTION 4: FULL ACCESS TO THE COMMUNITY

Standard No.	Standard Text	Decision
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community.	**Met/Not Met**

Guidance

DISCUSSION: INTERVIEW:
• Mandatory:
o Person supported and/or Family/advocate
o Program staff, FCP
• As Needed:
o Program Coordinator or service/care coordinator/manager
DOCUMENTATION REVIEW: Mandatory:
• Person Centered Plan (ISP or other name)
• Habilitation Plan(s)
• Documentation of individuals' time away from the site (e.g.: trip logs, community inclusion rosters
• Documentation of individual's spending preferences

OBSERVATION

- As Needed: And as opportunity arises during visit, observe if and how person interacts, communicates with support staff to access the community and actually goes into the community from the service site.

GUIDANCE:

- CMS regulation states, "The setting is integrated in and supports full access of individuals receiving HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS." ADM 2014-04 provides additional background and considerations to guide providers on what is meant by "full access" to the community "to the same degree of access" as others. Critical factors include ensuring that service and support delivery practices do not isolate people with disabilities from people who do not have disabilities and ensuring that service and support practices are not institutional in nature

- "Full access" means that providers/staff promote, facilitate, and support full access to the broader community for the person that is typical of the degree of access (and method of access) that non-disabled people have to their local community. The term, "same degree as others" is not met when all individuals in the home were transported to an activity via the agency bus regardless of preference for activities. However, in some instances, groups do enjoy engaging in the same activities. Meeting the requirement of "same degree as others" for group activities could occur if (a) it can be documented that group community activities were chosen individually by the person among options and (b) once individuals arrived they were encouraged and supported to interact with others who do not have disabilities rather than stay as an entire group that is insulated from the public at large.

- For example, in residential settings, when persons are supported choose from spending their evening at home versus joining their housemates who have chosen to go to a softball game versus going shopping with staff, then "same degree as others" is met. When persons supported in day and community settings, choose among community activities consistent with their preferences and interests and are supported to do travel to these activities via their preferred method (e.g.. public transportation, agency vehicle, walk, etc.), "same degree as others" is met.

SELECT "MET" If both are present:

- ✓ The Individual receiving services has full access to the community to the same degree as other members of their community whom are not receiving services, and;
- ✓ The access is based on the Individual's interests, preferences, and priorities.

SELECT "NOT MET" If either is present:

- ✓ The person doesn't access the community to the degree, and in a similar manner, that non-disabled, non-waiver supported persons do.
- ✓ • Despite access to the community, the person's access is not based on their interests, preferences, or priorities.

Standard No.	Standard Text	Decision
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.	**Met/Not Met**

Guidance

DISCUSSION: INTERVIEW:
• Mandatory:
o Person supported and/or Family/advocate
o Program staff, FCP
• As Needed:
o Program Coordinator or service/care coordinator/manager

DOCUMENTATION REVIEW: Mandatory:
• Person Centered Plan (ISP or other name)
• Habilitation Plan(s)
• Documentation of individuals' time away from the site (e.g.: trip logs, community inclusion rosters
• Documentation of individual's spending preferences

OBSERVATION:
As Needed: And as opportunity arises during visit, observe if and how person interacts, communicates with support staff to access the community in both planned and unscheduled ways, and actually goes into the community from the service site.

GUIDANCE:

- This standard verifies if the person accesses the community in the frequency and manner that he/she wants, just like any other adult and in accordance

to the same degree as the community at large. See if the person accesses the community regularly. Ask the person (and service providers) to describe how they access the community (public transportation, walking, taxi, staff, etc.) and who assists them in facilitating this.

- For purposes of this standard, "regularly" should be defined by the person, in accordance with what their wishes and desires are and should be reflected in the person's Habilitation Plan/other documentation that becomes part of the Plan. It should not include only activities that are part of the person's day program hours if the person attends waiver day program as this assessment is reviewing the person's home/community life through his/her residential supports. Note: Community size may influence level of participation. For example, when the number of options is limited by the location or size of the community, the type and variety of participation should match that of others in the community. If the person's community is rural with perhaps, comparatively fewer opportunities to be out and about during typical hours of business, it would be expected that that is the same for his/her neighbors. But again, rural living is to be chosen by the individual and if it's not consistent with his/her preferences for community life, then this disconnect should be addressed via person-centered planning.

SELECT "MET" If both are present:

- ✓ The individual regularly accesses the community, to the degree she/he prefers.
- ✓ The person has this community access in both scheduled and unscheduled ways, as she/he prefers.

SELECT "NOT MET" if any are present:

- ✓ Evidence shows that he/she is not supported, empowered, or enabled to participate in desired activities to the degree she/he prefers, in either scheduled or impromptu ways.
- ✓ Evidence shows that activities are scheduled by others without input from individuals regarding individual interests and preferences.
- ✓ Staff/provider and/or individual report chronic barriers such as lack of transportation or lack of available support persons that hinder opportunities for participation in scheduled and unscheduled events.

Standard No.	Standard Text	Decision
4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are meaningful to them for the period of time desired.	**Met/Not Met**

Guidance

DISCUSSION: INTERVIEW:
• Mandatory:
o Person supported and/or Family/advocate
• As Needed:
o Program staff, FCP*
o Program Coordinator or service/care coordinator/manager

DOCUMENTATION REVIEW: As Needed:
• Person-centered plan (ISP or other name)
• Community Activity documentation
• Staffing schedules

• Any available documentation in person's record re: satisfaction with services (e.g. Individual/family satisfaction survey; pre-ISP planning questionnaire; CQL POM interview summary, etc.)

OBSERVATION:

As Needed:

• Visualize supports needed to access the community, for example:

o transportation options (e.g. WC van, enough vehicles, public transportation stop nearby, schedule for regional transport vendor, etc.) o mobility supports (e.g. electric WC for uneven surfaces in town)

o cell phone for person to check in when he/she is in community alone, etc.

GUIDANCE:

(The agency level review protocol will also address how the provider solicits satisfaction feedback from persons supported and/or their families/advocates regarding supports and services to access the community and activities per their preferences. The standard there will help evaluate how the agency responds to satisfaction of its individuals as a whole.) Here, this standard, at the level of the person supported, is to be evaluated primarily based on the perspective of the person (and/or family/advocate as needed.)

- Service Provider's input should not be the sole basis for verifying the person's satisfaction, however, input from the supports that best knows the individual is advisable in making this determination, if the individual and/or family/advocate are unable to provide this evidence of satisfaction.
- In addition to interviews, review of supporting documentation and observations can be used to verify satisfaction at the individual level.) E.g. A young man lives in his parents' home and expresses a strong desire to learn to become a weatherman. Service providers are responsible to find ways for him to explore and access community resources toward this goal, i.e. library and internet resources, local continuing education, visit a local television news station to volunteer as a community weather watcher, etc. Agency would provide transportation to him and support him to gain the pre requisites, help build a rain gauge in his yard, etc., to pursue this interest. This would be evidenced by hab documentation, interview with person and/or family/advocate, community hab or community pre-vocational staff (with the person's feedback being primary in assessing if he is satisfied.)
- Person-centered planning activities should document his interest and if the agency doesn't provide the supports to him to explore paths to this goal, thinking it is too lofty for him, it would be expected to be 'Not Met' with him presumably dissatisfied.

SELECT "MET" If (Any):

- ✓ The individual expresses satisfaction with agency provision of supports to go out and participate in the community in activities that interest him.
- ✓ He/she denies the presence of systemic and ongoing barriers to access the community e.g., site rules, staffing challenges, lack of transportation, lack of creative, goal-targeted habilitation plans, etc.
- ✓ Service plan activities aimed at meeting the person's desired level of community access/activities are being implemented and the person is satisfied.

SELECT "NOT MET" If either:

- ✓ The person reports dissatisfaction with their ability to participate in his/her preferred, meaningful activities and there is no valid agency limitation, barrier, or justification, beyond agency control, for this lack of access.
- ✓ Service plan activities aimed at meeting the person's desired level of access are not being implemented and the person is dissatisfied and/or negatively impacted.

SECTION 5: RELATIONSHIPS		
Standard No.	**Standard Text**	**Decision**
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	**Met/Not Met**

Guidance

DISCUSSION: *INTERVIEW:*
• Mandatory:
o Person supported and/or Family/advocate
• As Needed:
*o Program staff, FCP**
o Program Coordinator or service/care coordinator/manager
OBSERVATION:
• If possible & acceptable to the person supported, observe interactions between them and the people that are important to them.
DOCUMENTATION REVIEW:
Mandatory:
• Person-centered plan (ISP or other name)
• Habilitation plan(s)

GUIDANCE:

- The person should have the opportunity to develop close, private and personal relationships without unnecessary barriers or imposed obstacles. Look for evidence that agency staff actively support the ability of the person to maintain meaningful relationships. The person should be aware that they may invite people of their choosing to visit them at their program site and be assisted to do so. The person should also be aware that they may visit with others in the community. Even if the person expresses little to no interest in having visitors to his/her program site, the person should understand that it is his/her right.

- Visitors should have access to all appropriate areas of the site when visiting and should not be denied entry to common areas and/or the person's room (unless there is a compliant, valid rights modification in place.) The facility may require visitors to sign in and/or notify the facility administrator that they are in the site or complete other procedures to ensure the safety and welfare of residents and staff. However, procedures should not unnecessarily restrict visitors for the convenience of staff and/or to restrict the person from freedom of association. Similarly, in Family Care Homes it is reasonable to have some basic expectations regarding visitation in place that are respectful to the well-being of all members of the household, but still facilitate the individual's ability to have visitors in the home in a manner and frequency that he/she wants.

- In residential settings, visitation overnight must be allowable (unless there is a compliant, valid rights modification in place) subject to limits in lease or other agreement that prevent visitation from being stretched into legal occupancy.

- Some individuals may not express or not be capable to express interest in visitation by family, friends, co-workers, and others. However, the provider is expected to support all individuals to maintain and/or develop social relationships to the degree desired by the person. This obligation is continuous and should not be stopped based on an individual's past responses. Staff/FCP can remind individuals that they may invite people to the site and that they will support them in any way possible. They may also use certain events as an opportunity to suggest to the person how to engage a friend in the event (e.g. "Saturday is your birthday and you said you wanted a BBQ. What do you think about inviting Sally to join the party?") For individuals who cannot/will not express their desire or interest, staff should be observant of their reaction to family members and other people. If they and others in their circle agree that the person may benefit from visits with people the person seems to enjoy, they should provide the supports to facilitate such visits.

- It is understood that in a shared living situation, the privacy needs of other residents must also be respected, but there should be an agency effort to communicate and coordinate between the affected parties rather than having blanket site rules restricting when and how a person can receive visitors. Potential barriers restricting the person from having visitors or visiting others should be addressed.

SELECT "MET" IF either is present:

- ✓ There is sufficient evidence which shows there is ongoing and consistent support to assist the person to foster and maintain the continuity of his/her important relationships.
- ✓ The person is encouraged and supported to invite their friends, family, relatives, and significant others, etc. to their service site (i.e., home, day, in the community) during times they select, if they so choose.

SELECT "NOT MET" If either:

- ✓ Evidence shows that staff/FCP do not actively support the person to build and maintain personal relationships (with those other than with paid staff) to the degree that the person desires.
- ✓ The person is dissatisfied with the support provided by agency staff/FCP to build and maintain personal relationships which may or may not include barriers to having visitors of his/her choosing to their program setting (i.e. home, day setting, in the community.) elect "MET" If either the 1st or 2nd bullet PLUS the 3rd is evident.

SECTION 6: LIVING ARRANGEMENTS

Standard No.	Standard Text	Decision
6-1	The individual is satisfied with their living situation and does not express a desire (when questioned) to move to another living setting and/or with another roommate.	**Met/Not Met**

Guidance

INTERVIEW:
• Mandatory:
o Person supported and/or Family/advocate
• As Needed:
o Program staff, FCP*
o Program Coordinator or service/care coordinator/manager*

DOCUMENTATION REVIEW:
• As Needed:
o Person-centered plan, (ISP or other name)
o Res hab plan
o Any available documentation in person's record re: satisfaction with services (e.g. Individual/family satisfaction survey; pre-ISP planning questionnaire; CQL POM interview summary, etc.)

OBSERVATION:
• Mandatory:
o Interactions between Individual and house mates, roommate, and supports
o Comfort level of individual in their residence

GUIDANCE:
(The agency level review protocol will also address how the provider solicits satisfaction feedback from persons supported and/or their families/advocates regarding their choice of home and roommate. The standard there will help evaluate how the agency responds to satisfaction of its individuals as a whole.) Here, at the level of the person supported, this standard is to be evaluated primarily based on the perspective of the person (and/or family/advocate as needed.)

- It is important to determine whether the person is satisfied with his/her current living situation. Provider input alone is not sufficient to determine the person's satisfaction. Interview with the person (and/or family/advocate if needed) is the primary means of validating this standard. Then, if more information is needed regarding the satisfaction level with his/her living arrangement, obtain it through observation, record review (e.g. person centered planning records, satisfaction survey records) and interview with staff, program coordinator, FCP or service/care coordinator/manager.

SELECT "MET" IF:
- ✓ Based on the feedback of the individual, he/she is satisfied with their living arrangement and roommate and does not express a desire to move or to have another roommate.

SELECT "NOT MET" IF:

- ✓ Based on the feedback of the individual, he/she is not satisfied with their living arrangement and roommate and expresses a desire to move or to have another roommate.

Standard No.	Standard Text	Decision
6-2	If the individual is NOT satisfied with living situation, there is evidence that the staff is proactively working to find an alternate arrangement based on the person's needs, choices and preferences in a timely manner.	**Met/Not Met/NA**

Guidance

INTERVIEW:

• Mandatory:
o Person supported and/or Family/advocate
• As Needed:
o Program staff, FCP
o Program Coordinator or service/care coordinator/manager

DOCUMENTATION REVIEW:

• Mandatory:
o Person Centered Plan (ISP or other name)
• As Needed:
o Program coordination or MSC on going documentation re: response to dissatisfaction
o Documentation in person's record re: satisfaction with services (e.g. Individual/family satisfaction survey; pre-ISP planning questionnaire; CQL POM interview summary, etc.)

OBSERVATION:

• Mandatory:
o Interactions between Individual and house mates, roommate and supports
o Comfort level of individual in their residence

GUIDANCE:

- Verify evidence (interview, record review) that the agency has taken steps to address any dissatisfaction that the individual has reported. If it appears that the individual is not satisfied with his/her current living arrangement, verify if their dissatisfaction has been recognized and that the agency is making efforts to address. It is the agency's obligation to educate the person about the range of choices that are available and to support the person in making an informed decision regarding his/her living situation. It is important for the agency to provide ways for the person to explore all of his/her living options. If the person is dissatisfied, the agency staff is responsible to notify the person's program coordinator and/or others that can assist the person to experience and/or locate alternative options.

- CMS has clarified that a residence is not required to make sure that every individual receiving HCBS has their own bedroom when receiving residential services. However, the rule does require that individuals be provided options of residential settings, including the option of a private room. This includes providing them with information about all relevant potential options, not just options and environments readily available. The person's preferences in deciding where he/she lives, and with whom they live, are a priority. Sometimes options are limited, but the agency should be making viable efforts to find creative solutions to honor the person's individual preferences as much as possible in their current environment until their chosen option can be accessed. The residential support staff should be aware of the needs and preferences of the individual and should respond positively to requests that are within their control to influence.

SELECT "MET" If any of the following apply:

- ✓ Agency staff is assisting the person in a timely manner to find an alternative roommate/living arrangement and/or is helping the person to resolve differences to their satisfaction, if appropriate.
- ✓ If the person wants a new roommate, the answer would only be 'Met' if evidence indicates that the residential staff/provider are doing everything that they can to work on alternatives to satisfy the person. (E.g. changes in the room design and/or schedules for more privacy until an entirely new roommate situation can be found.)
- ✓ If the person wants to move to another residence, the answer would be 'Met' if the evidence indicates that the residential staff/provider is doing everything they can to assist the person. This would include regular communications with the program coordinator and family members/advocates, discussions of options with the person, visits to alternative living settings, etc.

SELECT "NOT MET" IF :

- ✓ There are clear indications that the person is not satisfied with their current living situation, and that the agency is aware, but there is no evidence of viable action being taken to help the person to locate alternatives and/or to improve the situation.

Select "NA" IF:

- ✓ The person is satisfied with living situation.

Standard No.	Standard Text	Decision
6-3	The individual's personal living spaces(s) reflect their individualized interest and tastes.	**Met/Not Met**

Guidance

INTERVIEW:

• Mandatory:
o Person supported and/or Family/advocate
• As Needed:
o Program staff, FCP
o Program Coordinator or service/care coordinator/manager

DOCUMENTATION REVIEW:

• Mandatory:
o Person Centered Plan (ISP or other name)
• As Needed:
o Personal Spending documentation

OBSERVATION:
Mandatory:
• Visually observe person's personal space and décor, with their permission.

GUIDANCE:

- The person is encouraged and supported to make changes to furnishings or decorations in their personal living space as and when they choose. This includes the person directing the plan to purchase décor items, making the purchase, installing the decorative items, etc. Service providers support the person to the degree the person wants in this pursuit but do not direct it or have to 'approve' it for the person to proceed. If the person has a laid back, casual approach to organizing their personal space, that is to be respected. As long as the person's space is not unhealthy, out of compliance with their lease agreement, or hazardous for them, it is theirs to control. Staff/FCP still have the role of teaching best practices and providing positive support in assisting the person to make informed choices about their personal environment, but they are not there to be the 'room police'.
- Consistent with HCBS settings requirements, the person has the right to store and consume food safely in their room. Service providers continue to have the role of supporting them to exercise this right safely by providing positive supports, supporting informed decision making by the person and not engaging in power struggles over these rights. Interview with people who know the person well should demonstrate an understanding of the person's tastes and it is evident that the person is encouraged to decorate and keep his/her room as they prefer.

SELECT "MET" If (Any):

- ✓ Based on review of the person's person-centered service plan or habilitation plan and interview with the person, his/her bedroom reflects hobbies, interests, collections, family/friends, and memorable events, etc.
- ✓ The person reports being supported to keep his room in the order he sees fit, anywhere from relaxed to very orderly condition

SELECT "NOT MET" IF:

- ✓ The person reports not being supported to keep his room decorated or as orderly as he prefers.
- ✓ The person's personal space is not decorated or kept orderly in a way which reflects his personal tastes and preferences.

SECTION 7: SAFEGUARD PLANNING AND DELIVERY

Standard No.	Standard Text	Decision
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	**Met/Not Met**

Guidance

INTERVIEW:
Mandatory: Individual and/or family/advocate, service/care coordinator/manager, Direct support staff, FCP
As Needed: Program Managers, Clinical staff

DOCUMENTATION REVIEW:
Mandatory: SERVICE PLAN & referenced documents; IPOP/Safeguarding document(s); Habilitation Plan , Plan of care (by whatever name known, varies by program type)
As Needed: Clinical and medical evaluations, Behavioral intervention plans, Incident management records

OBSERVATION:
As needed:
• Observe individual in certified environments

GUIDANCE:

- Regulations and guidance applicable to nearly all OPWDD certified and funded facilities and services require service providers to identify and address individuals' safeguarding needs. In some facility or service types multiple regulatory and/or ADM references may apply.
- Safeguards include supervision, supports, and services to prevent or minimize risks to an individual's health, safety, or welfare, for example:
- Health:
    - An individual may need support or supervision to address mobility or allergy concerns
    - An individual may need supports or supervision to address swallowing or choking concerns
    - An individual may need supports or supervision for food allergy and other allergy precautions

- Behavioral Health:
    - An individual may need an individualized behavioral intervention plan or similar plan to maintain behavioral health
    - (Such plan may include certain levels of supervision or medication or other specialized interventions.)

- Home and Community:
    - An individual may need support or supervision during fire and other emergencies (For fire safety, see also standard 7-6)
    - An individual may need support or supervision during transportation or community activities
    - An individual may need support or supervision to prevent financial or other exploitation

- Safeguards may be necessary in a variety of circumstances, including but not limited to those listed above, depending on the individual's needs and service environment.

- Written instruction of the safeguards to be provided to the individual must be understandable to staff and other parties responsible to implement the safeguarding strategies.

- An individual's safeguarding needs and the supports and services to address them must be documented in the individual's service plans and/or plans of care, by whatever name known, in accordance with applicable regulations and guidance. Plans of care include, but are not limited to:
    - Person-centered service plans or individualized service plans (ISP) – applicable to MSC and PCSS (See 636-1 and ADM 2010-04) Note: Person-centered planning requirements in Subpart 636-1 apply to service coordination services (MSC and PCSS) and to HCBS waiver services; however, the regulatory references 636-1.3(b)(3), (4), and (8) above apply only to the service coordination function
    - Plans for protective oversight – applicable to IRAs (See 686.16). Note: IRA/FSRs are not required to have individual plans for protective oversight; however, the ISP and other records must include sufficient information on safeguards and supports to meet an individual's needs during respite at an IRA/FSR
    - Plans of services – applicable to CRs (See 671.6 and/or 633.10) including assessment of need for oversight and guidance in supportive CRs (See 686.8)
    - Written plans of care – applicable to private "residential" schools (See 81.6) and day training programs (See 85.6; Note: Some day training programs may have prevocational service habilitation plans for individuals who receive site-based prevocational services there these plans can function as the required written plan of care - see Habilitation Plan, below)
    - Program narratives – applicable to integrated residential communities (See 27.3)
    - Individual program plans – applicable to the specialty hospital (See 680.6) and day treatment programs (See 690.6)
    - Habilitation plan/safeguards applicable to residential, day, and community habilitation, site-based and community prevocational services, pathway to employment, and supported employment (See ADM 2012-01)
    - Note: The requirements in 633.10 also apply to OPWDD certified facilities.

- Agencies may title some of these required reports by other names; this as acceptable as long as the reports include required information and are in the form and format required by OPWDD for the type of service or facility. All documents that describe how to provide supports, if more than one is considered necessary by the provider, should align with each other and with the most current and correct information on how to support the person. Documentation may include the specific safeguard information or reference to another document with the details staff have available to them.
- Information on how to implement the safeguards may be detailed in a variety of formats, e.g., plans of nursing services, behavioral intervention plans, or other documents that are developed for that purpose and are accessible to staff providing services. Regardless of how the information is documented, it is most important that people providing services/supports understand and can properly implement the safeguards and supports the individual needs.

- Review pertinent documentation, such as clinical assessments (e.g., occupational, physical, or speech therapy) and health/medical care, behavioral intervention, fire drill, personal allowance, and incident management records, as applicable, to determine if the individual's needs were identified and addressed – in a timely manner - by his or her planning team. Observe the individual and their paid supports in the service environments, where applicable, and interview all relevant parties, as needed, to confirm or gather additional information.

SELECT "MET" IF:

✓ Record reviews, observations, and interview(s) present sufficient evidence that the individual's safeguarding needs and supports and services to address them are documented in the individual's plan of services (by whatever name known) in accordance with applicable regulatory requirements.

SELECT "NOT MET" IF:

✓ Record reviews, observations, and interview(s) do not present sufficient evidence that the individual's safeguarding needs and supports and services to address them are documented in the individual's plan of services (by whatever name known) in accordance with applicable regulatory requirements.

Standard No.	Standard Text	Decision
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory: Individual and/or family/advocate, service/care coordinator/manager, Direct support staff, FCP
As Needed: Program managers, Clinical staff

DOCUMENTATION REVIEW:

Mandatory: SERVICE PLAN & referenced documents; IPOP/Safeguarding document(s); Habilitation Plan, Plan of care (by whatever name known, varies by program type) IRMA/Incident documentation
As Needed: Clinical and medical evaluations, Behavioral intervention plans, Plans of Nursing Services

OBSERVATION:

Mandatory:
• Observe individual in certified environments

GUIDANCE:

Reminder: Supervision is addressed in Standard 7-3; Mobility is addressed in Standard 7-4; Dining Supports are addressed in Standard 7-5; Fire Safety is addressed in Standards 7-6 and 7-7; Financial stability is addressed in Standard 7-8

Each individual must be provided with safeguards and supports in accordance with his or her plan of services, by whatever name known, including but limited to the SERVICE PLAN, habilitation plan, or individual plan for protective oversight (For information on plans of services, see facility and program specific guidance for Standard 7-1, above).

Aside from supervision, dining, mobility, fire safety, and financial supports, safeguards may include interventions or use of equipment (e.g., weekly pill cases) to support self-administration of medication, self-care activities, and other daily living skills; interventions to address behavioral needs; and other interventions designed to safeguard and support an individual based on an individual's unique personal needs.

Note: Protections involving any modifications to an individual's rights are addressed in Section XXX of this protocol.

The service provider must also provide safeguards and supports in response to an individual's changing needs in a timely manner, even when the changes are not yet documented in the plan of services. These include, but are not limited to, changes in physician's orders to treat a new or acute condition. Hospital discharge plans or interventions to address immediate risks to an individual's health, safety, or welfare must be implemented without delay.

Staff/FCP providing services must be trained to properly implement the individual's safeguards and supports. Staffing numbers and staff deployment must be sufficient to provide them.

An individual's safeguarding needs and the supports and services to address them must be implemented in accordance with the individual's plan of care, and the individual's changing needs.

This standard does not apply to supervision, dining, mobility, fire safety, and financial supports, Supervision is addressed in Standard 7-3; Mobility is addressed in Standard 7-4; Dining Supports are addressed in Standard 7-5; Fire Safety is addressed in Standards 7-6 and 7-7; Financial Stability is addressed in Standard 7-8.

SELECT "MET" IF:

- ✓ Record reviews, observations, and interview(s) present sufficient evidence that the individual's safeguarding supports and services are properly implemented in accordance with the individual's plan of services (by whatever name known) and in accordance with the individual's existing and changing needs.
- ✓ For services with limited documentation, e.g. RESPITE, if there is no information in provided documentation and incidents to evidence that safeguards were not met, consider them met.

SELECT "NOT MET" IF:

- ✓ When record reviews, observations, and interview(s) present evidence that the individual's safeguarding supports and services are not properly implemented in accordance with the individual's plan of services (by whatever name known) and/or in accordance with the individual's existing and changing needs.

Standard No.	Standard Text	Decision
7-3	The individual is provided supervision per his/her written plan and as needed.	**Met/Not Met**

Guidance

INTERVIEW:
Mandatory: Individual and/or family/advocate, service/care coordinator/manager, Direct support staff, FCP
As Needed: Program managers, Clinical staff

DOCUMENTATION REVIEW:
Mandatory: SERVICE PLAN & referenced documents; IPOP/Safeguarding document(s); Habilitation Plan, Plan of care (by whatever name known, varies by program type) , IRMA/Incident Documentation
As Needed: Clinical evaluations, Behavioral intervention plans, Plans of Nursing Services

OBSERVATION:
Mandatory:
• Observe individual in certified environments

GUIDANCE:
Each individual must be provided with supervision in accordance with his or her plan of services, by whatever name known, including but limited to the SERVICE PLAN, habilitation plan, or individual plan for protective oversight (For information on plans of services, see facility and program specific guidance for Standard 7-1, above).
Individuals receiving services may need only limited supervision for specific activities, like self-administration of medication; extensive supervision, such as some form of one to one or two to one supervision; or any of the varied levels of supervision in between. In any case, each individual's plan of services must clearly describe the level, or levels, of supervision the individual needs from the service provider.
An individual may need the same level of supervision throughout the day, or may require different levels of supervision based on activities and service environments.
The levels of supervision must be described in sufficient detail so that direct support staff members/FCPs understand and consistently provide needed supervision and so that managers and others responsible for staffing, staff deployment, training, and oversight can plan, train, and monitor accordingly.
The service provider must also provide supervision in response to an individual's changing needs in a timely manner, even when the changes are not yet documented in the plan of services. These include, but are not limited to, changes in an individual's health, behavior, habits, or cognition. Supervision associated with immediate risks to an individual's health, safety, or welfare must be implemented without delay.
An individual's supervision safeguards and supports must be implemented in accordance with the individual's plan of care, and the individual's changing needs.
Considerations:
• Supervision needs may vary for the Individual depending on the circumstances surrounding the situation and/or current activity that the Individual is participating in. For example:
o An Individual may require different levels of supervision for site based services. I.e. At their residence, they need Periodic Observation of 30 minutes when engaged in an activity – While at Day Program, they need Periodic Observation of 5 minutes when engaged in an activity.

o An Individual may also require different levels of supervision while receiving non-site based waiver services. I.e. When independently accessing the community from his/her family care home, an Individual does not need supervision – When accessing the community via Community Habilitation, the Individual needs Range of Scanning supervision.

SELECT "MET" IF:

- ✓ Record reviews, observations, and interview(s) present sufficient evidence that the individual is provided with appropriate supervision in accordance with his or her plan of services (by whatever name known) and in accordance with his or her existing and changing needs.
- ✓ For services with limited documentation, e.g. RESPITE, if there is no information in provided documentation and incidents to evidence that safeguards were not met, consider them met.

SELECT "NOT MET" IF:

- ✓ Record reviews, observations, and interview(s) do not present sufficient evidence that the individual is provided with appropriate supervision in accordance with his or her plan of services (by whatever name known) and/or in accordance with his or her existing and changing needs.

Standard No.	Standard Text	Decision
7-4	The individual is provided mobility supports per his/her written plan and as needed.	**Met/Not Met/NA**

Guidance

INTERVIEW:

Mandatory: Individual and/or family/advocate, service/care coordinator/manager, Direct support staff, FCP
As Needed: Program managers, Clinical staff

DOCUMENTATION REVIEW:

Mandatory: SERVICE PLAN & referenced documents; IPOP/Safeguarding document(s); Habilitation Plan, Plan of care (by whatever name known, varies by program type) , IRMA/Incident documentation
As Needed: Clinical evaluations (esp. OT/PT/RN). Behavioral intervention plans, Plans of Nursing Services

OBSERVATION:

Mandatory:
• Observe individual in certified environments

GUIDANCE:

- Each individual must be provided with mobility supports in accordance with his or her plan of services, by whatever name known, including but limited to the person centered service plan, habilitation plan, or individual plan for protective oversight (For information on plans of services, see facility and program specific guidance for Standard 7-1, above).
- Mobility supports include, but are not limited to wheelchairs, walkers, canes, crutches, splints, braces, gait belts, and certain manual techniques service providers are trained to implement to support an individual receiving services. Mobility supports can also include environmental supports, like ramps, handrails, and lifts; vehicle modifications; and electronic environmental controls.

- Mobility supports are typically recommended based on clinical evaluation by physical and/or occupational therapist and ordered by a physician. Often a physical and/or occupational therapist will work with an individual and service providers to develop a plan to introduce and monitor use of a support and to train staff to assist, as applicable.
- An individual's specific supports for safe, functional mobility may vary based on environment and/or activity. E.g. supports needed in the community may be different than in the person's home, paved vs. unpaved surfaces, or based on observed abilities at any given time. .
- When an individual resides in an OPWDD certified residential facility, the residence typically has ongoing responsibility for ensuring that mobility supports are implemented as recommended and that equipment is maintained in good repair and made available for the individual's use. A habilitation, respite, or day services service provider may also have responsibility for implementing and monitoring mobility supports. When an individual lives alone in a non-certified setting or with family, the service/care coordinator/manager may gather information on and individual's use of mobility supports and seek professional services for the individual, when needed. In any case, each individual's plan of services must clearly describe mobility supports the individual needs (including a schedule for use, where needed), and do so in a manner that that is understood by people providing services.
- Mobility supports must be implemented in accordance with the individual's plan of care, and the individual's changing needs.
- The provider must be responsive to an individual's changing needs in a timely manner. Changes in an individual's gait (or falls) need to be assessed by an appropriate health care professional without delay. Information gathered during observation, interview, review of the individual's service record(s) and review of incidents, may provide information regarding appropriateness and responsiveness of mobility supports.

SELECT "MET" IF:

- ✓ Record reviews, observations, and interview(s) present sufficient evidence that the individual is provided with appropriate mobility supports in accordance with his or her plan of services (by whatever name known) and in accordance with his or her existing and changing needs.
- ✓ For services with limited documentation, e.g. RESPITE, if there is no information in provided documentation and incidents to evidence that mobility safeguards were not met, consider it met.

SELECT "NOT MET" IF:

- ✓ Record reviews, observations, and interview(s) do not present sufficient evidence that the individual is provided with appropriate mobility supports in accordance with his or her plan of services (by whatever name known) and/or in accordance with his or her existing and changing needs.

Select "NA" IF:

- ✓ The individual has no observed or documented need(s) for support to facilitate safe mobility.

Standard No.	Standard Text	Decision
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Mandatory: Individual and/or family/advocate, service/care coordinator/manager, Direct support staff, FCP
As Needed: Program managers, Clinical staff

DOCUMENTATION REVIEW:
Mandatory: SERVICE PLAN & referenced documents; IPOP/Safeguarding document(s); Habilitation Plan, Plan of care (by whatever name known, varies by program type) , Dining Plan if any, IRMA/Incident documentation
As Needed: Clinical evaluations, especially Speech and Nutrition, Behavioral intervention plans, Plans of Nursing Services

OBSERVATION:
Mandatory:
• Observe individual at mealtimes in appropriate certified environments

GUIDANCE:

- Each individual must be provided with dining supports in accordance with his or her plan of services, by whatever name known, including but limited to the person centered service plan, habilitation plan, or individual plan for protective oversight (For information on plans of services, see facility and program specific guidance for Standard 7-1, above).

- Dining supports include, but are not limited to:

    - levels of supervision and/or assistance an individual needs during meals;
    - food and/or fluid consistency modifications;
    - food or beverage presentation modifications or positioning needs;
    - equipment needs (scoop dish, modified utensils);
    - nutritional modifications (calories, fat/sodium/cholesterol content);
    - allergy/food sensitivity precautions; cultural (kosher/halal) or other (vegetarian/vegan, likes/dislikes) diet modifications; or
    - limitations on access to food and/or beverages.

- When an individual resides in an OPWDD certified residential facility, the residence has primary responsibility for ensuring that appropriate dining supports are developed and implemented for the individual. However, plans of services for all direct services an individual receives must include dining supports, when needed, and identify any adaptations necessary in each discrete service environment.

- Dining supports, including levels of supervision, must be described in sufficient detail so that direct supports understand and consistently provide needed supports and so that managers and others responsible for staffing, staff deployment, training, and oversight can plan, train, and monitor accordingly.

- The provider must be responsive to an individual's changing needs in a timely manner. Apparent changes in an individual's swallowing ability, including but not limited to choking incidents; or new food and/or eating related behavior, such as food seeking or rapid eating pace; or a new food sensitivity need to be assessed by an appropriate health care or clinical professional without delay.

- Dining supports must be implemented in accordance with the individual's plan of care, and the individual's changing needs, in conformance with applicable regulations and guidance. When observation is possible or required in certified settings, verify that needed supports and interventions related to dining are provided. When observation is not possible due to circumstances or community based services, verify through discussion, that people supporting the individual know and understand the supports they are expected to provide for dining, including consistencies, supervision and support/assistance. Delivery or non-delivery of supports may also occur through possible documentation of delivery of supports, review of incidents and untoward events, prn noted, etc.

SELECT "MET" IF:

- ✓ Record reviews, observations, and/or interview(s) present sufficient evidence that the individual is provided with appropriate dining supports in accordance with his or her plan of services (by whatever name known) and in accordance with his or her existing and changing needs for nor or more of the following: supervision, assistance, equipment, and food and beverage consistency.
- ✓ For services with limited documentation, e.g. RESPITE, and community based services if staff understand the person's needs, and there is no information in provided documentation and incidents to evidence that safeguards were not met, consider this met.

SELECT "NOT MET" IF:

- ✓ Record reviews, observations, and/or interview(s) evidence that the individual is not provided with appropriate dining supports in accordance with his or her plan of services (by whatever name known) and/or in accordance with his or her existing and changing needs for one or more of the following: supervision, assistance, equipment, and food and beverage consistency.

Select "NA" IF:

- ✓ No meals/mealtimes occur for the individual during their receipt of the service or in the service setting.

Standard No.	Standard Text	Decision
7-6	The individual's needs for support and assistance related to fire safety and evacuation are documented according to service/setting requirements.	**Met/Not Met**

Guidance

INTERVIEW:
Mandatory: Individual and/or family/advocate, Residential or day program manager and/or direct supports
As Needed: service/care coordinator/manager, Clinical staff

DOCUMENTATION REVIEW:
Mandatory: SERVICE PLAN & referenced documents; IPOP/Safeguarding document(s);Plan of care (by whatever name known, varies by program type)
As Needed: Fire Drill Records in appropriate certified settings, Behavioral intervention plans

GUIDANCE:

- There must be a review of each individual's ability to evacuate his or her home and service environment in the event of a fire or other emergency. The review must be specific and, at minimum, take into account the individual's health, cognition, and mobility, as well as the effect of certain medications the individual takes, and the physical characteristics of the home (and other environments where this may be necessary).
- In OPWDD certified supervised facilities, the review must be based on the individual's actual performance during fire and emergency evacuation drills conducted at the facility. (Any problems with an individual's evacuation must be addressed in a timely manner) This review may be documented in an individual's SERVICE PLAN or in a separate document maintained by the facility. In an IRA, the review must be documented in the individual's plan for protective oversight.
- In a supportive IRA or CR there is an underlying presumption and requirement that an individual will initiate and complete an evacuation of his or her home in three minutes or less without any prompts or assistance. But individuals who live in these settings must be reviewed at least annually, and as changes in status occur, to ensure their continued safety. The annual review must be documented in the IRA plan for protective oversight or in the CR plan for oversight and guidance.
- Fire safety must be addressed in the site specific plan for protective oversight at FSR/IRAs.
- For individuals who live in their own residence (i.e. non-certified settings, e.g. own home, with family), the service coordinator must document a review of fire safety needs and supports in the SERVICE PLAN.
- These fire safety reviews must also identify the level of supervision, adaptive equipment (e.g. bed shaker), and any environmental modifications (flashing lights) that the individual requires to waken (at home), when needed, and to safely evacuate the home or program area.
- Fire safety supports must be implemented in accordance with the individual's plan of care, and the individual's changing needs, in conformance with applicable regulations.
- Comprehensive fire safety requirements are addressed in section 8 of the site review protocol and Life Safety Code reviews, where applicable.

SELECT "MET" IF:

- ✓ Record reviews, observations, and interview(s) present sufficient evidence that the individual's fire safety needs, and supports and assistance to address them, are documented in the individual's plan of services (by whatever name known) or in a separate document maintained by a certified facility as applicable. This includes identification of needed monitoring, assistance, training, and assurance of equipment.

SELECT "NOT MET" IF:

- ✓ Record reviews, observations, and interview(s) do not present sufficient evidence that the individual's fire safety needs, and supports and assistance to address them, are documented in the individual's plan of services (by whatever name known) or in a separate document maintained by a certified facility as applicable.

Standard No.	Standard Text	Decision
7-7	The individual is provided the necessary supports and assistance related to fire safety and evacuation.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory: Individual and/or family/advocate, Residential or day program manager and/or direct supports
As Needed: service/care coordinator/manager, Clinical staff

DOCUMENTATION REVIEW:

Mandatory: SERVICE PLAN & referenced documents; IPOP/Safeguarding document(s); Plan of care (by whatever name known, varies by program type)
As Needed: Fire Drill Records as applicable to the setting, Behavioral intervention plans

GUIDANCE:

- Verify that individuals' fire safety needs are addressed as required and per the plan, e.g. training, assistance, supervision and/or provision of assistive equipment.
- Using information obtained from discussion with the individual (designee), SC/CM/CC and other service providers, review of documentation, and observation if appropriate, verify that the fire safeguards identified in the service plan are in place and being implemented.
- Through discussion and service notes verify that the SC/CM/CC follows up with the person, family and/or residential providers if applicable, to be sure that actions and recommendations from the fire safety assessment are implemented and appropriate.
- There should be ongoing monitoring that the person is independent or safely accommodated to evacuate his/her home in an emergency. This includes identification of needed monitoring, assistance, training, and assurance of equipment.

SELECT "MET" IF both of the following are present:

- ✓ Record reviews, observations, and interview(s) present sufficient evidence that the supports related to the individual's fire safety needs are provided.
- ✓ Record review, observations and interview(s) present sufficient evidence of monitoring that supports related to the individual's fire safety needs are adequate and provided.

SELECT "NOT MET" If any of the following are present:

- ✓ Record reviews, observations, and interview(s) evidence that the supports related to the individual's fire safety needs are not provided.
- ✓ Record review, observations and interview(s) do not provide evidence that monitoring that supports related to the individual's fire safety needs are adequate and provided.

Standard No.	Standard Text	Decision
7-8	The individuals are provided supports necessary to facilitate financial stability and freedom from financial exploitation.	**Met/Not Met**

Guidance

INTERVIEW :

Mandatory: Individual and/or family/advocate, Service/care coordinator/manager, Residential program manager, direct supports including FCP
As Needed: Direct support staff, Program managers

DOCUMENTATION REVIEW:

Mandatory: IRMA/Incidents reported for financial exploitation, Service Plan & referenced documents; IPOP/Safeguarding document(s); Habilitation Plan, Plan of care (by whatever name known, varies by program type), Personal allowance records and/or PEP for individuals residing in certified residential facilities
As Needed: Assessments, evaluations

GUIDANCE:

- Financial stability supports must be implemented in accordance with the individual's plan of care, and the individual's changing needs
- Individuals receiving services often need safeguards and supports to assist and ensure that they have financial resources necessary to live safely and comfortably management and protection of their personal funds.
- This standard is intended to verify the following, for individuals living in both certified and non-certified settings:
  - The person is supported to maintain the needed resources to obtain possessions and supplies necessary for comfortable daily living.
  - The person receives supports intended to address preventable financial exploitation.
- The level and type of supports to be discussed, determined and provided are dependent on the living circumstances and financial resources of the individual.
- An individual living in an OPWDD certified residence is guaranteed accommodations to ensure that all basic needs are met: safe housing, food/meals, needed supplies for routine daily living, basic furnishings, etc. This assurance therefore provides basis financial security in certified residences. However, safeguards related to security and freedom from exploitation of their personal allowance and earned income (if any) are necessary.
- Comprehensive personal allowance regulations in section 633.15 include specific recordkeeping and security requirements, as well as money management assessment and expenditure planning requirements, for individuals who reside in OPWDD certified residential facilities. Review personal allowance records and expenditure plans for those individuals to determine if individuals received the amount of personal allowance due to them and that expenditures were appropriate and accurately accounted for. Interview individuals, advocates, and staff about spending choices. Spending does not have to be exactly in accordance with the individual's personal expenditure plan, but should be in keeping with the individual's interests and choices.

Significant deviations from the plan, or transactions that are not accounted for must be reviewed further by survey staff to determine if funds were properly managed, as required. (See site review protocol, section 3, to review compliance with the details of those requirements further, when needed.)

- An individual living in non-certified settings may not be assured as great a degree of financial security. He/she may require supports to ensure that his/her financial resources are maintained and sufficient to meet their basic needs, and assistance/support for the security of any resources he/she manages.

- Things to consider:
  - Individuals should be primarily supported to ensure the financial security necessary to maintain her/his well-being. Promotion to develop money management skills may also be a consideration. Person-centered plan development may identify safeguards and supports to assist for individuals with the management and protection of their funds.
  - Habilitation plans may include outcomes to develop and improve an individual's money management or budgeting skills. Interview individuals, advocates, and staff about individuals' skills and need for support in this area. Determine if safeguards, supports, and services are provided as recommended, and in accordance with the individual's preferences and needs, to facilitate the individual's financial stability and protect the individual from financial exploitation.
  - Review that the person has the personal and household supplies that contribute to a quality of life. This may include items such as adequate food supply; supplies to maintain personal cleanliness and dental hygiene; supplies or resources to keep their living environment clean (cleaning products, broom, laundry supplies, etc.); clothing sufficient to allow changes for cleanliness and protect from the elements (e.g. shoes in adequate condition, boots, warm coat, gloves in winter, etc.). The person may be provided the supplies through their own fiscal resources, agency provided resources, family and natural supports, and/or community resources (e.g. food banks, special programs /donations).
  - The review the individual's needs to ensure they have enough or can obtain supplies quickly.
  - Sources of incomes (e.g. SSI and SSA, trust funds, personal allowance, clothing allowance, job/employment compensation
  - Supports in place and person(s) responsible to monitor and ensure that resources are sufficient and maintained. Supports may include direct management of funds, oversight of funds and spending, and training, etc.
  - Efforts to prevent financial exploitation of any resources of the individuals, both those held by the individual and managed by others. This may include personal allow funds managed by and agency, representative payee use of funds, debit cards, food assistance vouchers, etc. Individuals may be at risk for exploitation from parties responsible to assist with money management and fiscal matters, as well as family, friends, acquaintances, strangers, on-line and telephone scams etc.
  - The degree of assistance and oversight for management of money and protection from exploitation should be considered.
  - Best practice would include a person(s) designated to work actively with the person to foster the individual's independence in maintaining their resources and/or to be the support that is responsible to ensure that the person has what they need.
- Note: Incidents involving theft of a certain amount of an individual's funds and financial exploitation must be reported in accordance with Parts 624 and 625. The occurrence of such an incident does not - in itself - indicate that safeguards and supports were not provided to the individual; however, review is needed to ensure that any relevant recommendations were implemented to prevent future theft or financial exploitation of the individual (see standard 7-9, below).

SELECT "MET" IF any of the following are present:

- ✓ Record reviews, observations, and interview(s) present sufficient evidence that the individual is provided with appropriate supports for money management/financial stability in accordance with his or her plan of services (by whatever name known) and in accordance with his or her existing and changing needs.
- ✓ The individual has the resources they need.
- ✓ Despite diligent implementation of safeguards and/or monitoring, difficulties and issues occurred regarding the individual's financial security and protections, but were not preventable.

SELECT "NOT MET" IF any of the following are present:

- ✓ Record reviews, observations, and interview(s) present sufficient evidence that the individual is not provided with appropriate supports for money management/financial stability in accordance with his or her plan of services (by whatever name known) and in accordance with his or her existing and changing needs.
- ✓ The person does not have the resources they need.
- ✓ Difficulties and issues occurred regarding the individual's financial security and protections, but were not identified, or would likely have been preventable with adequate supports and oversight.

SECTION 8a: Health Services & Supports		
Standard No.	**Standard Text**	**Decision**
8a-1	A health assessment which identifies the individual's health care needs has been completed by a physician, PA, NP, or RN.	**Met/Not Met**

Guidance

DICUSSION:

As Needed:

• If it is unclear whether the person has had a comprehensive health or nursing assessment, discuss with the person and/or significant involved parties if an assessment of the person's health and health needs has been determined.

DOCUMENTATION REVIEW:

Mandatory:

• Review the person's record for documentation indicating that the person has had at least a baseline evaluation of their health or health care needs. This may be a comprehensive physical examination of all body systems or another general review of general health, health needs and need for health supports such as a comprehensive nursing assessment.

GUIDANCE:

- The purpose of this standard is to ensure that a person has had the status of their health and/or health care needs comprehensively assessed by a physician, physician's assistant, nurse practitioner or RN.

- Health Assessment by physician, physician's assistant, nurse practitioner: The assessment may be completed through a routine medical appointment such as a physical exam. It is a comprehensive physical examination of all body systems as a review of general health status. This standard is not intended to require an annual physical exam, but rather to determine that the person has had their medical needs evaluated to determine they are healthy with no significant diagnoses, or identify any health issues and health care needs. This is also not meant to be just a routine medical appointment with limited focus. Any routine medical appointments are based on the person's status and reviewed through other standards in the protocol. There may be several variables regarding how often an assessment of the person's health should occur. Factors may be age, diagnosis, medications and health history may affect how recently the last assessment occurred.
- Evidence of medical assessment by a physician, physician's assistance, nurse practitioner may include:

    - For individual living in a certified residence: A copy of the medical appointment consult form or other written documentation from the medical professional identifying their review and findings;
    - For individual living in their own home (non-certified home): A copy of the medical appointment consult form or other written documentation from the medical professional identifying their review and findings; or documentation of specific conversation with the individual and/or their supports, that identifies specific information about the medical assessment: the date, the medical professional who completed the assessment, the medical review activities (e.g. annual physical exam; review of body systems) and findings.
- Health Assessment by an RN:

- Any individual may benefit from a comprehensive nursing assessment identifying the health care concerns, needs and interventions relevant to the individual. However, an individual must have a comprehensive nursing assessment completed by the RN if they are a recipient of nursing delegated services via the exemption permitted for an individual receiving community based HCBS waiver service.
- The comprehensive nursing assessment must include the following information:
    - the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings;
    - the individual's strengths, goals, and care preferences;
    - current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional; and
    - a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy).
- The comprehensive assessment of the individual completed by the RN can be used to determine whether nursing tasks, in whole or in part, can be delegated to DSPs with adequate training and nursing supervision.
- An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.

SELECT "MET" If:

✓ There is documentation to evidence that a health assessment comprehensively assessing the general health status and needs of the person has occurred within the past three (3) years.

SELECT "NOT MET" If:

✓ There is not documentation to evidence that a health assessment comprehensively assessing the general health status and needs of the person has occurred within the past three (3) years.

Standard No.	Standard Text	Decision
8a-2	The individual has someone chosen/delegated to support them in coordinating their health care.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

Individual, Advocate: Discuss who helps the individual with doctor appointments and help them receive any specialized care at home.

As Needed and applicable: SC/CM/CC, RN with oversight, agency staff, support staff, FCP

DOCUMENTATION REVIEW:

Mandatory:

• Service plan dependent on the person's services and service environment (e.g. ISP, Treatment Plan, Program Plan, etc.)

GUIDANCE:

- The intent is to verify that there is someone designated and consistently monitoring the individual's receipt of health care services as needed:
  - Ensuring needed appointments with Health Care Professionals (HCP) are arranged and attended per the individual's informed choices and needs. This may include routine and/or as needed appointments when illness arises; and
  - Ensuring an effective arrangement for the provision of day to day routine health care interventions and oversight; as needed.
- The focus is that they verify that the person is supported to obtain medical services and care as any person without disabilities would.
- For an individual living in a certified residential setting the agency RN is ultimately responsible to monitor that an individual, per their needs and informed choice, has support for medical appointments/consults and routine health care in the home/setting are occurring.
- For an individual living in non-certified setting oversight may be provided by a family member, involved friend, or other natural support; a non-OPWDD paid support; or support and training toward independence through an HCBS Waiver Service, and/or SC/CM/CC oversight and coordination. Responsibility may be shared. The party responsible for oversight of health care should be identified in the service plan. If it has been determined that the person is capable of independently coordinating and ensuring their health care, this should be documented in their Service Plan.
- Note: For an individual living in a non-certified setting, receiving Delegated Nursing Services per the NPA exemption for HCBS services: The agency RN is only responsible to monitor the delivery of health related care provided during the provision of HCBS services in the community. For other issues see bullet above.

SELECT "MET" If both of the following are evident:

- ✓ The individual and/or their circle can identify the person(s) responsible to consistently oversee the individual's health care as needed.
- ✓ The service plan identifies the support provided by the chosen/delegated party(ies).

SELECT "NOT MET" IF:

- ✓ There is no person assuming oversight that the person receives needed health care and the person's access to or receipt of health care has been inadequate.

Standard No.	Standard Text	Decision
8a-3	The individual's service plan identifies the services and supports necessary to access and receive routine professional medical care and evaluation.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

• Individual (Designee): Discuss if the individual gets the medical services that they require and if they receive the help they need to facilitate that.

DOCUMENTATION REVIEW:

Mandatory:

• Service plan, as named for the service/service environment (e.g. ISP, Treatment Plan, Program).

• Health and health care documentation as applicable

GUIDANCE:

- Verify that the person's service plan includes strategies to ensure the individual's access to medical care and assessment per their needs and informed choices. This standard is not intended to verify that there is a health care plan to address specific health care needs/diagnoses of the person, but rather to ensure that needs for support are known, and there is an overall strategy to oversee, coordinate and provide support so that the person receives needed medical appointments and in home health care.
- The support must be individualized and the strategies will be dependent upon the health care needs and abilities of the individual as well as their living environment. Some individuals plans may indicate that they require total support to schedule, attend and communicate during appointments; have health care interventions provided by others; and monitoring that needed services are provided. Other individuals with more independent living skills, may have a plan that included independent scheduling of medical appointments and monitoring and reporting their own symptoms, but requires support in arranging medical transportation and explaining what the doctor is recommending. In any case, the plan must identify the necessary supports and parties (natural or paid supports) responsible to ensure that medical care and assessment is received by the individual.
    - For an individual living in a certified residential setting the plan may identify multiple strategies/supports, but will always require participation by the agency RN as responsible to ensure the plan is adequate.
    - For an individual living in non-certified setting the plan may identify one support or a coordinated combination of services and assistance by paid and unpaid supports. If it has been determined that the person is capable of independently ensuring and providing for their own health care, this should be documented in their Service Plan. However, as indicated in the previous standard, the identification of someone to monitor that they are receiving care needed is a safeguard.

SELECT "MET" If:

- ✓ The service plan includes a strategy for coordination of the individual's health care and routine receipt of health care services.

SELECT "NOT MET" IF either of the following are present:

- ✓ The service plan does not include a strategy for coordination of the individual's health care and routine receipt of health care services.
- ✓ The individual was refused medical care and treatment or has been unable to get to a physician's office due to barriers that are not addressed.

Standard No.	Standard Text	Decision
8a-4	The individual's routine health care providers are identified and known to the person and/or their supports.	**Met/Not Met**

Guidance

DISCUSSION :
Mandatory:
• Individual (designee): Ask the individual if they know who their doctors/medical providers and how to contact them, and where/how they can access the information

DOCUMENTATION REVIEW :
Mandatory:
• Service Record: Verify that health care providers are documented and the information is available to the individual and/or the people responsible to ensure their access to health care.

GUIDANCE:
- Verify that the individual and/or the people responsible to support them, know the names of their physician(s) and other health care providers and know how to contact them. The parties who would need to communicate with the health care providers must be able to access this information.

SELECT "MET" IF:
✓ The individual and/or their support(s) for access to medical providers know and have access to the names of and contact information of the individual's medical providers.

SELECT "NOT MET" IF:
✓ The individual and/or their support(s) for access to medical providers know and have access to the names of and contact information of the individual's medical providers.

Standard No.	Standard Text	Decision
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

Individual (Designee): Converse with the individual and their supports to determine if they know:

- When emergency medical care is necessary
- What to do to in an medical emergency

DOCUMENTATION REVIEW :

Mandatory:

- IRMA review for any medical emergency events that would have been reported through incidents
- Service Record and service notes that may include documentation of medical emergency events
- Service plan that may identify the individual's skills and safeguards

GUIDANCE:

- Determine the individual's status regarding the following:
  - If the individual lives independently and/or spends time alone in their home there should be evidence that strategies are put in place that enable them to request emergency services (e.g. contact 911).
  - The individual is able to access emergency medical care independently.
  - The individual understands events that are medical emergencies and require immediate care.
  - The individual as capable, has received or is receiving guidance and/or training regarding when they would need to and how to access emergency care in their community.
    - For all individuals: The individual's support(s) knows how and for what reasons to access the emergency care. Supports whether natural or paid staff, both individualized signs/symptoms to contact 911 as well as basic emergent signs of impairment in breathing, circulation and consciousness general to all individuals.

SELECT "MET" IF:

✓ There is sufficient evidence to verify one or both of the following as applicable:

- The individual if living or spending time independently, understands how and when to contact/request emergency medical services.
- The individual's supports (paid or unpaid) know how and when to access emergency medical services.

SELECT "NOT MET" IF:

✓ There is sufficient evidence to verify one or both of the following as applicable:

- The individual if living or spending time independently, does not understand how and when to contact/request emergency medical services.
- The individual's supports (paid or unpaid) do not know how and when to access emergency medical services.

Standard No.	Standard Text	Decision
8a-6	The individual receives routine medical exams/medical appointments per his/her health care professionals' recommendations.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

• Talk with the individual for their input on their participation in medical appointments, types of appointments and whether they see physicians when needed. Be sensitive to their privacy in the framing and location of the discussion.

As Needed:

• Speak with the staff members, FCP or natural supports assisting the person with medical appointments if documentation and discussion with the individual requires clarification

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence that medical appointments have occurred and the results of the appointments, E.g.:

• Medical Consult forms completed by the physician, clinician, health care provider
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency responsible to monitor care
• Health Care or Nursing Assessments that summarize medical appointments
• Service Plan reviews that summarize medical appointments
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on medical appointments

GUIDANCE:

- This standard is to focus on verification that the individuals has medical appointments with a physician, physician's assistant, or nurse practitioner associated with a medical practice or clinic, that is not emergency situations, and per their individualized needs. The intent is to ensure from a health care perspective, the person has the supports they need to be seen by their doctor/HCP per their informed choices and needs. The individual must be supported to seek medical services as anyone in the community would do. The supports required and designed for the individual will vary dependent on the person's residential environment.
- Reasons to use/seek health care services for purposes of this standard include:
    - Chronic Care: Care for the health conditions that are persistent or long lasting. Examples of Chronic health conditions may be diabetes, seizure disorders, diabetes, COPD, asthma, arthritis, heart disease, cancer. Chronic care includes care for diseases that require recurrent care and monitoring. Assess that the there is a means for the person to be seen by their physician with the frequency requested by the physician, for their conditions. Consider also whether the individuals and/or their supports understand their health status, diagnoses, and needs for professional medical monitoring.
    - Routine Care: Preventive health care is care/assessment for generally healthy individuals through regular physical exams aimed to ensure health has maintained/prevent illness rather than to monitor a known condition. This may include screening for medical problems as recommended and updating immunizations. Assess whether the opportunity and support as need are provided to the individual to receive routine care.
- The individual may make an informed decision to choose not to participate in medical appointments. If an individual chooses to not see the HCP as recommended, there should be evidence that he/she have received information regarding the reasons/conditions addressed by the medical appointment, and the benefits and consequences of not adhering to the Health Care Provider's recommendations.

- Validate that all medical appointments with established primary care and specialty medical providers are scheduled and completed per the providers' recommendations, the individual's needs, and his/her informed choices. This may include: Annual/Periodic Physical Exams per the Health Care Provider (HCP) recommendations, initial and follow up appointments for new symptoms, PT/OT appointments/sessions, or any other needed medical appointments known specialists (e.g. neurologist, cardiologist, endocrinologist, gynecologist, ophthalmologist, etc.)
- Verify that the individual has been attending medical appointments with the frequency as recommended by their physician or specialist. Documentation regarding health care may be not as extensive for individuals who live in non-certified settings, compared to what is necessary in certified residences where health care must be overseen by an RN. However ensure that regardless of setting, the evidence is in line with the person's written plan.
- For an individual living in a certified residential setting:
    - Clear documentation evidencing medical appointments and findings such as medical consult forms, prn notes, health care notes, etc. must be available as part of the individual's record.
    - If a medical appointment is cancelled there should be documentation of reason why and a reschedule date.
- For an individual living in non-certified setting
    - If the support for medical appointments is through paid OPWDD supports, there should be clear and complete documentation to show the support resulted in the intended result of medical care/appointments.
    - If the support for medical appointments is through natural or other supports, there should be evidence that the service/care/treatment coordinator or case manager is providing general oversight that health care needs are met including attendance at needed appointments
    - Converse with the individual and their supports to verify that appointments are completed.

SELECT "MET" IF:

- ✓ The individual is generally attending medical appointments with their health care providers with the frequency recommended by the HCPs and aligned with the persons needs and informed choice.
- ✓ Any missed appointments are competently rescheduled and attended, and the delay did not result in any negative outcome to the individual.
- ✓ The individual made an informed decision to not see the HCP as recommended/needed.

SELECT "NOT MET" IF:

- ✓ The individual has not attended multiple recommended medical appointments and there is not any documented explanation or justification.
- ✓ The individual did not receive needed support to schedule and attend medical appointments resulting in missed appointments.
- ✓ The individual missed a significant number of needed or recommended appointments resulting in delay of vital diagnosis, vital care, and negative outcome to the individual.
- ✓ By choice, the individual has not attended recommended medical appointments, however there is no evidence that this was an informed choice.

Standard No.	Standard Text	Decision
8a-7	The individual receives diagnostic evaluation/testing per his/her health care professionals' recommendations and standard safe practice (e.g. Lab work, x-rays, scans, MRIs, etc.).	**Met/Not Met**

Guidance

DICUSSION:

Mandatory:

• Talk with the individual for their input on their participation in medical testing. Be sensitive to their privacy in the framing and location of the discussion.

As Needed:

• Speak with the staff members, FCP or natural supports assisting the person with medical testing appointments if documentation and discussion with the individual requires clarification

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence that medical appointments have occurred and the results of the appointments, E.g.:

• Medical Consult forms completed by the physician, clinician, health care provider
• Documentation of testing: diagnostic reports, lab work reports, etc.
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency responsible to monitor care
• Health Care or Nursing Assessments that summarize medical appoints
• Service Plan reviews that summarize medical appointments
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on medical appointments

GUIDANCE:

- This standard is to verify that the individual accesses diagnostic medical tests and evaluations as recommended by his/her Health Care Professionals.
- Review the documentation for Lab work, bloodwork, medical testing and evaluations available in the individual's record.
- Verify that the individual has been received diagnostic testing related to health status as recommended by their physician.
- Documentation regarding health care will likely be less extensive for individuals who live in non-certified settings, compared to what is necessary in certified residences where health care must be overseen by an RN.
- For an individual living in a certified residential setting:

    - Clear documentation evidencing medical testing and findings such as actual documentation of the test results, prn notes, health care notes, etc. must be available as part of the individual's record.
    - Verify recommendations where completed, scheduled and reported as required.
    - Verify the agency has a system where by the information from medical appointments is relayed to the RN for appropriate action.
    - If a medical testing is cancelled there should be documentation of reason why and a reschedule date.
    - For an individual living in non-certified setting
    - If the support for medical care is through paid OPWDD supports, there should be clear and complete documentation to show the support resulted in the intended result of the individual receiving medical care and assessment they need.

- If the support for medical care is through natural or other supports, there should be evidence that the service/care/treatment coordinator or case manager is providing general oversight that health care needs are met including receipt of medical testing.
- Converse with the individual and their supports to verify that they are able to receive the medical testing their physician cites as necessary.

- Note: The individual may make an informed decision to choose not to undergo medical testing. If an individual chooses to not undergo an HCP recommended test, evaluation, lab work, etc.; there should be evidence that he/she have received information regarding the reasons/conditions for the evaluation and the benefits and consequences of not adhering to the Health Care Provider's recommendations.
- Considerations regarding diagnostic medical testing:
  - An exhaustive list of possible diagnostic testing will not be provided here, however examples include: bloodwork, urinalysis, EKG, mammography, colonoscopy, endoscopy, x-ray, MRI, etc. as appropriate to the individual's medical symptoms, conditions.
  - The RN (as applicable), designated health care advocate or SC/CC/CM should be advocating with the health care professional when diagnostic testing may be in the best interest of the individual, but not considered by the HCP.
- Lab work/Bloodwork
  - Many medications require frequent Lab monitoring to ensure therapeutic levels so that decisions can be made to adjust and monitor dosing.
  - Seizure medications: If a frequency of lab work has not been ordered, it should occur at least annually.
  - Lab work should be able to be assessed for high and low values compared to normal ranges.
  - In certified residential settings: If the Doctor and or specialist has not determined parameters for medications which require therapeutic labs for determining appropriate blood levels such as; Lithium, most all anti-seizure medications and Coumadin among many others, there must be evidence that the RN is providing adequate oversight and advocacy to ensure the labs are occurring as needed. The health and safety of the individuals taking these medications is being monitored by the RN or MD. * If you seek clarification on medications that require close monitoring, please consult a DQI RN.
  - In certified residences, the RN must review results of testing and collaborate with the physician on what action is required. When parameters for labs have not been ordered by the physician, ask the nurse how she monitors the person's levels and if there has ever been an issue of too high/low in their levels.
    Note: Many providers assume the nurse is notifying them of when levels need to be taken and many nurses assume the doctor is taking care of the monitoring and the communication does not occur. It is important that the RN know the frequency of lab work, conversation with the prescriber is vital.

SELECT "MET" IF any of the following are present:

- ✓ The individual is generally receiving medical diagnostic testing with the frequency recommended by the HCPs and aligned with the persons needs and informed choice.
- ✓ Any missed diagnostics are competently rescheduled and attended and the delay did not result in any negative outcome to the individual.
- ✓ The individual made an informed decision to not complete diagnostic testing as recommended/needed.

SELECT "NOT MET" IF any of the following are present:

- ✓ The individual has not received multiple recommended diagnostic tests and there is not any documented explanation or justification.
- ✓ The individual did not receive needed support to schedule and receive medical testing resulting in missed diagnostics.
- ✓ The individual missed a significant number of needed or recommended diagnostic tests resulting in delay of vital diagnosis, vital care, and negative outcome to the individual.
- ✓ By choice, the individuals has not received recommended medical diagnostic testing, however there is no evidence that this was an informed choice.

Standard No.	Standard Text	Decision
8a-8	The individual receives necessary dental exams and treatments.	**Met/Not Met**

Guidance

DICUSSION:

Mandatory:

• Talk with the individual for their input on dentist visits.

As Needed:

• Speak with the staff members, FCP or natural supports assisting the person with dental appointments if documentation and discussion with the individual requires clarification

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence that medical appointments have occurred and the results of the appointments, E.g.:

• Medical Consult forms completed by the physician, clinician, health care provider
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency responsible to monitor care
• Health Care or Nursing Assessments that summarize medical appoints
• Service Plan reviews that summarize medical appointments
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on medical appointments

GUIDANCE:

- This standard is to verify that the individual accesses dental care from Health Care Professionals as needed per their individualized needs.
    - Through record review, and when necessary, through conversations with the individual and/or advocates and people providing supports, verify that the individual has received necessary dental appointments and treatments over the last year. Cross reference any staff notes and medical notes to ensure any complaints of pain r/t tooth aches or mouth discomfort have been addressed as many individuals lack the ability to communicate specific concerns of pain or discomfort.
    - Documentation regarding professional dental care may be less extensive for individuals who live in non-certified settings, compared to what is necessary in certified residences where health care must be overseen by an RN.
- For an individual living in a certified residential setting:
    - Clear documentation evidencing needed professional dental cleaning, exams and advanced care must be available as part of the individual's record.
    - Verify that recommendations for professional dental care and assessment weere completed, scheduled and reported as required.
    - Verify the agency has a system where by the information from medical appointments is relayed to the RN for appropriate action.
    - If dental appointments are cancelled there should be documentation of reason why and a reschedule date.
- For an individual living in non-certified setting:
    - If the support for medical care is through paid OPWDD supports, there should be clear and complete documentation to show the support resulted in the intended result of the individual receiving the professional dental care they need.
    - If the support for medical care is through natural or other supports, there should be evidence that the service/care/treatment coordinator or case manager is providing general oversight that health care needs are met including receipt of professional dental care.
    - Converse with the individual and their supports to verify that they are able to receive the medical testing their physician cites as necessary.

- Note: The individual may make an informed decision to choose not to participate in dental appointments. If an individual chooses to not receive recommended care, there should be evidence that he/she have received information regarding the benefits and consequences of not participating.

SELECT "MET" IF any of the following are present:

- ✓ The individual is generally receiving professional dental care aligned with the persons needs and informed choice.
- ✓ Any missed dental appointments are competently rescheduled and attended and the delay did not result in any negative outcome to the individual.
- ✓ The individual made an informed decision to not attend the dental appointment(s).

SELECT "NOT MET" IF any of the following are present:

- ✓ The individual has not received multiple recommended dental appointments and there is not any documented explanation or justification.
- ✓ The individual did not receive needed support to schedule and receive professional dental care.
- ✓ The individual missed a significant number of needed or recommended dental appointment resulting in negative outcome to the individual.
- ✓ By choice, the individuals have not received recommended professional dental care, however there is no evidence that this was an informed choice.

Standard No.	Standard Text	Decision
8a-9	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender, and age.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

• Talk with the individual for their input on their participation in medical testing. Be sensitive to their privacy in the framing and location of the discussion.

As Needed:

• Speak with the staff members, FCP and supports assisting the person with medical testing appointments if documentation and discussion with the individual requires clarification

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence that medical appointments have occurred and the results of the appointments, E.g.:

• Medical Consult forms completed by the physician, clinician, health care provider
• Documentation of testing: diagnostic reports, lab work reports, etc.
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency responsible to monitor care
• Health Care or Nursing Assessments that summarize medical appointments
• Service Plan reviews that summarize medical appointments
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on medical appointments

GUIDANCE:

- This standard is to verify that the individual is able to access diagnostic medical tests and evaluation per recommended professional/ federal health care guidelines of good practice related to gender, age, ethnic background, etc. as would occur for the general public. This may overlap with review and findings of 8a-7, however the focus of this review is evaluation of the person's health evaluation per normative standards and receipt of supports and advocacy to obtain such supports when it is important to ensuring a comprehensive picture of the individual's status. The intent is not necessarily to mandate that this testing is complete. For example, a met/not met should not be determined only on the presence or absence of test

or procedure. However, there should be evidence of advocacy and/or discussion with appropriate parties regarding whether it should occur. How this occurs will be different for individuals living in certified residences with nursing oversight versus individuals living more independently.

- Review the documentation of medical appointments and medical evaluations and testing available in the individual's record.
- Determine whether the individual has received an evaluation per recommended standards.
- Documentation regarding health care will likely be less extensive for individuals who live in non-certified settings, compared to what is necessary in certified residences where health care must be overseen by an RN.
- For an individual living in a certified residential setting:
    - Clear documentation evidencing medical testing and findings such as actual documentation of the test results, prn notes, health care notes, etc. must be available as part of the individual's record.
    - Verify recommendations where completed, scheduled and reported as required.
    - Verify the agency has a system where by the information from medical appointments is relayed to the RN for appropriate action.
    - If a medical testing is cancelled there should be documentation of reason why and a reschedule date.
- For an individual living in non-certified setting
    - If the support for medical care is through paid OPWDD supports, there should be clear and complete documentation to show the support resulted in the intended result of the individual receiving medical care and assessment they need.
    - If the support for medical care is through natural or other supports, there should be evidence that the service/care/treatment coordinator or case manager is providing general oversight that health care needs are discussed and the person receives support and advocacy to receive the medical testing. This is especially imperative if the individual has risk factors making this testing more important to receive.
    - Converse with the individual and their supports to verify that they are able to receive the medical testing their physician cites as necessary as needed and wanted.
- Note: The individual may make an informed decision to choose not to undergo medical testing. If an individual chooses to not undergo an HCP recommended test, evaluation, lab work, etc.; there should be evidence that he/she have received information regarding the reasons/conditions for the evaluation and the benefits and consequences of not adhering to the Health Care Provider's recommendations.
- Considerations regarding normative recommended medical testing per gender, age, ethnic background, etc. E.g. breast exams, pap smears, colonoscopies, PSA tests, osteoarthritis screening (bone density scans) and many other recommended tests based on age/gender and risk.
- Evaluate if proper consulting/communication with the health care provider has occurred as advocacy for the individual.
- If there is justification and documentation by health care provider if recommended evaluation related to gender/age/risk is not completed.

SELECT "MET" IF any of the following are present:

- ✓ The individual is generally receiving medical diagnostic testing aligned with federal professional standards and informed choice.
- ✓ If diagnostics per federal recommendations are not completed, there is evidence of advocacy and reasoned decisions to not complete the evaluation.
- ✓ The individual made an informed decision to not complete diagnostic testing as recommended.

SELECT "NOT MET" IF any of the following are present:

- ✓ The individual has not received multiple federal recommended diagnostic tests and there is not any documented advocacy, explanation or justification.
- ✓ The individual did not receive recommended diagnostics resulting in delay of vital diagnosis, vital care, and negative outcome to the individual.
- ✓ By choice, the individuals have not received recommended medical diagnostic testing, however there is no evidence that this was an informed choice.

Standard No.	Standard Text	Decision
8a-10	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	**Met/Not Met/NA**

Guidance

DISCUSSION:

Mandatory:

• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions. Be sensitive to their privacy in the framing and location of the discussion.

As Needed:

• Speak with the staff members, FCP or natural supports assisting the person with routine health care if documentation and discussion with the individual requires clarification

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence that routine interventions to address health need have occurred: E.g.:

• Medical Consult forms that describe needed in-home/daily supports
• Health Care Plan, Nursing Care Plans as appropriate
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on routine health care supports and intervention

GUIDANCE:

- This standard is intended to evaluate that there is a written plan to address, ameliorate or monitor the individual's medical diagnosis/diagnoses are provided as needed and recommended. This does not apply to participation in medical appointments and testing in health care offices and facilities. This is intended to address needed interventions in day to day life in the individual's home and other environments.
- The RN is required to evaluate and plan care according to the individuals needs and they may delegate health care tasks to direct care staff.
- The RN familiar with the needs and conditions of the individual, must provide written instructions, a Plan of Nursing Services or other written directive for direct supports on all pertinent medical diagnosis/health needs that require care to address a health need. The written plan should provide step by step systematic instructions on the care, support and/or monitoring staff are to provide to the individual. The written plan/instructions should be written at a basic level, in plain English to ensure all support providers can understand it. The plan must be part of the service record and available to people responsible to provide the supports.
- Verify all significant medical conditions identified for the individual, both chronic and acute have a plan of nursing service, or similar written plan available for staff to access. Verify that all information on the condition and treatments and monitoring necessary by the DSPs and/or the RN in the provision of care/support to the individual is included in the plan.
- Through RN interview and mandatory document review, surveyor evaluates that written individualized PONS are developed based on the initial assessment and subsequent comprehensive nursing assessments. Without accurate and timely assessment, PONS, which inform the DSP to whom delegated nursing tasks have been assigned, become outdated and puts the individual at risk for inadequate nursing care. The PONS are to be reviewed both as needed and annually.
- Ensure that as the individual's health status changes, the written plan of nursing service(s) is revised, or new written instruction developed as applicable. For example, a person receiving a new diagnosis, has a recent fracture, or has been discharged from the hospital must have a written plan with adequate written instruction for direct support staff to ensure the individuals receives adequate care and treatment during services. The plans shall be individualized to the person and updated and d/cd as needed.

- Care plans related to health issues may be for long term/permanent conditions or short term health concerns,
- Care plans should include interventions consistent with physician's recommendations,
- Examples of diagnoses and health issue that require a protocol plan include (but are not limited to) diabetes, seizure disorder, constipation, history of dehydration, risk of swallowing and aspiration issues, hypertension, hospital discharge, post-surgical care, catheter care, tube feedings, colostomy care and many other medical treatments, etc.
- The plan related to health care (e.g. nursing care plan) should include at a minimum:
  - Brief description of problem/contributing factors;
  - Preventative measures to be provided to the individual relative to the health issue (or monitoring of individual's independent role in prevention); this may include dietary interventions ADA diet for diabetes, high fiber interventions and bowel tracking and interventions for constipation, fluid requirements for multiple conditions);
  - Direct interventions or routine care related to the health issue (or monitoring of the individual's independent role in prevention), e.g. prescribed medications to be administered, wound care, repositioning, etc.);
  - Signs and symptoms to look for and monitor, including skin condition, appetite, high/low parameters of vital measures taken if any are required, and how to identify pain/discomfort especially for individuals may not or cannot clearly communicate concerns to people that support them;
  - When to contact the RN and/or physician;
  - When to call 911.
  - Interventions to be provided by the RN or other professional.
- Verify that the written plans are accessible to staff responsible to implement.
- Additional guidance regarding content of care plans for some specific conditions is found in guidance for Site Protocol risk factors. In addition consider the following when determining whether a written plan is needed for an individual:
  - Risk factors for aspiration include weak gag reflexes, poor chewing/swallowing skills, GERD, food stuffing, inappropriate fluid consistency or food textures, medication side effects, and impaired mobility that result in an individual unable to sit upright while eating.
  - Risk factors for constipation include: neuromuscular degenerative disorders that impair the central nervous system's need to eliminate, spinal cord injuries or birth defects that affect neural responses needed for elimination (such as spina bifida), diets that do not contain enough fiber and fluids, poor swallowing skills with aspiration risk, medications that slow down gastric motility or draw too much fluid from GI tract, history of frequent bowel stimulant use leading to decreased bowel reactivity. Look for evidence of: hospitalizations or outpatient treatments for constipation related issues, diet orders to increase dietary fibers, bowel movements more than 2-3 days apart, and medications that have constipating side effects. When a PRN bowel medication (cathartic) is ordered it is vital that bowel movements are tracked and that the PRN is being given as directed to avoid, constipation, bowel impaction, loose stools or diarrhea. A PRN for bowel management must not be given if some sort of bowel monitoring is not in place as it is incumbent on the prescriber to know what signs and symptoms present would indicate a need for the medication.
  - Seizure prevention guidelines include taking antiepileptic medications on time as prescribed, promoting accurate documentation and record keeping of seizures that have occurred for review by a medical professional, encouraging good sleep-low stress-and good nutrition. Seizure intervention guidelines include having an individualized seizure protocol that includes:

    1. Description of the individual's normal seizure pattern
    2. Safety interventions
    3. Safety precautions at home and in the community
    4. Caregiver instructions on notifications, when to call 911, and the administration of PRN medications (if ordered).

- Risk of having dehydration: medical conditions such as kidney disease or diabetes that can result on fluid loss, excessive sweating-vomiting-drooling-diarrhea, frequent refusal of food and/or drink, unable to access fluids without assistance, dysphagia with coughing during meals, and inability to communicate thirst to caregivers. Prevention guidelines include: drinking enough water/day, alterative fluids are offered if individual frequently refuses fluids.

- Additional guidance as specific to delegated nursing services in delivery of community based HCBS Waiver Services, if determined that tasks can be delegated to DSPs. The plan of nursing services developed by the RN must identify the following:
- The nursing services to be provided to the individual, including delegated nursing tasks and medication administration;
- A description of the acute or chronic health condition being addressed;
- Individual-specific instructions for competently performing each delegated nursing task, required monitoring and documentation and criteria for identifying, reporting, or responding to problems or complications.
- The DSP(s) to whom the task is delegated;
- The date of the delegation;
- The RNs who will initially be assigned to supervise the DSP(s);
- The RN's signature;
- The RN may include specific information on RN supervision of the delegated tasks;
- Any changes to or termination of delegation of nursing services must be documented in the PONS along with the RN's signature.
- PONS must be accessible to staff.
- Please note: The relationship between RN and family care provider is not the same as RN and DSP. Training and instruction should be provided to the FCP in order to meet the needs of the individual, however these are not considered delegated nursing services. However, the RN should be providing oversight that the person's needs for routine health care in the family care home are provided competently.

SELECT "MET" If the following are evident as described:

- ✓ In certified setting other than FCH:
  - o A written care plan is in place, instructing the care and monitoring needed by the individual is in place for each of the individual's health diagnosis/condition that require care and/or oversight.
  - o The written care plan is clearly written and addresses the necessary aspects of care and monitoring for the health condition.
- ✓ In a Family Care home:
  - o The family care provider has the information and understanding necessary to provide adequate care and monitoring for the individual's health condition.

SELECT "NOT MET" If either of the following are evident:

- ✓ In certified setting other than FCH:
  - o A written care plan is not in place for each of the individual's health diagnosis/condition that require care and/or oversight.
  - o The written care plan is unclear and/or does not address the necessary aspects of care and monitoring for the health condition.
- ✓ In a Family Care Home:
  - o The family care provider does not have the information and understanding necessary to provide adequate care and monitoring for the individual's health condition.

SELECT "NA" IF:

- ✓ The individual has no documented or observed needs for support with medication or other health care needs.

Standard No.	Standard Text	Decision
8a-11	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions. Be sensitive to their privacy in the framing and location of the discussion.

As needed:

• Speak with the staff/supports assisting the person with routine health care if documentation and discussion with the individual requires clarification.

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence that routine interventions to address health need have occurred: E.g.:

• Medical Consult forms that describe needed in-home/daily supports;
• Health Care Plan, Nursing Care Plans as appropriate;
• Recording of health care services such as bowel charting and interventions, fluid monitoring, diabetic monitoring;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports;
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on routine health care supports and intervention.

OBSERVATION:

• As appropriate, needed and able in certified settings, observation may provide information relevant to delivery of services and supports related to the individual's health and well-being; e.g. repositioning, dietary interventions, etc.

GUIDANCE:

- This standard is intended to evaluate the interventions address, ameliorate or monitor the individual's medical diagnosis/diagnoses are provided as needed and recommended. This is intended to verify that needed interventions are provided in day to day life in the individual's home and other environments.
- Verify that the individual's supports/staff are implementing/delivering care and support required to address her/his health issues and per their written health care plans and physician's recommendations.
- Verify that any intervention that must be provided by the RN is provided.
- Verify that any necessary equipment related to implementation of health care plans is present. This may include for example: glucometers, lifts, hearing aids, orthotics, oxygen and delivery supplies, bi-pap, c-pap, humidifiers and etc.
- Evidence of needed interventions may be through documentation modalities specific to the service received and/or agency processes. This may include service notes, prn notes, nursing notes, medication and treatment records, service coordination notes, and specific service documentation sheets designed for collection of service delivery (e.g. bowel management tracking, glucose level testing, etc.).
- It may also be necessary to verify through staff discussion, staff's understanding of the care to provide to meet the health care needs of the individual.

- It may be appropriate that the individual assume responsibility for their own interventions, with staff or natural supports overseeing that the individual is appropriately addressing the health issue.
- An individual may make an informed decision to not follow recommendations for preventive and reactive health care.

SELECT "MET" If either of the following are evident:

- ✓ The individual is receiving needed health care interventions per the written plans and physician's recommendations.
- ✓ The individual has made an informed decision to not follow recommendations/plans to address health diagnoses/issues.

SELECT "NOT MET" If either of the following are evident:

- ✓ The individual is not receiving needed health care interventions per the written plans and physician's recommendations.
- ✓ The individual has decided to not follow recommendations/plans to address health diagnoses/issues without evidence of informed decision making.

SELECT "NA" IF:

- ✓ The individual has no documented or observed needs for supports with medication or other health care needs.

Standard No.	Standard Text	Decision
8a-12	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

• Talk with the RN responsible for oversight of the individual's health care in whole (certified residential setting) or in part (HCBS waiver service NPA exemption), to assess their understanding and oversight of the individual's health care and medication administration.

• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions, and interactions with the assigned RN. Be sensitive to their privacy in the framing and location of the discussion.

As Needed:

• Speak with the staff/supports assisting the person with routine health care regarding participation and support provided by the assigned RN.

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence RN coordination, oversight and participation in the individual's health care services, e.g.:

• Medical Consult forms that describe needed in-home/daily supports;
• Health Care Plan, Nursing Care Plans as appropriate;
• Recording of health care services such as bowel charting and interventions, fluid monitoring, diabetic monitoring;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports.

OBSERVATION:

• As appropriate, needed and able in certified settings, observation may provide information relevant to delivery of services and supports related to the individual's health and well-being; e.g. repositioning, dietary interventions, etc.

GUIDANCE:

- Applies to individuals in certified residential settings and recipients of delegated nursing services as part of the delivery of HCBS waiver services in the community.
- Based on a record review and interview, validate that oversight and monitoring of delegated nursing tasks is occurring by the RN. Oversight by the RN must include periodic and regular assessment of proficiency.
- The assigned RN is responsible to provide or ensure that the individual is receiving appropriate health care services including:
  - For the individuals in a certified residential setting:
    - Professional medical appointments with physicians appropriate to the individual's needs and recommendations;
    - Diagnostic medical evaluation;
    - Assurance that follow-up appointments, evaluations and care are provided per physician recommendations;
    - Routine health care assessment and interventions to be provided by the RN or direct support staff, necessary to improve or maintain health status dependent on the person's individualized needs;
    - Appropriate medication administration, including review of accuracy of the Medication Administration Record.
    - Revision to care, delegated services and health related service plans occur as needed.
    - The RN is responsible to review medical consults and physician communications and ensure recommendations are implemented.
    - The RN is responsible to ensure that the physician has reviewed any diagnostic results (e.g. lab work).
    - The RN is responsible to advocate for required and adequate health care for individuals assigned to their care.
  - For the individual receiving services in the course of community based HCBS waiver services:
    - All routine delegated health related care, medication administration to be provided by direct support staff;
    - Health care assessment and interventions to be provided by the RN.
    - Revisions to delegated services and health related service plans occur as needed.
- The RN is responsible to maintain current understanding of the individual's health status and needs and ensure that the physician is informed.
- Based on a review of documentation including nursing assessments, plans of nursing services, medical consults, diagnostic reports, medication and treatment administration records, and interview verify that the individual has received all the health care services they require in accordance with their health care needs.
- The RN's direct service and oversight activities must also be documented in the individual's service record.
- Note: the RN is responsible for oversight of these services in Family Care Settings also, however the services are not considered governed by the Nurse Practice Act.

SELECT "MET" If both of the following are evident:

- ✓ The individual is receiving needed health care per the written plans and physician's recommendations, unless the individual has made an informed decision to not receive care.
- ✓ There is documentation of RN provision of care and oversight of the individual's medical appointment, diagnostics, and routine care.

SELECTS "NOT MET" If any of the following are evident:

- ✓ The individual is not receiving needed/determined health care interventions per the written plans and physician's recommendations (not due to informed choice).
- ✓ There is no evidence of required RN oversight and provision of care.
- ✓ There is no evidence of RN advocacy with the individual's health care providers when needed.

Standard No.	Standard Text	Decision
8a-13	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	Met/Not Met/NA

Guidance

DISCUSSION:

Mandatory:

• Talk with the RN responsible for oversight of the individual's health care in whole (certified residential setting) or in part (HCBS waiver service NPA exemption).

• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions, and interactions with the assigned RN. Be sensitive to their privacy in the framing and location of the discussion.

• Speak with the people assisting the individual with routine health care regarding participation and support provided by the assigned RN.

DOCUMENTATION REVIEW:

Mandatory: Documents that evidence RN coordination, oversight and participation in the individual's health care services, e.g.:

• Medical Consult forms that describe needed in-home/daily supports;

• Health Care Plan, Nursing Care Plans as appropriate;

• Recording of health care services such as bowel charting and interventions, fluid monitoring, diabetic monitoring;

• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;

• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports.

• IRMA/Incident Documentation

OBSERVATION:

Events during observations in certified sites may provide information regarding this standard.

GUIDANCE:

- This standard reviews that staff/FCP supporting individuals understand the individualized plans, recognize status changes, and notify the appropriate medical and health care professionals per the person's specific health needs.
- Staff should evidence understanding of the individual's health issues, status and the conditions and symptoms related to his/her health diagnoses that need to be reported to the RN, physician, or activate 911.
- Staff working with the individuals must report diagnosis related signs and symptoms that would warrant further monitoring, care and treatment.
- Evidence of staff understanding is completion of notification when necessary. Through documentation review, verify staff have made proper notifications as needed per the individual's health issues.
- As referenced in descriptions of content of the health care plans, any such plan must identify conditions, symptoms and parameter highs and lows that must be reported and to whom.
- Examples of health issues that should be reported by direct support staff to designated professional include based on the individualized written plan: skin redness or injury, blood glucose levels, weight, oxygen saturation outside designated parameters, more than a designated number of seizures in a stated time period, etc.

SELECT "MET" If the following is evident:

✓ The RN, physician and/or EMS (911) are notified of the individual's condition as specified in the care plan.

SELECT "NOT MET" If the following is evident:

- ✓ The RN, physician and/or EMS (911) are not notified of the individual's condition when needed as specified in the care plan.

SELECT "NA" If either of the following are evident:

- ✓ The individual has no documented or observed needs for supports with medication or other health care needs; or
- ✓ Documentation and discussion indicate that there have been no occasions when the RN, other health care providers or 911 needed to be notified regarding the individual's condition, health or health care.

Standard No.	Standard Text	Decision
8a-14	The individual's emerging signs/symptoms are reported to a health care professional, and monitored and addressed appropriately.	Met/Not Met/NA

Guidance

DISCUSSION:

Mandatory:

• Talk with the RN responsible for oversight of the individual's health care in whole (certified residential setting) or in part (HCBS waiver service NPA exemption).
• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions, and interactions with the assigned RN. Be sensitive to their privacy in the framing and location of the discussion.
• Speak with the staff/FCP assisting the person with routine health care regarding participation and support provided by the assigned RN.

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence RN coordination, oversight and participation in the individual's health care services, e.g.:

• Medical Consult forms that describe needed in-home/daily supports;
• Health Care Plan, Nursing Care Plans as appropriate;
• Recording of health care services such as bowel charting and interventions, fluid monitoring, diabetic monitoring;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports.
• IRMA/Incident Documentation

OBSERVATION:

Events during observations in certified sites may provide information regarding this standard.

GUIDANCE:

- Separate from the previous standard, this standard reviews that staff supporting individuals recognize general signs and symptoms of illness/status change that must be brought to the attention of the RN or physician (PA,NP) and that care and monitoring are quickly provided to the individual.
  The focus of this standard is on Acute Care (but non-emergency): Active but short term treatment for onset of illness or injury. These include conditions where symptoms are of sudden onset.
- They appear, change or worsen rapidly. Think about the conditions when you make an unplanned medical appointment for yourself or a family member. Assess whether individuals are receiving health care when needed as they become ill or injured and/or have the ability/supports to do so if the need arises. Consider whether the person and/or their supports have an understanding of signs and symptoms for which medical assessment or intervention should be sought.

- In certified residences and where/when delegated nursing services are delivered, the RN is responsible to educate direct support staff and ensure competence to know when and how to notify the RN, MD, NP or PA of emerging health care needs of the individual so that prompt care and monitoring may occur.
- Signs and symptoms to report may include but are not limited to: changes in strength, mobility or level of alertness/consciousness; changes in appetite, fluid intake, and output (urine, bowel); high or low body temperatures, blood pressure, or pulse; changes in vocalizations, personality and responses; loss of function; and/or increase in tremors or tics.
- Staff and/or supports working with the individuals must report emerging signs and symptoms that would warrant further monitoring, care and treatment.
- Verify the following through documentation review:
    - Staff appropriately and swiftly report symptoms and they emerge to the appropriate health care professional(s);
    - The RN assures staff are provided instruction of additional care, monitoring and care necessary.
    - Continued care, monitoring, assessment and reporting of the individual's status occurs until the health concern is resolved, by the direct support staff, RN or other professional as needed and appropriate to level of expertise needed.
- Verify that documentation evidences all reporting, instruction to staff, care, monitoring, medical assessment provided and changes in health status positive or regressive.

SELECT "MET" If the following is evident:

- ✓ The individual's emerging health issues and changing health status are appropriately reported and addressed until resolution.

SELECT "NOT MET" If any of the following is evident:

- ✓ The individual's emerging health issues and changing health status are not appropriately reported, and/or addressed until resolution.
- ✓ Staff does not report symptoms that must be brought to the attention of the RN or other HCP.
- ✓ Although symptoms and health care changes are reported, appropriate care and monitoring is not provided.
- ✓ Although symptoms and health care changes are reported to the RN or other HCP, the professional does not provide instruction to staff regarding additional care and monitoring to occur.

SELECT "NA" IF:

- ✓ The individual had no documented illnesses, injuries, or acute or emerging symptoms that require action or monitoring.

Standard No.	Standard Text	Decision
8a-15	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	**Met/Not Met/NA**

Guidance

DISCUSSION:

As needed:

- Talk with the RN responsible for oversight of medication administration;
- Talk with the individual, especially those with responsibility for or learning self-administration skills
- Speak with the staff/providers responsible for medication administration.

DOCUMENTATION REVIEW:

Mandatory:

- Medication Administration Record (MAR)
- Physician's orders
- IRMA/Incident documentation
- Agency reporting of medication administration issues (non-Part 624)

As Needed:

- Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

GUIDANCE:

- Based on review of the Medication Administration Record (MAR) and the medical chart as needed, verify the following:
- All medications are prescribed by a physician, nurse practitioner, or physician's assistant;
- The medication prescription/order is current;
- The medication order is accurately transcribed on the individual's Medication Administration Record regarding medication name, dosage, time of administration, and route of administration.
- If medication orders change, the MAR must accurately and clearly document the prescribed medication addition, discontinuation, or change.
- If inaccuracies are identified on the MAR, verify that the RN is completing review of the MAR for accuracy and completeness.
- Note: Although ordered as part of the individual's health and dietary care, nutritional supplements such as Boost and Ensure are not medications and do not need to be on the MAR. In addition, there is no need for a MD order for things like Keri Lotion, Listerine, chap-stick, sun screen and they need not be documented on a MAR.

SELECT "MET" If the following is evident:

- ✓ The Medication Administration Record accurately documents all medications and treatment prescribed for the individual.

SELECT "NOT MET" If either of the following is evident:

- ✓ The Medication Administration Record includes one or more inaccurate or outdated medication orders.
- ✓ The Medication Administration Record includes one or more error in medication name, dosage, time of administration, and/or route of administration.

SELECT "NA" If either of the following are present:

- ✓ The individual is not prescribed any medications, including prn or over-the-counter medications;
- ✓ The individual lives in a certified supportive residence (e.g. Supportive Apt., IRA w/o 24-hour supervision), is capable of independent medication self-administration and the mechanism for supervision to ensure that the person is taking medication as required does not include their use or staff use of a MAR.
- ✓ The person self-administers medication without supervision in a day program setting.

Standard No.	Standard Text	Decision
8a-16	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	**Met/Not Met/NA**

Guidance

DISCUSSION:

As needed:

• Talk with the RN responsible for oversight of medication administration;
• Talk with the individual, especially those with responsibility for or learning self-administration skills
• Speak with the staff/providers responsible for medication administration.

DOCUMENTATION REVIEW:

Mandatory:

• Assessment of ability to self-administer medication
• Medication Administration Record (MAR)
• Agency reporting of medication administration issues (non-Part 624)

As Needed:

• Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

GUIDANCE:

- Verify that the medical professional has completed or provided input and approved an assessment of the individual's ability to self-administer medications.
- While the RN is typically the medical professional completing the assessment, a physician, physician's assistant (PA) or nurse practitioner (NP) may also complete the assessment.
- This assessment not only identifies the individual's ability to self-administer, but must also document the level of support and assistance needed by the person to ensure they receive medication as prescribed.
- The assessment must be completed /reviewed at least annually. When the individual's skills/abilities remain unchanged, it is not necessary that a new assessment document be completed. It is acceptable for the RN to document their review of the individual's abilities/skills and findings, and date and sign their review on a previously completed self-administration assessment.
- Day programs may accept assessments that are completed by OPWDD certified residential nursing staff if adequate, or complete their own evaluation.
- If a day program accepts medication administration responsibility for someone who does not live in an OPWDD certified setting, the program must complete the evaluation.
- Assessment by an LPN is not sufficient without review and written approval of the RN, Physician, PA, or NP.

SELECT "MET" If the following is evident:

- ✓ The RN (or other medical professional) has completed or approved a written assessment/review of the individual's ability to administer medication annually.

SELECT "NOT MET" If any of the following is evident:

- ✓ The RN has not completed or approved a written assessment/review of the individual's ability to administer medication.
- ✓ The RN has not completed or approved a written assessment/review of the individual's ability to administer medication annually.

SELECT "NA" If any of any following are present:

- ✓ The individual in a day program or day service (non-residential) is not prescribed any medications, including prn or over-the-counter medications;
- ✓ The individual does not receive medication during time spent in receipt of day services;
- ✓ The day program does not accept responsibility for medication administration.

NOTE: While routinely a person my not receive medications during time in day program, if at any time, the individual needs to receive medications in the day program (e.g. headache, seasonal allergies, antibiotic for infection, etc.), even if temporary, an assessment for self –administration capabilities must be completed.

Standard No.	Standard Text	Decision
8a-17	The individual receives or self-administers medications and treatments safely as prescribed.	**Met/Not Met**

Guidance

DISCUSSION:

As needed:

- Talk with the RN responsible for oversight of medication administration;
- Talk with the individual, especially those with responsibility for or learning self-administration skills
- Speak with the staff/providers responsible for medication administration.

DOCUMENTATION REVIEW:

Mandatory:

- Medication Administration Record (MAR)
- Physician's orders
- IRMA/Incident documentation
- Agency reporting of medication administration issues (non-Part 624)

As Needed:

- Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

OBSERVATION:

As Needed:

- Only as determined necessary, observation of medication pass may provide additional evidence of individual's accurate receipt of medications.

GUIDANCE:

- Review the MAR and/or other relevant documentation to verify that all prescribed medication and treatments are administered or self-administered.
- Verify that medication administration and oversight is documented as required by agency policy.

- Medication administered by staff/FCP:
- Staff must document on the MAR to evidence medication administration per agency policy.
    - Review the MARs for the past 6 months at a minimum. Verify that the majority of medication administration occasions are documented.
    - Blank on the MAR may or may not indicate failure to administer medications correctly or negative impact. Consider the specific medication prescribed and impact of missed dose, whether the agency has a supplemental mechanism to evidence medication administration (e.g. staff initialing of medication blister pack), medication counts, or other means to ensure the receipt of the medication and/or impact of isolated omission.
- Verify that when PRN medication is administered for the prescribed condition(s):
    - The effectiveness of the medication to address the condition is documented;
    - Administration of a PRN medication does not exceed 2 days, unless specified by the practitioner or the practitioner has been contacted for extended use of the medication.
    - The RN or other Health Care Professional provides oversight as to whether the condition be treated by the PRN warrants further medical treatment and follow up.
- If issues with medication administration and/or documentation were evident in earlier documentation, but correct administration and documentation is evident in the most recent months, consider the issue addressed and corrected. However, if problems are continuing, pursue further clarification.
- If there are concerns whether medications are correctly administered and/or if there are many blanks on the MAR, determine whether the agency/facility took action to verify that medication was administered and took corrective action to assure accurate medication administration and documentation. Additional information or explanations of blanks or missed administrations may be explained on the back of the MAR.
- Self-administration of medication by the individual:
    - The agency/facility must monitor and verify that the individual is taking their medication as prescribed per effective agency mechanism.
    - The actions taken by agency staff/FCP to verify correct self-administration must be documented per agency policy.
    - Verify that the individual is taking medication as prescribed through review of agency documentation of oversight.
    - If the individual is not consistently taking their prescribed medication, verify that it is based on an informed choice vs. lack of supports to assist the individual in self-administration.
    - The RN is responsible to oversee that the individual receives medications and care as prescribed by the physician. AMAP (medication certified staff) are administering medication under the license of the RN through the Nurse Practice Act exemption. The RN should therefore implement actions to monitor competent medication administration.
    - Medication error practices will be reviewed in a separate standard.

SELECT "MET" If the following is evident:

- ✓ Medications are administered correctly and generally documented correctly.

SELECT "NOT MET" IF either of the following are evident:

- ✓ It could not be evidenced that medications are not administered correctly;
- ✓ Documentation of medication administration is frequently not documented and/or not documented correctly including prn medications.

SELECT "NA" If any of any following are evident:

- ✓ The individual is not prescribed any medications, including prn or over-the-counter medications;
- ✓ The individual is not prescribed any medications, including prn or over-the counter medications, during time in the service/service setting;
- ✓ The service is a day program that does not accept responsibility for medication administration.

Standard No.	Standard Text	Decision
8a-18	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA

Guidance

DISCUSSION:

As needed:

- Talk with the RN responsible for oversight of medication administration;
- Talk with the individual, especially those with responsibility for or learning self-administration skills
- Speak with the staff/providers responsible for medication administration.

DOCUMENTATION REVIEW:

Mandatory:

- Medication Administration Record (MAR)
- Physician's orders
- IRMA/Incident documentation
- Agency reporting of medication administration issues (non-Part 624)

As Needed:

- Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

GUIDANCE:

- The RN is responsible to oversee that the individual receives medications and care as prescribed by the physician. AMAP (medication certified staff) are administering medication under the license of the RN through the Nurse Practice Act exemption. The RN should therefore implement actions to monitor competent medication administration.
- Medication administration and administration process errors must be reported, investigated and remediated as follows:
  - According to Part 624 requirements (when Part 624 definition of medication error is met);
  - According to agency policy and procedure for administration and process errors not requiring part 624 reporting.
  - Review medication error reporting pertaining to the individual, occurring in the past 12 months.
  - Verify that the agency identified and reported medication errors as necessary per regulation and policy.
  - Verify that each reported event was investigated to determine circumstances regarding the error and root causes.
  - Verify that actions necessary to correct the issue and prevent recurrence have been taken, and are effective in reducing/eliminating errors in the administration of the individual's medication, ensuring safe and correct provision of medication supports.
- Note: There is no specific action required to address medication administration errors. Options are open to the agency per their policy and may include retraining, recertification, increased monitoring or decertification of medication administration privileges, so long as they are shown to be effective. As the RN is responsible for medication administration, the RN should lend their clinical knowledge in deciding corrective action.

SELECT "MET" If both of the following are evident:

- ✓ Problems and errors in administration of the individual's prescribed medications were appropriately reported and documented.
- ✓ Errors in administration of the individual's medication are competently reviewed and remediated.

SELECT "NOT MET" IF any of the following are evident:

- ✓ Problems and errors in administration of the individual's prescribed medications occurred but were not identified by agency staff.
- ✓ Problems and errors in administration of the individual's prescribed medications were not reported and documented.
- ✓ Errors in administration of the individual's medication are not competently reviewed/investigated.
- ✓ Errors were not adequately remediated to prevent likelihood of future occurrences.

SELECT "NA" IF:

- ✓ No medication errors occurred.

Standard No.	Standard Text	Decision
8a-19	The individual's medication regimen is reviewed on a regular basis by a designated professional.	**Met/Not Met**

Guidance

DISCUSSION:

As needed:

• Talk with the RN responsible for oversight of the individual's health care.

DOCUMENTATION REVIEW:

Mandatory:

• Documentation of the medication regimen review.

As Needed:

• Medical Consult forms that describe needed in-home/daily supports;
• Diagnostic lab work results;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports.
• Health Care Plan, Nursing Care Plans as appropriate.

GUIDANCE:

- For individuals in certified residential settings, a review of the individual's entire medication regimen must be completed and documented semi-annually by a medical professional: RN, pharmacist, physician, physician's assistant, nurse practitioner.
- This review must be comprehensive, include a look at all possible drug interactions, side effects, warnings, contraindications, effectiveness regarding the diagnosis intended to address, and the completion and results of related and required lab work.
- Information provided for the medication regimen review must be current and accurate. All new medications, all discontinued medications, and medication dosage or administration changes must be provided. This review must look at the total medication dosing regimen that the person has, in order to find and evaluate issues before they occur. The review must include use of PRN, over the counter medications, and herbal supplement as part of the whole regimen.
- The review must document recommendations for action of follow-up, when necessary. If there is need for action or follow-up, there must be evidence that this is brought to the timely attention of the relevant physician/health care provider. Decisions related to the recommendations must also be documented.

- It is very important that the review includes attention to and effect of medications which predispose a person to extrapyramidal signs and symptoms (e.g. hand tremors, lip smacking, twitching, shuffled gait) as these signs and symptoms can lead to more serious effects to the individual. Nurses are trained to be aware of these side effects for those medications responsible and prescribers such as neurologist will often check for this and prescribe regular monitoring for this.

SELECT "MET" If both of the following are evident:

- ✓ A comprehensive medication regimen review is completed semi-annually and documented.
- ✓ Action is taken on any recommendations and suggested follow-up, if any.

SELECT "NOT MET" If any of the following are evident:

- ✓ The medication regimen review is not completed with frequency required (semi-annually).
- ✓ The medication regimen review is not comprehensive, e.g. lacks inclusion of all prescribed medications, and lacks consideration of all relevant elements (in second bullet of guidance).
- ✓ Action is not taken on recommendations and suggested follow-up, if any.

Standard No.	Standard Text	Decision
8a-20	The individual exhibits a healthy lifestyle and/or receives support(s) to replace the unhealthy behaviors with healthier actions.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

• Talk with the individual for their input on their life, lifestyle, and support wanted, needed, and/or received to establish and or maintain healthy routines.

As Needed:

• Speak with the staff/providers assisting the person with life routines day to day.

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence routine activities and supports, as well as health needs and recommendations, e.g.:

• Person centered service plan;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical Consult forms that describe health concerns and recommendations;
• Health Care Plan, Nursing Care Plans as appropriate;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports;
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on routine health care supports and intervention.

OBSERVATION:

• As appropriate, needed and able in certified settings, observation may provide information relevant to delivery of services and supports related to the individual's well-being, etc.

GUIDANCE:

- This is a quality indicator reviewing for evidence of supports provided as needed and desired to assist the individual in a healthy lifestyle as any person with or without a disability would choose based on informed decisions.

- "Healthy lifestyle" refers to behaviors including but not limited to: healthy eating habits, appropriate exercise, sleep habits, moderation in activities (e.g. alcohol consumption), and abstinence of other activities (e.g. illegal drug use).
- "Unhealthy" behaviors include but are not limited to: tobacco use/abuse, excessive alcohol consumption, illegal and excessive drug use, unprotected sex with unknown and/or multiple partners, and disregard of physician's recommendations for positive or abstinence behaviors related to known diagnoses or health risks (e.g. behaviors related to dietary habits, following a medication regimen, etc.).
- Look for evidence in documentation and through interview that the individual has been educated and counseled on risks/benefits, effects of positive vs. high-risk behaviors and that the agency RN and/or other service providers has taken action to encourage the person in a lifestyle that benefits their well-being. This may include periodic education, connections with appropriate clinicians, support groups, or partnership with other individuals striving to achieve or maintain the healthier lifestyle.
- Individuals have the right to make informed decisions, even if we do not agree with the decision.
- Individuals who do not have the cognition to support informed decision making should be supported in the healthy lifestyle to the degree recommended by health care providers and overall quality of life as determine by the person's circle of support/service planning team.

SELECT "MET" If the following is evident:

- ✓ Reasonable efforts and supports have been provided to the individual to maintain or encourage actions aligned with a healthy/healthier lifestyle.
- ✓ An individual engaging in behaviors determined to be unhealthy for them, has been provided with appropriate information regarding the behavior(s), offered interventions and support to change behaviors, but made an informed decision regarding their activities.
- ✓ The individual is dependent on other for supports and daily activities and is receiving the assistance necessary to maintain/improve lifestyle to benefit their overall health.

SELECT "NOT MET" If any of the following are evident:

- ✓ There is no evidence that reasonable efforts and supports have been provided to the individual to maintain or encourage actions aligned with a healthy/healthier lifestyle.
- ✓ An individual engaging in behaviors determined to be unhealthy for them, has been provided with information regarding the behavior(s), and has not been offered interventions and support to change behaviors.

Standard No.	Standard Text	Decision
8a-21	The individual is provided choice in health care providers.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

• Talk with the individual for their input regarding their satisfaction, comfort and communication with doctors and medical providers.
• Discuss the same issues with supports and/or staff that may accompany the individual to medical appoints and their impressions.
• Discuss opportunities for choice with RN, other team members and the SC/CM/CC.

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence routine activities and supports, as well as health needs and recommendations, e.g.:

• Person centered service plan;

• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical Consult forms that describe health concerns and recommendations;
• Health Care Plan, Nursing Care Plans as appropriate;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports;
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on routine health care supports and intervention.

GUIDANCE:

- The focus of this standard is to determine if the individual (designee) understand that they voice opinions regarding their health care providers. They should be should be afforded the opportunity to make choices regarding their health care providers, and request changes in their health care providers/physicians.
- Inquire if they have been provided the opportunity to discuss with members of their circle/team, their experiences with their physicians including comfort and satisfaction.
- As appropriate based on their input, ensure the individual was supported to meet other medical providers so they may choose another if they determine they would like to do so.
- Individuals with limited communication abilities provide input to regarding health care interventions, through behaviors, vocalizations, cooperation or lack of cooperation. Staff and health care providers should be attentive to their non-verbal communication and accommodate changes in care and providers as able.
- Choice may apply to a primary care physicians and specialists and clinical providers.

SELECT "MET" If the following is evident:

✓ The individual (designee) is asked for input regarding their experience with their medical provider(s).
✓ The individual (designee) is offered the opportunity to make a choice or choose a different medical provider.

SELECT "NOT MET" If any of the following are evident:

✓ The individual (designee) is not asked for input regarding their experience with their medical provider(s).
✓ The individual (designee) is not afforded the opportunity to make a choice or choose a different medical provider as needed.

Standard No.	Standard Text	Decision
8a-22	The individual is supported to advocate and is included in informed decision-making related to medical care and treatment.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:
• Talk with the individual (designee) to determine their understanding of their health diagnoses, education received regarding their health, treatments and lifestyle to maintain/improve their health, and participation in health care decisions. Be sensitive to their privacy in the framing and location of the discussion.
• RN as applicable.
As Needed:
• Speak with the staff/supports assisting the person with routine health care if documentation and conversation with the individual requires clarification.

DOCUMENTATION REVIEW:

Mandatory:
Documents that evidence that routine interventions to address health need have occurred: E.g.:
• Medical Consult forms that describe needed in-home/daily supports;

• Health Care Plan, Nursing Care Plans as appropriate;
• Recording of health care services such as bowel charting and interventions, fluid monitoring, diabetic monitoring;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports;
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on routine health care supports and intervention.

GUIDANCE:

- This standard is intended to review the extent that the individual is supported to understand their health, health care needs and participate to the greatest extent possible in decisions regarding their care.
- As with other aspects of an individual's life, the person should be encouraged and supported to determine how their health needs are supported/addressed. This may include a range of levels of participation dependent on the individual's understanding and informed decision making abilities. The goal is that individuals are active participants in ensuring their best health.
- Individuals appropriately educated in the considerations of their health and health care, may make informed decision in whole or for any particular component of their medical care and treatment, including to not adhere to physician's recommendations for medication and other treatments and interventions. This requires verification that the individual has been provided information in a manner that they can understand, regarding their diagnosis, and the benefits and risks of following/not following health routines.
- Individual participation and advocacy does not need to be all or nothing. Individuals can participate in discussions and make limited decisions regarding their health care routines without having of a full informed decision making understanding. For example:
    - Participate in discussions regarding health care options, ask questions and provide input.
    - Determine preferred time of day for health related interventions such as respiratory therapy, physical therapy exercises, etc.
    - Providing input regarding preferred exercise activities, locations, and times of day, to facilitate physician recommendations to address obesity or diabetes.
    - Assisting with food consistency alterations at mealtime to address aspiration concerns (e.g. assist with use of food processer).
    - With assistance, create menus that coincide with health related dietary needs, e.g. celiac disease, diabetes.
    - Provide input on medications and how they make them feel.
    - o Individuals with limited communication abilities provide input to regarding health care interventions, through behaviors, vocalizations, cooperation or lack of cooperation. Staff should be attentive to their non-verbal communication, communicate observations with health care professionals, and accommodate changes in care and interventions as able.
- Determine also whether their advocates and supports in discussion with the person have made reasoned decisions and documented the basis for the decisions, if it is decided that their incompletion of health routines will not be addressed.

SELECT "MET" If the following is evident:

- ✓ The individual (designee) is invited and encouraged to participate in discussions and decision making regarding their health care and health related interventions.
- ✓ The individual's input is acknowledged and accommodated to the degree possible.
- ✓ The individual's informed decision is respected.

SELECT "NOT MET" If any of the following are evident:

- ✓ The individual (designee) is not invited and encouraged to participate in discussions and decision making regarding their health care and health related interventions.
- ✓ The individual's input is not acknowledged and accommodated.
- ✓ The individual's informed decision is not respected.

Standard No.	Standard Text	Decision
8a-23	Individuals have been given the opportunity to have advanced directives in place (DNR order, healthcare proxy, or living will).	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

- Talk with the individual to determine information provided regarding health care decisions, designating supports and planning for future health care and end of life decisions.
- Talk with the individual's family, advocate, guardian as appropriate.
- Talk with the RN in certified residential setting, about how advance directives are approached with the individual.
- Talk with the SC/CM/CC when appropriate, about how advance directives are approached with the individual.

DOCUMENTATION REVIEW:

Mandatory:

Documents that may evidence discussions and actions regarding advance directives and any that are in place, e.g.:

- Documentation of advance directives in place, if any: e.g. DNR, Health Care Proxy, etc.;
- Daily notes, health care notes, nursing notes, and/or prn notes that may reference discussions and decision making;
- Medical, Health Care or Nursing Assessments that may reference advance directive discussions and decision making;
- Service coordination-Care Coordination-Case Management-Treatment Coordination notes that may reference advance directive discussions and decision making.

GUIDANCE:

- The individual has the right to determine advance directives regarding health care decisions.
- A health care decision is any decision to consent or refuse to consent to health care.
- Every individual has the right to a health care proxy and to have advanced directives in place.
- Verify that actions were taken with the individual (designee) to discuss advance directive options, how they may benefit the person by having them in place.
- Verify that the individual is given the opportunity to exercise this right to make designate a health care proxy, create a living will.
- Verify that the individual is provided the information and support they need in decision making.
- Verify through conversation with the individual and/or his/her guardian, family member, or advocate; and review of the individual's record as described above.

SELECT "MET" If the following is evident:

- ✓ The individual has been given information and the opportunity to make decisions regarding advance directives.

SELECT "NOT MET" If the following is evident:

- ✓ The individual has not been given information and/or the opportunity to make decisions regarding advance directives.

Standard No.	Standard Text	Decision
8a-24	For those that have advanced directives, they are completed properly in accordance with the Healthcare Decisions Act.	**Met/Not Met/NA**

Guidance

DISCUSSION:

Mandatory:

- Talk with the RN in certified residential setting, about how advance directives are approached with the individual.
- Talk with the SC/CM/CC when appropriate, about how advance directives are approached with the individual.

DOCUMENTATION REVIEW:

Mandatory:

Advance directive documents: e.g. Health Care Proxy, Living Will, DNR documentation.

- Daily notes, health care notes, nursing notes, and/or prn notes that may reference discussions and decision making;
- Medical, Health Care or Nursing Assessments that may reference advance directive discussions and decision making;
- Service coordination-Care Coordination-Case Management-Treatment Coordination notes that may reference advance directive discussions and decision making.

GUIDANCE:

- When any advanced directive is in place:
  - Verify that the documentation evidencing the directive is correctly completed.
  - Verify that staff/FCP supporting the individual are aware of the advanced directive and content.
  - Verify that staff/providers working with the individual knows how to access the information for questions and or clarification.
  - It is important that this information is available for medical consults, emergency care and/ or hospital admissions.
- Information on health care choices and advance directives may be found on the OPWDD website in the February 2012 document HEALTH CARE CHOICES: WHO CAN DECIDE?
- A person may have assigned a health care agency via Health Care Proxy, have a Living Will, and have a DNR concurrently.

- HEALTH CARE PROXY:
- A Health Care Proxy is a document delegating the authority to make health care decisions, executed in accordance with applicable requirements.
- o A health care agent is an adult to whom authority to make health care decisions is delegated pursuant to a properly executed health care proxy.
- o The health care proxy must sufficiently identify the principal (individual) and the agent and it must clearly indicate the principal's intent to give the agent authority to make health care decisions.
- A health care proxy is a document created by an individual (the principal) which names another person as his or her health care agent to have the authority to make health care decisions if and when the principal is determined to be incapable of making medical care decisions for himself or herself.
- A person does not need to have the capability of making and understanding all medical care decisions for himself or herself in order to be able to make a health care proxy. A person simply has to understand that he or she is giving another person (the health care agent) the authority to make medical care decisions on his or her behalf if and when he or she is not capable of making these decisions.

- A health care proxy does not require a person to know in advance all the types of decisions that may arise in the future. Instead, a person's health care agent can interpret his or her wishes as medical circumstances change, and make decisions a person could not have known would have to be made. However, a person can include instructions in a health care proxy if he or she wishes to do so.
- The determination of the person's understanding should be documented in the person's record. While it is preferred that the determination is in the form of an evaluation or assessment by a psychologist, it is not a requirement.
- If the individual has an appointed guardian, consideration should be given to appointing the guardian as the health care agent.
- No one may create a health care proxy for another person.
- The health care proxy document must be signed and dated by the individual in the presence of two adult witnesses who must also sign the proxy. Assistance may be provided to the individual in completing the health care proxy form. Another party may sign and date a health care proxy document for the individual if the individual is unable to do it and instructs that party to sign in the presence of two adult witnesses. In this case, the witnesses must also sign the proxy document and attest that the person appeared to execute the proxy willingly and free from duress.
- A party appointed as an agent/proxy cannot act as a witness to the completion of a health care proxy.
- If the person resides in an OPWDD operated or certified facility:
    - § At least one witness must be someone who is not affiliated with the facility in which the person resides.
    - § In addition, at least one witness must be a NYS licensed physician or a clinical psychologist who either:
        (1) is employed by a DDSO; or
        (2) has been employed for at least two years in an OPWDD operated or certified facility; or
        (3) has specialized training and two years' experience serving persons with developmental disabilities; or
        (4) has at least three years' experience serving persons with developmental disabilities.

- LIVING WILL
    - A living will is a document that provides specific instructions about health care treatment.
    - A living will is generally used to declare wishes to refuse life-sustaining treatment under specific circumstances that may arise in the future.
    - A living will does not appoint a "health care agent" and does not replace a health care proxy. It is generally used when a person wants to make his or her wishes known concerning health care, but does not have someone available to act as health care agent.

- WITHHOLDING LIFE-SUSTAINING TREATMENT PER THE HEALTH CARE DECISIONS ACT:
    - Life-sustaining treatment means medical treatment including cardiopulmonary resuscitation and nutrition and hydration provided by means of medical treatment, which is sustains life functions and without which, according to reasonable medical judgment, the patient will die within a relatively short time period. Cardiopulmonary resuscitation is presumed to be life sustaining treatment.
    - DO NOT RESUSCITATE ORDER (DNR) is instruction not to attempt cardiopulmonary resuscitation in the event a person suffers cardiac or respiratory arrest. Such instructions may cover any cardiopulmonary resuscitation measures or may be limited depending on the scope of the consent.
    - Non-hospital DNR order is do not resuscitate instruction issued for a person who is not a resident of a developmental center; or instructions issued for a person in a developmental center, hospital, psychiatric center or residential health care facility which is to take effect only after the person leaves such a facility.
    - As of June 1, 2010, the Health Care Decisions Act process must be followed for all decisions involving the withholding or withdrawing of life-sustaining treatment, including DNR orders. DNR orders issued prior to June 1, 2010 remain effective.
    - o See pages 18-19 HEALTH CARE CHOICES: WHO CAN DECIDE? for requirements to execute an order to without life sustaining treatment such as DNR.

SELECT "MET" if the following is evident:

- ✓ If the individual has a directive related to health care, it is executed and documented correctly; and
- ✓ The advance directive document is available for reference by those responsible to ensure its execution.

SELECT "NOT MET" If the following is evident:

- ✓ If the individual has a directive related to health care, it is not executed and documented correctly; and/or
- ✓ The advance directive document is not available for reference by those responsible to ensure its execution.

SELECT "NA" IF:

- ✓ The individual does not have an advance directive related to health care.

Standard No.	Standard Text	Decision
8a-25	The individual's service record/service plan is maintained to reflect current status of the individual's health.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

Discuss health status, health services and needs for support regarding health with the following:

- Individual (Designee)
- Service Coordinator/Care Manager/Case Manager, etc.
- RN in certified residential settings

DOCUMENTATION REVIEW:

Mandatory:

- Service plan, as named for the service/service environment (e.g. ISP, Treatment Plan, Program).
- Nursing Assessment
- Health assessment

GUIDANCE:

- This standard is intended to ensure that the individual's record includes documentation of the current status of an individual's health. Dependent on service type/environment, the staff/FCP should be able to easily identify current diagnoses, current medications, current allergies, and current needs for health supports, for reference. This does not necessarily have to be all in one document, but the information should be located easily through, attachments or references to other documents easily located in the record. Sources of the information may be the ISP and attachments, nursing assessment and attachments, comprehensive health care assessment, or "Ready to Go" packet in certified residential settings.

SELECT "MET" If the following is evident:

- ✓ The individual's record includes easily accessible information on the person's current health status.

SELECT "NOT MET" If the following is evident:

- ✓ The individual's record does not include easily accessible information on the person's current health status.

Standard No.	Standard Text	Decision
8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA

Guidance

DISCUSSION:

Mandatory:

- Talk with the individual (designee) for their input regarding their satisfaction, comfort and communication with doctors and medical providers.
- Discuss the same issues with supports and/or staff that may accompany the individual to medical appoints and their impressions.
- Discuss opportunities for choice with team members and the SC/CM/CC.

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence routine activities and supports, as well as health needs and recommendations, e.g.:

- Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
- Medical Consult forms that describe health concerns and recommendations;
- Health Care Plan, Nursing Care Plans as appropriate;
- Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports;
- Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on routine health care supports and intervention.

GUIDANCE:

- Based on discussion suggested above, consider the individual's satisfaction and understanding of their health care and health interventions.
- The focus of this standard is to determine if the individual (designee) understand that they have the right to request additional information about their health, diagnosis, and recommendations for treatments by requesting a second medical opinion and/or submitting a grievance/complaint regarding service provided.
- The individual be should be afforded the opportunity to consider the input from more than one physician for the same condition(s), and benefit from the confidence if findings concur, or consider options if they do not.
- While the standard states "second" opinion, this is not intended to limit the right to two opinions.
- Based on documentation and discussion, determine if the person is informed that they may file a complaint about their experience with medical provider or medical care and/or request/seek a second opinion.
- Determine whether the individual is supported to seek another medical provider, arrange and attend the appointment, and/or communicate their complaints, concerns, grievances.
- Knowledge and support in the components of this standard are particularly impactful when the person is dissatisfied with treatment, communication or treatment results; as well as when new diagnoses or recommendations for treatment are offered.

SELECT "MET" If the following is evident:

- ✓ The individual (designee) is offered the opportunity to seek another medical opinion and/or file a grievance regarding medical care as needed or desired.

SELECT "NOT MET" If the following is evident:

- ✓ The individual (designee) is not offered the opportunity to seek another medical opinion and/or file a grievance regarding medical care as needed or desired, especially when issues with adequate professional health care are evident or decisions regarding treatment options that may significantly impact the person's life, arise.

SELECT "NA" If any of the following are present:

- ✓ The individual has no significant health diagnoses or concerns and rarely needs medical attention or intervention.

Standard No.	Standard Text	Decision
8a-27	The individual is given access to family planning resources and sexuality education and/or counseling if desired.	Met/Not Met/NA

Guidance

DISCUSSION:

Mandatory:

- Talk with the individual (designee) for their input regarding their interest in sexuality education, family planning, with sensitivity to their privacy.
- Discuss the same issues with people that support/work closely with the individual.
- Discuss the individual's circumstances and opportunities provided for family planning and sexuality counseling with the SC/CM/CC, RN or other team members.

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence routine activities and supports, as well as health needs and recommendations, e.g.:

- Daily notes, health care notes, nursing notes, and/or prn notes;
- Clinical, Nursing or Medical Assessments and/or Consult forms;
- Health Care Plans, Nursing Care Plans as appropriate;
- Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on routine health care supports and intervention.

GUIDANCE:

- Based on the life circumstances, interests and personal desired outcomes of the individual determine either their known interest in sexuality education and/or whether they would benefit from participation is such counseling/education.
- Clarify needs and interests with the individual and their supports.
- Interview appropriate team members such as service coordinator, care manager, case manager, RN, and other staff or support persons regarding the individual's needs of family planning and/or sexuality counseling/training.
- Verify that the individual is participating in family planning and/or sexuality training or counseling according to their needs/interested and receives the support they need to participate and facilitate understanding of the information.

SELECT "MET" IF:

- ✓ Individuals are supported to access and sexuality and or family training/counseling according to their needs and interests.

SELECT "NOT MET" IF:

- ✓ Individuals are not supported to access sexuality and or family training/counseling according to their needs and interests.

SELECT "NA" If:

- ✓ The individual's person centered plan describes an individual for whom education/information to understand their own and others' body, sexuality, sexual relationships, or family planning, is of no interest or no benefit in their quality of life and/or improvement or maintenance of relationships.

Standard No.	Standard Text	Decision
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory: Individual (designee), Service Coordinator, Care Manager, case manager, treatment coordinator
RN as applicable

DOCUMENTATION REVIEW:

Any and all documentation reviewed to evaluate the previous standards in this section.

GUIDANCE:

- Based on all previous review activities make a determination on whether holistically, the person is generally receiving adequate health services per needs and informed choice in a manner that allows them to live as independently as possible.
- Consider whether the person has experienced any significant health events that are related to incompletion of health routines. This may include a significant exacerbation in their conditions, hospitalization, injury requiring more than first aid, etc. that are a result of inadequate supports to ensure routine care in day to day life and/or inadequate supports to access professional medical care as recommended per diagnosis or prn when signs and symptoms are presented.
- This applies to health problems/worsening that are preventable if adequate care is available and provided. Serious worsening of health due to natural progression of the individual's diagnosis despite adequate care should not be considered contributing to decision making for this standard if care provider was adequate.
- This is not meant to be a repeat reflection of earlier decisions of "not met".

SELECT "MET" IF:

- ✓ The individual, for the most part is healthy and/or benefitting from competent supports to access health care and ensure adequate health care at home.

SELECT "NOT MET" IF:

- ✓ The individual, is not assuring or receiving adequate health care supports, resulting in negative outcomes such as new or exacerbation of health issues.

Standard No.	Standard Text	Decision
8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall with the medical care that the individual receives.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory: Individual (designee), Service Coordinator, Care Manager, case manager, treatment coordinator

RN as applicable

DOCUMENTATION REVIEW:

Any and all relevant documentation that may note satisfaction with medical care and services, e.g. SC/CM/CC notes, person centered plan, prn notes, nursing notes.

GUIDANCE:

- Based on review activities determine whether the person and advocate are pleased with the health care service/support received and whether they agree that they are provided as intended and adequately meeting their medical needs and need for assistance to appropriately address their health. This standard is based upon the individual's perception. It may or may not be an accurate assessment based on your review of the service.

SELECT "MET" If any of the following are evident:

- ✓ The person is satisfied with the medical care and supports received.
- ✓ The person reports that he/she benefits from the health care services.

SELECT "NOT MET If any of the following are met:

- ✓ The person is satisfied with the medical care and supports received.
- ✓ The person reports that he/she benefits from the health care services.

SECTION 8b: HEALTH SERVICES & SUPPORTS - COMMUNITY BASED WAIVER SERVICES

Qualifier Question: The agency's waiver certification includes approval to provide delegated nursing services per the NPA expansion to selected community based HCBS services, and is providing such services to the individual in the course of community based waiver service delivery.	**Yes**	**No**

Standard No.	Standard Text	Decision
8b-1	A medical assessment which identifies the individual's health care needs has been completed by a physician, PA, NP, or RN.	**Met/Not Met**

Guidance

DISCUSSION:

As Needed:

• If it is unclear whether the person has had a comprehensive health or nursing assessment, discuss with the person and/or significant involved parties if an assessment of the person's health and health needs has been determined.

DOCUMENTATION REVIEW:

Mandatory:

• Review the person's record for documentation indicating that the person have had at least a baseline evaluation of their health or health care needs. This may be a comprehensive physical examination of all body systems or another general review of general health, health needs and need for health supports such as a comprehensive nursing assessment.

GUIDANCE:

- The purpose of this standard is to ensure that a person receiving health care services during HCBS Waiver service delivery has had the status of their health and/or health care needs comprehensively assessed by the assigned RN.
- An individual must have a comprehensive nursing assessment completed by the RN if they are a recipient of nursing delegated services via the exemption permitted for an individual receiving community based HCBS waiver service.
- The comprehensive nursing assessment must include the following information:
    - The individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings;
    - The individual's strengths, goals, and care preferences;
    - Current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional; and
    - A review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy).
- The comprehensive assessment of the individual completed by the RN can be used to determine whether nursing tasks, in whole or in part, can be delegated to DSPs with adequate training and nursing supervision.
- An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.

SELECT "MET" If the following is evident:

- ✓ There is a current documented Nursing Assessment that comprehensively assesses the health and health needs of the person related to delivery of nursing delegated services during HCBS Waiver service delivery.

SELECT "NOT MET" If any of the following are present:

- ✓ A Nursing Assessment has not been completed.
- ✓ The Nursing Assessment is not current and accurate.
- ✓ The Nursing Assessment does not comprehensively assess/address the health and health needs of the person related to delivery of nursing delegated services during HCBS Waiver service delivery.

Standard No.	Standard Text	Decision
8b-2	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions. Be sensitive to their privacy in the framing and location of the discussion.

As Needed:

• Speak with the staff or natural supports assisting the person with routine health care if documentation and discussion with the individual requires clarification

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence that routine interventions to address health need have occurred: E.g.:

• Medical Consult forms that describe needed in-home/daily supports
• Health Care Plan, Nursing Care Plans as appropriate
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on routine health care supports and intervention

GUIDANCE:

- This standard is intended to evaluate that there is a written plan to address, ameliorate or monitor the individual's medical diagnosis/diagnoses are provided as needed and recommended. This does not apply to participation in medical appointments and testing in health care offices and facilities. This is intended to address needed interventions in day to day life in the individual's home and other environments.
- The RN is required to evaluate and plan care according to the individuals needs and they may delegate health care tasks to direct care staff.

- The RN familiar with the needs and conditions of the individual, must provide written instructions, a Plan of Nursing Services or other written directive for direct support staff on all pertinent medical diagnosis/health needs that require care to address a health need. The written plan should provide step by step systematic instructions on the care, support and/or monitoring staff are to provide to the individual. The written plan/instructions should be written at a basic level, in plain English to ensure all staff can understand it. The plan must be part of the service record and available to staff responsible to provide the supports.
- Verify all significant medical conditions identified for the individual, both chronic and acute have a plan of nursing service, or similar written plan available for staff to access. Verify that all information on the condition and treatments and monitoring necessary by the DSPs and/or the RN in the provision of care/support to the individual is included in the plan.
- Through RN interview and mandatory document review, surveyor evaluates that written individualized PONS are developed based on the initial assessment and subsequent comprehensive nursing assessments. Without accurate and timely assessment, PONS, which inform the DSP to whom delegated nursing tasks have been assigned, become outdated and puts the individual at risk for inadequate nursing care. The PONS are to be reviewed both as needed and annually.
- Ensure that as the individual's health status changes, the written plan of nursing service(s) is revised, or new written instruction developed as applicable. For example a person receiving a new diagnosis, has a recent fracture, or has been discharged from the hospital must have a written plan with adequate written instruction for direct support staff to ensure the individuals receives adequate care and treatment during services. The plans shall be individualized to the person and updated and d/cd as needed.
- Care plans related to health issues may be for long term/permanent conditions or short term health concerns,
- Care plans should include interventions consistent with physician's recommendations,
- Examples of diagnoses and health issue that require a protocol plan include (but are not limited to) diabetes, seizure disorder, constipation, history of dehydration, risk of swallowing and aspiration issues, hypertension, hospital discharge, post-surgical care, catheter care, tube feedings, colostomy care and many other medical treatments, etc.
- The plan related to health care (e.g. nursing care plan) should include at a minimum:
    - Brief description of problem/contributing factors;
    - Preventative measures to be provided to the individual relative to the health issue (or monitoring of individual's independent role in prevention); this may include dietary interventions (e.g. ADA diet for diabetes, high fiber interventions and bowel tracking and interventions for constipation, fluid requirements for multiple conditions);
    - Direct interventions or routine care related to the health issue (or monitoring of the individual's independent role in prevention), e.g. prescribed medications to be administered, wound care, repositioning, etc.);
    - Signs and symptoms to look for and monitor, including skin condition, appetite, high/low parameters of vital measures taken if any are required, and how to identify pain/discomfort especially for individuals may not or cannot clearly communicate concerns to people that support them;
    - When to contact the RN and/or physician;
    - When to call 911.
    - Interventions to be provided by the RN or other professional.
- Verify that the written plans are accessible to staff responsible to implement.

- Additional guidance regarding content of care plans for some specific conditions is found in guidance for Site Protocol risk factors. In addition consider the following when determining whether a written plan is needed for an individual:
- Risk factors for aspiration include weak gag reflexes, poor chewing/swallowing skills, GERD, food stuffing, inappropriate fluid consistency or food textures, medication side effects, and impaired mobility that result in an individual unable to sit upright while eating.
- Risk factors for constipation include: neuromuscular degenerative disorders that impair the central nervous system's need to eliminate, spinal cord injuries or birth defects that affect neural responses needed for elimination (such as spina bifida), diets that do not contain enough fiber and fluids, poor swallowing skills with aspiration risk, medications that slow down gastric motility or draw too much fluid from GI tract, history of frequent bowel stimulant use leading to decreased bowel reactivity. Look for evidence of: hospitalizations or outpatient treatments for constipation related issues, diet orders to increase dietary fibers, bowel movements more than 2-3 days apart, and medications that have constipating side effects.
  When a PRN bowel medication (cathartic) is ordered it is vital that bowel movements are tracked and that the PRN is being given as directed to avoid, constipation, bowel impaction, loose stools or diarrhea. A PRN for bowel management must not be given if some sort of bowel monitoring is not in place as it is incumbent on the prescriber to know what signs and symptoms present would indicate a need for the medication.
- Seizure prevention guidelines include taking antiepileptic medications on time as prescribed, promoting accurate documentation and record keeping of seizures that have occurred for review by a medical professional, encouraging good sleep-low stress-and good nutrition. Seizure intervention guidelines include having an individualized seizure protocol that includes
    1. Description of the individual's normal seizure pattern,
    2. Safety interventions
    3. Safety precautions at home and in the community
    4. Caregiver instructions on notifications, when to call 911, and the administration of PRN medications (if ordered).
- Risk of having dehydration: medical conditions such as kidney disease or diabetes that can result on fluid loss, excessive sweating-vomiting-drooling-diarrhea, frequent refusal of food and/or drink, unable to access fluids without assistance, dysphagia with coughing during meals, and inability to communicate thirst to caregivers. Prevention guidelines include: drinking enough water/day, alterative fluids are offered if individual frequently refuses fluids.
- Additional guidance as specific to delegated nursing services in delivery of community based HCBS Waiver Services, if determined that tasks can be delegated to DSPs. The plan of nursing services developed by the RN must identify the following:
- The nursing services to be provided to the individual, including delegated nursing tasks and medication administration;
- A description of the acute or chronic health condition being addressed;
- Individual-specific instructions for competently performing each delegated nursing task, required monitoring and documentation and criteria for identifying, reporting, or responding to problems or complications.
- The DSP(s) to whom the task is delegated;
- The date of the delegation;
- The RNs who will initially be assigned to supervise the DSP(s);
- The RN's signature;
- The RN may include specific information on RN supervision of the delegated tasks;
- Any changes to or termination of delegation of nursing services must be documented in the PONS along with the RN's signature.

- PONS must be accessible to staff.

SELECT "MET" If both of the following are evident:

- ✓ A written care plan is in place, instructing the care and monitoring needed by the individual is in place for each of the individual's health diagnosis/condition that require care and/or oversight.
- ✓ The written care plan is clearly written and addresses the necessary aspects of care and monitoring for the health condition.

SELECT "NOT MET" If either of the following are evident:

- ✓ A written care plan is not in place for each of the individual's health diagnosis/condition that require care and/or oversight.
- ✓ The written care plan is unclear and/or does not address the necessary aspects of care and monitoring for the health condition.

Standard No.	Standard Text	Decision
8b-3	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	**Met/Not Met/NA**

Guidance

DISCUSSION:

Mandatory:

• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions. Be sensitive to their privacy in the framing and location of the discussion.

As Needed:

• Speak with the staff/supports assisting the person with routine health care if documentation and discussion with the individual requires clarification.

DOCUMENTATION REVIEW:

Mandatory based on agency practices:

Documents that evidence that routine interventions to address health need have occurred: E.g.:

• Medical Consult forms that describe needed in-home/daily supports;
• Health Care Plan, Nursing Care Plans as appropriate;
• Recording of health care services such as bowel charting and interventions, fluid monitoring, diabetic monitoring;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports;
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on routine health care supports and intervention.

OBSERVATION:

• As appropriate, needed and able in certified settings, observation may provide information relevant to delivery of services and supports related to the individual's health and well-being; e.g. repositioning, dietary interventions, etc.

GUIDANCE:

- This standard is intended to evaluate the interventions address, ameliorate or monitor the individual's medical diagnosis/diagnoses are provided as needed and recommended. This is intended to verify that needed interventions are provided in day to day life in the individual's home and other environments.
- Verify that the individual's supports/staff are implementing/delivering care and support required to address her/his health issues and per their written health care plans and physician's recommendations.
- Verify that any intervention that must be provided by the RN are provided.
- Verify that any necessary equipment related to implementation of health care plans is present. This may include for example: glucometers, lifts, hearing aids, orthotics, oxygen and delivery supplies, bi-pap, c-pap, humidifiers and etc.
- Evidence of needed interventions may be through documentation modalities specific to the service received and/or agency processes. This may include service notes, prn notes, nursing notes, medication and treatment records, service coordination notes, and specific service documentation sheets designed for collection of service delivery (e.g. bowel management tracking, glucose level testing, etc.).
- It may also be necessary to verify through staff discussion, staff's understanding of the care to provide to meet the health care needs of the individual.
- It may be appropriate that the individual assume responsibility for their own interventions, with staff or natural supports overseeing that the individual is appropriately addressing the health issue.
- An individual may make an informed decision to not follow recommendations for preventive and reactive health care.

SELECT "MET" If either of the following are evident:

- ✓ The individual is receiving needed health care interventions per the written plans and physician's recommendations.
- ✓ The individual has made an informed decision to not follow recommendations/plans to address health diagnoses/issues.

SELECT "NOT MET" If either of the following are evident:

- ✓ The individual is not receiving needed health care interventions per the written plans and physician's recommendations.
- ✓ The individual has decided to not follow recommendations/plans to address health diagnoses/issues without evidence of informed decision making.

SELECT "NA" IF:

- ✓ The individual needs support only for medication administration and/or monitoring. There are no documented, discussed or observed needs for additional delegated health care services during delivery of community based HCBS services.

Standard No.	Standard Text	Decision
8b-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory:
• Talk with the RN responsible for oversight of the individual's health care in whole (certified residential setting) or in part (HCBS waiver service NPA exemption), to assess their understanding and oversight of the individual's health care and medication administration.
• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions, and interactions with the assigned RN. Be sensitive to their privacy in the framing and location of the discussion.
As Needed:
• Speak with the staff /supports assisting the person with routine health care regarding participation and support provided by the assigned RN.

DOCUMENTATION REVIEW:
Mandatory:
Documents that evidence RN coordination, oversight and participation in the individual's health care services, e.g.:
• Medical Consult forms that describe needed in-home/daily supports;
• Health Care Plan, Nursing Care Plans as appropriate;
• Recording of health care services such as bowel charting and interventions, fluid monitoring, diabetic monitoring;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports.

OBSERVATION:
• As appropriate, needed and able in certified settings, observation may provide information relevant to delivery of services and supports related to the individual's health and well-being; e.g. repositioning, dietary interventions, etc.

GUIDANCE:
- Applies to individuals in certified residential settings and recipients of delegated nursing services as part of the delivery of HCBS waiver services in the community.
- Based on a record review and interview, validate that oversight and monitoring of delegated nursing tasks is occurring by the RN. Oversight by the RN must include periodic and regular assessment of proficiency.
- The assigned RN is responsible to provide or ensure that the individual is receiving appropriate health care services including:
    - For the individuals in a certified residential setting:
        - Professional medical appointments with physicians appropriate to the individual's needs and recommendations;
        - Diagnostic medical evaluation;
        - Assurance that follow-up appointments, evaluations and care are provided per physician recommendations;

- Routine health care assessment and interventions to be provided by the RN or direct support staff, necessary to improve or maintain health status dependent on the person's individualized needs;
- Appropriate medication administration, including review of accuracy of the Medication Administration Record.
- Revision to care, delegated services and health related service plans occur as needed.
- The RN is responsible to review medical consults and physician communications and ensure recommendations are implemented.
- The RN is responsible to ensure that the physician has reviewed any diagnostic results (e.g. lab work).
- The RN is responsible to advocate for required and adequate health care for individuals assigned to their care.

o For the individual receiving services in the course of community based HCBS waiver services:

- All routine delegated health related care, medication administration to be provided by direct support staff;
- Health care assessment and interventions to be provided by the RN.
- Revisions to delegated services and health related service plans occur as needed.

- The RN is responsible to maintain current understanding of the individual's health status and needs and ensure that the physician is informed.
- Based on a review of documentation including nursing assessments, plans of nursing services, medical consults, diagnostic reports, medication and treatment administration records, and interview verify that the individual has received all the health care services they require in accordance with their health care needs.
- The RN's direct service and oversight activities must also be documented in the individual's service record.

SELECT "MET" If both of the following are evident:

✓ The individual is receiving needed health care per the written plans and physician's recommendations, unless the individual has made an informed decision to not receive care.
✓ There is documentation of RN provision of care and/or oversight of the individual's medical appointment, diagnostics, and routine care.

SELECT "NOT MET" If any of the following are evident:

✓ The individual is not receiving needed/determined health care interventions per the written plans and physician's recommendations (not due to informed choice).
✓ There is no evidence of required RN oversight and/or provision of care.
✓ There is no evidence of RN advocacy with the individual's health care providers when needed.

Standard No.	Standard Text	Decision
8b-5	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory:
• Talk with the RN responsible for oversight of the individual's health care in whole (certified residential setting) or in part (HCBS waiver service NPA exemption).
• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions, and interactions with the assigned RN. Be sensitive to their privacy in the framing and location of the discussion.
• Speak with the staff assisting the person with routine health care regarding participation and support provided by the assigned RN.

DOCUMENTATION REVIEW:
Mandatory:
Documents that evidence RN coordination, oversight and participation in the individual's health care services, e.g.:
• Medical Consult forms that describe needed in-home/daily supports;
• Health Care Plan, Nursing Care Plans as appropriate;
• Recording of health care services such as bowel charting and interventions, fluid monitoring, diabetic monitoring;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports.
• IRMA/Incident Documentation

OBSERVATION:
Events during observations in certified sites may provide information regarding this standard.

GUIDANCE:
- This standard reviews that staff supporting individuals understand the individualized plans, recognize status changes, and notify the appropriate medical and health care professionals per the person's specific health needs.
- Staff should evidence understanding of the individual's health issues, status and the conditions and symptoms related to his/her health diagnoses that need to be reported to the RN, physician, or activate 911.
- Staff working with the individuals must report diagnosis related signs and symptoms that would warrant further monitoring, care and treatment.
- Evidence of staff understanding is demonstration of notification when necessary. Through documentation review, verify staff have made proper notifications as needed per the individual's health issues.
- As referenced in descriptions of content of the health care plans, any such plan must identify conditions, symptoms and parameter highs and lows that must be reported and to whom.

- Examples of health issues that should be reported by direct support staff to designated professional include based on the individualized written plan: skin redness or injury, blood glucose levels, weight, oxygen saturation outside designated parameters, more than a designated number of seizures in a stated time period, etc.

SELECT "MET" If the following is evident:

✓ The RN, physician and/or EMS (911) are notified of the individual's condition as specified in the care plan.

SELECT "NOT MET" If the following is evident:

✓ The RN, physician and/or EMS (911) are not notified of the individual's condition when needed as specified in the care plan.

SELECT "NA" IF:

✓ Documentation and discussion indicate that there have been no occasions when the RN, other health care providers or 911 needed to be notified regarding the individual's condition, health or health care.

Standard No.	Standard Text	Decision
8b-6	The individual's service record/service plan is maintained to reflect current status of the individual's health.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

Discuss health status, health services and needs for support regarding health with the following:

• Individual (Designee)
• Service Coordinator/Care Manager/Case Manager, etc.
• RN in certified residential settings

DOCUMENTATION REVIEW:

Mandatory:

• Service plan, as named for the service/service environment (e.g. ISP, Treatment Plan, Program).
• Nursing Assessment
• Health assessment

GUIDANCE:

- This standard is intended to ensure that the individual's record includes documentation of the current status of an individual's health. Dependent on service type/environment, the staff should be able to easily identify current diagnoses, current medications, current allergies, and current needs for health supports, for reference. This does not necessarily have to be all in one document, but the information should be located easily through, attachments or references to other documents easily located in the record. Sources of the information may be the ISP and attachments, nursing assessment and attachments, comprehensive health care assessment, or "Ready to Go" packet in certified residential settings.

SELECT "MET" If the following is evident:

- ✓ The individual's record includes easily accessible information on the person's current health status.

SELECT "NOT MET" If the following is evident:

- ✓ The individual's record does not include easily accessible information on the person's current health status.

SECTION 8c: HEALTH SERVICES & SUPPORTS - COMMUNITY BASED WAIVER SERVICES

Qualifier Question: Does the person receive support for medication administration during delivery of this service?	**Yes**	**No**

Standard No.	Standard Text	Decision
8c-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	**Met/Not Met**

Guidance

DISCUSSION:
As needed:
• Talk with the RN responsible for oversight of medication administration;
• Talk with the individual, especially those with responsibility for or learning self-administration skills
• Speak with the staff responsible for medication administration.

DOCUMENTATION REVIEW:
Mandatory:
• Medication Administration Record (MAR)
• Physician's orders
• IRMA/Incident documentation
• Agency reporting of medication administration issues (non-Part 624)
As Needed:
• Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

GUIDANCE:

- Based on review of the Medication Administration Record (MAR) and the medical chart as needed, verify the following:
  - All medications are prescribed by a physician, nurse practitioner, or physician's assistant;
  - The medication prescription/order is current;
  - The medication order is accurately transcribed on the individual's Medication Administration Record regarding medication name, dosage, time of administration, and route of administration.
  - If medication orders change, the MAR must accurately and clearly document the prescribed medication addition, discontinuation, or change.
  - If inaccuracies are identified on the MAR, verify that the RN is completing review of the MAR for accuracy and completeness.
  - Note: Although ordered as part of the individual's health and dietary care, nutritional supplements such as Boost and Ensure are not medications and do not need to be on the MAR. In addition, there is no need for a MD order for things like Keri Lotion, Listerine, chap-stick, sun screen and they need not be documented on a MAR.

SELECT "MET" If the following is evident:

- ✓ The Medication Administration Record accurately documents all medications and treatment prescribed for the individual.

SELECT "NOT MET" If any of the following is evident:

- ✓ The Medication Administration Record includes one or more inaccurate or outdated medication orders.
- ✓ The Medication Administration Record includes one or more error in medication name, dosage, time of administration, and/or route of administration.

Standard No.	Standard Text	Decision
8c-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	**Met/Not Met**

Guidance

DISCUSSION:

As needed:

• Talk with the RN responsible for oversight of medication administration;
• Talk with the individual, especially those with responsibility for or learning self-administration skills
• Speak with the staff responsible for medication administration.

DOCUMENTATION REVIEW:

Mandatory:

• Assessment of ability to self-administer medication
• Medication Administration Record (MAR)
• Agency reporting of medication administration issues (non-Part 624)

As Needed:

• Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

GUIDANCE:

- Verify that the RN has completed at least an annual assessment of the individual's ability to self-administer medications.
- This assessment not only identifies the individual's ability to self-administer, but must also document the level of support and assistance needed by the person to ensure they receive medication as prescribed.
- When the individual's skills/abilities remain unchanged, it is not necessary that a new assessment document be completed. It is acceptable for the RN to document their review of the individual's abilities/skills and findings, and date and sign their review on a previously completed self-administration assessment.
- While the RN is typically the medical professional completing the assessment, a physician, physician's assistant or nurse practitioner may also complete the assessment.

SELECT "MET" If the following is evident:

- ✓ The RN has completed and documented an assessment/review of the individual's ability to administer medication annually.

SELECT "NOT MET" If any of the following is evident:

- ✓ The RN has not completed and documented an assessment/review of the individual's ability to administer medication.
- ✓ The RN has not completed and documented an assessment/review of the individual's ability to administer medication annually.

Standard No.	Standard Text	Decision
8c-3	The individual receives or self-administers medications and treatments safely as prescribed.	**Met/Not Met/NA**

Guidance

DISCUSSION:
As needed:
• Talk with the RN responsible for oversight of medication administration;
• Talk with the individual, especially those with responsibility for or learning self-administration skills
• Speak with the staff responsible for medication administration.

DOCUMENTATION REVIEW:
Mandatory:
• Medication Administration Record (MAR)
• Physician's orders
• IRMA/Incident documentation
• Agency reporting of medication administration issues (non-Part 624)
As Needed:
• Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

OBSERVATION:
As Needed:
• Only as determined necessary, observation of medication pass may provide additional evidence of individual's accurate receipt of medications.

GUIDANCE:
- Review the MAR and/or other relevant documentation to verify that all prescribed medication and treatments are administered or self-administered.
- Verify that medication administration and oversight is documented as required by agency policy.
- Medication administered by staff:
- Staff must document on the MAR to evidence medication administration per agency policy.
- Review the MARs for the past 6 months at a minimum. Verify that the majority of medication administration occasions are documented.
- Blank on the MAR may or may not indicate failure to administer medications correctly or negative impact. Consider the specific medication prescribed and impact of missed dose, whether the agency has a supplemental mechanism to evidence medication administration (e.g. staff initialing of medication blister pack), medication counts, or other means to ensure the receipt of the medication and/or impact of isolated omission.
- Verify that when PRN medication is administered for the prescribed condition(s):

- § The effectiveness of the medication to address the condition is documented;
- § Administration of a PRN medication does not exceed 2 days, unless specified by the practitioner or the practitioner has been contacted for extended use of the medication.
- § The RN or other Health Care Professional provides oversight as to whether the condition be treated by the PRN warrants further medical treatment and follow up.
- If issues with medication administration and/or documentation were evident in earlier documentation, but correct administration and documentation is evident in the most recent months, consider the issue addressed and corrected. However, if problems are continuing, pursue further clarification.
- If there are concerns whether medications is correctly administered and/or if there are many blanks on the MAR, determine whether the agency/facility took action to verify that medication was administered and took corrective action to assure accurate medication administration and documentation. Additional information or explanations of blanks or missed administrations may be explained on the back of the MAR.
- Self-administration of medication by the individual:
    - The agency/facility must monitor and verify that the individual is taking their medication as prescribed per effective agency mechanism.
    - The actions taken by agency staff to verify correct self-administration must be documented per agency policy.
    - Verify that the individual is taking medication as prescribed through review of agency documentation of oversight.
    - If the individual is not consistently taking their prescribed verify that it is based on an informed choice vs. lack of supports to assist the individual in self-administration.
    - The RN is responsible to oversee that the individual receives medications and care as prescribed by the physician. AMAP (medication certified staff) are administering medication under the license of the RN through the Nurse Practice Act exemption. The RN should therefore implement actions to monitor competent medication administration.
    - Medication error practices will be reviewed in a separate standard.

SELECT "MET" If the following is evident:

- ✓ Medications are administered correctly and generally documented correctly.

SELECT "NOT MET" IF either of the following is evident:

- ✓ It could not be evidenced that medications are not administered correctly;
- ✓ Documentation of medication administration is frequently not documented and/or not documented correctly including prn medications.

SELECT "NA" IF:

- ✓ Only prn medications are prescribed and administration was not necessary.

Standard No.	Standard Text	Decision
8c-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	**Met/Not Met**

Guidance

DISCUSSION:

As needed:

• Talk with the RN responsible for oversight of medication administration;
• Talk with the individual, especially those with responsibility for or learning self-administration skills
• Speak with the staff responsible for medication administration.

DOCUMENTATION REVIEW:

Mandatory:

• Medication Administration Record (MAR)
• Physician's orders
• IRMA/Incident documentation
• Agency reporting of medication administration issues (non-Part 624)

As Needed:

• Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

GUIDANCE:

- The RN is responsible to oversee that the individual receives medications and care as prescribed by the physician. AMAP (medication certified staff) are administering medication under the license of the RN through the Nurse Practice Act exemption. The RN should therefore implement actions to monitor competent medication administration.
- Medication administration and administration process errors must be reported, investigated and remediated as follows:
    - according to Part 624 requirements (when Part 624 definition of medication error is met);
    - According to agency policy and procedure for administration and process errors not requiring part 624 reporting.
    - Review medication error reporting pertaining to the individual, occurring in the past 12 months.
    - Verify that the agency identified and reported medication errors as necessary per regulation and policy.
    - Verify that each reported event was investigated to determine circumstances regarding the error and root causes.
    - Verify that actions necessary to correct the issue and prevent recurrence have been taken, and are effective in reducing/eliminating errors in the administration of the individual's medication, ensuring safe and correct provision of medication supports.
- Note: There is no specific action required to address medication administration errors. Options are open to the agency per their policy and may include retraining, recertification, increased monitoring or decertification of medication administration privileges, so long as they are shown to be effective. As the RN is responsible for medication administration, the RN should lend their clinical knowledge in deciding corrective action.

SELECT "MET" If both of the following are evident:

- ✓ Problems and errors in administration of the individual's prescribed medications were appropriately reported and documented.
- ✓ Errors in administration of the individual's medication are competently reviewed and remediated.

SELECT "NOT MET" IF any of the following are evident:

- ✓ Problems and errors in administration of the individual's prescribed medications occurred but were not identified by agency staff.
- ✓ Problems and errors in administration of the individual's prescribed medications were not reported and documented.
- ✓ Errors in administration of the individual's medication are not competently reviewed/investigated.
- ✓ Errors were not adequately remediated to prevent likelihood of future occurrences.

SELECT "NA" IF:

- ✓ No medication errors occurred.

Standard No.	Standard Text	Decision
8c-5	The individual's medication regimen is reviewed on a regular basis by a designated professional.	**Met/Not Met**

Guidance

DISCUSSION:

As needed:

• Talk with the RN responsible for oversight of the individual's health care.

DOCUMENTATION REVIEW:

Mandatory:

• Documentation of the medication regimen review.

As Needed:

• Medical Consult forms that describe needed in-home/daily supports;
• Diagnostic lab work results;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports.
• Health Care Plan, Nursing Care Plans as appropriate.

GUIDANCE:

- For individuals in certified residential settings, a review of the individual's entire medication regimen must be completed and documented semi-annually by a medical professional: RN, pharmacist, physician, physician's assistant, nurse practitioner.
- This review must be comprehensive, include a look at all possible drug interactions, side effects, warnings, contraindications, effectiveness regarding the diagnosis intended to address, and the completion and results of related and required lab work.

- Information provided for the medication regimen review must be current and accurate. All new medications, all discontinued medications, and medication dosage or administration changes must be provided. This review must look at the total medication dosing regimen that the person has, in order to find and evaluate issues before they occur. The review must include use of PRN, over the counter medications, and herbal supplement as part of the whole regimen.
- The review must document recommendations for action of follow-up, when necessary. If there is need for action or follow-up, there must be evidence that his is brought to the timely attention of the relevant physician/health care provider. Decisions related to the recommendations must also be documented.
- It is very important that the review includes attention to and effect of medications which predispose a person to extrapyramidal signs and symptoms (e.g. hand tremors, lip smacking, twitching, shuffled gait) as these signs and symptoms can lead to more serious effects to the individual. Nurses are trained to be aware of these side effects for those medications responsible and prescribers such as neurologist will often check for this and prescribe regular monitoring for this.

SELECT "MET" If both of the following are evident:

- ✓ A comprehensive medication regimen review is completed semi-annually and documented.
- ✓ Action is taken on any recommendations and suggested follow-up, if any.

SELECT "NOT MET" If any of the following are evident:

- ✓ The medication regimen review is not completed with frequency required (semi-annually).
- ✓ The medication regimen review is not comprehensive, e.g. lacks inclusion of all prescribed medications, and lacks consideration of all relevant elements (in second bullet of guidance).
- ✓ Action is not taken on recommendations and suggested follow-up, if any.

SECTION 8d: HEALTH SERVICES & SUPPORTS - DAY & TEMPORARY SERVICES

Qualifier Question: The individual receives supports related to health care delivered by the site/program staff.	**Yes**	**No**

Standard No.	Standard Text	Decision
8d-1	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s) addressed during services at the site.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions. Be sensitive to their privacy in the framing and location of the discussion.

As Needed:

• Speak with the staff or natural supports assisting the person with routine health care if documentation and discussion with the individual requires clarification

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence that routine interventions to address health need have occurred: E.g.:

• Medical Consult forms that describe needed in-home/daily supports
• Health Care Plan, Nursing Care Plans as appropriate
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on routine health care supports and intervention

GUIDANCE:

- This standard is intended to evaluate that there is a written plan to address, ameliorate or monitor the individual's medical diagnosis/diagnoses are provided as needed and recommended. This does not apply to participation in medical appointments and testing in health care offices and facilities. This is intended to address needed interventions in day to day life in the individual's home and other environments.
- The RN is required to evaluate and plan care according to the individuals needs and they may delegate health care tasks to direct care staff.
- The RN familiar with the needs and conditions of the individual, must provide written instructions, a Plan of Nursing Services or other written directive for direct support staff on all pertinent medical diagnosis/health needs that require care to address a health need. The written plan should provide step by step systematic instructions on the care, support and/or monitoring staff are to provide to the individual. The written plan/instructions should be written at a basic level, in plain English to ensure all staff can understand it. The plan must be part of the service record and available to staff responsible to provide the supports.

- Verify all significant medical conditions identified for the individual, both chronic and acute have a plan of nursing service, or similar written plan available for staff to access.
- Verify that all information on the condition and treatments and monitoring necessary by the DSPs and/or the RN in the provision of care/support to the individual is included in the plan.
- Through RN interview and mandatory document review, surveyor evaluates that written individualized PONS are developed based on the initial assessment and subsequent comprehensive nursing assessments. Without accurate and timely assessment, PONS, which inform the DSP to whom delegated nursing tasks have been assigned, become outdated and puts the individual at risk for inadequate nursing care. The PONS are to be reviewed both as needed and annually.
- Ensure that as the individual's health status changes, the written plan of nursing service(s) is revised, or new written instruction developed as applicable. For example, a person receiving a new diagnosis, has a recent fracture, or has been discharged from the hospital must have a written plan with adequate written instruction for direct support staff to ensure the individuals receives adequate care and treatment during services. The plans shall be individualized to the person and updated and d/cd as needed.
- Care plans related to health issues may be for long term/permanent conditions or short term health concerns,
- Care plans should include interventions consistent with physician's recommendations,
- Examples of diagnoses and health issue that require a protocol plan include (but are not limited to) diabetes, seizure disorder, constipation, history of dehydration, risk of swallowing and aspiration issues, hypertension, hospital discharge, post-surgical care, catheter care, tube feedings, colostomy care and many other medical treatments, etc.
- The plan related to health care (e.g. nursing care plan) should include at a minimum:
    - Brief description of problem/contributing factors;
    - Preventative measures to be provided to the individual relative to the health issue (or monitoring of individual's independent role in prevention); this may include dietary interventions (e.g. ADA diet for diabetes, high fiber interventions and bowel tracking and interventions for constipation, fluid requirements for multiple conditions);
    - Direct interventions or routine care related to the health issue (or monitoring of the individual's independent role in prevention), e.g. prescribed medications to be administered, wound care, repositioning, etc.);
    - Signs and symptoms to look for and monitor, including skin condition, appetite, high/low parameters of vital measures taken if any are required, and how to identify pain/discomfort especially for individuals may not or cannot clearly communicate concerns to people that support them;
    - When to contact the RN and/or physician;
    - When to call 911.
    - Interventions to be provided by the RN or other professional.
    - Verify that the written plans are accessible to staff responsible to implement.
    - Additional guidance regarding content of care plans for some specific conditions is found in guidance for Site Protocol risk factors. In addition consider the following when determining whether a written plan is needed for an individual:
- Risk factors for aspiration include weak gag reflexes, poor chewing/swallowing skills, GERD, food stuffing, inappropriate fluid consistency or food textures, medication side effects, and impaired mobility that result in an individual unable to sit upright while eating.

- Risk factors for constipation include: neuromuscular degenerative disorders that impair the central nervous system's need to eliminate, spinal cord injuries or birth defects that affect neural responses needed for elimination (such as spina bifida), diets that do not contain enough fiber and fluids, poor swallowing skills with aspiration risk, medications that slow down gastric motility or draw too much fluid from GI tract, history of frequent bowel stimulant use leading to decreased bowel reactivity. Look for evidence of: hospitalizations or outpatient treatments for constipation related issues, diet orders to increase dietary fibers, bowel movements more than 2-3 days apart, and medications that have constipating side effects.
- When a PRN bowel medication (cathartic) is ordered it is vital that bowel movements are tracked and that the PRN is being given as directed to avoid, constipation, bowel impaction, loose stools or diarrhea. A PRN for bowel management must not be given if some sort of bowel monitoring is not in place as it is incumbent on the prescriber to know what signs and symptoms present would indicate a need for the medication.
- Seizure prevention guidelines include taking antiepileptic medications on time as prescribed, promoting accurate documentation and record keeping of seizures that have occurred for review by a medical professional, encouraging good sleep-low stress-and good nutrition. Seizure intervention guidelines include having an individualized seizure protocol that includes 1. Description of the individual's normal seizure pattern, 2. Safety interventions 3. Safety precautions at home and in the community 4. Caregiver instructions on notifications, when to call 911, and the administration of PRN medications (if ordered).
- Risk of having dehydration: medical conditions such as kidney disease or diabetes that can result on fluid loss, excessive sweating-vomiting-drooling-diarrhea, frequent refusal of food and/or drink, unable to access fluids without assistance, dysphagia with coughing during meals, and inability to communicate thirst to caregivers. Prevention guidelines include: drinking enough water/day, alterative fluids are offered if individual frequently refuses fluids.
- Additional guidance as specific to delegated nursing services in delivery of community based HCBS Waiver Services, if determined that tasks can be delegated to DSPs. The plan of nursing services developed by the RN must identify the following:
- The nursing services to be provided to the individual, including delegated nursing tasks and medication administration;
- A description of the acute or chronic health condition being addressed;
- Individual-specific instructions for competently performing each delegated nursing task, required monitoring and documentation and criteria for identifying, reporting, or responding to problems or complications.
- The DSP(s) to whom the task is delegated;
- The date of the delegation;
- The RNs who will initially be assigned to supervise the DSP(s);
- The RN's signature;
- The RN may include specific information on RN supervision of the delegated tasks;
- Any changes to or termination of delegation of nursing services must be documented in the PONS along with the RN's signature.
- PONS must be accessible to staff.

SELECT "MET" If both of the following are evident:

- ✓ A written care plan is in place, instructing the care and monitoring needed by the individual is in place for each of the individual's health diagnosis/condition that require care and/or oversight.
- ✓ The written care plan is clearly written and addresses the necessary aspects of care and monitoring for the health condition.

SELECT "NOT MET" If either of the following are evident:

- ✓ A written care plan is not in place for each of the individual's health diagnosis/condition that require care and/or oversight.
- ✓ The written care plan is unclear and/or does not address the necessary aspects of care and monitoring for the health condition.

SELECT "NA" IF:

- ✓ The individual has no documented or observed needs for support with medication or other health care needs.

Standard No.	Standard Text	Decision
8d-2	The individual receives the needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	**Met/Not Met**

Guidance

DISCUSSION:

Mandatory:

• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions. Be sensitive to their privacy in the framing and location of the discussion.

As Needed:

• Speak with the staff/supports assisting the person with routine health care if documentation and discussion with the individual requires clarification.

DOCUMENTATION REVIEW:

Mandatory:

Documents that evidence that routine interventions to address health need have occurred: E.g.:

• Medical Consult forms that describe needed in-home/daily supports;
• Health Care Plan, Nursing Care Plans as appropriate;
• Recording of health care services such as bowel charting and interventions, fluid monitoring, diabetic monitoring;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports;
• Service coordination-Care Coordination-Case Management-Treatment Coordination notes that report on routine health care supports and intervention.

OBSERVATION:

• As appropriate, needed and able in certified settings, observation may provide information relevant to delivery of services and supports related to the individual's health and well-being; e.g. repositioning, dietary interventions, etc.

GUIDANCE:

- This standard is intended to evaluate the interventions address, ameliorate or monitor the individual's medical diagnosis/diagnoses are provided as needed and recommended. This is intended to verify that needed interventions are provided in day to day life in the individual's home and other environments.
- Verify that the individual's supports/staff are implementing/delivering care and support required to address her/his health issues and per their written health care plans and physician's recommendations.

- Verify that any intervention that must be provided by the RN are provided.
- Verify that any necessary equipment related to implementation of health care plans is present. This may include for example: glucometers, lifts, hearing aids, orthotics, oxygen and delivery supplies, bi-pap, c-pap, humidifiers and etc.
- Evidence of needed interventions may be through documentation modalities specific to the service received and/or agency processes. This may include service notes, prn notes, nursing notes, medication and treatment records, service coordination notes, and specific service documentation sheets designed for collection of service delivery (e.g. bowel management tracking, glucose level testing, etc.).
- It may also be necessary to verify through staff discussion, staff's understanding of the care to provide to meet the health care needs of the individual.
- It may be appropriate that the individual assume responsibility for their own interventions, with staff or natural supports overseeing that the individual is appropriately addressing the health issue.
- An individual may make an informed decision to not follow recommendations for preventive and reactive health care.

SELECT "MET" If either of the following are evident:

- ✓ The individual is receiving needed health care interventions per the written plans and physician's recommendations.
- ✓ The individual has made an informed decision to not follow recommendations/plans to address health diagnoses/issues.

SELECT "NOT MET" If either of the following are evident:

- ✓ The individual is not receiving needed health care interventions per the written plans and physician's recommendations.
- ✓ The individual has decided to not follow recommendations/plans to address health diagnoses/issues without evidence of informed decision making.

Standard No.	Standard Text	Decision
8d-3	The individual's service record/service plan is maintained to reflect current status of the individual's health needs being addressed.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory:
Discuss health status, health services and needs for support regarding health with the following:
• Individual (Designee)
• Service Coordinator/Care Manager/Case Manager, etc.
• RN in certified residential settings

DOCUMENTATION REVIEW:
Mandatory:
• Service plan, as named for the service/service environment (e.g. ISP, Treatment Plan, Program).
• Nursing Assessment
• Health assessment

GUIDANCE:
- This standard is intended to ensure that the individual's record includes documentation of the current status of an individual's health. Dependent on service type/environment, the staff should be able to easily identify current diagnoses, current medications, current allergies, and current needs for health supports, for reference. This does not necessarily have to be all in one document, but the information should be located easily through, attachments or references to other documents easily located in the record. Sources of the information may be the ISP and attachments, nursing assessment and attachments, comprehensive health care assessment, or "Ready to Go" packet in certified residential settings.

SELECT "MET" If the following is evident:
✓ The individual's record includes easily accessible information on the person's current health status.

SELECT "NOT MET" If the following is evident:
✓ The individual's record does not include easily accessible information on the person's current health status.

Standard No.	Standard Text	Decision
8d-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory:
• Talk with the RN responsible for oversight of the individual's health care in whole (certified residential setting) or in part (HCBS waiver service NPA exemption), to assess their understanding and oversight of the individual's health care and medication administration.
• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions, and interactions with the assigned RN. Be sensitive to their privacy in the framing and location of the discussion.
As Needed:
• Speak with the staff /supports assisting the person with routine health care regarding participation and support provided by the assigned RN.

DOCUMENTATION REVIEW:
Mandatory:
Documents that evidence RN coordination, oversight and participation in the individual's health care services, e.g.:
• Medical Consult forms that describe needed in-home/daily supports;
• Health Care Plan, Nursing Care Plans as appropriate;
• Recording of health care services such as bowel charting and interventions, fluid monitoring, diabetic monitoring;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports.

OBSERVATION:
• As appropriate, needed and able in certified settings, observation may provide information relevant to delivery of services and supports related to the individual's health and well-being; e.g. repositioning, dietary interventions, etc.

GUIDANCE:
- Applies to individuals in certified residential settings and recipients of delegated nursing services as part of the delivery of HCBS waiver services in the community.
- Based on a record review and interview, validate that oversight and monitoring of delegated nursing tasks is occurring by the RN. Oversight by the RN must include periodic and regular assessment of proficiency.
- The assigned RN is responsible to provide or ensure that the individual is receiving appropriate health care services including:
- For the individuals in a certified residential setting:
    - Professional medical appointments with physicians appropriate to the individual's needs and recommendations;
    - Diagnostic medical evaluation;
    - Assurance that follow-up appointments, evaluations and care are provided per physician recommendations;

  - Routine health care assessment and interventions to be provided by the RN or direct support staff, necessary to improve or maintain health status dependent on the person's individualized needs;
  - Appropriate medication administration, including review of accuracy of the Medication Administration Record.
  - Revision to care, delegated services and health related service plans occur as needed.
  - The RN is responsible to review medical consults and physician communications and ensure recommendations are implemented.
  - The RN is responsible to ensure that the physician has reviewed any diagnostic results (e.g. lab work).
  - The RN is responsible to advocate for required and adequate health care for individuals assigned to their care.
- for the individual receiving services in the course of community based HCBS waiver services:
  - All routine delegated health related care, medication administration to be provided by direct support staff;
  - Health care assessment and interventions to be provided by the RN.
  - Revisions to delegated services and health related service plans occur as needed.
- The RN is responsible to maintain current understanding of the individual's health status and needs and ensure that the physician is informed.
- Based on a review of documentation including nursing assessments, plans of nursing services, medical consults, diagnostic reports, medication and treatment administration records, and interview verify that the individual has received all the health care services they require in accordance with their health care needs.
- The RN's direct service and oversight activities must also be documented in the individual's service record.

SELECT "MET" If both of the following are evident:

- ✓ The individual is receiving needed health care per the written plans and physician's recommendations, unless the individual has made an informed decision to not receive care.
- ✓ There is documentation of RN provision of care and oversight of the individual's medical appointment, diagnostics, and routine care.

SELECT "NOT MET" If any of the following are evident:

- ✓ The individual is not receiving needed/determined health care interventions per the written plans and physician's recommendations (not due to informed choice).
- ✓ There is no evidence of required RN oversight and provision of care.
- ✓ There is no evidence of RN advocacy with the individual's health care providers when needed.

Standard No.	Standard Text	Decision
8d-5	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	**Met/Not Met**

Guidance

DISCUSSION:
Mandatory:
• Talk with the RN responsible for oversight of the individual's health care in whole (certified residential setting) or in part (HCBS waiver service NPA exemption).
• Talk with the individual for their input on their health care needs, receipt of needed health care interventions and support needed and/or received regarding their routine health care interventions, and interactions with the assigned RN. Be sensitive to their privacy in the framing and location of the discussion.
• Speak with the people assisting the individual with routine health care regarding participation and support provided by the assigned RN.

DOCUMENTATION REVIEW:
Mandatory:
Documents that evidence RN coordination, oversight and participation in the individual's health care services, e.g.:
• Medical Consult forms that describe needed in-home/daily supports;
• Health Care Plan, Nursing Care Plans as appropriate;
• Recording of health care services such as bowel charting and interventions, fluid monitoring, diabetic monitoring;
• Daily notes, health care notes, nursing notes, and/or prn notes as used by the agency/persons responsible to monitor care;
• Medical, Health Care or Nursing Assessments that summarize routine health care interventions and supports.
• IRMA/Incident Documentation

OBSERVATION:
Events during observations in certified sites may provide information regarding this standard.

GUIDANCE:
- This standard reviews that staff/FCP supporting individuals understand the individualized plans, recognize status changes, and notify the appropriate medical and health care professionals per the person's specific health needs.
- Staff should evidence understanding of the individual's health issues, status and the conditions and symptoms related to his/her health diagnoses that need to be reported to the RN, physician, or activate 911.
- Staff working with the individuals must report diagnosis related signs and symptoms that would warrant further monitoring, care and treatment.
- Evidence of staff understanding is completion of notification when necessary. Through documentation review, verify staff have made proper notifications as needed per the individual's health issues.
- As referenced in descriptions of content of the health care plans, any such plan must identify conditions, symptoms and parameter highs and lows that must be reported and to whom.

- Examples of health issues that should be reported by direct support staff to designated professional include based on the individualized written plan: skin redness or injury, blood glucose levels, weight, oxygen saturation outside designated parameters, more than a designated number of seizures in a stated time period, etc.

SELECT "MET" If the following is evident:

✓ The RN, physician and/or EMS (911) are notified of the individual's condition as specified in the care plan.

SELECT "NOT MET" If the following is evident:

✓ The RN, physician and/or EMS (911) are not notified of the individual's condition when needed as specified in the care plan.

SELECT "NA" IF either of the following are evident:

✓ The individual has no documented or observed needs for supports with medication or other health care needs; or documentation and discussion indicate that there have been no occasions when the RN, other health care providers or 911 needed to be notified regarding the individual's condition, health or health care.

SECTION 8e: HEALTH SERVICES & SUPPORTS – TEMPORARY DAY SERVICES

Qualifier Question: Does the person receive support for medication administration during delivery of this service?	**Yes**	**No**

Standard No.	Standard Text	Decision
8e-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	**Met/Not Met/NA**

Guidance

DISCUSSION:
As needed:
• Talk with the RN responsible for oversight of medication administration;
• Talk with the individual, especially those with responsibility for or learning self-administration skills
• Speak with the staff/providers responsible for medication administration.

DOCUMENTATION REVIEW:
Mandatory:
• Medication Administration Record (MAR)
• Physician's orders
• IRMA/Incident documentation
• Agency reporting of medication administration issues (non-Part 624)
As Needed:
• Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

GUIDANCE:

- Based on review of the Medication Administration Record (MAR) and the medical chart as needed, verify the following:
- All medications are prescribed by a physician, nurse practitioner, or physician's assistant;
- The medication prescription/order is current;
- The medication order is accurately transcribed on the individual's Medication Administration Record regarding medication name, dosage, time of administration, and route of administration.
- If medication orders change, the MAR must accurately and clearly document the prescribed medication addition, discontinuation, or change.
- If inaccuracies are identified on the MAR, verify that the RN is completing review of the MAR for accuracy and completeness.
- Note: Although ordered as part of the individual's health and dietary care, nutritional supplements such as Boost and Ensure are not medications and do not need to be on the MAR. In addition, there is no need for a MD order for things like Keri Lotion, Listerine, chap-stick, sun screen and they need not be documented on a MAR.

SELECT "MET" If the following is evident:

- ✓ The Medication Administration Record accurately documents all medications and treatment prescribed for the individual.

SELECT "NOT MET" If any of the following is evident:

- ✓ The Medication Administration Record includes one or more inaccurate or outdated medication orders.
- ✓ The Medication Administration Record includes one or more error in medication name, dosage, time of administration, and/or route of administration.

SELECT "NA" If any of the following are present:

- ✓ The individual is not prescribed any medications, including prn or over-the-counter medications;
- ✓ The individual lives in a certified supportive residence (e.g. Supportive Apt., IRA w/o 24 hour supervision), is capable of independent medication self-administration and the mechanism for supervision to ensure that the person is taking medication as required does not include their use or staff use of a MAR.
- ✓ The person self-administers medication without supervision in a day program setting.

Standard No.	Standard Text	Decision
8e-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	**Met/Not Met/NA**

Guidance

DISCUSSION:

As needed:

• Talk with the RN responsible for oversight of medication administration;
• Talk with the individual, especially those with responsibility for or learning self-administration skills
• Speak with the staff/providers responsible for medication administration.

DOCUMENTATION REVIEW:

Mandatory:

• Assessment of ability to self-administer medication
• Medication Administration Record (MAR)
• Agency reporting of medication administration issues (non-Part 624)

As Needed:

• Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

GUIDANCE:

• Verify that the medical professional has completed or provided input and approved an assessment of the individual's ability to self-administer medications. The assessment mat least an annual
• While the RN is typically the medical professional completing the assessment, a physician, physician's assistant (PA) or nurse practitioner (NP) may also complete the assessment.
• This assessment not only identifies the individual's ability to self-administer, but must also document the level of support and assistance needed by the person to ensure they receive medication as prescribed.
• The assessment must be completed /reviewed at least annually. When the individual's skills/abilities remain unchanged, it is not necessary that a new assessment document be completed. It is acceptable for the RN to document their review of the individual's abilities/skills and findings, and date and sign their review on a previously completed self-administration assessment.
• Day programs may accept assessments that are completed OPWDD certified residential nursing staff if adequate, or complete their own evaluation.
• If a day program accepts medication administration responsibility for someone who does not live in an OPWDD certified setting, the program must complete the evaluation.
• Assessment by an LPN is not sufficient without review and written approval of the RN, Physician, PA, or NP.

SELECT "MET" If the following is evident:

- ✓ The RN (or other medical professional) has completed or approved a written assessment/review of the individual's ability to administer medication annually.

SELECT "NOT MET" If any of the following is evident:

- ✓ The RN has not completed or approved a written assessment/review of the individual's ability to administer medication.
- ✓ The RN has not completed or approved a written assessment/review of the individual's ability to administer medication annually.

SELECT "NA" If any of any following are present:

- ✓ The individual in a day program or day service (non-residential) is not prescribed any medications, including prn or over-the-counter medications;
- ✓ The individual does not receive medication during time spent in receipt of day services;
- ✓ The day program does not accept responsibility for medication administration.
- ✓ **NOTE**: While routinely a person my not receive medications during time in day program, if at any time, the individual needs to receive medications in the day program (e.g. headache, seasonal allergies, antibiotic for infection, etc.), even if temporary, an assessment for self –administration capabilities must be completed.

Standard No.	Standard Text	Decision
8e-3	The individual receives medications and treatments safely as prescribed.	**Met/Not Met/NA**

Guidance

DISCUSSION:
As needed:
• Talk with the RN responsible for oversight of medication administration;
• Talk with the individual, especially those with responsibility for or learning self-administration skills
• Speak with the staff/providers responsible for medication administration.

DOCUMENTATION REVIEW:
Mandatory:
• Medication Administration Record (MAR)
• Physician's orders
• IRMA/Incident documentation
• Agency reporting of medication administration issues (non-Part 624)
As Needed:
• Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

OBSERVATION:
As Needed:
• Only as determined necessary, observation of medication pass may provide additional evidence of individual's accurate receipt of medications.

GUIDANCE:
• Review the MAR and/or other relevant documentation to verify that all prescribed medication and treatments are administered or self-administered.
• Verify that medication administration and oversight is documented as required by agency policy.
• Medication administered by staff/FCP:
  • Staff must document on the MAR to evidence medication administration per agency policy.
    § Review the MARs for the past 6 months at a minimum. Verify that the majority of medication administration occasions are documented.
    § Blank on the MAR may or may not indicate failure to administer medications correctly or negative impact. Consider the specific medication prescribed and impact of missed dose, whether the agency has a supplemental mechanism to evidence medication administration (e.g. staff initialing of medication blister pack), medication counts, or other means to ensure the receipt of the medication and/or impact of isolated omission.
  • Verify that when PRN medication is administered for the prescribed condition(s):
    § The effectiveness of the medication to address the condition is documented;
    § Administration of a PRN medication does not exceed 2 days, unless specified by the practitioner or the practitioner has been contacted for extended use of the medication.
    § The RN or other Health Care Professional provides oversight as to whether the condition be treated by the PRN warrants further medical treatment and follow up.

• If issues with medication administration and/or documentation were evident in earlier documentation, but correct administration and documentation is evident in the most recent months, consider the issue addressed and corrected. However if problems are continuing, pursue further clarification.
• If there are concerns whether medications is correctly administered and/or if there are many blanks on the MAR, determine whether the agency/facility took action to verify that medication was administered and took corrective action to assure accurate medication administration and documentation. Additional information or explanations of blanks or missed administrations may be explained on the back of the MAR.

Self-administration of medication by the individual:
• The agency/facility must monitor and verify that the individual is taking their medication as prescribed per effective agency mechanism.
• The actions taken by agency staff/FCP to verify correct self-administration must be documented per agency policy.
• Verify that the individual is taking medication as prescribed through review of agency documentation of oversight.
• If the individual is not consistently taking their prescribed verify that it is based on an informed choice vs. lack of supports to assist the individual in self-administration.
• The RN is responsible to oversee that the individual receives medications and care as prescribed by the physician. AMAP (medication certified staff) are administering medication under the license of the RN through the Nurse Practice Act exemption. The RN should therefore implement actions to monitor competent medication administration.
• Medication error practices will be reviewed in a separate standard.

SELECT "MET" If the following is evident:
- ✓ Medications are administered correctly and generally documented correctly.

SELECT "NOT MET" IF either of the following are present:
- ✓ It could not be evidenced that medications are not administered correctly;
- ✓ Documentation of medication administration is frequently not documented and/or not documented correctly including prn medications.

SELECT "NA" If any of any following are present:
- ✓ The individual is not prescribed any medications, including prn or over-the-counter medications;
- ✓ The individual is not prescribed any medications, including prn or over-the counter medications, during time in the service/service setting;
- ✓ The service is a day program that does not accept responsibility for medication administration.

Standard No.	Standard Text	Decision
8e-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	**Met/Not Met/NA**

Guidance

DISCUSSION:
As needed:
• Talk with the RN responsible for oversight of medication administration;
• Talk with the individual, especially those with responsibility for or learning self-administration skills
• Speak with the staff responsible for medication administration.

DOCUMENTATION REVIEW:
Mandatory:
• Medication Administration Record (MAR)
• Physician's orders
• IRMA/Incident documentation
• Agency reporting of medication administration issues (non-Part 624)
As Needed:
• Health care documentation in the individual's record (e.g. medical consults, health care notes, nursing assessments)

GUIDANCE:
The RN is responsible to oversee that the individual receives medications and care as prescribed by the physician. AMAP (medication certified staff) are administering medication under the license of the RN through the Nurse Practice Act exemption. The RN should therefore implement actions to monitor competent medication administration.
Medication administration and administration process errors must be reported, investigated and remediated as follows:
o according to Part 624 requirements (when Part 624 definition of medication error is met);
o According to agency policy and procedure for administration and process errors not requiring part 624 reporting.
• Review medication error reporting pertaining to the individual, occurring in the past 12 months.
o Verify that the agency identified and reported medication errors as necessary per regulation and policy.
o Verify that each reported event was investigated to determine circumstances regarding the error and root causes.
o Verify that actions necessary to correct the issue and prevent recurrence have been taken, and are effective in reducing/eliminating errors in the administration of the individual's medication, ensuring safe and correct provision of medication supports.
§ Note: There is no specific action required to address medication administration errors. Options are open to the agency per their policy and may include retraining, recertification, increased monitoring or decertification of medication administration privileges, so long as they are shown to be effective. As the RN is responsible for medication administration, the RN should lend their clinical knowledge in deciding corrective action.

SELECT "MET" If both of the following are evident:
- ✓ Problems and errors in administration of the individual's prescribed medications were appropriately reported and documented.
- ✓ Errors in administration of the individual's medication are competently reviewed and remediated.

SELECT "NOT MET" IF any of the following are evident:

- ✓ Problems and errors in administration of the individual's prescribed medications occurred but were not identified by agency staff.
- ✓ Problems and errors in administration of the individual's prescribed medications were not reported and documented.
- ✓ Errors in administration of the individual's medication are not competently reviewed/investigated.
- ✓ Errors were not adequately remediated to prevent likelihood of future occurrences.

SELECT "NA" IF:

- ✓ No medication errors occurred.

SECTION 9: BEHAVIOR SUPPORTS

Qualifier Question: The individual receives behavior supports/ the program/service includes implementation of a Behavior Support Plan.	**Yes**	**No**

Standard No.	Standard Text	Decision
9-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	**Met/Not Met**

Guidance

INTERVIEW:

• As Needed:
o Psychologist/BIS
o Person or clinician who wrote FBA
o Clinical supervisor of above staff
o Human Resources or agency training staff

DOCUMENTATION REVIEW:

• Mandatory:
o Functional Behavioral Assessment (FBA)
o Behavior Support Plan (BSP)
• As Needed:
o Person Centered Plan

GUIDANCE:

- The Functional Behavioral Assessment (FBA) should be completed before the behavior support plan is written. It should provide the information needed to develop a sound plan. A good FBA assures individualization of a BSP.
- In exceptional circumstances (e.g. unexpected admission to a day Habilitation program) a behavior support plan may need to be developed or modified using historical information before the functional assessment is completed in order to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment must be completed within 60 days of admission or the commencement of services and the behavior support plan should be revised as needed to incorporate any new information.
- *Note: The FBA must be completed by a clinician trained in FBA techniques. Training of personnel completing the FBAs will be evaluated in annually as part of the agency level review. However, if the adequacy of the FBA is so inadequate to result in development of an ineffective or inadequate BSP, and you believe it may be the outcome of the unqualified staff completing the FBA, pursue verification of appropriate training of staff completing the FBAs at that time if needed.*

SELECT "MET" IF:

- ✓ An FBA has been completed prior to the effective date of the BSP. (In exceptional circumstances: The FBA is dated no more than 60 days after the beginning of use of the BSP.)

SELECT "NOT MET" IF (Any):

- ✓ FBA is dated after the beginning of the use of the BSP, and there were no exceptional circumstances necessitating and, therefore, allowing it.
- ✓ Under exceptional circumstances allowing FBA development post BSP implementation, the FBA is completed greater than 60 days after BSP use.
- ✓ The FBA, due to exceptional circumstances was written at least 60 days after the commencement of services and the information it contains impacts implementation of its BSP but the BSP was not updated to reflect this new information.

Standard No.	Standard Text	Decision
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
o Person or clinician who wrote FBA
o Psychologist/BIS
o Person supported, as willing and able
o Program staff, FCP
o Family/advocate

DOCUMENTATION REVIEW:
• Mandatory:
o Functional Behavioral Assessment (FBA)
o BSP
• As Needed:
o Person Centered Plan
o Habilitation plan for the service
o Medical or other descriptive clinical records related to behavior

OBSERVATION:
As Needed: and as opportunity presents, to gather additional information regarding the behaviors described in the FBA.

GUIDANCE:

- The FBA must include the following for each challenging behavior targeted in the Behavior Support Plan. Contextual factors are factors that contribute to and facilitate the behavior. They may include:

- Antecedents, triggers, social, physical, medical, environmental, social, and/or psychiatric conditions that create and/or contribute to the behaviors
- The reason for and/or purpose of the behavior
- Factors and conditions that may maintain the behavior
  - The FBA should evaluate behavior in context for situation and location.
  - Behaviors to be addressed during delivery of community based waiver services, should consider its manifestation in that circumstance.
- The FBA should reflect the applicability/purpose of behaviors to the settings in which they apply. E.g. an individual seeks and shreds paper, magazines, (any paper available) as a soothing coping mechanism when stressed. While the behavior can be adequately managed in the residence, this presents a greater challenge in the community. Medical appoints are stressful to the individual and the waiting room typically has target objects.

SELECT "MET" If both of the following are present:

- ✓ The FBA identifies the challenging behaviors identified in the Behavior Support Plan.
- ✓ The FBA considers and identifies the context and unique circumstances regarding each target behavior addressed.

SELECT "Not Met" IF (Any):

- ✓ The FBA does not identify and sufficiently consider challenging behaviors identified in the Behavior Support Plan.
- ✓ The FBA does not consider and identify the context and unique circumstances regarding each target behavior addressed.
- ✓ The FBA is written vaguely and does not adequately provide the foundation for development of the Behavior Support Plan.

Standard No.	Standard Text	Decision
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:
o Person or clinician who wrote FBA
o Psychologist/BIS
o Person supported, as willing and able
o Program staff, FCP
o Family/advocate

DOCUMENTATION REVIEW:

• Mandatory:
o Functional Behavioral Assessment (FBA)
o BSP
• As Needed:
o Person Centered Plan
o Habilitation plan for the service

o Medical or other descriptive clinical records related to behavior

OBSERVATION:
As Needed: and as opportunity presents, to gather additional information regarding the behaviors described in the FBA.

GUIDANCE:
- FBA must evaluate and identify those conditions and factors that may contribute positively to the reduction, prevention, or elimination of behaviors. These elements assist in reducing the likelihood that challenging behaviors will be displayed or sustained.
- The FBA should consider/identify strategies that are known to or may prevent the exhibition of a target behavior. These may include support of incongruent behaviors, support of coping behaviors, desensitization exercises, environmental accommodations, etc.
- The FBA should consider/identify known or suspected incentives or reinforcers that may positively influence the individual to exhibit positive behaviors and minimize target behaviors.
- Observations may contribute to understanding relevant positive influences to reduce target behavior.

SELECT "MET" If both are present:
- ✓ FBA considers individualized environmental and social factors that contribute to reducing the target behavior.
- ✓ The FBA identifies individualized reinforces that may impact reduction of the target behavior.

SELECT "NOT MET" IF (Any):
- ✓ The FBA does not consider individualized environmental and social factors that contribute to reducing the target behavior.
- ✓ The FBA does not identify individualized reinforces that may impact reduction of the target behavior.
- ✓ The FBA does not identify known positive factors or reinforcers.

Standard No.	Standard Text	Decision
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Person or clinician who wrote FBA
• Psychologist/BIS
• Person supported, as willing and able
• Program staff, FCP
• Family/advocate

DOCUMENTATION REVIEW:
• Mandatory:

o Functional Behavioral Assessment (FBA)
o BSP
• As Needed:
o Person Centered Plan
o Medical or other descriptive clinical records related to behavior
o Ongoing documentation specific for the Person supported, including behavioral charting
o RIA and/or information in IRMA if such exists for the person, as related to his/her behavioral history

OBSERVATION:
As Needed: and as opportunity presents, to gather additional information regarding the behaviors described in the FBA.

GUIDANCE:
Baseline information is the information known about the behavior at the time of the FBA is completed.
A baseline description of the behavior includes but is not limited to:

- Frequency of challenging behavior (e.g. daily, a few times per month, etc.)
- Duration of challenging behavior (e.g. brief outbursts versus prolonged period of hours)
- Intensity and/or latency across settings (e.g. more challenging behavior in the community or at home; no experience of it at day setting)
- Activities that might influence challenging behavior (e.g. staff changing shift or parent leaving for work; leaving their home; dining with visitors present; unpredictable schedule changes)
- People or their roles (e.g. clinical white coats or a uniform worn by medical or security staff, respectively) that might influence challenging behavior
- Times of day that might influence challenging behavior (e.g. meal time; sunset; middle of night)

SELECT "MET" IF:

- ✓ The FBA includes a baseline description of the challenging behavior which includes: frequency, duration, intensity/latency, associated activities and people or their roles and time of day, as relevant to the behavior.

SELECT "NOT MET" IF (Any):

- ✓ The FBA does not include known baseline information as described above, regarding the challenging behaviors.
- ✓ There is no baseline description of the challenging behavior in the FBA.

Standard No.	Standard Text	Decision
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

• Person or clinician who wrote FBA

• Clinician(s) whose level of credential is required for supervision and development of specific plan interventions (see Additional Guidance for specific level of interventions requiring this supervision)

DOCUMENTATION REVIEW:

• Mandatory: Behavior Support Plan (BSP)

• As Needed: *

o Personnel records regarding qualifications of BSP author

o Staff training records of the BSP author

GUIDANCE:

All behavior support plans must be developed and supervised by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques, under the following conditions:

- Level 1 Behavioral Intervention Specialists (BIS) may develop and/or provide supervision for behavioral support plans or services that do not include restrictive/intrusive interventions.
- Level 2 BIS may develop behavioral support plans or services that do not include restrictive/intrusive interventions under the supervision of Level 1 BIS.
- Behavior support plans or services which include restrictive/intrusive interventions may be developed by a Level 1 or a Level 2 BIS under the supervision of a licensed psychologist or licensed clinical social worker (LCSW)
- The review that BIS staff meet the educational and experiential requirements and receive oversight by a licensed psychologist or licensed clinical social worker if behavior support plans or services include restrictive/intrusive interventions will occur annually at the agency review. However, if you have serious concerns due to the quality or content of the behavior services plan, you may verify during this visit.

SELECT "MET" IF:

- ✓ The Behavior Support Plan without restrictive/intrusive interventions is written and supervised by:
  - o A Behavioral Intervention Specialist 1 (BIS1) , Licensed Psychologist or a Licensed Clinical Social Worker (LCSW); or
  - o A Behavioral Intervention Specialist 2 (BIS2) under the supervision of a BIS1, Licensed Psychologist or a Licensed Clinical Social Worker (LCSW)
- ✓ A Behavior Support Plan with restrictive/intrusive interventions is written and supervised by:
  - o A BIS1 or a BIS2, under the supervision of a licensed psychologist or LCSW
  - o A licensed psychologist or LCSW.)

SELECT "NOT MET" IF (Any):

- ✓ The BSP that does not include restrictive interventions is not written and supervised by the qualified professional as described above
- ✓ The BSP that includes restrictive interventions is not written and supervised by the qualified professional as described above

Standard No.	Standard Text	Decision
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- Qualified professional who wrote the BSP
- Psychologist/BIS
- Person supported, as willing and able
- Family/advocate other natural supports, as needed
- Support staff, FCP

DOCUMENTATION REVIEW:

Mandatory: BSP; includes FBA

As Needed:

- Ongoing documentation, records kept by staff or other parties who support the person which describe behavior and its context
- Medical and/or other clinical records kept by involved staff or parties
- Clinical assessments and/or plans created by involved clinicians

GUIDANCE:

Through interview with the individual, the clinician and other vested parties and documentation review, verify that the individual, their advocates and natural supports, staff and other appropriate people provided input into the plan as appropriate. Appropriate others include those working or routinely interacting with the person in community settings when the plan is designed to be used in community settings.

SELECT "MET" IF:

- It was clinically appropriate for the individual and/or his family, advocates, other natural supports or others involved with BSP implementation to be consulted on the BSP development and these persons were consulted in creating the BSP.

SELECT "NOT MET" IF (Any):

- ✓ The person and the other invested parties noted above were:

- o not approached to give their consult to the development of the BSP and there was no contraindication to them giving input.
- o approached, gave input to the writer of the plan but their input was not considered in development of the BSP.

Standard No.	Standard Text	Decision
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Qualified professional who wrote the FBA
• Qualified professional who wrote the BSP

DOCUMENTATION REVIEW:
Mandatory:
• FBA
• BSP

GUIDANCE:

- The BSP methods and strategies identified are developed using the information and criteria presented in the Individual's FBA. There should be a direct correlation between the assessment information and the plan developed. As the FBA must include description of the relationships between: frequency; duration; intensity; latency; influences of co-occurring activities; certain persons or their roles and time of day, and the challenging target behavior, these influences must inform the strategies employed by the BSP to help the person regain self-control. These influences must relate to the setting in which the support is given. If a BSP is to be used in the community, the FBA should form the basis of why and the BSP should describe the strategies for that environment. A BSP strategy which has no clear basis in the FBA does not meet this standard. The FBA and BSP must align with each other and apply to the setting(s) of use.

SELECT "MET" If both are present:

- ✓ The strategies, both positive and reactive identified in the, are based on what the FBA has described as the factors (e.g. environment, frequency, duration, time of day, etc.) which describe and influence it.
- ✓ The challenging target behavior(s) in the BSP are identified and clearly described in the FBA.

SELECT "NOT MET" If either are present:

- ✓ BSP strategies, methods and interventions are not related to factors the FBA states influence the challenging behavior.
- ✓ A challenging target behavior addressed in the BSP, is not included in the FBA.

Standard No.	Standard Text	Decision
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Qualified professional who wrote the FBA
• Qualified professional who wrote the BSP

DOCUMENTATION REVIEW:
Mandatory:
• FBA
• BSP

OBSERVATION:
As Needed: and as opportunity presents, to gather additional information regarding the behaviors described in the FBA.

GUIDANCE:

- A specific description should be present for each behavior addressed in the BSP. For example, 'acting out' is a vague term which is inadequate for an acceptable BSP. Clear descriptions of each targeted challenging behavior, which anyone who is supporting the person would reasonably be able to identify, are required in the BSP. The description should be specific to each setting where the behavior presents if different across settings.

SELECT "MET" IF:

✓ BSP includes clear specific descriptions of all challenging target behaviors addressed in the Behavior Support Plan.

SELECT "NOT MET" If either are present:

✓ The challenging target behaviors included in the BSP are vague/not clearly described.

Standard No.	Standard Text	Decision
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Qualified professional who wrote the FBA
• Qualified professional who wrote the BSP
• Psychologist/BIS

DOCUMENTATION REVIEW:
Mandatory:
• FBA
• BSP

OBSERVATION:
As Needed: Observe interactions between support staff and the individual

GUIDANCE:

- Strategies preferred to be used first, are positive approaches, strategies and supports designed to teach and reward replacement behaviors. An established hierarchy may be appropriate for positive/teaching strategies, preventive and diffusive strategies, as well as reactive interventions.
- The plan should clearly describe:
  - what strategies to implement, initially when a target behavior presents, and;
  - the conditions which signal the need to advance to other strategies.
- In all cases, a hierarchy of approaches, strategies and supports should begin with the least intrusive and progress to more intrusive approaches, strategies and supports only when lesser interventions prove ineffective.
- Intrusive interventions must be used only when the lesser interventions or methods prove ineffective and the evidence/conditions as described in the BSP which make it necessary to implement more restrictive or intrusive methods, are presenting.
- The setting in which the plan is being used may influence the hierarchy and this should be described. E.g. a person who is known to run away from support staff when he is anxious may be in greater danger to himself and others in a shopping mall than when he is at home. The hierarchy should be designed to be used in the settings and environments that the person is supported.

SELECT "MET" IF:

- ✓ The BSP contains a hierarchy of proactive approaches, initial interventions and clear behavioral indicators to move to more restrictive interventions for specific challenging behaviors in the support settings the plan is to be used in.

SELECT "NOT MET" If any are present:

- ✓ The BSP does not identify a hierarchy of strategies, supports, approaches from least to most restrictive.
- ✓ Interventions are identified in the BSP but it is not clear that that implementer must start with least restrictive interventions before advancing to more restrictive.
- ✓ A hierarchy of strategies are included in the BSP, but there are no clear descriptions of behavioral indicators to guide staff when to advance to more restrictive interventions.

Standard No.	Standard Text	Decision
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- Individual
- Family/ advocate
- Qualified professional who wrote the FBA
- Qualified professional who wrote the BSP

DOCUMENTATION REVIEW:

Mandatory:

- FBA
- BSP

OBSERVATION:

As Needed: Observe interactions between support staff & Person supported

GUIDANCE:

- The BSP must identify strategies and activities designed to increase and facilitate skills necessary to demonstrate adaptive behaviors. Examples may include teaching new skills, practice scenarios, coaching, and incentive and reinforcement strategies.
- As with all services/supports the approaches to foster adaptive and alternative behaviors should be individualized. Identification of the strategies should be guided by the information in the Functional Behavioral Assessment.
- The strategies should encompass the support environments that the person uses, if different strategies are required. E.g. perhaps strategies to teach a person to respect personal space, when he receives community habilitation, may need to be subtler to prevent embarrassing him in public than the strategy employed at home which may possibly be more direct.

SELECT "MET" IF:

- ✓ The BSP describes practical, concrete direction to actively assist the person to use/display alternate coping/positive strategies/behaviors as alternates to targeted challenging behaviors.

SELECT "NOT MET" IF:

- ✓ The BSP does not describe practical, concrete direction to actively assist the person to use/display alternate coping/positive strategies/behaviors as alternates to targeted challenging behaviors.

Standard No.	Standard Text	Decision
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

• Qualified professional who wrote the FBA
• Qualified professional who wrote the BSP

DOCUMENTATION REVIEW:

Mandatory:

• FBA
• BSP

OBSERVATION:

As Needed:

• Observe support staff with person supported in as many service settings or environments as needed.

GUIDANCE:

- The BSP must always include describe supports, strategies and interventions to address the challenging behavior(s) that are not intrusive or restrictive. The plan should make it clear that the less restrictive starts should be routinely implemented first (with exceptions for urgent conditions described in the plan).
- As reviewed above, the BSP must identify strategies in a hierarchical manner. This hierarchy should include non-restrictive or least restrictive approaches, and not only include restrictive approaches (unless proven clinically necessary).
- OPWDD stresses that the least restrictive intervention or least intrusive methods be used at all times.
  Note: There may be circumstances when the BSP instructs to implement a strategy that is not introductory in an assumed hierarchy of

restrictiveness/intrusion. So long as this approach is congruent with analysis of the individual and their behaviors captured in the FBA, this is acceptable.

SELECT "MET" IF:

- ✓ The BSP hierarchy of interventions includes less or non-restrictive supports appropriate to support the person with challenging behavior.

SELECT "NOT MET" IF (Any):

- ✓ The BSP includes only intrusive interventions.
- ✓ The BSP identifies interventions but the hierarchy instructs use of more restrictive interventions before use of less restrictive/intrusive interventions, with no clinical justification.

Standard No.	Standard Text	Decision
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	**Met/Not Met**

Guidance

INTERVIEW:

• Mandatory:
o DSPs and other staff responsible to implement plan, FCP
• As Needed:
o Person supported/Family/advocate
o Program management
o Program Coordinator or MSC
o Psychologist/BIS

DOCUMENTATION REVIEW:

• Mandatory:
o BSP
o FBA
o RIA
o Documentation of plan implementation and behavior tracking
• As Needed:
o Training records related to above documents

OBSERVATION:

Observe interactions between support providers & person supported
• Mandatory: during observation in certified sites
• As needed: only when necessary in other service delivery environments

GUIDANCE:

- Training must be provided to a staff member or FCP when it is expected that they implement strategies in the plan either alone or in support of other staff members, in whatever support setting they work with the person. This training should be provided prior to working alone with the person and whenever a plan is revised. There should also be oversight to ensure staff are competent to implement the BSP correctly.
- Through interview of staff/FCP working with the individual, observation (dependent on site and circumstances), and documentation review as needed, verify that service providers understand the BSP that they are responsible to implement. As indicated above, observation (certified sites) and interview of staff/FCP are mandatory to validate this standard.
- As proactive approaches described in the BSP should be routinely implemented, it is expected that positive approaches should be demonstrated by staff working with the person.
- Observation, interview and documentation related to implementation of the BSP are the true evaluation of staff's understanding of target behaviors and strategies to be implemented proactively and reactively to address the behaviors. Review of training records may be necessary if necessary to follow-up on concerns or questions following interview and observation (when required).

SELECT "MET" IF:

✓ Per interview, observation and documentation review, staff/FCP responsible for BSP implementation demonstrate understanding of the target challenging behaviors the plan addresses and specific strategies to use to prevent, ameliorate or stop the behaviors.

SELECT "NOT MET" If either are present:

✓ Per interview, observation and documentation review staff/FCP responsible for BSP implementation DO NOT demonstrate understanding of the target challenging behaviors the plan addresses and specific strategies to use to prevent, ameliorate or stop the behaviors.

Standard No.	Standard Text	Decision
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- Program staff, FCP
- Program management
- Psychologist/BIS

DOCUMENTATION REVIEW:

Mandatory:

- BSP
- Behavior data collection and documentation

GUIDANCE:

- The BSP should describe the specific information to be documented for each behavior and a standardized methodology for collection of information about targeted behaviors. This may include frequency, intensity, antecedents, strategies implemented and effectiveness.
- Documentation necessary may be individualized to the person's plan and challenges. E.g. if a behavior is to be documented by check marks on a grid, then it should be done that way for all evidence of that single behavior, so that analysis can be done. If a narrative is expected, it should be done in such a way that it can be analyzed. Whatever the documentation method, it should be clearly described in the BSP so that staff consistently implement.
- The collection of information regarding both positive and negative behaviors is needed so treatment effectiveness progress may be evaluated.

SELECT "MET" IF:

✓ The BSP includes description of the specific method of standardized documentation/data collection sufficient to evaluate display of desired positive behaviors, each targeted challenging behaviors, and effectiveness of strategies and interventions used.

SELECT "NOT MET" IF (Any):

✓ The BSP does not instruct/describe the documentation to be provided to collect data sufficient to evaluate plan effectiveness.
✓ The BSP data collection methodologies do not include collection of both positive and negative behavioral data.
✓ The BSP instruction on collection of behavioral data is vague/unclear.

Standard No.	Standard Text	Decision
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:
• Qualified professional who wrote the BSP
• Qualified professional who reviews and analyzes the BSP

DOCUMENTATION REVIEW:

Mandatory:
• BSP
• Behavioral data collection documentation
• Behavioral data analysis documentation
• Service plan review documentation

GUIDANCE:

• The BSP must identify the frequency/periods of review of the BSP effectiveness.
• The review of effectiveness of interventions must occur no less frequently than semi-annually.
• This review may occur more frequently if required by the Individual's Behavioral Support Plan.

SELECT "MET" If both are present:
• The BSP includes a schedule to review the effectiveness of interventions on, at least, an every six-month basis.

SELECT "NOT MET" If any are present:
• The BSP doesn't contain such a schedule to review effectiveness of interventions of the BSP.
• An effectiveness review schedule is included in the BSP, but it is less often than every six months.

Standard No.	Standard Text	Decision
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Person supported
• Family/advocate
• Program management
• Program Coordinator or MSC
• Qualified professional who wrote the BSP
• Qualified professional who reviews and analyzes the BSP

DOCUMENTATION REVIEW:
• Mandatory:
o BSP
o Behavioral data collection documentation
o Behavioral data analysis documentation
• As Needed:
o Service plan review documentation

GUIDANCE:
- As described above, the person's BSP must describe the behavioral data to be collected and the plan to review for effectiveness of the BSP interventions.
- Verify that the data is being documented and subsequently reviewed by the qualified professional responsible for supervising the plan.
- Verify that the review includes all of the service settings in which the plan is used; if it addresses behavior in multiple settings, it should be evaluated for the effectiveness of the interventions in all settings.
- Analysis must include measurable or specific terms on the frequency, duration and intensity of the challenging behavior, (for example: frequency expressed in days, hours, weeks, months; duration expressed in seconds, minutes, hours, days; intensity of sound, physical actions, language or vocalizations.)

- Analysis of positive replacement behaviors must also occur in this review (for example, how many times a person successfully gained control by listening to music in his room, after feeling frustrated by a situation.)
- This review should be documented and available.
- The documented analysis of effectiveness should be consistent with the behavioral data/documentation provided and reviewed.
- It is expected that discovery based on the review results in reasoned decision making regarding plan continuance or revision.

SELECT "MET" If all are present:

- ✓ Behavioral data is being documented by support staff, and;
- ✓ Behavioral data is being reviewed and analyzed competently by qualified professional.
- ✓ The review includes analysis of frequency, duration or intensity of challenging behaviors, and demonstration of replacement behaviors.

SELECT "NOT MET" IF:

- ✓ Any of the elements of the criteria in 'Met' above are not present.

Standard No.	Standard Text	Decision
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory:

• Direct support and program staff, FCP

As Needed:

• Psychologist/BIS

• Program management staff

DOCUMENTATION REVIEW:

Mandatory:

Training documentation on OPWDD-approved training course in positive behavioral strategies and physical intervention techniques

OBSERVATION:

Mandatory (appropriate sites) and as opportunity arises to observe the staff implement their training on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques with the person

GUIDANCE:

- If the individual's BSP includes any physical restrictive intervention techniques, staff/supports must have had, within the past year, an OPWDD-approved course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques.

- Staff or person who support him also must have been certified, or recertified, in the use of positive behavioral approaches, strategies and/or supports and in the use of physical intervention techniques by an instructor, instructor-trainer or master trainer.
- Interview of persons who work with the person to verify their proficiency with the training is mandatory. Staff or person who support the person must be able to describe how their training is used in working with the person as directed in the BSP.

SELECT "MET" IF:

- ✓ Staff/FCP have been trained using OPWDD-approved curriculum in positive approaches and the physical interventions by the qualified trainer, within the past one year, when the BSP includes physical restrictive interventions.
- ✓ Staff/FCP demonstrate understand behavior support strategies.

SELECT "NOT MET" IF:

- ✓ Those who support the person have not had the required training under 'Met' above, in the past one year.

SELECT "NA" IF:

- ✓ The plan does not include any physical interventions.

SECTION 9a: RIGHT LIMITATIONS, RESTRICTIONS, & INTRUSIVE INTERVENTIONS

Qualifier Question: RESTRICTIVE/INTRUSIVE INTERVENTIONS used and/or LIMITATIONS ON THE INDIVIDUAL'S RIGHTS are used to address behavior and/or part of the individual's Behavior Support Plan.	**Yes**	**No**

Standard No.	Standard Text	Decision
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- Qualified professional who wrote the BSP
- Qualified professional who wrote the FBA

DOCUMENTATION REVIEW:

Mandatory:

- FBA
- BSP restrictive/intrusive interventions and/or limitation
- Documentation of occurrences of challenging behavior

GUIDANCE:

- Verify that the behavior and its consequences are described so that the necessity for the specific restriction/intrusion/limitation to address that behavior is clear.
- The FBA should create the foundation for this description and justification in the BSP.
- The description should adequately demonstrate that the use of the restriction/intrusion/limitation is integral to the protection or maintenance of the well-being of the person or others, and/or the cessation or prevention of the behavior with the potential for serious consequences.

SELECT "MET" IF:

✓ The BSP describes each targeted challenging behavior in a manner that clearly justifies use of the intrusive/restrictive intervention or limitation.

SELECT "NOT MET" If:

✓ Description of the challenging behavior(s), in the BSP, is not sufficient to justify the use of restrictions/limitations/intrusions applied to the behavior(s).

Standard No.	Standard Text	Decision
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Qualified professional who wrote the BSP
• Qualified professional who wrote the FBA

DOCUMENTATION REVIEW:
Mandatory:
BSP containing restrictive/intrusive interventions and/or limitation
As Needed:
FBA

GUIDANCE:

- This applies to BSPs with restrictive, intrusive or right limiting interventions.
- This should include a description of all positive, less intrusive and/or other restrictive or intrusive approaches that have been tried but have not been successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights.
- An explanation of why the less intrusive alternatives are insufficient to maintain or ensure the health or safety or personal rights of the Individual (or others) should be included.

SELECT "MET" If both are present:

- ✓ The BSP includes a description of positive, less intrusive interventions which have been tried but were unsuccessful prior to the inclusion of the restrictions in the BSP.
- ✓ There is an explanation as to why the less intrusive interventions were inadequate to maintain or ensure the health, safety or personal rights of the person or others.

SELECT "NOT MET" IF:

- ✓ Either of the requirements under 'Met' above are absent in the BSP.

Standard No.	Standard Text	Decision
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed:

- Program staff, FCP
- Program management staff
- Qualified professional who wrote and/or monitors the BSP

DOCUMENTATION REVIEW:

Mandatory:

- BSP restrictive/intrusive interventions and/or limitation
- Service documentation
- Behavioral data

As Needed: FBA

GUIDANCE:

- The individual's activities or services might need to be postponed (time limited restriction of activity) to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities. Criteria for such action, based on individualized FBA and risk factors must be included in the Behavior Support Plan.
- The inclusion of clear criteria for use of this rights restriction in the BSP serves to prevent the postponement of activities or services from being used as a punitive measure against the person. BSP strategies do not include punishment.

SELECT "MET" IF:

- ✓ When a BSP includes an intervention for postponement of services or activities, there is clear criteria and description of circumstances for when this protective/preventive, but restrictive intervention should be used.

SELECT "NOT MET" If any are present:

- ✓ When a BSP includes an intervention for postponement of services or activities, there is no or unclear criteria and/or description of circumstances for when this protective/preventive, but restrictive intervention should be used.
- ✓ Postponement or denial of activity or services is implemented but not included in the behavior support plan.
- ✓ Postponement of activities is used as a punishment or negative consequence for the person as opposed to a support for their safety and/or that of others.

SELECT "NA" IF :

- ✓ The BSP doesn't include intervention to postpone the person's activities or services and postponement/denial of activity has not been implemented.

Standard No.	Standard Text	Decision
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Qualified professional who wrote and/or monitors the BSP
• Program staff, FCP
• Program management staff

DOCUMENTATION REVIEW:
Mandatory:
BSP
Service and Behavior documentation and data collection

OBSERVATION:
Observe interactions and strategies used:
• Mandatory: during observation in certified sites

GUIDANCE:
- This applies to BSPs with restrictive, intrusive or right limiting interventions.
- The BSP must include a plan to fade, minimize eliminate or transition restrictions and limitations is required for every type of restriction or limitation included in the plan to modify or control behavior.
- This aspect of the BSP should identify reasonable criteria and circumstances and approaches to reducing, transitioning or eliminating each restriction/limitation.
- These criteria must be able to be evaluated based on behavioral documentation expected per the plan.
- Fading should also take into account prudent monitoring and safeguarding while interventions are transitioned.
- Interventions to which this applies include: physical interventions, medication, mechanical restraints, the use of time-out and any other professionally accepted methods (e.g. response cost, overcorrection, negative practice and satiation) that have been determined by the agency/facility or implemented in a manner to be restrictive/intrusive because they may present a risk to a person's protection or encroach unduly on a person's normal activities.
- It is incumbent upon the person monitoring the plan to determine when interventions may be modified.

SELECT "MET" If the following are evident:
- ✓ The BSP describes a realistic, achievable plan to fade, reduce or eliminate restrictive strategies.
- ✓ The BSP plan includes safeguards and monitoring that must be implemented while intrusive strategies are faded or eliminated, and more positive approaches transitioned.

SELECT "NOT MET" If any are present:

- ✓ No plan to fade the restrictions/intrusions/limitations are included in the BSP.
- ✓ A fading plan is documented in the BSP but its criteria are unrealistic and minimize the likelihood that the person can achieve incremental fading of the restrictions in the plan.
- ✓ A fading plan is lacking for most of the restrictive interventions described in the BSP.

Standard No.	Standard Text	Decision
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

• Program staff, FCP
• Program management staff
• Psychologist/BIS

DOCUMENTATION REVIEW:

Mandatory:

• BSP containing restrictive/intrusive interventions and/or limitations
• Documentation records of BSP implementation
• RIA

GUIDANCE:

- This applies to BSPs with restrictive, intrusive or right limiting interventions.
- The BSP should clearly describe what needs to be documented for each restrictive intervention and/or use of limitation implemented, the format for this documentation and the frequency of the documentation.

SELECT "MET" IF:

- ✓ The BSP clearly describes what to document, how and where to document, and how often staff/FCP should document the implementation of restrictions and limitations implemented.

SELECT "NOT MET" If either of the following are evident:

- ✓ The BSP does not clearly describe what to document, how and/or where to document, and how often staff/FCP should document the implementation of restrictions and limitations implemented.
- ✓ The BSP description of what must be documented is not related to the strategies identified in the BSP.

Standard No.	Standard Text	Decision
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	**Met/Not Met**

Guidance

INTERVIEW:
As Needed: Qualified professional who wrote the BSP Qualified professional who reviews and analyzes the BSP

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• Documentation of the periodic review and analysis

GUIDANCE:

- The schedule for the review and analysis of implementation of BSP interventions must occur at least semi-annually. It can be done more frequently, if specified by the Behavioral Support Plan.
- The results of this review must be documented.
- The information should be sufficient to determine if the BSP is effective and/or should be revised. Assess this standard both for inclusion of review schedule in the BSP as well as completion of the review.

Note: A behavior support plan incorporating the use of restrictive physical interventions and/or time-out rooms is prohibited in family care homes and hourly community habilitation. However, a behavior support plan incorporating restrictive physical interventions in hourly community habilitation may be permitted if specifically authorized by OPWDD.

SELECT "MET" If all are present:

- ✓ The BSP identifies the schedule for the review of the use and effectiveness of interventions, of at least every six months.
- ✓ There is documentation evidencing the review of interventions implemented. It includes a review of the frequency, duration, intensity, and outcomes of implementation.

SELECT "NOT MET" If any are present:

- ✓ The BSP does not identify the schedule for the review of the use and effectiveness of interventions, of at least every six months.
- ✓ The review schedule is either not set at a specific interval of time or the interval is greater than every six months.
- ✓ The review of interventions implemented is not documented.
- ✓ Review documentation does not include a review of the frequency, duration, intensity, and outcomes of implementation.

Standard No.	Standard Text	Decision
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• BIS or licensed qualified professional
• HRC Chair or other committee members

DOCUMENTATION REVIEW:
Mandatory:
• Human Rights Committee (HRC) approval documentation
• Written Informed Consent (WIC) documentation
• BSP

GUIDANCE:

- A behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention must be approved by the behavior plan/human rights committee or whatever name used by the agency. The committee is the agency designated oversight and approval body, uniquely created for to review that the BSP includes required and appropriate content, and the strategies to address behavior are appropriate and justified.
- Verify that the designated committee has reviewed the plan prior to implementation and annually.
- Committee approval must be provided prior to implementation or renewal of the BSP.
- The approval process must ensure that the plan has all required components per 633.16(e) (i.e. Developed by qualified person, includes required information).
- Written informed consent (WIC) must be obtained prior to approval.

SELECT "MET" If all applicable requirements are evident:

- ✓ There is documentation that evidences (HRC) committee approval of the BSP with restrictions/intrusions prior to its initial implementation (if new plan).
- ✓ BSP was not implemented until WIC obtained.
- ✓ There is current documentation that evidences (HRC) committee approval of the BSP in the past year.
- ✓ It is evident that HRC approval was given only for plans that includes all required components.
- ✓ There is current WIC documentation.
- ✓ BSP was implemented only after the HRC approval was obtained.

SELECT "NOT MET" If any are evident:

- ✓ HRC approval is not present.
- ✓ HRC approval is older than one year.

- ✓ HRC process didn't include oversight of all required components for a BSP containing restrictive interventions or right restrictions.
- ✓ WIC is not present prior to implementations.
- ✓ There is evidence that the BSP was implemented before HRC approval was obtained.

Standard No.	Standard Text	Decision
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• BIS or licensed qualified professional
• Person supported and/or family/advocate who provided or would be responsible to provide written informed consent (WIC)

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• WIC documentation

GUIDANCE:

- There should be documentation to evidence that written informed consent (WIC) was obtained prior to implementing a BSP with restrictive/intrusive interventions. Written informed consent must be documented with the consenting party's signature and their relationship to the person and a date.
- When appropriate, WIC should first be sought from the individual. WIC Guidance regarding parties who may provide informed consent is found in the regulatory references below:
  - 633.16(g)(6) - Hierarchy of parties appropriate to provide consent
  - 633.16(g)(7) – Determination of an individual's capacity to give informed consent
  - 633.16(g)(8) – Informed Consent Committee

- Time Limited Verbal Consent:
  - Per 633.16(f)(5)(ii) if written informed consent cannot be obtained within a reasonable period of time prior to the initiation or continuance of a plan, verbal consent may be accepted only for the period of time before written informed consent can be reasonably obtained.
  - Verbal consent must be witnessed by two members of the staff, and documented in the person's record. This verbal consent is valid for a period of up to 45 days and may not be renewed.
  - The specific requirements that must be followed to obtain appropriate written informed consent can be found in section 633.16(g), including involved parties that can provide the consent, starting with the individual receiving supports, when appropriate.
    (See Standard 9e-2 re: informed consent for plans including medications).

SELECT "MET" If either are present:

- ✓ WIC was obtained from the appropriate person prior to the implementation of the BSP containing restrictive and/or intrusive intervention(s).
- ✓ When necessary, time limited verbal consent was obtained, but followed by WIC within 45 days to allow for continuance of the BSP.

SELECT "NOT MET" If either are present:

- ✓ WIC was not obtained from the appropriate person prior to the implementation of the BSP containing restrictive and/or intrusive intervention(s).
- ✓ When necessary, time limited verbal consent was obtained prior to implementation, but WIC has not been received and 46+ days have elapsed, AND the plan's restrictive/intrusive interventions continue to be implemented.

Standard No.	Standard Text	Decision
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

• BIS or licensed qualified professional

• Person supported and/or family/advocate who provided or would be responsible to provide written informed consent (WIC)

DOCUMENTATION REVIEW:

Mandatory:

• BSP

• WIC documentation

GUIDANCE:

- Written Informed Consent (WIC) must be sought and obtained for continued implementation of behavior support plans with restrictive and/or intrusive interventions.
- The (WIC) from an appropriate consent giver must be current within the 12 months of the date of the survey visit.
- Review the WIC documentation for the 2 most recent years/consents, to determine that the facility/service is effectively ensuring continuance of WIC within 12 months of the prior consent.

SELECT "MET" IF either of the following are present:

- ✓ WIC, from the appropriate consent giver is current within 12 months of the date of the survey visit.
- ✓ The agency has initiated timely communications with the consent giver to facilitate consent within 12 months, and has assertively pursued its receipts, but it has not been obtained within required time frame. The agency staff is assertively pursuing consent from another approving body, e.g. agency informed consent committee.

SELECT "NOT MET" If either of the following are present is present:

- ✓ WIC was obtained longer ago than 13 months since the previous consent.
- ✓ There is no evidence of conscientious pursuit of written informed consent within the 12-month consent period.

Standard No.	Standard Text	Decision
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory:

• Program staff, FCP

As Needed:

• Person supported
• Family/Advocate
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:

Mandatory:

• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes

OBSERVATION:

As Needed:

If an opportunity arises during observation in certified settings.

GUIDANCE:

- Based on review activities, determine whether right limitations are implemented/imposed in accordance with BSP instructions.
- The BSP must explicitly describe when and how right limitations are to be used to address challenging behaviors. This includes circumstances to implement the limitation, durations, and criteria to lift the limitation for each intervention.
- Rights limitations must never be used for the convenience of staff/FCP, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
- Examples of Rights Limitations include denial or limited access to the internet and social media, limitations in personal communications or association, limitation or removal of personal property, limitations in freedom of movement in and out of the home, limitations in activities or independent participation in some activities, audio or video monitoring, etc.
- See standard below regarding criteria to be met to limit or modify personal rights.
- Be observant for indicators of rights limitations that may be evidences during observation and documentation review. Verify that there is an associated approved BSP strategy for this, appropriately justified. Examples of possible indicators include but are not limited to:

- Observation may indicate individual's lack of access to possessions or needed item, locked closets, sparse bedrooms absent of belonging, etc.
- Documentation may indicate denial of activities, possessions, or other interventions that demonstrate a restriction, limitation or intrusion.

SELECT "MET" If the following is evident:

- ✓ The rights' limitations described in the individual's BSP were implemented only in the circumstances and manner described in the BSP.

SELECT "NOT MET" IFeither of the following are evident:

- ✓ Rights limitations related to behaviors were implemented, but the limitation(s) was not an approved strategy included in the BSP.
- ✓ Rights limitations related to behaviors were implemented but not implemented under the approved circumstances or in the same manner described in the BSP.

Standard No.	Standard Text	Decision
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Mandatory:
• Program staff, FCP
As Needed:
• Person supported and/or family/advocate
• Program management staff
• Psychologist/BIS

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes

OBSERVATION:
As Needed:
If an opportunity arises during observation in certified settings.

GUIDANCE:

- If an individual's behavior required use of any emergency limitation of the person's rights, verify that the person's record includes documentation regarding the emergency rights' limitations. The circumstances regarding the implementing the emergency limitations should clearly indicate clinical necessity. The anticipated duration of the limitation or criteria for removal must be specified.

SELECT "MET" IF:

✓ If an emergency situation required the temporary limitation of a person's rights, a clinical justification, an anticipated duration of the limit or criteria for removal of the limitation is documented.

SELECT "NOT MET" IF:

✓ An emergency situation resulted in the temporary limitation of a person's rights, but no clinical justification, anticipated duration of the limit or criteria for removal of the limitation was documented.

SELECT "NA" IF:

✓ For this individual, there was no use of a rights limitation in an emergency.

Standard No.	Standard Text	Decision
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:
• Psychologist/BIS
• Program management staff and/or other support team members
• Person supported and/or family/advocate

DOCUMENTATION REVIEW:

Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes

GUIDANCE:

- 'Repeat use' of an unplanned limitation means more than four times in a 30-day period.
- The comprehensive review must be done by the person's program planning team in consultation with a licensed psychologist, a licensed clinical social worker, or Behavioral Intervention Specialist.
- The purpose of the review is to determine if there is a need for a BSP to address the exhibited behavior, a need to change or revise an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.

- The review, its findings and decisions should be documented in the person's service record.

SELECT "MET" if unplanned rights limitation occurred more than 4 times in a 30-day period and both of the following are evident:

- ✓ The person's service planning team conducted a comprehensive review of the occurrences, the need for a BSP, the adequacy of the current BSP, need for revision, or criteria for development of a BSP in the future.
- ✓ The meeting, its findings and decisions are documented.

SELECT "NOT MET" IF:

- ✓ Either of the criteria under 'Met' are absent.

SELECT "NA" IF:

- ✓ There was no use of repeated emergency or unplanned rights limitations for this individual.

SECTION 9b: MECHANICAL RESTRAINING DEVICES

Qualifier Question: MECHANICAL RESTRAINING DEVICES are used with the individual to address behavior and/or included in their BSP.	**Yes**	**No**

Standard No.	Standard Text	Decision
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Psychologist/BIS
• Program management staff and/or other support team members
• Person supported and/or family/advocate

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes
As Needed:
Plans developed by clinicians (e.g. OT, PT, RN, etc.) which describe use of adaptive equipment used by the person which are not subject to the requirements of this regulation.

OBSERVATION:
As Needed:
If opportunity presents, implementation of the mechanical restraining device.

GUIDANCE:
- The BSP must clearly describe why use of mechanical restraints is necessary. The FBA should provide the foundation for this justification.
- A mechanical restraining device is any physical apparatus or equipment used to limit or control challenging behavior. The apparatus or equipment cannot be easily removed by the person, may restrict the free movement or normal functioning or normal access to a portion or portions of a person's body, or may totally immobilize a person.
- The following types of mechanical restraining devices may be used without specific OPWDD approval of the specific device:

- mittens, helmets, face masks, goggles, sleeve boards (by whatever name known), clothing (e.g., jumpsuit, leotard, or custom-designed clothing such as shirts or pants made of non-shred able HW cloth), bolsters, and mats used to safely contain a person;
- lap trays, seatbelts, and harnesses when used to maintain an ambulatory person in a fixed location for the purpose of enhancing services; and
- the use of a seatbelt, harness, or mechanical brake to maintain a non-ambulatory person in a fixed location for the purpose of preventing risk to health or safety resulting from challenging behavior.
- Other mechanical devices, or modifications of the above devices, require specific review and approval by OPWDD. Verify this has been received by the agency. If approved, the provider agency will have documentation via email or letter from OPWDD Statewide Services Division. For state operated services, the Area Director will verify through the Statewide Services Division.

NOTE THE FOLLOWING:

- Mechanical restraining devices used as a support to achieve proper body position, balance, or alignment, as part of a medical or dental procedure or as a medical or dental safeguard are not subject to the requirements of this section.
- Nothing in 633.16 precludes the use of mechanical restraining device(s) while a person is an inpatient or resident under the auspices of a non-OPWDD operated or certified facility, program or service (e.g., mental health provider, medical hospital, or jail). The use of a mechanical restraining device in these types of settings is not subject to the provisions of this section and is subject instead to the applicable policies and rules of that provider.
- The use of devices to limit movement for the safe transport of the individual in vehicles, wheelchairs, etc., is not considered to be the use of a mechanical restraining device, and is not subject to the requirements of this section.

SELECT "MET" If the following is evident:

- ✓ The BSP clearly describes why use of the mechanical restraining device to address/manage the individual's challenging behavior is clinically justified.

SELECT "NOT MET" If either of the following are present:

- ✓ The BSP does not clearly describe why use of the mechanical restraining device to address/manage the individual's challenging behavior is clinically justified, so that is cannot be assured that its use is necessary.
- ✓ The BSP rationale for the use of the mechanical restraining device is inconsistent with what is in the FBA regarding the target behavior its use is designed to address.

Standard No.	Standard Text	Decision
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

• Direct Support Staff, FCP

• Program management staff and/or other support team members

• Psychologist/BIS

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes
• Care plan if any medical monitoring is required

OBSERVATION:
As Needed:
If opportunity presents, implementation of the mechanical restraining device.

GUIDANCE:
- The BSP must describe actions necessary for the safe and appropriate application of devices and other actions staff to take in association with the use of devices.
- In addition to when and how to apply the mechanical device/restraint, the plan should also describe:
- Monitoring to occur during periods the device is applied, including indicators, behaviors or physical signs/symptoms to note.
- Supervision level and supports to provide during device use that may be different than provided when device is not in use,
- Environmental considerations,
- Activity considerations, etc.

SELECT "MET" IF:
✓ The BSP clearly describes what service providers must do to support and monitor the individual when the device is used.

SELECT "NOT MET" IF:
✓ The BSP does not clearly describe what service providers must do to support and monitor the individual when the device is used.

Standard No.	Standard Text	Decision
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Program management staff and/or other support team members
• Psychologist/BIS

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes
• Care plan if any medical monitoring is required

OBSERVATION:
As Needed:
If opportunity presents, implementation of the mechanical restraining device.

GUIDANCE :

- The BSP should include clear instruction as follows:
  - a description of the individual's behavior and/or behavior progression that indicates the need to use the mechanical restraining device
  - all alternative strategies or actions to be implemented by staff prior to using the device
  - Clear criteria and conditions for application of device
  - Clear individualized behavioral criteria for when device should be removed
- Instruction regarding maximum duration of device application, including acknowledgement of release as describe in NOTE below.
- Note: Regarding maximum duration of device application: Per 633.16(j)(4)(ii)(i) In the absence of a physician's order for a shorter time period for release, the individual must be released from the device at least once every hour and fifty minutes for not less than ten (10) minutes. They must be provided opportunities for movement, eating, drinking and toileting. In the absence of a physician's order specifying otherwise, this is not applicable if the person is asleep, however the opportunities describe above must be offered immediately upon waking. If an individual requests release for movement or toileting prior to specify time period per plan, the opportunity should be provided ASAP.

SELECT "MET" If both are present:

✓ The BSP describes all of the bulleted information under “Guidance” regarding the use of the mechanical restraining device.

SELECT "NOT MET" IF:

✓ The BSP does not describe all of the bulleted information under “Guidance” regarding the use of the mechanical restraining device.

Standard No.	Standard Text	Decision
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

• Program management staff and/or other support team members

• Psychologist/BIS

DOCUMENTATION REVIEW:

Mandatory:

• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes
• Care plan if any medical monitoring is required

OBSERVATION:

As Needed:

If opportunity presents, implementation of the mechanical restraining device.

GUIDANCE:

- 9b-2 addresses actions to be taken by staff including monitoring actions to take. This standard reviews that the specific time intervals between monitoring activities is included in the plan.
- The BSP should specify the maximum time interval between monitoring the person while mechanical restraints are used (e.g. “every 10 minutes”).

SELECT "MET" IF:

✓ BSP specifies the maximum time interval between monitoring the person while mechanical restraints are used.

SELECT "NOT MET" IF:

✓ BSP does not specify the maximum time interval between monitoring the person while mechanical restraints are used.

Standard No.	Standard Text	Decision
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- Program management staff and/or other support team members
- Psychologist/BIS
- Person supported
- Family/Advocate

DOCUMENTATION REVIEW:

Mandatory:

- BSP

GUIDANCE:

- Ensure that the BSP describes the plan to reduce or eliminate the use of the mechanical restraining device. The BSP should:
- Identify clear criteria to fade or eliminate use of restraint;
- Ensure the criteria is based on information documented per the plan (i.e., what staff are recording to track behaviors should align with the fading criteria);
- Take into account prudent monitoring to ensure the person's safety;
- Include concrete rationale for decisions to continue use of the device.

SELECT "MET" If the following are evident:

✓ The BSP clearly describes a plan to reduce or eliminate use of the mechanical restraining device.

SELECT "NOT MET" If any are present:

✓ The BSP clearly describes a plan to reduce or eliminate use of the mechanical restraining device.

Standard No.	Standard Text	Decision
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Program management staff and/or other support team members
• Psychologist/BIS
• Person supported
• Family/Advocate

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• Physician's orders
• Care plan if any medical monitoring is required

GUIDANCE:
- The physician's order for use of a mechanical restraining device must be in the person's service record.
- The physician's order must specify:
- the type of device to be used;
- an expiration date for the order;
- any special considerations related to the use of the device based on the person's medical condition, including the monitoring which is required during and after use of the device. This must incorporate specific components such as checking of vital signs and circulation if needed;
- the order must be renewed with the frequency specified in the plan but no less frequently than every 6 months.
- The BSP guidance should be consistent with the physician's order.
- Note: If the device is used solely to maintain an ambulatory person in a fixed location or position for the purpose of enhancing the delivery of care or services (e.g. medical interventions), a physician's order is not required.

SELECT "MET" IF:
✓ There is a current (every six months) written physician's order for the device meeting the content requirements above.

SELECT "NOT MET" If either are present:
✓ There is not a written physician's order for the device meeting the content requirements above.
✓ There written physician's order is not current (every six months).

Standard No.	Standard Text	Decision
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	**Met/Not Met/NA**

Guidance

INTERVIEW:
As Needed:
• Program management staff and/or other support team members
• Psychologist/BIS
• Person supported
• Family/Advocate

DOCUMENTATION REVIEW:
Mandatory:
• BSP containing restrictive/intrusive interventions and/or limitation
• Physician's orders
• Care plan if any medical monitoring is required

GUIDANCE :
- If the BSP includes use of immobilization of extremities, there must be a physician's order for the intervention.
- A written physician's order for use of devices resulting in immobilization of both of the sets of extremities or total body immobilization can be written only after the physician's personal examination of the person. The following elements must be present:
  - The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days.
  - The review must be documented.
- This does not apply to the planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures or care routines, or emergency evacuations. Such use must be documented in a separate plan and order under separate requirements (at least annually).

SELECT "MET" IF:
✓ There is a current (every 90 days) written physician's order for the immobilization device meeting the content requirements above.

SELECT "NOT MET" If either are present:
✓ There is not a written physician's order for the immobilization device meeting the content requirements above.
✓ There written physician's order is not current (every 90 days).

SELECT "NA" IF:
✓ Immobilization of the extremities or total immobilization is not part of the plan for this individual.

Standard No.	Standard Text	Decision
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	**Met/Not Met/NA**

Guidance

INTERVIEW:
As Needed:
• Program management staff and/or other support team members
• Psychologist/BIS
• Person supported
• Family/Advocate

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• HRC approval
• Physician's orders
• Care plan if any medical monitoring is required
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes

OBSERVATION:
Mandatory; Look at the device which has been modified to familiarize yourself with the device and how it corresponds to the modification described in the plan.

GUIDANCE:
- Identify the type of device(s) described in the BSP.
- Modification of commercial devices or use of devices specially created for use by the individual but not available commercially, must have additional review and approval by the Behavior Plan/Human Rights Committee (as required for any mechanical restraining device) and OPWDD via the Commissioner's Review Committee.
- HRC Approval: As reviewed previously, the Human Rights Committee must review all mechanical restraining devices and provide approval when warranted. In the case of devices not available commercially (fabricated or modified commercial devices), the documentation of HRC review and approval must indicate active review of the modified device (visualization of the device and how used), circumstances for the need and justification for use of a fabricated or modified commercial device.
- OPWDD Approval: Verify OPWDD approval has been received by the agency. If approved, the provider agency will have documentation via email or letter from OPWDD Statewide Services Division. For state operated services, the Area Director will verify approval by contacting the Statewide Services Division.

SELECT "MET" If both are present:

- ✓ There is documented review and approval by agency Human Rights committee of the device and the BSP identifying use of the device.
- ✓ There is documented review and approval by OPWDD Commissioners Review Committee of the device.

SELECT "NOT MET" IF either of the following are present:

- ✓ There is not documented review and approval by agency Human Rights committee of the device and the BSP identifying use of the device.
- ✓ There is not documented review and approval by OPWDD Commissioners Review Committee of the device.

SELECT "NA" IF:

- ✓ The BSP and service implementation do not include use of any Mechanical Restraining device not commercially available.

Standard No.	Standard Text	Decision
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed: Clinical staff, Psychologist/BIS , Program management staff and/or other support team members, Person supported, Family/Advocate

DOCUMENTATION REVIEW:

Mandatory:

• BSP

• Service notes, assessments or consultation documentation that may evidence involvement of the clinician

GUIDANCE:

- Modification of commercial devices must be done with the consultation of an Occupational or Physical Therapist. This consultation and input by the clinician must be documented in the person's record.
- The role of the clinician in ongoing consultation regarding the device and device use is documented in the BSP when ongoing monitoring is needed.

SELECT "MET" If both of the following are evident:

- ✓ There is documentation of the consultation with the PT/OT regarding any mechanical restraining device that is fabricated or modified from its original commercial form.
- ✓ When necessary, the BSP includes description of the OT/PT clinician in ongoing monitoring of the device and/or use of the device.

SELECT "NOT MET" If either is present:

- ✓ There is not documentation of the consultation with the PT/OT regarding any mechanical restraining device that is fabricated or modified from its original commercial form.

- ✓ When ongoing monitoring is needed, the role of the clinician in ongoing consultation regarding the device and device is not documented in the BSP.

SELECT "NA" IF:

- ✓ The Mechanical Restraining device for this Individual has not been fabricated or modified from commercial product, therefore no expectation of a OT/PT consultation.

Standard No.	Standard Text	Decision
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory:
• Program staff, FCP
As Needed:
• Person supported
• Family/Advocate
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:

Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes

OBSERVATION:

As Needed: If opportunity presents, implementation of the mechanical restraining device.

GUIDANCE:

- Based on required review activities determine whether mechanical restraining devices were used in accordance with BSP direction for when and how the mechanical restraining devices are to be used to address challenging behaviors. Ensure that the devices are implemented in accordance with the criteria for when and how to apply, support and monitoring to be provided during use, etc. RELEASE/REMOVAL will be reviewed
- Mechanical restraining devices can only be used per the plan, and therefore use in an emergency is not permitted.

SELECT "MET" IF:

- ✓ Evidence gathered demonstrates that the mechanical training device was used according to the BSP.

SELECT "NOT MET" IF:

- ✓ Evidence gathered reveals that mechanical training device was not used according to the direction in the BSP.

Standard No.	Standard Text	Decision
9b-11	The individual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met

Guidance

INTERVIEW:

Mandatory:
• Program staff
As Needed:
• Person supported
• Family/advocate
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:

Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes
• Care plan if any medical monitoring is required

GUIDANCE:

- This "full record" must be present for each use of mechanical restraining devices. A "full record" means:
  - a description of the event that caused the device to be applied
  - the time it was applied
  - the times when monitoring occurred
  - the findings of monitoring activities and any actions taken
  - the time of release
  - Any other information required by the BSP

SELECT "MET" IF:

- ✓ There is documentation for each use of the mechanical restraining device, including all of the content elements in 'Guidance' above.

SELECT "NOT MET" If any of the following are evident:

- ✓ There is not documentation for each use of the mechanical restraining device.
- ✓ There is documentation for each use of the mechanical restraining device, but it consistently lacks one or more of the content elements in 'Guidance' above.
- ✓ There is documentation for use of the mechanical restraining device, but it frequently lacks entry of one or more of the content elements in 'Guidance' above (i.e. There are multiple blanks.) Note: Infrequent rare blanks/omissions over time of a content element should be considered regarding impact on the individual and impact on ability to assess effectiveness of the use of the device.

Standard No.	Standard Text	Decision
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes' intervals or according to physician's orders.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory:

- Program staff

As Needed:

- Person supported
- Family/Advocate
- Program management staff
- Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:

Mandatory:

- BSP
- RIA
- BSP implementation documentation and behavior tracking
- IRMA/Incident review
- Service notes, program, prn or other daily notes
- Physician's orders
- Care plan if any medical monitoring is required

OBSERVATION:
As Needed: If opportunity presents, implementation of the mechanical restraining device.

GUIDANCE:

- The form and format for documentation of mechanical restraint use should include information on the application and removal of devices.
- Documentation should demonstrate that the person was released from the device when he/she met the criteria for release or when specified by the doctor's order if less than 1 hour and 50 minutes. The BSP should not represent a longer period of maximum time than the order.
- Be alert to a mechanical restraining device always being used for the full one hour and fifty minutes prior to release. If this is per the plan, inquire how this was determined necessary if justification is not clear in the plan. If the BSP has criteria for release earlier than 1' 50", but use always goes to maximum, make further inquiry regarding why staff implementing have determined this to be necessary if implementation documentation does not provide clear justification.
- If the person requests release for movement or access to a toilet before the specified time period has elapsed, verify that this is afforded to him/her as soon as possible.
- When released, the person should be provided the opportunity for movement, exercise, necessary eating, drinking and toileting.
- If the person has fallen asleep while wearing a mechanical device, he/she does not need to be released while asleep. Opportunity for movement, exercise, necessary eating, drinking and toileting must be provided immediately.

SELECT "MET" If the all of the following are evidenced:

- ✓ There is documentation of the application and removal of the mechanical restraining device;
- ✓ The person was released; per criteria in the BSP/physician's order; within maximum duration described in plan, whichever duration is shorter.
- ✓ The person was released as soon as possible after they requested to move or to use the toilet;

SELECT "NOT MET" If any of the following are evident:

- ✓ There is not documentation of the application and removal of the mechanical restraining device;
- ✓ The person was not released; per criteria in the BSP/physician's order; within maximum duration described in plan, whichever duration is shorter.
- ✓ The person was not released as soon as possible after they requested to move or to use the toilet;
- ✓ The person was not provided opportunity for movement, exercise, necessary eating, drinking and toileting as soon as possible after release from the mechanical restraining device;
- ✓ If the person fell asleep with the MRD in place, they were given opportunity for movement, exercise, necessary eating, drinking and toileting immediately upon awakening.

Standard No.	Standard Text	Decision
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred.	Met/Not Met

Guidance

INTERVIEW:
Mandatory:
• Program staff
As Needed:
• Person supported
• Family/Advocate
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes
• Physician's orders
• Care plan if any medical monitoring is required

OBSERVATION:
As Needed: If opportunity presents, implementation of the mechanical restraining device.

GUIDANCE:
- If a person is released by necessity from the mechanical restraining device before the time limit specified in the order and BSP, and the person is no longer exhibiting behavior that necessitates restraining techniques, it is no longer necessary to employ the device. Under these circumstances, the restraining device should not be reemployed.
- The device must only be re-applied IF the challenging behavior requiring application presents itself, AND the individual has been permitted release time required by regulation and the BSP.

SELECT "MET" IF:
✓ Review activities evidence that the person's mechanical restraining device was not reapplied after release (even if sooner than release criteria) unless the behavior justifying application is again demonstrated.

SELECT "NOT MET" IF:
✓ Review activities evidence that the person's mechanical restraining device was reapplied after release (even if sooner than release criteria) even though the behavioral criteria for application was not demonstrated.

Standard No.	Standard Text	Decision
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Mandatory:
• Program staff
As Needed:
• Person supported
• Family/Advocate
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes
• Physician's orders
• Care plan if any medical monitoring is required

OBSERVATION:
As Needed: If opportunity presents, implementation of the mechanical restraining device.

GUIDANCE:
• Immobilizing devices are any device which will prevent the free movement of both arms, and both legs, or totally immobilize the person.
• Part 633.16 defines a senior member of an agency's staff as that staff member, who is designated by the chief executive officer (CEO) as a senior member of the administrative structure of an agency, and as such, may carry out designated responsibilities delegated by the CEO. This may be someone who is responsible for a group of applicable facilities (e.g., Team Leader, residence manager, head of shift, unit supervisor).
• Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person must stay in continuous visual and auditory range for the duration of the use of the device.
• In the context of a medical or dental examination or procedure, the supervision must be by a healthcare provider or staff designated by the healthcare provider.

SELECT "MET" If the first two bullets below are both present and that if it's appropriate, the third is present:
• Tracking or other documentation (and interview/observation support) evidences that use of the immobilizing device was done under the supervision of a senior

staff member designated by the CEO.
• Continual visual and auditory contact with the person in the immobilizing device was maintained
• That if the immobilizing device was used in the context of a medical or dental exam, that the supervision was done by a healthcare provider or its designated staff.

SELECT "NOT MET" If any are present:
• Evidence shows that the immobilizing MRD was not used under the supervision of the senior, CEO-designated staff.
• Evidence shows that continual visual and auditory contact with the person was not maintained.
• Evidence shows that a medical context for use of the device was not supervised by a healthcare provider or its designated staff.

SELECT "NA" IF:
Evidence demonstrates that there has been no application of the immobilizing device for this individual.

Standard No.	Standard Text	Decision
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met

Guidance

OBSERVATION:
Mandatory; Look at the device to verify its cleanliness and integrity as a safely working device

GUIDANCE:
- Visually examine the device being used by the person. If issues with condition are noted, interview staff regarding procedures for cleaning and/or maintenance of the device(s).

SELECT "MET" IF:
✓ The device is maintained in good repair and is in sanitary condition.

SELECT "NOT MET" IF:
✓ The device is not maintained in good repair and/or it is not in sanitary condition.

Standard No.	Standard Text	Decision
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	**Met/Not Met/NA**

Guidance

INTERVIEW:
Mandatory:
• Program staff. FCP
As Needed:
• Person supported
• Family/Advocate
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes
• Physician's orders
• Care plan if any medical monitoring is required

OBSERVATION:
As Needed: If opportunity presents, implementation of the mechanical restraining device.

GUIDANCE:
• Verify that helmets with chin straps are not used while a person is sleeping, or in a prone or reclining position unless specifically approved by OPWDD.
• If use of helmet with chin strap for atypical use is approved by OPWDD, the provider agency must have documentation via email or letter from OPWDD Statewide Services Division. For state operated services, the Area Director will verify approval by contacting the Statewide Services Division.

SELECT "MET" IF:
- ✓ Evidence shows that person is not asleep, prone or reclining when wearing a helmet with a helmet chin strap.
- ✓ There is documentary evidence of OPWDD approval of use of atypical use of chin strap helmet.

SELECT "NOT MET" IF:
- ✓ Evidence shows that person wears the helmet with chin strap while asleep and/or positioned as prone and/or reclining without OPWDD approval of atypical use.

SELECT "NA" IF:
- ✓ Helmet with chin strap is not part of the Individual's plan.

SECTION 9c: PHYSICAL INTERVENTIONS

Qualifier Question: Physical Interventions are used with the individual and/or included in their Behavior Support Plan.	**Yes**	**No**

Standard No.	Standard Text	Decision
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	**Met/Not Met**

Guidance

INTERVIEW:
Mandatory:
• Program staff
As Needed:
• Person supported
• Family/Advocate
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes
• Physician's orders
• Care plan if any medical monitoring is required

OBSERVATION:
Observe interactions and strategies used:
• Mandatory: during observation in appropriate certified sites

GUIDANCE:

- Determine whether physical interventions were used safely and in accordance with BSP guidelines. There should be information in RIA for physical interventions implemented. Physical Interventions used must be the same interventions identified in the Behavior Support Plan, and used in the same hierarchy as put forth in the plan. The technique must be applied safely, with the minimal amount of force necessary to safely interrupt the challenging behavior.

  NOTE: Restrictive Physical interventions cannot be used in Family Care Homes.

SELECT "MET" IF:

- ✓ Evidence demonstrates that physical interventions were applied safely, with least force necessary and in accordance with the criteria and hierarchy of interventions listed in the BSP.

SELECT "NOT MET" If any of the following are present:

- ✓ Evidence reveals that physical interventions were implemented which were not those listed in the BSP.
- ✓ Evidence reveals that physical interventions were implemented but not based on the hierarchy of least restrictive to most restrictive in the BSP.
- ✓ Evidence reveals that physical interventions were implemented with more force than necessary to safely interrupt the challenging behavior.

Standard No.	Standard Text	Decision
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory:

• Program staff, FCP

As Needed:

• Person supported
• Family/Advocate
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:

Mandatory:

• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes
• Physician's orders
• Care plan if any medical monitoring is required

OBSERVATION:

Observe interactions and strategies used:

• Mandatory: during observation in appropriate certified sites

GUIDANCE:

- Based on possible observation, interview, review of documents and reports, determine whether physical interventions were used safely and in accordance with BSP guidelines. The intervention should have been stopped in the following situations:
- When the person's behavior which necessitated application of the intervention had diminished sufficiently or had ceased as identified in the plan;
- Immediately, if the person appeared to be physically at risk;
- The continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode cannot exceed 20 minutes.
- NOTE: Restrictive Physical interventions cannot be used in Family Care Homes.

SELECT "MET" IF:

✓ Evidence reveals that staff stopped the use of the physical intervention when any of the criteria was met (behavior diminished or ceased per BSP criteria; signs of physical risk of harm; or 20 minutes' duration of application of the physical intervention, whichever occurred first.)

SELECT "NOT MET" IF:

✓ Evidence reveals that staff did not stop the use of the physical intervention when any of the criteria was met (behavior diminished or ceased per BSP criteria; signs of physical risk of harm; or 20 minutes' duration of application of the physical intervention, whichever occurred first.)

Standard No.	Standard Text	Decision
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory:
• Program staff
As Needed:
• Person supported
• Family/Advocate
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:

Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes
• Physician's orders
• Care plan if any medical monitoring is required

• Medical or clinical notes regarding person's health status

OBSERVATION:
Observe interactions and strategies used during observation in appropriate certified sites

NOTE: Restrictive Physical interventions cannot be used in Family Care Homes.

GUIDANCE:

- Verify that the person was assessed for injury as required and that the following occurred:
- Body check inspections and the findings of the inspection is documented in RIA;
- If an injury is suspected, that appropriate medical care is provided.
- Note: Any injury which meets the definition of a reportable or significant incident or minor notable occurrence is reported in accordance with Part 624. However, correct reporting is reviewed in a different Section of the protocol.

SELECT "MET" If first bullet is evident and if indicated, the second also:

- ✓ Body check inspection for injuries was performed after any type of physical intervention technique was applied by staff.
- ✓ If medical care was indicated as a result of the body inspection, this was given to person.

SELECT "NOT MET" If either are noted:

- ✓ There is no evidence that a body check inspection for injuries was performed after any physical intervention technique applied by staff.
- ✓ There is evidence that the individual sustained an injury requiring medical care as a result of a physical intervention but it was not provided.

Standard No.	Standard Text	Decision
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	**Met/Not Met/NA**

Guidance

INTERVIEW:
As Needed:
• Program staff
• Person supported
• Family/Advocate
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP
• Other appropriate parties to whom notification is required (MSC, Care Coordinator, appropriate clinician, CAB, etc.)

DOCUMENTATION REVIEW:

Mandatory:

- BSP
- RIA
- BSP implementation documentation and behavior tracking
- IRMA/Incident review
- Service notes, program, prn or other daily notes
- Physician's orders

NOTE: Restrictive Physical interventions cannot be used in Family Care Homes.

GUIDANCE:

The following people must be notified within two business days of the use of an intermediate or restrictive physical intervention used in an emergency. This notification must be made unless the person is a capable adult who objects to this notification.

- The service coordinator or party designated with the responsibility for coordinating a person's plan of services
- The appropriate clinician, if applicable
- The person's guardian, parent, actively involved family member
- Representative of the Consumer Advisory Board (for Willowbrook Class members)
- Correspondents or Advocates

SELECT "MET" If either of the following are evident:

- ✓ The appropriate parties were notified of an intermediate or restrictive physical intervention used in an emergency, within 2 business days.
- ✓ The person is a capable adult who objects to notification to others of an intermediate or restrictive physical intervention used in an emergency.

SELECT "NOT MET" If any are evident:

- ✓ Notification of an intermediate or restrictive physical intervention used in an emergency was not done within 2 business days.
- ✓ Appropriate parties were not notified of an intermediate or restrictive physical intervention used in an emergency (for which there was no objection by a capable adult).
- ✓ Notification was done to parties despite the objection of the capable adult.

SELECT "NA" IF:

- ✓ There was no emergency use of physical intervention.

Standard No.	Standard Text	Decision
9c-5	Repeated emergency use of physical interventions in a 30-day period or six-month period resulted in a comprehensive review.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed:

- Program staff
- Person supported
- Family/advocate
- Program management staff
- Psychologist/BIS responsible for writing and supervision of the BSP
- Other appropriate parties to whom notification is required (MSC, Care Coordinator, appropriate clinician, CAB, etc.)

DOCUMENTATION REVIEW:

Mandatory:

- BSP
- RIA
- BSP implementation documentation and behavior tracking
- IRMA/Incident review
- Service notes, program, prn or other daily notes

NOTE: Restrictive Physical interventions cannot be used in Family Care Homes.

GUIDANCE:

- Repeated use means: More than two times in a 30-day period or four or more times in a six-month period.
- The comprehensive review must be done by the person's program planning team in consultation with a licensed psychologist, a licensed clinical social worker, or Behavioral Intervention Specialist.
- The purpose of the review is to determine if there is a need for a BSP to address the exhibited behavior, a need to change or revise an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future. The review and determinations must be documented.
- Review documentation to verify that an appropriate review has occurred.

SELECT "MET" If emergency use of a physical intervention occurred more than 2x in a 30-day period or 4 or more times in a six-month period and both of the following are present:

- ✓ The person's service planning team conducted a comprehensive review of the occurrences, the need for a BSP, the adequacy of the current BSP, need for revision, or criteria for development of a BSP in the future.
- ✓ The meeting, its findings and decisions are documented.

SELECT "NOT MET" IF:

- ✓ Either of the criteria under 'Met' are absent.

SELECT "NA" IF:

- ✓ There was no emergency repeated use of emergency physical interventions meeting the frequency and time frame excesses noted in the guidance.

Standard No.	Standard Text	Decision
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- Program staff
- Person supported
- Program management staff
- Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:

Mandatory:

- BSP
- RIA
- BSP implementation documentation and behavior tracking
- IRMA/Incident review
- Service notes, program, prn or other daily notes

OBSERVATION:

Observe interactions and strategies used during observation in appropriate certified sites

GUIDANCE:

- In OPWDD certified programs/settings, use of restrictive physical intervention must be reported via the Restrictive Intervention Application (RIA).
  - The report in RIA should have all appropriate fields completed.
  - Through documentation review, verify that the information entered in RIA is accurate, based on other documentation and information available.
  - RIA entry must occur within 5 business days of use of the intervention.
- NOTE: For behavior services provided in non-certified settings (e.g. delivery of Community Habilitation) reporting/documenting use of a restrictive physical intervention may occur on paper only. RIA entry is not required.

SELECT "MET" IF both of the following are evident:

- ✓ In OPWDD certified sites, RIA entry was completed within five business days following the use of a restrictive physical intervention.
- ✓ The RIA entry is consistent with other information available regarding the behavior and strategy implementation.

SELECT "NOT MET" IF either of the following are evident:

- ✓ In OPWDD certified sites, RIA entry was NOT completed when applicable.
- ✓ In OPWDD certified sites, RIA entry was NOT completed within five business days following the restrictive physical intervention.

SECTION 9d: TIME OUT

Qualifier Question: Time Out is used with the individual and/or included in the Behavior Support Plan.	**Yes**	**No**

Standard No.	Standard Text	Decision
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed:
• Program staff
• Person supported
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:
Mandatory:
• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes

OBSERVATION:
Mandatory:
Observe interactions and strategies used during observation in appropriate certified sites.

GUIDANCE:

- Based on visual evidence, interview and review of documents and reports, determine whether use of the time-out strategy was implemented safely and in accordance with the BSP criteria and instruction.
- Time-out use will be documented in RIA (certified settings).
- The plan must be followed regarding circumstance for initiation of time-out as well as adherence to criteria and time frames for release from time-out.
- Time Out should not be used for any behavior other than that specified in the BSP.
- Time-out cannot be used in an emergency in the absence of a written plan.
- It cannot be used as a form of punishment or retribution or for the convenience of staff.
- 'Time away', when a person is redirected to a quieter or less stimulating area of the program and where staff do not actively prevent egress from that area, is not considered a form of time-out.

SELECT "MET" If the following are evident:

- ✓ The use of time-out was implemented only in accordance with the criteria and hierarchy of interventions listed in the individual's BSP.
- ✓ Time out was implemented with the methodology directed in the BSP.

SELECT "NOT MET" If any of the following are evident:

- ✓ Use of time-out was implemented for behaviors NOT directed by the criteria and hierarchy in the BSP.
- ✓ Time-out was not implemented with the methodology directed in the BSP.
- ✓ Time-out was implemented but is not included in the BSP.

Standard No.	Standard Text	Decision
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- Program staff
- Person supported
- Program management staff
- Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:

Mandatory:

- BSP
- RIA
- BSP implementation documentation and behavior tracking
- IRMA/Incident review
- Service notes, program, prn or other daily notes

OBSERVATION:

Mandatory:

Observe interactions and strategies used during observation in appropriate certified sites.

GUIDANCE:

- Constant auditory and visual contact is mandated to ensure that if the Individual engages in behavior that poses a risk to their health or safety, staff intervenes to prevent injury.
- Guidance to provide this monitoring should be clearly indicated in the BSP.
- Documentation for implementation of time-out should indicate the provided monitoring support. Verify that it is appropriate.

SELECT "MET" If both are present:

✓ Evidence demonstrates that constant auditory and visual monitoring of the person in time-out was maintained by staff.

SELECT "NOT MET" If either of the following are present:

✓ Evidence reveals that constant auditory and visual monitoring of the individual, while in time-out was not maintained by staff.

Standard No.	Standard Text	Decision
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

• Program staff
• Person supported
• Program management staff
• Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:

Mandatory:

• BSP
• RIA
• BSP implementation documentation and behavior tracking
• IRMA/Incident review
• Service notes, program, prn or other daily notes

OBSERVATION:

Mandatory:

Observe interactions and strategies used during observation in appropriate certified sites.

GUIDANCE:

- The individualized guidance for maximum placement in time-out and criteria for release must be clearly indicated in the person's BSP. This time cannot exceed one continuous hour.
- Documentation of implementation of the time-out strategy should include time-out entry and exit time.
- Through observation when event occurs and documentation review verify that durations do not exceed one hour.

SELECT "MET" IF:

✓ Evidence demonstrates that placement of the person in the time-out room did not exceed one continuous hour.

SELECT "NOT MET" IF:

✓ Evidence reveals that use of the time-out room for the person in time-out exceeded one continuous hour.

Standard No.	Standard Text	Decision
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed:

- Program staff
- Person supported
- Program management staff
- Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:

Mandatory:

- BSP
- RIA
- BSP implementation documentation and behavior tracking
- IRMA/Incident review
- Documentation of team meetings/reviews
- Service notes, program, prn or other daily notes

OBSERVATION:

Mandatory:

Observe interactions and strategies used during observation in appropriate certified sites.

GUIDANCE:

- If a time-out room is used on 5 or more occasions within a 24 hour period, there must be evidence that the BSP adequacy and content was reviewed by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.

  The review and determinations must be documented.

SELECT "MET" IF the Time Out room was used 5 or more times in a 24 hour period and all of the following are evident:

- ✓ The person's service planning team including the Psychologist/LCSW/BIS, conducted a comprehensive review of the occurrences, the adequacy of the current BSP and need for revision.
- ✓ The review was conducted within 3 business days of the referenced 24 hour period.
- ✓ The meeting, its findings and decisions are documented.

SELECT "NOT MET" IF the TO room was used 5 or more times in 24 hour period and any of the following are evident:

- ✓ The person's service planning team conducted a comprehensive review of the occurrences, the adequacy of the current BSP and need for revision, however the Psychologist/LCSW/BIS did not participate.
- ✓ The review was conducted after 3 business days of the referenced 24 hour period, with no justifiable reason for delay.
- ✓ The meeting, its findings and decisions are not documented.

SELECT "NA" IF:

- ✓ Use of a time-out room on five or more occasions in a 24 hour period, did not occur.

Standard No.	Standard Text	Decision
9d-5	The use of a time out room was reported electronically to OPWDD.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- Program staff
- Person supported
- Program management staff
- Psychologist/BIS responsible for writing and supervision of the BSP

DOCUMENTATION REVIEW:

Mandatory:

- BSP
- RIA
- BSP implementation documentation and behavior tracking
- IRMA/Incident review
- Service notes, program, prn or other daily notes

GUIDANCE:

- The use of time-out must be reported in RIA.
- Review documentation in RIA to verify that each use of time-out was reported and all required information was entered into the application and is accurate per documentation available in the person's record or service documentation.

SELECT "MET" IF both of the following are evident:

- ✓ RIA entry was completed within five business days following the use of a time out; and
- ✓ The RIA entry is consistent with other information available regarding the behavior and time out implementation.

SELECT "NOT MET" If any of the following are evident:

- ✓ RIA entry was NOT completed regarding use of time out.
- ✓ RIA entry was NOT completed within five business days following the use of time out.
- ✓ The RIA entry is NOT consistent with other information available regarding the behavior and time out implementation.

SECTION 9e: BEHAVIOR MEDICATIONS - GENERAL

Qualifier Question: Medication is used as a behavior support.	**Yes**	**No**

Standard No.	Standard Text	Decision
9e-1	Medication to address the individual's challenging behavior or a symptom of a diagnosed co-occurring psychiatric disorder is administered only as a part of a BSP or Monitoring Plan which includes additional interventions.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory:

- Program staff

As Needed

- RN
- Psychologist/BIS responsible for writing and supervision of the BSP or medication monitoring plan
- Program management staff and/or other support team members
- Person supported
- Family/Advocate

DOCUMENTATION REVIEW:

Mandatory:

- BSP or Medication Monitoring Plan
- Medication Administration Record (MAR)
- Prescriber's orders
- Program or other communication daily notes
- Behavior tracking documentation
- IRMA
- RIA

GUIDANCE:

- If medication is prescribed to address challenging behavior a Behavior Support Plan must be in place.
- If medication is prescribed to address symptoms associated with a diagnosed co-occurring psychiatric disorder but, no other challenging behavior, and no restrictive/intrusive interventions or rights limitations are necessary, a Monitoring Plan may be in place in lieu of a BSP. 633.16(j)(5)(vi).
- A Medication Monitoring Plan cannot be used for medication prescribed to address challenging behavior in the absence of a diagnosed, qualifying, co-occurring psychiatric diagnosis. In the absence of a diagnosed, qualifying, co-occurring psychiatric disorder a BSP, together with its FBA, must be used.
- Medication can only be one part of the BSP or Monitoring Plan. The Plans must also include other interventions intended to reduce/eliminate the challenging behaviors or target symptoms. Supportive, re-directive and alternative interventions to address, alter or prevent the behaviors and/or symptoms must be included in the plan in addition to medication use. See also 633.16(j)(7).

- If any intervention, other than medication, is restrictive, intrusive or rights limiting, the plan must be a BSP.
- The plan must identify the medications and the behavior or symptom addressed.

SELECT "MET" If the following applicable statements are evident:

- ✓ A Behavior Support Plan is in place in any of the following conditions:
  - o Medication is administered to address a challenging behavior that is unrelated to/not a symptom of a co-occurring psychiatric disorder; and/or
  - o Medication is administered to address a challenging behavior and the BSP also includes interventions that are restrictive, intrusive or rights limiting.
  - o Medication is administered to address a symptom of a co-occurring psychiatric disorder, and restrictive, intrusive or rights limiting interventions are also used.
- ✓ A Medication Monitoring Plan is in place if all of the evident in the following conditions are met:
  - o Medication is administered to address only a symptom or behavior associated with a co-occurring psychiatric disorder.
  - o There are no other behaviors addressed in the plan, only those that are a documented as a symptom of the co-occurring psychiatric disorder.
  - o No restrictive, intrusive or rights limiting interventions are used.
  - o Whichever type of plan is in place, the plan includes alternative and supportive interventions to address, alter or prevent the behaviors and/or symptoms for which the medications are prescribed.

SELECT "NOT MET" If any of the following are present:

- ✓ Medication is prescribed/administered to address challenging behaviors or symptoms of co-occurring psychiatric disorder but there is no written support plan in place (BSP or
- ✓ Medication Monitoring Plan dependent on the individual's specific behaviors and interventions).
- ✓ A Medication Monitoring Plan is in place; however, the person requires a BSP based on criteria identified in guidance above.
- ✓ Supportive, re-directive and alternative interventions designed to reduce or eliminate the challenging behaviors or target symptoms are not included in the BSP or Medication Monitoring Plan.

Standard No.	Standard Text	Decision
9e-2	Written Informed Consent for use of medication by the individuals has been obtained and is current.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- RN
- Psychologist/BIS responsible for writing and supervision of the BSP
- Person supported
- Family/advocate responsible for giving written informed consent (WIC).
- Program management staff and/or other support team members

DOCUMENTATION REVIEW:

Mandatory:

- Written Informed Consent documentation
- BSP or Medication Monitoring Plan
- Written Informed Consent (WIC) documentation
- MAR
- Prescriber's orders
- RIA
- BSP implementation documentation and behavior tracking
- IRMA/Incident review
- Service notes, program, prn or other daily notes

GUIDANCE:

- There should be documentation that written informed consent (WIC) was obtained prior to administering medication to address behavior. Written informed consent must be documented with the consenting party's signature and their relationship to the person and a date and available in the person's record.
- If it is necessary for the medication to be administered before written informed consent can reasonably be obtained, verbal consent may be accepted for only the period of time before written informed consent can be reasonably obtained. Verbal consent must be witnessed by two members of the staff and documented in the person's record. This verbal consent may be considered valid for a period of up to 45 days and may not be renewed.
- Please also note that Part 633.16(j)(5)(iv) allows the administration of medication in an emergency situation if the following conditions are met:
- Medication may be administered in an emergency, without informed consent, with the express intent of controlling a person's challenging behavior or acute symptoms of a diagnosed co-occurring psychiatric condition when:
    - the person's behavior constitutes an immediate risk to the health or safety of the person or others; or
    - in a physician's judgment, an emergency exists that creates an immediate need for the administration of such medication, and an attempt to secure informed consent would result in a delay which would increase the risk to the health or safety of the person or others.

- The administration of such medication may only continue for as long as one of the conditions in clause (a) of this subparagraph exists.
- The use of the medication, along with the prescription/order and a note on its effectiveness, shall be documented in the person's record.
- The emergency use of medication to manage challenging behavior or acute symptoms of a diagnosed co-occurring psychiatric condition in more than four (4) instances in a
- 14-day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, a licensed clinical social worker or Behavioral Intervention Specialist, within three business days of the fifth medication administration;
    - The team shall determine if there is a need for a behavior support plan to address the behavior or symptom that necessitated the emergency use of medication, or a need to modify an existing plan, or to establish the criteria for a future decision that a plan will be needed. Such a determination shall be documented.
    - The emergency administration of the medication may continue until the program planning team meets.
- Whenever it is or has been necessary to utilize any medication to control challenging behavior or acute symptoms of a diagnosed co-occurring psychiatric condition in an emergency, the duly authorized surrogate consent giver in accordance with paragraph (g)(6) of this section, the service coordinator or party designated as responsible for coordinating a person's plan of services, and the appropriate clinician (e.g., licensed psychologist, licensed clinical social worker, Behavioral Intervention Specialist, physician), if applicable, shall be notified within the next two business days.
- Additional information on informed consent can be found in 633.16(g).

SELECT "MET" If either are present:

- ✓ WIC was obtained from the appropriate person prior to the administration of the medication.
- ✓ When necessary, time limited verbal consent was obtained, but followed by WIC within 45 days to allow for continuance of the BSP.
- ✓ Medication was administered in an emergency situation without WIC, however all the additional actions in 633.16(j)(5)(iv) described above are implemented as appropriate to the situation.

SELECT "NOT MET" If either are present:

- ✓ WIC was not obtained from the appropriate person prior to the administration of the medication not deemed an emergency.
- ✓ Time limited verbal consent was obtained prior to implementation, but WIC has not been received and 46+ days have elapsed with continued medication administration.

Standard No.	Standard Text	Decision
9e-3	When the plan includes the medication the Individual's service record includes a semi-annual medication regimen review that is used to evaluate the benefits/risk of continuation.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory:

• Program staff

As Needed

• RN (or other medical professional as necessary)
• Psychologist/BIS responsible for writing and supervision of the BSP or medication monitoring plan
• Program management staff and/or other support team members
• Person supported
• family/advocate

DOCUMENTATION REVIEW:

Mandatory:

• Medication regimen review documentation (e.g. Med Regimen Review form, physician consult form that documents med regimen review, pharmacy review document, etc.)
• BSP or Medication Monitoring Plan
• Medication Administration Record (MAR)
• Prescriber's orders
• Program or other communication daily notes
• IRMA
• RIA

GUIDANCE:

- The semi-annual medication regimen review must include all medications prescribed to address behaviors or psychiatric symptoms. The medication regimen required to meet this standard is not separate from the review required for all medications the individual is prescribed/takes. This requirement is meant to ensure that the medications associated with a plan to address behavior are part of the review of the full medication regimen.
- The medication regimen review must be completed in accordance with the requirements in 633.17(a)(18)(i)-(ii)(a)-(e), which requires the following:
    - The review shall be made by a registered nurse, physician, physician's assistant, or pharmacist.
    - The medication regimen review shall include, at a minimum:
        - A review of the person's medication record for potential adverse reactions, allergies, interactions, contraindications, or irregularities; related laboratory work shall be included in this review.

- An assessment of the person's response to medication therapy to determine if the medication is achieving the stated objectives established by the prescribing practitioner.
- Recommendations to the primary and/or consulting practitioner of any indicated changes in the person's medication regimen.
- Determination of the need for a more frequent review depending upon the person's medical status.
- Documentation of the review, findings, and any recommendations made.

SELECT "MET" If both are evident:

- ✓ A medication regimen review inclusive of behavior medication is documented and completed in accordance with the content and considerations in NYCRR Part 633.17(a)(18)(i)-(ii)(a)-(e) as noted in Guidance above.
- ✓ The medication regimen reviews are conducted semi-annually.

SELECT "NOT MET" If any of the following are evident:

- ✓ The medication regimen reviews are not being conducted.
- ✓ The medication regiment reviews are not completed timely extending with extended durations greater than 6 months between reviews. (Used reasoned judgment for the rare occasion of lateness provided no negative outcome could be expected.)
- ✓ Medication regimen reviews are being conducted but without regard for the required content and considerations of 633.17(a)(18)(i)-(ii)(a)-(e) noted in guidance.
- ✓ The medication regimen reviews are not documented.

Standard No.	Standard Text	Decision
9e-4	The Individual's service record includes evidence that the prescriber was consulted regarding administration and continued effectiveness of the medication.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory:

• Program staff

As Needed

• RN (or other medical professional as necessary)
• Psychologist/BIS responsible for writing and supervision of the BSP or medication monitoring plan
• Person supported
• family/advocate
• Program management staff and/or other support team members

DOCUMENTATION REVIEW:

Mandatory:

• Medication regimen review documentation
• Medication Administration Record (MAR)
• Prescriber's orders
• Nursing notes, clinical notes
• PRN, service or other daily notes used by agency
• BSP implementation documentation and behavior tracking
• IRMA
• RIA

GUIDANCE:

- The medical professional who prescribes medication should be involved in the review of medication use and its effectiveness. The results of the medication regimen reviews should be provided to the prescriber and other health care providers as necessary, particularly when concerns, irregularities or recommendations are identified.
- Any concerns, questions, or irregularities brought to the attention of the prescriber or raised by the prescriber should be documented, as well as any related decisions, resolutions or requested follow-up.
- Consultation with the prescriber may include attention to the benefits of continuing the medication(s); risk inherent in potential side effects, allergies, drug interactions, contraindications, or lab irregularities; and/or effectiveness/ineffectiveness of medication in addressing the co-occurring symptom or challenging behavior.

SELECT "MET" If all of the following are evident:

- ✓ The medication prescriber is informed of significant medication regimen review findings.
- ✓ Facility/agency clinician (e.g. RN or Psychologist) consults with the prescriber regarding any irregularities concerns, recommendations, or possible ineffectiveness of medication.
- ✓ The consultation/discussion and related decisions are documented.

SELECT "NOT MET" If any of the following are present:

- ✓ The medication prescriber is NOT informed of significant medication regimen review findings.
- ✓ Facility/agency clinician (e.g. RN or Psychologist) DOES NOT consult with the prescriber regarding any irregularities concerns, recommendations, or possible ineffectiveness of medication.
- ✓ The consultation/discussion and related decisions are NOT documented.

Standard No.	Standard Text	Decision
9e-5	The Individual's service record includes evidence that the use of medication is having a positive effect on his/her behavior or target symptoms.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:
• RN (or other medical professional as necessary)
• Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan

• Program management staff and/or other support team members
• Person supported
• family/advocate
• Program staff

DOCUMENTATION REVIEW:

Mandatory:
• Medication regimen review documentation
• BSP or Medication Monitoring Plan
• Medication Administration Record (MAR)
• Prescriber's orders
• Nursing notes or other clinical notes
• PRN, service or other daily notes used by agency
• BSP implementation documentation and behavior tracking
• IRMA
• RIA

GUIDANCE:

- In order to justify the ongoing use of medication(s) to control challenging behavior or address psychiatric symptoms, the positive effect of the medication(s) prescribed and administered must be demonstrated and documented.
- The required documentation of behavioral occurrences and strategies implemented will assist in the review of the impact of the medication has on the person's behaviors. The evidence of positive effect should be based upon documented objective observations related to the behavior(s) for which the medication is prescribed. E.g. Documentation that states "person doing better" is inadequate to demonstrate medication effectiveness.
- Evidence of positive effect on behavior or symptom might objectively be stated as "SPECIFIC BEHAVIOR presented an average of 2x weekly since SPECIFIC MEDICATION has been incorporated into the Behavior Service Plan 3 months ago, a reduction from the 2x daily before medication use.
- Evidence may also be conveyed by an increase in positive behaviors such as # of instances when individual displays an alternate neutral or positive behavior when prompted by staff upon recognition of early warning sign of likely challenging behavior.

SELECT "MET" If both of the following are evident:

- ✓ Documentation evidences that the medication is having a positive effect on the person's behavior or target psychiatric symptoms.
- ✓ The documentation objectively describes observable, measurable evidence of the medication's effects on target behavior or symptoms.

SELECT "NOT MET" If any of the following are indicated:

• There is no documentation regarding medication effectiveness.
• There is no documentation evidencing that the medication use is resulting in positive effect on the person's behavior or psychiatric symptoms.
• Documentation of medication's effect on the person's target behavior or psychiatric symptoms is subjective or vague.

Standard No.	Standard Text	Decision
9e-6	The Individual's service record includes evidence that the effectiveness of the medication has been re-evaluated at least semi-annually at the program plan review with required service attendees.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed :

• Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
• RN
• Person supported and/or family/advocate
• Program planning team member(s)

DOCUMENTATION REVIEW:

Mandatory:

• Service Plan Review documentation (e.g. meeting minutes, Service or Treatment Plan)
• BSP or Medication Monitoring Plan
• Nursing notes or other clinical notes
• PRN, service or other daily notes used by agency
• BSP implementation documentation and behavior tracking
• IRMA
• RIA

GUIDANCE:

- The effectiveness of medications provided to address challenging behaviors or symptoms of a co-occurring psychiatric diagnosis must be review semi-annually by individual's service planning team in conjunction with the service plan reviews.
- It is required that applicable clinicians participate and/or consult in this review (licensed psychologist, licensed clinical social worker, or Behavior Intervention Specialist, and a health care professional), as well as other involved parties, i.e. the individuals, family/guardian/advocates, service providers
- This team evaluation of the medication as part of the semi-annual service plan review must be documented. The documentation of the review should evidence that the following was considered in the review:
    - Ensuring the medication is at the minimum and most effective dose;
    - Identifying a potential need for a medication with fewer or less intrusive side effects as appropriate;
    - Evaluating the evidence presented to support continuation of the medication at a maintenance level, or
    - Recommending reduction or discontinuation of medication use if clinically indicated and authorized by the prescriber.

SELECT "MET" If the following is evident:

✓ There is documentation that indicates that the program planning team and required clinicians met and consulted at least semi-annually and evaluated the medication effectiveness according to considerations described in Guidance.

SELECT "NOT MET" If any of the following is indicated:

- ✓ There is not documentation to evidence that the program planning team with required clinicians consult at least semiannually regarding the medication effectiveness.
- ✓ There is not documentation to evidence that the team's review includes considerations described in Guidance.
- ✓ Required clinicians did not participate in the review of medication effectiveness.

Standard No.	Standard Text	Decision
9e-7	Medications were administered in accordance with requirements.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed

• RN (or other medical professional as necessary)
• Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
• Program management staff and/or other support team members
• Person supported
• family/advocate
• Program staff

DOCUMENTATION REVIEW:

Mandatory:

• BSP or Medication Monitoring Plan
• Medication Administration Record (MAR)
• Prescriber's orders
• Nursing notes or other clinical notes
• PRN, service or other daily notes used by agency
• BSP implementation documentation and behavior tracking
• IRMA
• RIA

GUIDANCE:

Routine Administration

• Verify that medications to address/modify behavior/symptoms, including those with PRN orders, are administered as prescribed by the physician and per instruction, if any, in the Behavior Support or Medication Monitoring Plan. This includes but is not limited to the following:
o Behavior medications are administered in the dosage, frequency and manner prescribed and described in the plan if applicable;
o PRN medications are administered only according to the methodology and observable behavioral criteria described in the prescription and/or BSP or Medication Monitoring Plan. (9f-2 will review that necessary information is included in the plan.)

• In most instances this standard addresses medication that has been prescribed and is part of a BSP or Monitoring Plan.
Exceptional Circumstances Only:
• Occasionally it will be necessary for the benefit of the individual, to administer medication without a BSP in place. In such cases, per Part 633.16(j)(5)(v) the short term use of medication, without a Behavior Support Plan is allowed if the following conditions are present:
o Per 633.16(j)(5)(v)(b)(1)-(4)
(1) an untoward or unanticipated condition, reaction, symptom, event or situation has occurred which creates exceptional circumstances that, if left untreated could potentially lead to an emergency situation;
(2) the circumstances resulting from the event are expected to last for a time period longer than that which can be considered an emergency (meaning that it is expected that this will situation will require sustained medication administration, rather than an isolated occurrence of emergency administration);
(3) the medication is deemed to be the most effective course of treatment; and
(4) the medication is ordered by a prescriber
o Per 633.16(j)(5)(v)(d)
§ Within five working days of the first administration of the medication or of the admission to such programs of a person with such a pre-existing medication regimen, a person's program planning team, in consultation with a licensed psychologist, licensed clinical social worker, or Behavioral Intervention Specialist, shall conduct a review of the circumstances which necessitated the use of such medication.
§ The program planning team shall determine if it is necessary to develop a behavior support plan to modify or control the behavior or to modify an existing plan of services, or shall establish the criteria for a future decision that a plan will be needed.
§ All determinations shall be documented.
o Per 633.16(j)(5)(v)(e) Without incorporation into a behavior support plan and written informed consent, the administration of the medication shall not continue for more than 30 consecutive days and no more than 45 days in a calendar year. Meaning:
§ The administration of medication can only continue beyond 30 consecutive days or 45 days in calendar year, if incorporated into a BSP and with receipt of written informed consent.
§ The administration of the medication must be discontinued if an associated BSP is not developed and/or written informed consent is not received within the timeframe.

SELECT "MET" IF:

- ✓ Medications part of BSP or Medication Monitoring Plan:
  - o Documentation verifies that medications are administered as prescribed; and
  - o Medications are administered only per the instruction and when observable behavioral criteria for administration is evident.
- ✓ Short term medication administration, not part of a BSP:
  - o Documentation verifies that medications are administered as prescribed; and
  - o Conditions described under “Exceptional Circumstances” above are met.

SELECT "NOT MET" If any of the following are indicated:

- ✓ Medications part of BSP or Medication Monitoring Plan:
  - o Survey findings indicate occurrences of missed administrations and/or erroneous administration.
  - o PRN medication was administered without evidence of the prerequisite behavioral criteria being met.
- ✓ Short term medication administration, not part of a BSP:
  - o Documentation verifies that medications are administered as prescribed; and
  - o Conditions described under “Exceptional Circumstances” above are met.

SECTION 9f: PRN BEHAVIOR MEDICATIONS

Qualifier Question: The individual is either prescribed PRN MEDICATIONS for behavior or co-occurring symptoms AND/OR medications were ordered in an emergency situation.	**Yes**	**No**

Standard No.	Standard Text	Decision
9f-1	When prn medication is prescribed to address behavior or symptoms of a psychiatric disorder, this strategy is included in the Individual's Behavioral Support or Monitoring Plan.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed:
RN (or other medical professional as necessary)
Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
Program management staff and/or other support team members
Person supported
family/advocate
Program staff

DOCUMENTATION REVIEW:

Mandatory:
BSP or Medication Monitoring Plan
Medication Administration Record (MAR)
Prescriber's orders
Nursing notes or other clinical notes
PRN, service or other daily notes used by agency
BSP implementation documentation and behavior tracking
IRMA
RIA

GUIDANCE:

- ✓ The Behavior Support Plan or Medication Monitoring Plan must identify the PRN medication prescribed and the specific behavior(s) and/or symptom(s) addressed.

SELECT "MET" IF:

- ✓ Behavior Support Plan or Medication Monitoring Plan identifies the PRN medication prescribed and the specific behavior(s) and/or symptom(s) addressed.

SELECT "NOT MET" IF:

- ✓ The Behavior Support Plan or Medication Monitoring Plan does not identify the PRN medication prescribed and the specific behavior(s) and/or symptom(s) addressed.

SELECT "NA" IF:

- ✓ The individual is not prescribed prn medication to be administered to address exhibited behaviors.

Standard No.	Standard Text	Decision
9f-2	The Individual's service record includes evidence of the display of the behavior(s) or symptom(s) for which the PRN medication is being prescribed in the past 12 months.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:
RN (or other medical professional as necessary)
Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
Program management staff and/or other support team members
Person supported
family/advocate
Program staff

DOCUMENTATION REVIEW:

Mandatory: BSP or Medication Monitoring Plan
Medication Administration Record (MAR)
Prescriber's orders
Nursing notes or other clinical notes
PRN, service or other daily notes used by agency
BSP implementation documentation and behavior tracking
IRMA
RIA

GUIDANCE:

- There must be documentation of recent history of the display of the behavior for which the prn medication is prescribed (behavior occurring in the last 12 months or since inclusion in the plan). This is to ensure that a prn medication is not being prescribed for challenging behaviors that are not currently problematic.

SELECT "MET" IF:

- ✓ The Individual's record includes a documentation of the behavior(s) or symptom(s) for which the PRN medication is being prescribed in the past 12 months.

SELECT "NOT MET" If any of the following are evident:

- ✓ There is no documentation of the behavior(s) or symptom(s) for which the PRN medication is prescribed.

- ✓ There is a documented history of the behavior(s) or symptom(s) for which the PRN medication is prescribed, however it has been greater than 12 months since any occurrence.

SELECT "NA" IF:

- ✓ The individual is not prescribed prn medication to be administered to address exhibited behaviors.

Standard No.	Standard Text	Decision
9f-3	The Individual's Behavioral Support or Monitoring Plan provides instruction and guidance for administration of the PRN medication, consistent with the prescriber's order.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed :
RN (or other medical professional as necessary)
Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
Program management staff and/or other support team members
Person supported
family/advocate
Program staff

DOCUMENTATION REVIEW:

Mandatory:
BSP or Medication Monitoring Plan
Medication Administration Record (MAR)
Prescriber's orders
Nursing notes or other clinical notes
PRN, service or other daily notes used by agency
BSP implementation documentation and behavior tracking
IRMA
RIA

GUIDANCE:

The BSP or Monitoring plan should state the following information, and consistent with the medication order:

- Conditions under which the "as-needed" medication is to be administered. Conditions may include: the series of intervention/strategies that must be implemented/attempted unsuccessfully before med administration, etc.;
- Nature and degree of the individual's behavior or symptoms, e.g. the specific behaviors and intensity of behavior that must be exhibited warrant administration;
- Prescriber's recommendations regarding proximity to any scheduled medication administration; e.g. assurance of safe timing of medications in conjunction with administration of other medications, if appropriate;
- Expected therapeutic effects regarding the person's behavior, following administration;

- Conditions under which re-administration is allowable including frequency of re-administration

SELECT "MET" If all are present:

✓ The BSP or Medication Monitoring Plan provides clear individualized instruction and guidance for the administration of the prn medication(s) to the individual consistent with the content described above under “Guidance”.

SELECT "NOT MET" If any of the following are present:

✓ The BSP or Medication Monitoring Plan does not provide clear individualized instruction/guidance for the administration of the prn medication(s) to the individual.

✓ The plan does not include the content areas regarding administration of a PRN as described above under “Guidance”.

SELECT "NA" IF:

✓ The individual is not prescribed prn medication to be administered to address exhibited behaviors.

Standard No.	Standard Text	Decision
9f-4	The Individual's Behavioral Support or Monitoring Plan provides instruction and guidance for administration of the PRN medication, consistent with the prescriber’s order.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed :

Ø RN (or other medical professional as necessary)
Ø Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
Ø Program management staff and/or other support team members
Ø Person supported
Ø family/advocate
Ø Program staff

DOCUMENTATION REVIEW:

Mandatory:

Ø BSP or Medication Monitoring Plan
Ø Medication Administration Record (MAR)
Ø Prescriber’s orders
Ø Nursing notes or other clinical notes
Ø PRN, service or other daily notes used by agency
Ø BSP implementation documentation and behavior tracking
Ø IRMA
Ø RIA

GUIDANCE:

- The BSP or Monitoring plan should state the following information, and consistent with the medication order:
- Conditions under which the "as-needed" medication is to be administered. Conditions may include: the series of intervention/strategies that must be implemented/attempted unsuccessfully before med administration, etc.;
- Nature and degree of the individual's behavior or symptoms, e.g. the specific behaviors and intensity of behavior that must be exhibited warrant administration;
- Prescriber's recommendations regarding proximity to any scheduled medication administration; e.g. assurance of safe timing of medications in conjunction with administration of other medications, if appropriate;
- Expected therapeutic effects regarding the person's behavior, following administration;
- Conditions under which re-administration is allowable including frequency of re-administration

SELECT "MET" If all are present:

✓ The BSP or Medication Monitoring Plan provides clear individualized instruction and guidance for the administration of the prn medication(s) to the individual consistent with the content described above under "Guidance".

SELECT "NOT MET" If any of the following are present:

✓ The BSP or Medication Monitoring Plan does not provide clear individualized instruction/guidance for the administration of the prn medication(s) to the individual.

✓ The plan does not include the content areas regarding administration of a PRN as described above under "Guidance".

SELECT "NA" IF:

✓ The individual is not prescribed prn medication to be administered to address exhibited behaviors.

Standard No.	Standard Text	Decision
9f-5	The Individual's service record includes evidence that any adverse or unexpected side effects were reported to the PRN prescriber immediately and the planning team by the next business day.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed:

• RN (or other medical professional as necessary)
• Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
• Program management staff and/or other support team members
• Person supported

• family/advocate
• Program staff

DOCUMENTATION REVIEW:
Mandatory: Medication regimen review documentation,
BSP or Medication Monitoring Plan
• Medication Administration Record (MAR)
• Prescriber's orders
• Nursing notes or other clinical notes
• PRN, service or other daily notes used by agency
• BSP implementation documentation and behavior tracking
• IRMA
• RIA

GUIDANCE:

- Results/Effects observed after prn medication administration that are substantively different from the intended effect, and any adverse side effects, must be reported to:
    - the prescriber immediately, and
    - the person's program planning team no later than the next business day.
- The plan and/or medication administration instructions should include this reporting instruction and how this notification should occur.
- Adverse or unexpected effects reported, must be described in clear, behavioral terms. I.e. Instead of vaguely stating the person "wasn't himself," after taking the PRN medication, the communication should describe specific observations e.g. The person "began to speak rapidly", "paced and could not concentrate for more than a minute to any one task", etc.

SELECT "MET" If all are evident:

- ✓ Documentation in the service record shows that the adverse/unexpected side effects of the PRN medication were immediately reported to the prescriber immediately;
- ✓ Documentation in the service record shows that the adverse/unexpected side effects of the PRN medication were reported to the program planning team by the next business day; and recorded as directed in the plan.
- ✓ Documentation provides clear information regarding the observed adverse effects.

SELECT "NOT MET" If any of the following are indicated:

- ✓ Adverse or unexpected effects resulting from PRN medication administration were not reported to the prescriber and/or the program planning team.
- ✓ Adverse or unexpected effects resulting from PRN medication administration were not reported within required time frames.
- ✓ Documentation/Description of the adverse effects of the PRN medication is not clearly documented and non-specific regarding the effects observed.

SELECT "NA" IF:

- ✓ There have been no adverse or unexpected side effects experienced by the individual in relation to taking the prn medication.

Standard No.	Standard Text	Decision
9f-6	Use of PRN Medications on more than four (4) separate days in a 14-day period resulted in consideration of a recommendation for incorporation into a regular drug regimen.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed :

- RN (or other medical professional as necessary)
- Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
- Program management staff and/or other support team members
- Person supported
- family/advocate
- Program staff

DOCUMENTATION REVIEW:

Mandatory:

- Medication regimen review documentation
- BSP or Medication Monitoring Plan
- Medication Administration Record (MAR)
- Prescriber's orders
- Nursing notes or other clinical notes
- PRN, service or other daily notes used by agency
- BSP implementation documentation and behavior tracking
- IRMA
- RIA

GUIDANCE:

- If the use of the PRN medication has been necessary frequently as described in the standard statement, there must be documentation demonstrating that this was brought to the attention of the clinician responsible for the BSP or Monitoring plan and the health care professional.
- The parties involved must review/consider the need to regularly incorporate use of the medication into the routine medication regimen vs. continuation of the medication as a PRN. This review and decisions must be documented in the person's record, and recommendation made to the prescriber.
- For purposes of this regulation, one day equals a 24 hour period.

SELECT "MET" If PRN medication was administered to the individual on more than four separate days in a 14-day period and both are evident:

- ✓ The program planning team and required clinicians consulted to assess the appropriateness of continued PRN administration versus inclusion as a part of the regular medication regimen.
- ✓ The outcome of this consult and actions taken are recorded.

SELECT "NOT MET" If PRN medication was administered to the individual on more than four separate days in a 14-day period and any of the following are indicated:

- ✓ The program planning team and required clinicians did not consult to review/consider regular use of the medication.
- ✓ There is no documentation to evidence the program planning team and required clinicians consulted to review/consider regular use of the medication.
- ✓ The PRN medication was incorporated into the regular drug regimen but there was no evidence of team discussion and decision making.
  The team and clinicians consulted but there is no evidence of decisions made and actions taken.

SELECT "NA" IF :

- ✓ The PRN medication has not been used, by the individual, on more than four separate days in a 14-day period.

Standard No.	Standard Text	Decision
9f-7	Lack of use of a PRN medication during a six-month period resulted in a review of the BSP and a recommendation to the prescriber.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed:

• RN (or other medical professional as necessary)
• Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
• Program management staff and/or other support team members
• Person supported
• family/advocate
• Program staff

DOCUMENTATION REVIEW :

Mandatory:

• Medication regimen review documentation
• BSP or Medication Monitoring Plan
• Medication Administration Record (MAR)
• Prescriber's orders
• Nursing notes or other clinical notes
• PRN, service or other daily notes used by agency
• BSP implementation documentation and behavior tracking
• IRMA
• RIA

GUIDANCE:

- If it has not been necessary to administer a PRN medication prescribed for behaviors a review of its continued need should be conducted.

- The review must be completed by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist.
- The review should include a review of the individual's behaviors and the written plan, and result in a recommendation to the prescriber regarding the appropriateness of continuing the as-needed medication as part of the plan. The review and decision made should be documented in the person's service record. If the order is continued, a clear justification for continuance must be included in the documentation of the review.

SELECT "MET" If there has been no need to use the PRN medication for behavior in the past six months and the following are evident:

- ✓ The program planning team, in consultation with the required clinicians, reviewed the BSP or monitoring plan, and made a recommendation to the prescriber as to the appropriateness of continuing to include the PRN med in the plan.
- ✓ The review and resulting recommendation is documented in the person's record.
- ✓ When applicable, if the recommendation is to continue to include use of the PRN medication in the BSP or Medication Monitoring Plan, justification is documented.

SELECT "NOT MET" If there has been no need to use the PRN medication for behavior in the past six months any of the following are present:

- ✓ No consultation/review of the need for continuation of the PRN occurred.
- ✓ A consultation/review of the need for continuation of the PRN occurred but did not include the involved clinicians.
- ✓ The review occurred but was not documented.
- ✓ The review occurred but there is no evidence that the provider was informed of the recommendation.
- ✓ The recommendation was to continue the use of the PRN medication, but there is no documented justification.

SELECT "NA" IF:

- ✓ There has been no six-month period without use of the PRN medication to address the individual's behavior/symptoms.

Standard No.	Standard Text	Decision
9f-8	Effectiveness of the medication ordered in an emergency is documented in the Individual's record.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed :

- RN (or other medical professional as necessary)
- Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
- Program management staff and/or other support team members
- Person supported
- Family/Advocate
- Program staff

DOCUMENTATION REVIEW:

Mandatory: Medication regimen review documentation
• BSP or Medication Monitoring Plan
• Medication Administration Record (MAR)
• Prescriber's orders
• Nursing notes or other clinical notes
• PRN, service or other daily notes used by agency
• BSP implementation documentation and behavior tracking
• IRMA
• RIA

GUIDANCE:

- When medication is used in an emergency per 633.16(j)(5)(iv)(a) the medication order and the documentation describing its effect must be entered into the individual's record.
- An emergency medication order is different from a standing PRN medication order that has been included in the BSP.
- 633.16(j)(5)(iv)(a) states: Medication may be administered in an emergency, without informed consent, with the express intent of controlling a person's challenging behavior or acute symptoms of a diagnosed co-occurring psychiatric condition when:
- the person's behavior constitutes an immediate risk to the health or safety of the person or others; or
- in a physician's judgment, an emergency exists that creates an immediate need for the administration of such medication, and an attempt to secure informed consent would result in a delay which would increase the risk to the health or safety of the person or others.

SELECT "MET" IF:

✓ The person's record documents all of the following: the emergency use of the medication, the prescriber's order for the medication, and a record of the effectiveness of the medication.

SELECT "NOT MET" IF:

✓ There is no documentation of one or more of the following: the emergency use of the medication, the prescriber's order for it or a record of the effectiveness of the medication.

SELECT "NA" IF:

✓ There has been no use of an emergency medication order.

Standard No.	Standard Text	Decision
9f-9	Emergency use of medication in more than 4 instances in a 14-day period resulted in a comprehensive review.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed :

• RN (or other medical professional as necessary)
• Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
• Program management staff and/or other support team members
• Person supported
• Family/Advocate
• Program staff

DOCUMENTATION REVIEW:

Mandatory: Medication regimen review documentation

• BSP or Medication Monitoring Plan
• Medication Administration Record (MAR)
• Prescriber's orders
• Nursing notes or other clinical notes
• PRN, service or other daily notes used by agency
• BSP implementation documentation and behavior tracking
• IRMA
• RIA

GUIDANCE:

- The emergency use of medication to control challenging behavior or acute symptoms of a co-occurring diagnosed psychiatric disorder more than four (4) times in a 14-day period requires a comprehensive review by the program planning team in consultation with the licensed psychologist, a licensed clinical social worker or behavioral intervention specialist.
- The review must occur within three business days of the fifth medication administration.
- The review must be documented.

SELECT "MET" IF emergency use of medication occurred on more than four separate days in a 14 day period and both of the following are evident:

- ✓ The program planning team and required clinicians consulted to assess the appropriateness of medication use and consider inclusion as a part of the regular medication regimen and written plan.
- ✓ The outcome of this consult and actions taken are recorded.

SELECT "NOT MET" IF emergency use of medication occurred on more than four separate days in a 14 day period and any of the following is evident:

- ✓ The program planning team and required clinicians did not consult to review/consider regular use of the medication.

- ✓ There is no documentation to evidence the program planning team and required clinicians consulted to review/consider regular use of the medication.
- ✓ The medication used on an emergency basis was incorporated into the regular drug regimen but there was no evidence of team discussion and decision making.
- ✓ The team and clinicians consulted but there is no evidence of decisions made and actions taken.

SELECT "NA" IF:

- ✓ There was no use of emergency medication in more than four instances in a 14-day period.

Standard No.	Standard Text	Decision
9f-10	Use of PRN medications in conjunction with a restrictive physical intervention technique were reported electronically to OPWDD.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed:

- RN (or other medical professional as necessary)
- Psychologist/BIS or other responsible for writing and supervision of the BSP or medication monitoring plan
- Program management staff and/or other support team members
- Person supported
- Family/Advocate
- Program staff

DOCUMENTATION REVIEW:

Mandatory:

- Medication regimen review documentation
- BSP or Medication Monitoring Plan
- Medication Administration Record (MAR)
- Prescriber's orders
- Nursing notes or other clinical notes
- PRN, service or other daily notes used by agency
- BSP implementation documentation and behavior tracking
- IRMA
- RIA

GUIDANCE:

- When administered in conjunction with a physical intervention, RIA entry IS required for:
- PRN medication administration.
- Emergency medication administration.
- RIA requests information for use of "as needed" (PRN) medication if necessary and related to the same behavioral event as the restrictive physical interventions. Implementation of both actions must be recorded in RIA.
- Review the individual's service implementation and RIA to validate that the information in RIA is accurate and complete.

- RIA entry is NOT required for prn medication administration that is part of plan, when administered independent of a physical intervention.

SELECT "MET" If either of the following is present:

✓ The use of PRN medication, in conjunction with a restrictive physical intervention was reported electronically in RIA.

SELECT "NOT MET" If any of the following are present:

✓ The use of PRN medication, in conjunction with a restrictive physical intervention was not reported electronically in RIA.

SELECT "NA" IF:

✓ PRN behavior medication was not administered in conjunction with implementation of a restrictive physical intervention.

SECTION 9g: MEDICATION MONITORING PLANS ONLY

Qualifier Question: The individual has a monitoring plan only, as medications are prescribed to treat only the co-occurring diagnosed psychiatric disorders as diagnosed by a physician, psychiatrist, or psychiatric nurse practitioner.	**Yes**	**No**

Standard No.	Standard Text	Decision
9g-1	The Individual's record identifies the symptoms he/she exhibits and each co-occurring psychiatric disorder diagnosis.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- RN (or other medical professional as necessary)
- Psychologist/BIS or other responsible for writing and supervision of the medication monitoring plan
- Program management staff and/or other support team members
- Person supported
- Family/Advocate
- Program staff

DOCUMENTATION REVIEW:

Mandatory:

- Medication regimen review documentation
- Medication Monitoring Plan
- Medication Administration Record (MAR)
- Prescriber's orders
- Nursing notes or other clinical notes
- PRN, service or other daily notes used by agency
- Medication Monitoring Plan implementation documentation and behavior tracking
- IRMA

GUIDANCE :

- Verify that there is documentation of the behavioral symptom(s) of each co-occurring psychiatric disorder for which medication(s) are prescribed.
- This information may be found in documentation of the prescribing physician's evaluation/medical consult or other documentation of this determination by the medical professional providing or knowledgeable of the diagnosis and prescribed medications.

SELECT "MET" IF:

- ✓ The person's record includes a description of the symptoms of the diagnosed co-occurring psychiatric disorders for which each behavior medication is prescribed.

SELECT "NOT MET" If any of the following are indicated:

- ✓ There is no record of the diagnoses, or description of the symptoms of the co-occurring psychiatric disorder(s) associated with the medication(s) prescribed;
- ✓ The diagnosis of a co-existing psychiatric disorder was made by someone other than a physician, psychiatrist or a psychiatric nurse practitioner.

Standard No.	Standard Text	Decision
9g-2	The Individual's Monitoring Plan clearly identifies target symptoms associated with each medication prescribed for a psychiatric disorder.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed: RN (or other medical professional as necessary)
• Psychologist/BIS or other responsible for writing and supervision of the medication monitoring plan
• Program management staff and/or other support team members
• Person supported
• family/advocate
• Program staff

DOCUMENTATION REVIEW:

Mandatory: Medication regimen review documentation
• Medication Monitoring Plan
• Medication Administration Record (MAR)
• Prescriber's orders
• Nursing notes or other clinical notes
• PRN, service or other daily notes used by agency
• Medication Monitoring Plan implementation documentation and behavior tracking
• IRMA

GUIDANCE:

- In order to monitor the effectiveness of the medication prescribed and administered due to symptoms/behaviors of a co-occurring psychiatric disorder, the target symptoms must be clearly identified and operationally defined for the individual, so that reliable data collection can occur, to assess the effectiveness of the medications. .
  If more than one medicine is prescribed to treat the co-existing psychiatric disorder, then the target symptoms for each medicine need to be described.

SELECT "MET" If the following is evident:

- ✓ The target symptoms of the diagnosed co-existing psychiatric disorder for which medication is prescribed, are clearly described in the monitoring plan in behavioral/observable terms.

SELECT "NOT MET" If any of the following are indicated:

- ✓ Target symptoms of the diagnosed co-existing psychiatric disorder for which medication is prescribed are not identified in the monitoring plan;
- ✓ The target symptoms are vague and not individualized to the person
- ✓ There is no psychiatric diagnosis associated with the symptoms/behaviors identified in the Medication Monitoring Plan (therefore the plan should be a BSP).

Standard No.	Standard Text	Decision
9g-3	The Individual's Monitoring Plan includes the method to measure and document symptom reduction and functional improvement.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

• RN (or other medical professional as necessary)
• Psychologist/BIS or other responsible for writing and supervision of the medication monitoring plan
• Program management staff and/or other support team members
• Person supported
• Family/Advocate
• Program staff

DOCUMENTATION REVIEW:

Mandatory:

• Medication regimen review documentation
• Medication Monitoring Plan
• Medication Administration Record (MAR)
• Prescriber's orders
• Nursing notes or other clinical notes
• PRN, service or other daily notes used by agency
• Medication Monitoring Plan implementation documentation and behavior tracking
• IRMA

GUIDANCE:

- The monitoring plan must describe the documentation to be provided by staff regarding symptoms and functional behaviors. The instruction must be specific and objective so that the evaluation of the plan and effectiveness of the medication to address the symptoms/behaviors associated with the co-occurring psychiatric diagnosis is meaningful.
- In addition to what to document, the plan must also describe, where, how and how often to document.

- The plan should include collection of both specific positive/functional behavior and targeted symptoms as both are important for purposes of review of strategies in the plan.

SELECT "MET" IF:

✓ The medication monitoring plan clearly describes the objective information to document regarding the individual's targeted symptoms/behaviors and desired functional behaviors.

SELECT "MET" If any of the following are present:

✓ The medication monitoring plan does not provide any instruction regarding documentation of observed behaviors/symptoms or functional behaviors exhibited by the individual.

✓ The medication monitoring plan does not clearly describe the objective information to document regarding the targeted symptoms/behaviors and desired functional behaviors.

Standard No.	Standard Text	Decision
9g-4	The Individual's Monitoring Plan includes alternative interventions (other than medication).	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:
• RN (or other medical professional as necessary)
• Psychologist/BIS or other responsible for writing and supervision of the medication monitoring plan
• Program management staff and/or other support team members
• Person supported
• Family/Advocate
• Program staff

DOCUMENTATION REVIEW:

Mandatory:
• Medication regimen review documentation
• Medication Monitoring Plan
• Medication Administration Record (MAR)
• Prescriber's orders
• Nursing notes or other clinical notes
• PRN, service or other daily notes used by agency
• Medication Monitoring Plan implementation documentation and behavior tracking
• IRMA

GUIDANCE:

- In addition to medication, the Medication Monitoring Plan must include other instruction to implement other interventions intended to reduce/eliminate the challenging behaviors or target symptoms. Supportive, re-directive and alternative interventions and activities to foster functional behavior must be described in the plan.

SELECT "MET" If the following applicable statements are evident:

✓ The Medication Monitoring Plan includes direction for alternative and supportive interventions to address, alter or prevent the behaviors and/or symptoms for which the medications are prescribed.

SELECT "NOT MET" If any of the following are present:

✓ The Medication Monitoring Plan does not include direction for supportive, re-directive and alternative interventions designed to reduce or eliminate the challenging behaviors or target symptoms included in the BSP or Medication Monitoring Plan.

Standard No.	Standard Text	Decision
9g-5	The individual's Monitoring Plan is developed by a qualified clinician.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

• Psychologist/BIS/LCSW/NP responsible for writing and supervision of the medication monitoring plan
• Program management staff and/or other support team members
• Program staff

DOCUMENTATION REVIEW:

Mandatory:

• Medication regimen review documentation
• Medication Monitoring Plan
• Prescriber's orders
• Medication Monitoring Plan implementation documentation and behavior tracking

GUIDANCE:

- A Monitoring plan must only be developed by a licensed psychologist, licensed clinical social worker, behavioral intervention specialist (BIS) or licensed psychiatric nurse practitioner.

SELECT "MET" IF:

✓ The monitoring plan was written by a licensed psychologist, licensed clinical social worker, behavioral intervention specialist (BIS) or licensed psychiatric nurse practitioner.

SELECT "NOT MET" If any of the following are present:

✓ The monitoring plan was written by someone other than a psychologist, licensed clinical social worker, behavioral intervention specialist (BIS) or licensed psychiatric nurse practitioner.

Standard No.	Standard Text	Decision
9g-6	The effectiveness of the individual's Monitoring Plan in improving the quality of his/her life is reviewed as identified in the plan.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed:

- RN (or other medical professional as necessary)
- Psychologist/BIS or other responsible for writing and supervision of the medication monitoring plan
- Program management staff and/or other support team members
- Person supported
- Family/Advocate
- Program staff

DOCUMENTATION REVIEW:

Mandatory:

- Medication regimen review documentation
- Medication Monitoring Plan
- Medication Administration Record (MAR)
- Prescriber's orders
- Nursing notes or other clinical notes
- PRN, service or other daily notes used by agency
- Medication Monitoring Plan implementation documentation and behavior tracking
- IRMA

GUIDANCE:

- At least on a semi-annual basis, or more often, if indicated, the program planning team in consult with the licensed psychologist, licensed psychiatric nurse practitioner, licensed clinical social worker, or a behavioral intervention specialist who wrote and/or is responsible for monitoring the plan must review and discuss the findings from the documentation/date data collected regarding the individual's display of symptoms/behaviors and functional behaviors, in order to evaluate the effectiveness of the medication/medication monitoring plan, and whether the medication administration and strategies are improving the person's quality of life. The monitoring plan must describe how the review is to occur and with what frequency.

SELECT "MET" If the following is evident:

- ✓ There is documentation that indicates that the program planning team and required clinicians met and consulted at least semi-annually and using objective documented information, evaluated the medication monitoring plan's effectiveness in improving quality of life,

SELECT "NOT MET" If any of the following is indicated:

- ✓ There is not documentation to evidence that the program planning team and required clinicians consult at least semiannually to evaluate the medication monitoring plan effectiveness.
- ✓ There is not documentation to evidence that the team's review includes consideration of objective documented information.
- ✓ Required clinicians did not participate in the review of the medication monitoring plan.

SECTION 10a: INCIDENT MANAGEMENT: REPORTING

Standard No.	Standard Text	Decision
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	**Met/Not Met/NA**

Guidance

INTERVIEW:

Mandatory: Direct Support Staff, individuals receiving services, Program Management, FCP

As Needed: Family members, Agency Management Staff, MSC or program coordinator

DOCUMENTATION REVIEW:

- Mandatory: Communication logs, accident reports, ISP's, habilitation plans, daily notes, service notes, IRMA Review
- As Needed: Medical appointment records

GUIDANCE:

- Answer for the service as a whole.
- Survey staff will review documentation related to the service provided for the individual (e.g. ISP, habilitation plan, treatment plan, service notes, daily notes, health care documentation, case notes, etc.) as the documentation may also provide information regarding possible incidents.
- Speak with staff, individuals receiving services, family members (if necessary) regarding significant events involving individuals. Ask if there have been any recent significant events, injuries, ER visits, etc. Follow up on any information provided by staff to assess whether it should have been reported as an incident or notable occurrence and whether it was or was not.

SELECT "MET" IF:

✓ All events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.

SELECT "NOT MET" IF:

✓ Events involving the individual that meet the definition of reportable incident or notable occurrence have NOT been reported.

SELECT "NA" IF:

✓ There were no events meeting the definition of a reportable incident or notable occurrence involving the individual.

Standard No.	Standard Text	Decision
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	**Met/Not Met/NA**

Guidance

INTERVIEW:

Mandatory: Direct Support Staff, individuals receiving services, FCP

As Needed: Family members, MSC, Clinicians

DOCUMENTATION REVIEW:

- Mandatory: Accident reports, ISP, habilitation plans, service notes, daily notes, case notes, IRMA Review.
- As Needed: Medical appointment records

GUIDANCE:

- This applies to the service as a whole.
- This applies to events occurring not under the auspices of the agency.
- Survey staff will review documentation specific to the service for the individual (e.g. ISP, Habilitation Plans, service notes, daily notes, case notes, health care documentation, etc.) as this documentation may also provide information regarding possible incidents.
- Speak with staff, individuals receiving services, FCPs, family members (if necessary) regarding significant events involving individuals. Ask if there have been any recent significant events, injuries, ER visits, etc. Follow up on any information provided by staff to assess whether it should have been reported as an incident or notable occurrence and whether it was or was not.

SELECT "MET" IF:

- ✓ All events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.

SELECT "NOT MET" IF:

- ✓ Events and situations as defined in Part 625 involving the individual that are required to be reported have NOT been reported to OPWDD.

SELECT "NA" IF:

- ✓ There were no events defined in 625 as required to be reported, involving the individual.

SECTION 10b: INCIDENT MANAGEMENT: Reported in IRMA

Standard No.	Standard Text	Decision
10b-1	Immediate care and treatment identified and needed was provided to the individual.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed: Direct Support Staff, Individual, Program RN, Family Members, Agency Management, MSC, FCP

DOCUMENTATION REVIEW:
- Mandatory: IRMA-Incident Review
- As Needed: Medical appointment records, daily notes, case notes, monthly summaries,

GUIDANCE:
- Answer for each incident reviewed.
- The IRMA reporting of the event should document initial treatment and care provided to the person (e.g.) medical assessment and care, support, supervision, counseling, alternate activity or space, separation from person, etc.).
- Verify implementation through documentation review and interview.
- Ensure the care provided was adequate to the situation reported.
- Ensure the care and treatment was provided timely.
- The agency must take the necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care.

SELECT "MET" IF:
- ✓ Immediate care and treatment identified was adequate to the situation reported and provided timely to the individual.

SELECT "NOT MET" IF either of the following are evident:
- ✓ Immediate care and treatment identified was inadequate or not provided to the individual.
- ✓ Immediate care and treatment identified was not provided timely to the individual.

Standard No.	Standard Text	Decision
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed: Direct Support Staff, Management staff, Individual, Family Members, MSC, FCP

DOCUMENTATION REVIEW:
• Mandatory: Incident review minutes, IRMA Review
• As Needed: daily notes, case notes

GUIDANCE:

- Answer for each incident reviewed.
- The IRMA reporting of the event should document initial actions taken to protect the individual(s). Verify that this was implemented through documentation review and interview. Ensure that the actions appear to be adequate.
- Part 633.9 identifies specific actions a provider can take, based on its evaluation of a situation, to protect individuals from harm and abuse is reported. These actions include:
  - Removal, reassignment, relocation or suspension of the alleged abuser, consistent with appropriate collective bargaining agreements and applicable provisions of the Civil Service Law or other applicable laws or regulations.
  - Increasing the degree of supervision of the alleged abuser.
  - Provision of counseling to the alleged abuser.
  - Provision of increased training to the alleged abuser and staff pertinent to the prevention and remediation of abuse.
  - Increasing supervision and providing additional support to restore a secure environment to the affected staff and persons in the facility.
  - Removal or relocation of the person, consistent with his or her developmental needs (or any court order applicable to the person) when it is determined that there is a risk to such individual if he or she continues to remain in the program.
  - Provision of counseling to the individual and to other persons in the facility.
- OPWDD requires that every provider has written procedures for implementing protective actions allowed by Part 633.9, including evaluation of the seriousness of the situation, and that those procedures are known to agency staff. For example, the agency should define, in written procedures, what is meant by “increased supervision” and ensure that its managers are aware of the procedures to be implemented when “increased supervision” is required. Note-agency policies and procedures will be reviewed in the agency review.
- OPWDD requires that providers of services must consider the seriousness of an allegation when implementing immediate protective actions. If a staff person is suspected of abuse, neglect, or mistreatment which poses a serious and immediate threat to an individual’s health and safety, the staff person may not continue to work in direct contact with individuals with developmental disabilities until investigation is completed.

SELECT " MET" IF either of the following are evident:

- ✓ Initial measures to protect the individual from harm and abuse, were implemented immediately.
- ✓ Initial measures to protect the individual from harm and abuse were appropriate to the situation reported.

SELECT "NOT MET" IF either of the following are evident:

- ✓ Initial measures to protect the individual from harm and abuse, were NOT implemented immediately.
- ✓ Initial measures to protect the individual from harm and abuse were NOT appropriate to the situation reported.

Standard No.	Standard Text	Decision
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed: Agency incident management staff

DOCUMENTATION REVIEW:

- Mandatory: IRMA Review, IRC Minutes, Incident Report
- As Needed: Supporting documents.

GUIDANCE:

- Answer for each incident reviewed.
- Review investigation reports and investigative record when available as entered into IRMA. Request and review additional documentation from the provider agency for events that do not require record upload and/or entry into IRMA (e.g. MNOs).
- Investigations may vary in their scope and intensity depending on the event, location and circumstances. In all cases, investigation reports/records should demonstrate every effort to determine what happened. In some cases, the investigation may need to determine whether the event actually occurred. Investigative reports should include specifics such as what happened, when it happened, who was involved; who was present, where the situation occurred, and whether the event is indicative of abuse, neglect or mistreatment. Staffing levels, environmental factors, immediate response/protective actions and/or care provided, and relevant information from the individual's program plan and/or health care plan should also be considered. Based on analysis of that information the investigation report should provide an explanation of why the event happened by identifying contributing factors and probable causes. Based on the identified causes and contributing factors appropriate recommendations should be made to address the event and to prevent similar events from occurring in the future.
- The required form and format of the investigation should result in the inclusion of the following types of information as appropriate to the event:
  - Appropriate medical examination of the injured person.
  - Witnesses to the incident shall be identified and interviewed.
  - Interviews should be conducted separately by qualified, objective parties.
  - Pertinent information shall be reviewed (e.g., records, photos, observations of incident scene, expert assessments).
  - Physical evidence, if any shall be identified and appropriate steps taken to safeguard and preserve it.
- The following are required for investigations of reportable incidents and serious notable incidents, inclusive of information in the form 149 (dated 4/30/15).
  - Identifying data, such as the name(s) of person(s) receiving services involved in the incident or occurrence; the date the incident or occurrence was reported and/or discovered; the classification of the incident; and the incident/occurrence number. For incidents/occurrences entered into IRMA this includes the master incident number assigned by IRMA;
  - A description of the incident or notable occurrence

- Immediate protections provided to person(s) receiving services;
- Investigatory question(s);
- A description of the investigative process and specific evidence obtained;
- A summary of the evidence obtained in the investigation;
- Conclusions, including findings (substantiated or unsubstantiated) in the case of a report of abuse or neglect; and
- Recommendations, including recommendations for remedial actions.
- Review of the investigation should consider the following:
- Were the circumstances of the event (e.g. timeframe, place, people present, activity, etc.) established?
- Did the investigation include a review of immediate care provided to individuals?
- Was information gathered (e.g., statements and/or interviews) from witnesses and all other relevant parties? (These parties may include, but are not limited to, clinical service providers who can provide relevant information, but who did not witness the incident.)
- Were relevant medical and clinical assessments conducted prior or subsequent to the incident and was relevant documentation reviewed?
- Was other documentation reviewed based on the nature of the event? (These records may include staff communication logs, staff schedules, service plans, IPOPs, BSPs and behavior documentation, prn notes, medication records, training records, etc.)
- Were conclusions made based on the findings
- Were recommendations made to address causes of the incident and prevention of similar incident?

- Paragraph 624.5(h)(4)(i) requires that the investigative report must be in the form and format specified by OPWDD. The “Form OPWDD 149” (dated 4/30/15) is the required form and format specified by OPWDD. The form must be completed for all investigations that a provider agency is required to complete, including reportable incidents and all notable occurrences.

SELECT "MET" IF:

- ✓ The investigation of Reportable Incidents and Notable Occurrences involving the individual is documented and generally thorough as noted in the guidance. Any information or detail omitted is likely to have no impact on the conclusion, protective actions, and recommendations resulting from the investigation.

SELECT "NOT MET" IF:

- ✓ The investigation of Reportable Incidents and Notable Occurrences involving the individual is not thorough and/or not properly documented as indicated in the guidance. Relevant information was not reviewed or pursued in the investigation process, and/or not documented as part of the investigation/investigation summary.

Standard No.	Standard Text	Decision
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed: Agency incident management staff

DOCUMENTATION REVIEW:
- Mandatory: IRMA Review, IRC Minutes, Incident Report
- As Needed: Supporting documents

GUIDANCE:
- Answer for each incident reviewed.
- When the agency is responsible for the investigation:
  - The investigation should be completed no later than 30 days after the incident or serious notable occurrence is reported to the Justice Center and/or OPWDD
- In the case of a minor notable occurrence, the investigation should be completed no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA.
- An investigation shall be considered complete upon completion of the investigative report.
- Completion of a specific investigation beyond 30 days may occur if there is adequate justification to do so. The agency must document its justification for the extension. Examples include request by outside entity (e.g. police) to delay or circumstances beyond an agency's control
- Note: The agency should be considered in compliance if the investigation has been completed within the required time frame, but is awaiting the Letter of Determination from the Justice Center. (This status information should be noted in the agency's 30 day updates.)
- Per 624.5(e)(1)(iii) the investigative report should be entered into IRMA within 5 working days of report availability

SELECT "MET" IF both of the following are evident:
- ✓ The investigation is completed and documented within 30 days as described in guidance.
- ✓ There is documentation of an acceptable justification for extension for an investigation not completed within 30 days.

SELECT "NOT MET" IF:
- ✓ The investigation is NOT completed and documented within 30 days and there is not acceptable justification for extension.

Standard No.	Standard Text	Decision
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	**Met/Not Met/NA**

Guidance

INTERVIEW:
As Needed: Individual, Management, Direct support staff, Clinical Staff, Family, RN, MSC

DOCUMENTATION REVIEW:
- Mandatory: IRMA Review (e.g. OPWDD form 161), IRC minutes
- As Needed: Supporting documentation (e.g. staff training, Medical consults, assessments, written plans, policies, schedules, agency wide communication

OBSERVATION:
As Needed (if site based): Physical Plant for changes, equipment, staff supervision of individuals

GUIDANCE:
- Answer for each incident reviewed.
- This requirement is meant to address verification of the implementation of actions that are recommended by non-Justice Center sources: i.e. the agency investigator; OPWDD Office of Investigations and Internal Affairs (OIIA); and/or Agency Incident Review Committee. Implementation of Justice Center recommendations are reviewed in #9 below.
- Actions taken or to be taken to address issues identified in investigation of an incident/occurrence and/or prevent similar events are required to be entered in IRMA. Review what is documented and verify that the actions related to the person, the site (if appropriate) or the service were implemented.
- The corrective actions may be identified by: the agency investigator; OPWDD Office of Investigations and Internal Affairs (OIIA); Agency Incident Review Committee or the Justice Center investigation or letter of determination (if JC is the source, review under #9 below). These corrective and/or preventive recommendations and or actions will be documented in the investigative report, IRC minutes or may be identified as a separate plan for prevention/correction/remediation, e.g. Corrective Action Plan (CAP). The actions may include site and support staff training, staffing issues, supervision and oversight, service plan clarifications, revision of the ISP/program plan related to changes in the services, supports or care; etc.
    - REGARDING CAPs: For reports of abuse/neglect a plan for prevention/remediation must be developed within 60 days of the date of the Letter of Determination from the Justice Center. The plan must include projected dates of implementation and the agency staff responsible to monitor the implementation and efficacy or the actions. As of 01/01/15 this plan is referred to as the Corrective Action Plan (CAP). Agencies are required to upload/enter CAP information for reportable incidents of abuse/neglect occurring after January 1, 2015. IRMA will enable this upload effective January 15, 2015.
- In IRMA you will be able to review:
    - The completed OPWDD 161-Corrective Action Plan Submission Form. The OPWDD 161 will indicate all corrective actions recommended and the agency response/actions to be taken in response to each recommendation.
    - Documentation evidencing the implementation of each recommendation (e.g. staff training sign-in sheet, revised service plan, communication memo, revised policy and procedure, equipment purchase, etc.)

- On Site Verification:
  - While documentation of actions taken will be available in IRMA, DQI surveyors may need to complete additional activities on survey to verify that actions required were implemented and effective, (e.g. verify that staff understand their responsibilities related to training, new procedures, new service plan result in improved supervision or better strategies to address behaviors; verify that equipment has been provided and helpful, verify that medical interventions are provided, etc.) Take action to verify those actions related to the person, the site (if applicable) and or the service. This should be verifiable through observation, interview and additional (if necessary) documentation review.
- Some systemic agency corrective actions that would not be verifiable in the site or service level operations will be reviewed during a separate process during the agency review.

SELECT "MET" IF any of the following are evident:

- ✓ There is evidence that actions/measures recommended to prevent similar events were implemented.
- ✓ There is evidence that actions/measures recommended to prevent similar events are in process and sufficient to prevent similar events.
- ✓ If any action/measure recommended to prevent similar events is not implemented, there is documentation to evidence that this decision is reasoned and does not put the person(s) at risk.

SELECT "NOT MET" IF any of the following are evident:

- ✓ There is NOT evidence that actions/measures recommended to prevent similar events were implemented.
- ✓ There is NOT evidence that actions/measures recommended to prevent similar events are in process and sufficient to prevent similar events.
- ✓ If the agency decided NOT to implement an action/measure recommended to prevent similar events, there is NOT documentation to evidence that this decision is reasoned and does not put the person(s) at risk.

SELECT "NA" IF:

- ✓ No recommendations to prevent similar events were made and none appear to be necessary.

Standard No.	Standard Text	Decision
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	**Met/Not Met/NA**

Guidance

INTERVIEW:
As Needed: Individual, Management, Direct support staff, Clinical Staff, Family, RN, MSC, FCP

DOCUMENTATION REVIEW:
Mandatory: IRMA Review (e.g. OPWDD form 161), IRC minutes
As Needed: Supporting documentation (e.g. staff training, Medical consults, assessments, written plans, policies, schedules, agency wide communication

OBSERVATION:
As Needed: Physical Plant for changes, equipment, staff supervision of individuals

GUIDANCE:
IRMA information will include OPWDD recommendations for an event. See BPC Preparation Instructions in general guidance.
Review the information within IRMA and take action to verify those actions related to the person, the site and or the service. These may include site and support staff training, staffing issues, supervision and oversight, service plan clarifications, etc. This should be verifiable through documentation review, observation (if site-based) and interview dependent on the actions needed.
Systemic agency corrections will be reviewed during a separate process.

SELECT "MET" IF:
- ✓ Actions reported in IRMA in response to recommendations were implemented as reported.

SELECT "NOT MET" IF:
- ✓ Actions reported in IRMA in response to recommendations were not implemented as reported.

SELECT "NA" IF:
- ✓ No recommendations resulted from the investigation and incident review and none appear to be necessary.

Standard No.	Standard Text	Decision
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	**Met/Not Met/NA**

Guidance

INTERVIEW:
As Needed: Individual, Agency Management, Direct support staff, Family, RN, Clinical staff, MSC

DOCUMENTATION REVIEW:
Mandatory: IRMA Review (e.g. OPWDD form 161), IRC minutes
As Needed: Supporting documentation (e.g. staff training, Medical consults, assessments, written plans, policies, schedules, agency wide communication

OBSERVATION:
As Needed: Physical Plant for changes, equipment, staff supervision of individuals

GUIDANCE:

- Answer for each Reportable Incident of Abuse or Neglect reviewed that resulted in recommendations from the Justice Center.
- This requirement is different from 10-6 above as it applies only to Corrective Action Plans (CAPs) developed in response to recommendations directed by the Justice Center. So while recommendations for actions to address, prevent, and correct can come from multiple sources as noted in 10-6 above, this review is specifically for the actions taken on recommendations resulting from the Justice Center investigation or letter of determination.
- For reports of abuse/neglect a plan for prevention/remediation must be developed within 60 days of the date of the Letter of Determination from the Justice Center The plan must include projected dates of implementation and the agency staff responsible to monitor the implementation and efficacy or the actions. As of 01/01/15 this plan is referred to as the Corrective Action Plan (CAP).
- Agencies are required to upload/enter CAP information for reportable incidents of abuse/neglect occurring after January 1, 2015. IRMA will enable this upload effective January 15, 2015.
- In IRMA you will be able to review:
    - The completed OPWDD 161-Corrective Action Plan Submission Form. The OPWDD 161 will indicate all corrective actions recommended and the agency response/actions to be taken in response to each recommendation.
- Documentation evidencing the implementation of each recommendation (e.g. staff training sign-in sheet, revised service plan, communication memo, revised policy and procedure, equipment purchase, etc.) shall be uploaded into IRMA with the OPWDD 161.
- On Site Verification:
    - While documentation of actions taken will be available in IRMA, surveyors may need to complete additional activities on survey to verify that actions required were implemented and effective. (e.g. verify that staff understand their responsibilities related to training, new procedures, new service plan result in improved supervision or better strategies to address behaviors; verify that equipment has been provided and helpful, verify that medical interventions are provided, etc.) Take action to verify those actions related to the person, the site (if applicable) and or the service. This should be verifiable through observation, interview and additional (if necessary) documentation review.
- Some systemic agency corrective actions, that would not be verifiable in the site or service level operations, will be reviewed during a separate process during agency reviews.

SELECT "MET" IF all of the following are evident:

- ✓ Corrective Action plan (OPWDD 161) was completed.
- ✓ Corrective Action plan documents all recommendations and lists corrections for each with implementation dates and staff responsible.
- ✓ Supporting documentation is available in IRMA to verify completion of all corrections.

SELECT "NOT MET" IF any of the following are evident:

- ✓ Corrective Action plan (OPWDD 161 was NOT completed.
- ✓ Corrective Action plan does not capture all recommendations addressed in the Letter of Determination from the Justice Center.
- ✓ It cannot be verified corrections were implemented.

SELECT "NA" IF:

- ✓ No recommendations resulted from the investigation and incident review and no Corrective Action Plan was required.

Standard No.	Standard Text	Decision
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	**Met/Not Met**

Guidance

INTERVIEW:

Mandatory: Individual, Direct support staff, Agency Management
As Needed: Family, Clinical staff, MSC

DOCUMENTATION REVIEW:

- Mandatory: IRMA Review, IRC Minutes
- As Needed: Supporting Documentation (e.g. Communication logs, staffing schedules, daily logs, medical records, change in service plans, case notes)

GUIDELINE:

- Answer for each incident reviewed.
- When the event comes to the agency's attention that requires agency action, the agency is expected to intervene in a manner they have judged to be appropriate for the situation: these may include but are not limited to the following:
  - (b)(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline);
  - (b)(2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties;
  - (b)(3) interviewing the involved individual and/or witnesses;
  - (b)(4) assessing and monitoring the individual;
  - (b)(5) reviewing records and other relevant documentation; and
  - (b)(6) educating the individual about his or her choices and options regarding the matter.

- The agency is expected to intervene to support in protections for a Part 625 event as deemed necessary when the involved adult meet the following criteria [625.3 (c)]:

- (c)(1) the individual resides in a residence certified or operated by OPWDD (or a family care home);
- (c)(2) the individual receives day program services certified or operated by OPWDD;
- (c)(3) the individual receives Medicaid Service Coordination (MSC) or Plan of Care Support Services (PCSS) authorized by OPWDD; and/or
- (c)(4) the individual receives Home and Community Based Services (HCBS) waiver services authorized by OPWDD.

- The IRMA reporting of the event should document actions taken to protect/assist the individual. Verify that this was implemented through documentation review and interview. Ensure that the actions appear to be adequate.

SELECT "MET" IF:

✓ The Agency has taken action to facilitate the protection of the individual involved in reported 625 event/situations.

SELECT "NOT MET" IF:

✓ The Agency has not taken action within its ability to facilitate the protection of the individual involved in reported 625 event/situations.

Standard No.	Standard Text	Decision
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed: Individual, Agency Management, Direct support staff, RN, Family, Behavior staff, clinical staff, MSC, FCP

DOCUMENTATION REVIEW:

- Mandatory: IRMA Review, Communication logs, IRC minutes
- As Needed: Supporting documents (e.g. ISP, Service plans, IPOP, Behavior plans, Daily logs, staff training, Medical records, nursing plans, Waiver Plans., New Policies, New equipment, Staffing schedules, case notes)

GUIDANCE:

- IRMA information will include OPWDD recommendations for an event. See BPC Preparation Instructions in general guidance.
- Review the information and take action to verify those actions related to the person, the site (if applicable) and or the service. These may include site and support staff training, staffing issues, supervision and oversight, service plan/safeguard clarifications, etc. This should be verifiable through documentation review, observation and interview dependent on the actions needed.
- Systemic agency corrections will be reviewed during a separate process.

SELECT "MET" IF:

✓ For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.

SELECT "NOT MET" IF:

✓ For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were NOT implemented as reported.

SECTION 10c: INCIDENT MANAGEMENT: Not Reported in IRMA

Qualifier: There are Minor Notable Occurrence reported through the agency process but not entered into IRMA.	**Yes**	**No**

Standard No.	Standard Text	Decision
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed: Direct Support Staff, Individual, Program RN, Family Members, Agency Management, MSC, FCP

DOCUMENTATION REVIEW:

- Mandatory: IRMA-Incident Review
- As Needed: Medical appointment records, daily notes, case notes, monthly summaries,

GUIDANCE:

- Answer for each incident reviewed.
- The IRMA reporting of the event should document initial treatment and care provided to the person (e.g.) medical assessment and care, support, supervision, counseling, alternate activity or space, separation from person, etc.).
- Verify implementation through documentation review and interview.
- Ensure the care provided was adequate to the situation reported.
- Ensure the care and treatment was provided timely.
  The agency must take the necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care.

SELECT "MET" IF:

- ✓ Immediate care and treatment identified was adequate to the situation reported and provided timely to the individual.

SELECT "NOT MET" IF either of the following are evident:

- ✓ Immediate care and treatment identified was inadequate or not provided to the individual.
- ✓ Immediate care and treatment identified was not provided timely to the individual.

Standard No.	Standard Text	Decision
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed: Direct Support Staff, Management staff, Individual, Family Members, MSC, FCP

DOCUMENTATION REVIEW:
- Mandatory: Incident review minutes, IRMA Review
- As Needed: daily notes, case notes

GUIDANCE:
- Answer for each incident reviewed.
- The IRMA reporting of the event should document initial actions taken to protect the individual(s). Verify that this was implemented through documentation review and interview. Ensure that the actions appear to be adequate.
- Part 633.9 identifies specific actions a provider can take, based on its evaluation of a situation, to protect individuals from harm and abuse is reported. These actions include:
  Removal, reassignment, relocation or suspension of the alleged abuser, consistent with appropriate collective bargaining agreements and applicable provisions of the Civil Service Law or other applicable laws or regulations.
  - Increasing the degree of supervision of the alleged abuser.
  - Provision of counseling to the alleged abuser.
  - Provision of increased training to the alleged abuser and staff pertinent to the prevention and remediation of abuse.
  - Increasing supervision and providing additional support to restore a secure environment to the affected staff and persons in the facility.
  - Removal or relocation of the person, consistent with his or her developmental needs (or any court order applicable to the person) when it is determined that there is a risk to such individual if he or she continues to remain in the program.
  - Provision of counseling to the individual and to other persons in the facility.
- OPWDD requires that every provider has written procedures for implementing protective actions allowed by Part 633.9, including evaluation of the seriousness of the situation, and that those procedures are known to agency staff. For example, the agency should define, in written procedures, what is meant by “increased supervision” and ensure that its managers are aware of the procedures to be implemented when “increased supervision” is required. Note-agency policies and procedures will be reviewed in the agency review.
- OPWDD requires that providers of services must consider the seriousness of an allegation when implementing immediate protective actions. If a staff person is suspected of abuse, neglect, or mistreatment which poses a serious and immediate threat to an individual’s health and safety, the staff person may not continue to work in direct contact with individuals with developmental disabilities until investigation is completed.

SELECT "MET" IF both of the following are evident:

- ✓ Initial measures to protect the individual from harm and abuse, were implemented immediately.
- ✓ Initial measures to protect the individual from harm and abuse were appropriate to the situation reported.

SELECT "NOT MET" IF either of the following are evident:

- ✓ Initial measures to protect the individual from harm and abuse, were NOT implemented immediately.
- ✓ Initial measures to protect the individual from harm and abuse were NOT appropriate to the situation reported.

Standard No.	Standard Text	Decision
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	**Met/Not Met**

Guidance

INTERVIEW:

As Needed: Agency incident management staff

DOCUMENTATION REVIEW:

- Mandatory: IRMA Review, IRC Minutes, Incident Report
- As Needed: Supporting documents.

GUIDANCE:

- Answer for each incident reviewed.
- Review investigation reports and investigative record when available as entered into IRMA. Request and review additional documentation from the provider agency for events that do not require record upload and/or entry into IRMA (e.g. MNOs).
- Investigations may vary in their scope and intensity depending on the event, location and circumstances. In all cases, investigation reports/records should demonstrate every effort to determine what happened. In some cases, the investigation may need to determine whether the event actually occurred. Investigative reports should include specifics such as what happened, when it happened, who was involved; who was present, where the situation occurred, and whether the event is indicative of abuse, neglect or mistreatment. Staffing levels, environmental factors, immediate response/protective actions and/or care provided, and relevant information from the individual's program plan and/or health care plan should also be considered. Based on analysis of that information the investigation report should provide an explanation of why the event happened by identifying contributing factors and probable causes. Based on the identified causes and contributing factors appropriate recommendations should be made to address the event and to prevent similar events from occurring in the future.
- The required form and format of the investigation should result in the inclusion of the following types of information as appropriate to the event:
  Appropriate medical examination of the injured person.
  Witnesses to the incident shall be identified and interviewed.
  Interviews should be conducted separately by qualified, objective parties.

Pertinent information shall be reviewed (e.g., records, photos, observations of incident scene, expert assessments).
Physical evidence, if any shall be identified and appropriate steps taken to safeguard and preserve it.

- The following are required for investigations of reportable incidents and serious notable incidents, inclusive of information in the form 149 (dated 4/30/15).
  - Identifying data, such as the name(s) of person(s) receiving services involved in the incident or occurrence; the date the incident or occurrence was reported and/or discovered; the classification of the incident; and the incident/occurrence number. For incidents/occurrences entered into IRMA this includes the master incident number assigned by IRMA;
  - A description of the incident or notable occurrence
  - Immediate protections provided to person(s) receiving services;
  - Investigatory question(s);
  - A description of the investigative process and specific evidence obtained;
  - A summary of the evidence obtained in the investigation;
  - Conclusions, including findings (substantiated or unsubstantiated) in the case of a report of abuse or neglect; and
  - Recommendations, including recommendations for remedial actions.
- Review of the investigation should consider the following:
  - Were the circumstances of the event (e.g. timeframe, place, people present, activity, etc.) established?
  - Did the investigation include a review of immediate care provided to individuals?
  - Was information gathered (e.g., statements and/or interviews) from witnesses and all other relevant parties? (These parties may include, but are not limited to, clinical service providers who can provide relevant information, but who did not witness the incident.)
  - Were relevant medical and clinical assessments conducted prior or subsequent to the incident and was relevant documentation reviewed?
  - Was other documentation reviewed based on the nature of the event? (These records may include staff communication logs, staff schedules, service plans, IPOPs, BSPs and behavior documentation, prn notes, medication records, training records, etc.)
  - Were conclusions made based on the findings
  - Were recommendations made to address causes of the incident and prevention of similar incident?
- Paragraph 624.5(h)(4)(i) requires that the investigative report must be in the form and format specified by OPWDD. The “Form OPWDD 149” (dated 4/30/15) is the required form and format specified by OPWDD. The form must be completed for all investigations that a provider agency is required to complete, including reportable incidents and all notable occurrences.

SELECT "MET" IF:

- ✓ The investigation of Reportable Incidents and Notable Occurrences involving the individual is documented and generally thorough as noted in the guidance. Any information or detail omitted is likely to have no impact on the conclusion, protective actions, and recommendations resulting from the investigation.

SELECT "NOT MET" IF:

- ✓ The investigation of Reportable Incidents and Notable Occurrences involving the individual are not thorough and/or not properly documented as indicated in the guidance. Relevant information was not reviewed or pursued in the investigation process, and/or not documented as part of the investigation/investigation summary.

Standard No.	Standard Text	Decision
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	**Met/Not Met**

Guidance

INTERVIEW:
As Needed: Agency incident management staff

DOCUMENTATION REVIEW:
- Mandatory: IRMA Review, IRC Minutes, Incident Report
- As Needed: Supporting documents

GUIDANCE:
- Answer for each incident reviewed.
- When the agency is responsible for the investigation:
  - The investigation should be completed no later than 30 days after the incident or serious notable occurrence is reported to the Justice Center and/or OPWDD
- In the case of a minor notable occurrence, the investigation should be completed no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA.
- An investigation shall be considered complete upon completion of the investigative report.
- Completion of a specific investigation beyond 30 days may occur if there is adequate justification to do so. The agency must document its justification for the extension.
- Examples include request by outside entity (e.g. police) to delay or circumstances beyond an agency's control
- Note: The agency should be considered in compliance if the investigation has been completed within the required time frame, but is awaiting the Letter of Determination from the Justice Center. (This status information should be noted in the agency's 30 day updates.)
- Per 624.5(e)(1)(iii) the investigative report should be entered into IRMA within 5 working days of report availability

SELECT "MET" IF either of the following are evident:
- ✓ The investigation is completed and documented within 30 days as described in guidance.
- ✓ There is documentation of an acceptable justification for extension for an investigation not completed within 30 days.

SELECT "NOT MET" IF:
- ✓ The investigation is NOT completed and documented within 30 days and there is not acceptable justification for extension.

Standard No.	Standard Text	Decision
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	**Met/Not Met/NA**

Guidance

INTERVIEW:
As Needed: Individual, Management, Direct support staff, Clinical Staff, Family, RN, MSC, FCP

DOCUMENTATION REVIEW:
- Mandatory: IRMA Review, IRC minutes
- As Needed: Minor Notable occurrences and supporting documentation in hard copy if MNOs in voluntary agencies are not entered into IRMA. For all MNO, additional supporting documentation at the site may be necessary to review (e.g. staff training, Medical consults, assessments, written plans, policies, schedules, agency wide communications)

OBSERVATION:
- As Needed (if site based): Physical Plant for changes, equipment, staff supervision of individuals

GUIDANCE:
Answer for each incident reviewed.
- This requirement is meant to address verification of the implementation of actions that are recommended by non-Justice Center sources: i.e. the agency investigator; OPWDD Office of Investigations and Internal Affairs (OIIA); and/or Agency Incident Review Committee. Implementation of Justice Center recommendations are reviewed in #9 below.
- Actions taken or to be taken to address issues identified in investigation of an incident/occurrence and/or prevent similar events are required to be entered in IRMA. Review what is documented and verify that the actions related to the person, the site (if appropriate) or the service were implemented.
- The corrective actions may be identified by: the agency investigator; OPWDD Office of Investigations and Internal Affairs (OIIA); Agency Incident Review Committee or the Justice Center investigation or letter of determination. These corrective and/or preventive recommendations and or actions will be documented in the investigative report, IRC minutes or may be identified as a separate plan for prevention/correction/remediation, e.g. Corrective Action Plan (CAP). The actions may include site and support staff training, staffing issues, supervision and oversight, service plan clarifications, revision of the ISP/program plan related to changes in the services, supports or care; etc.
    - Documentation evidencing the implementation of each recommendation should be available (e.g. staff training sign-in sheet, revised service plan, communication memo, revised policy and procedure, equipment purchase, etc.)
- On Site Verification:
    - Documentation of actions taken may be available in IRMA for Minor notable occurrences (MNO). State operated programs and services are required to enter information into IRMA for all classifications of incidents. However, entry of Minor notable occurrences occurring in voluntary agencies is optional. DQI surveyors may need to complete review of MNO via paper while at the agency.
    - In addition, on site review may need to occur to verify that actions required were implemented and effective, (e.g. verify that staff understand their responsibilities related to training, new procedures, new service plan result in improved supervision or better strategies to address behaviors; verify that equipment has been provided and helpful, verify that medical interventions are provided, etc.) Take action to verify those

actions related to the person, the site (if applicable) and or the service. This should be verifiable through observation, interview and additional (if necessary) documentation review.

- Some systemic agency corrective actions that would not be verifiable in the site or service level operations will be reviewed during a separate process during the agency review.

SELECT "MET" IF any of the following are present:

- ✓ There is evidence that actions/measures recommended to prevent similar events were implemented.
- ✓ There is evidence that actions/measures recommended to prevent similar events are in process and sufficient to prevent similar events.
- ✓ If any action/measure recommended to prevent similar events is not implemented, there is documentation to evidence that this decision is reasoned and does not put the person(s) at risk.

SELECT "NOT MET" IF any of the following are present:

- ✓ There is NOT evidence that actions/measures recommended to prevent similar events were implemented.
- ✓ There is NOT evidence that actions/measures recommended to prevent similar events are in process and sufficient to prevent similar events.
- ✓ If the agency decided NOT to implement an action/measure recommended to prevent similar events, there is NOT documentation to evidence that this decision is reasoned and does not put the person(s) at risk.

SELECT "NA" IF:

- ✓ No recommendations to prevent similar events were made and none appear to be necessary.

Standard No.	Standard Text	Decision
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	**Met/Not Met/NA**

Guidance

INTERVIEW:

As Needed: Individual, Management, Direct support staff, Clinical Staff, Family, RN, MSC, FCP

DOCUMENTATION REVIEW:

- Mandatory: IRMA Review (e.g. OPWDD form 161), IRC minutes
- As Needed: Hard copies of incident, investigation and IRC minutes and any supporting documentation of recommendation implementation (e.g. staff training, Medical consults, assessments, written plans, policies, schedules, agency wide communication) if agency does not enter Minor Notable Occurrences (MNOs) in IRMA.

OBSERVATION:

- As Needed: Physical Plant for changes, equipment, staff supervision of individuals

GUIDANCE:

- Review of Minor Notable incidents may occur through IRMA review or review of hard copies at the agency dependent on agency processes. State operated facilities and services are required to enter all classifications of incident, including MNOs into IRMA. Use of IRMA for MNOs (only MNOs) is optional for voluntary provider agencies.
- Review the information within IRMA or via hard copy and take action to verify those actions related to the person, the site and or the service. These may include site and support staff training, staffing issues, supervision and oversight, service plan clarifications, etc. This should be verifiable through documentation review, observation (if site-based) and interview dependent on the actions needed.
- Systemic agency corrections will be reviewed during a separate process.

SELECT "MET" IF:

✓ Recommendations identified in the investigation or incident review committee (IRC) review were implemented.

SELECT "NOT MET" IF:

✓ Recommendations identified in the investigation or incident review committee (IRC) review were not implemented.

SELECT "NA" IF:

No recommendations resulted from the investigation and incident review and none appear to be necessary.

SECTION 11: QUALITY OF LIFE SUMMARY

Standard No.	Standard Text	Decision
11-1	The person has the resources to obtain possessions and supplies necessary for comfortable daily living.	**Met/Not Met**

Guidance

GUIDANCE:

- Using information gathered in all review activities make a determination regarding outcomes related to this standard statement.
- It is possible for this standard to be met even if a regulatory requirement was not met, if it did not impact the person's financial stability.
- The intent of this quality indicator is to review that the person has the financial stability necessary to have personal and household supplies that contribute to a quality of life.
- Sufficient resources includes: money from any source, entitlements and other resources (e.g. support to use food bank) for food, shelter, and daily living. This may include items such as basic utilities (electricity, heat); adequate food supply; supplies to maintain personal cleanliness and dental hygiene; supplies or resources to keep their living environment clean (cleaning products, broom, laundry supplies, etc.); clothing sufficient to allow changes for cleanliness and protect from the elements (e.g. shoes in adequate condition, boots, warm coat, gloves in winter, etc.). The person may be provided the supplies through their own fiscal resources, agency provided resources, family and natural supports, and/or community resources (e.g. food banks, special programs /donations).
- Determine whether the individual has what they need and/or can obtain supplies quickly.

SELECT "MET" IF:

✓ The individual has sufficient resources as described above to live safely and comfortably.

SELECT "NOT MET" IF:

✓ The individual lacks or was exploited to give up sufficient resources as described above, resulting in unfit living conditions and/or harm to individual well-being.

Standard No.	Standard Text	Decision
11-2	The individual is living as independently as able in the home/living environment they choose.	**Met/Not Met**

Guidance

GUIDANCE:

- Using information gathered in all review activities make a determination regarding outcomes related to this standard statement.
- It is possible for this standard to be met even if a regulatory requirement was not met.
- The individual's input should be the primary determiner of the living situation that works best for them within reasonable cost and appropriate safeguards (see other standards).
- Consider whether the individual's living environment according to their personal skills and needs, generally provides the environmental, equipment, assistive technology, training and designated human supports to facilitate their independence.
- Even if a person requires total support, if they are receiving it, they are living as independently as possible. However, if an individual is capable of managing aspects of their life, but denied this opportunity, they are not living as independently as able.
- This is not meant to be a judgement of the appropriateness of the current living environment (e.g. they are living and home, but surveyor believes they could be successful in their own apartment). It is meant to assess the degree of independence in their current chosen home or in their current residence with action being taken to assist them to secure the residential environment they prefer.
- In addition to home of choice, the individual should be afforded the opportunity to live in their community of choice.

SELECT "MET" If either are evident:

- ✓ The individual is living as independently as they are able in their chosen residential setting.
- ✓ The individual is living as independently as they are able in their current residence, and is receiving supports and participating in activities to seek and attain the preferred residential setting.

SELECT "NOT MET" If any of the following are evident:

- ✓ The individual is dissatisfied with their residential setting and is not supported adequately to address dissatisfaction.
- ✓ The individual is not living as independently as they are able in their chosen residential setting.
- ✓ The individual prefers a more independently residential environment, but is not being supported towards that outcome.

Standard No.	Standard Text	Decision
11-3	The person is maintaining/improving and/or developing meaningful relationship(s).	**Met/Not Met**

Guidance

GUIDANCE:

- Using information gathered in all review activities make a determination regarding outcomes related to this standard statement.
- It is possible for this standard to be met even if a regulatory requirement was not met.
- Relationships include but are not limited to:
  - Familial relationships: e.g. parents, step parents, grandparents, siblings, cousins, aunts, etc.
  - Family friends
  - Personal friends from childhood, neighborhood, work, church, school, day settings, etc.
  - Romantic relationships
- CONSIDERATIONS:
  - This outcome is a choice as expressed by the individual and may not be important to all people.
  - The person may be exactly where they want to be regarding this OPWDD value. If the person does not want to increase or change relationships, the agency respects this choice.
  - Relationships for purposes of this standard are those that are personal and meaningful to the person. It is intended to look beyond the staff and service recipients they see every day because of their routine, but would not/do not seek out otherwise. (NOTE: this is also not meant to exclude a housemate with whom they have established a true friendship, enjoying and seeking to spend time in varied activities in and out of the home.)
  - There are different kinds of relationships and what the person wants is individualized. It may be they want changes in a variety of ways; e.g. they want to meet and make a new friend who likes baseball games, or they want a best friend; or they have a significant other but need support/education in developing a sexual relationship with them; or they may want to start visitations with a sister who lives out of state; etc.
  - Satisfaction or dissatisfaction with who they have in their life and the level and type of interaction should be considered. Is it “just right” with family visits, but would like to speak on the phone more often? Would they like to get together with a friend(s) more frequently for recreational activities? Do they really enjoy their privacy and being just seeing their grandmother once a month or do they want something more? Etc.
  - In accordance to the person’s wishes and his/her circumstances determine if their experiences are aligned appropriately and/or moving progressively toward what they want.
  - Unless clinically contraindicated, there should not be barriers in place to prevent the person from pursuing a sexual relationship.
  - An intimate relationship may mean sexual or a close personal friendship with another person.
  - Per their needs/want the person should receive assistance and education to learn social skills, about healthy relationships, and explore social occasions as a means to explore and develop relationships.
  - Consider whether the individual is participating in activities that lead to their desired outcome regarding relationships.

SELECT "MET" If the applicable outcomes are evident as personalized to the individual's wants:

- ✓ The individual is maintaining/improving relationships established and important to them;
- ✓ The individual is developing new relationships and/or involved in activities expected to lead to this outcome.
- ✓ The individual is dissatisfied with the current status of relationships but satisfied with the supports provided and participating in activities to help them achieve their desired outcome regarding relationships.

SELECT "NOT MET" If any of the following are evident:

- ✓ The individual is dissatisfied with the status of their personal relationships regarding with whom, frequency and type of contact, with no supports or unsatisfactory support to attain the relationships they want;
- ✓ The individual is not supported to maintain/achieve desired outcomes regarding personal relationships.

Standard No.	Standard Text	Decision
11-4	The person is employed, doing volunteer work or participating in other integrated meaningful activities, per their desires/life goals.	**Met/Not Met**

Guidance

GUIDANCE:

- Using information gathered in all review activities make a determination regarding outcomes related to this standard statement.
- It is possible for this standard to be met even if a regulatory requirement was not met.
- This standard is intended to determine if the individual is routinely spending their "day" in the manner they choose and want. This IS NOT asking if they determine their own schedules, what they do during time at home socially or leisurely. This is looking in the more traditional sense of how a person spends their day: paid work, job skills training, volunteer activities, education/school, personal skill development, retirement.
- Consider if they think the activity (ies) in this regard are meaningful to the person and congruent with their personal outcomes/goals.
- Consider what the person wants to be doing with their life regarding how they contribute, start their own business or whether they earn a paycheck, whether they want to develop other life skills, whether they want to continue their education, and whether they decide they are done with all that and ready to retire and engage in more social groups, etc. The services and supports designed for them should correlate with their desired outcomes as needed.
- A person also may be satisfied with their program/service enrollment, e.g. they prefer HCBS waiver day habilitation program, but the choices of activities offered do not support the person's desired outcomes to develop skills so that they may volunteer at the soup kitchen.
- Program enrollments and activities are related to desired outcomes and do not appear to be "busy work" or "time fillers". Discuss with the individuals and their supports the purpose of activities if it is not clearly evident before making judgment.
- In most cases this is considered what the person does outside the home, but this does not exclude individualized activities that the person may do from their home as meaningful activities.

SELECT "MET" If either of the following are evident:

- ✓ The individual's daily routine meaningful activities/service enrollment/work are per their choice and preference.

- ✓ The individual's is not participating in their desired outcome re: meaningful activities, or dissatisfied with current activities (e.g. wants a job) but is satisfied with the supports provided and participating in activities to help them achieve their desired outcome.

SELECT "NOT MET" IF either of the following are evident:

- ✓ The individual is dissatisfied with their daily activities with no supports or unsatisfactory support to attain their desired outcome re: work, program enrollment, program activities relationships they want.

Standard No.	Standard Text	Decision
11-5	The person is maintaining their desired role in their community.	**Met/Not Met**

Guidance

GUIDANCE:

- Using information gathered in all review activities make a determination regarding outcomes related to this standard statement.
- It is possible for this standard to be met even if a regulatory requirement was not met.
- Determine whether the individual is experiencing their community and is a member of their community per their interest and desired outcome.
- Determine whether the person has, or appears to have, a sense of belonging in the community per their interest.
- Consider whether the individuals' preferences and interests are matched with available events and activities in the neighborhood and community.
- This standard looks at whether the individual is active in their community to the degree the want.
- Active in their community may include but is not limited to:
  - Participation in community events
  - Participation in community organizations and memberships
  - Use of community vendors, businesses and services
  - Social and recreational activities in the community
  - Being recognized and known as a member of the community, being known by name and appreciated by others in the community.
- Desired role considerations include frequency and degree of community membership. Some individuals may appreciate a high frequency, high visibility role in the community; others a low profile, low frequency and others any variation in between.
- Not all people desire this outcome or are comfortable with increased community participation. If the individual does not want to increase their role within the community, that choice should be respected but offered from time to time as people's choices and preferences change over time.

SELECT " MET "If either of the following are evident:

- ✓ The individual's community participation is meaningful per their choice and preference for establishment of their community role.
- ✓ The individual's is not participating in their community as desired or has not attained their desired community role, but is satisfied with the supports provided and participating in activities to help them achieve their desired outcome.

SELECT "NOT MET" IF either of the following are evident:

- ✓ The individual is dissatisfied with their community participation/role and has no supports or unsatisfactory support to attain their desired outcome.
- ✓ The individual is not supported to maintain/achieve desired outcomes regarding their community role/participation.

Standard No.	Standard Text	Decision
11-6	The individual is living safely/receiving supports to live safely in their home/living environment, according to informed choices and responsible consideration.	**Met/Not Met**

Guidance

GUIDANCE:

- Using information gathered in all review activities make a determination regarding outcomes related to this standard statement.
- It is possible for this standard to be met even if a regulatory requirement was not met.
- This Quality Indicator involves safety in the home related to environmental issues and individual behaviors. Medical/Health issues related to living safety are addressed elsewhere.
- Living involves risk. Quality of Life is not exclusively determined by the absence of risk and negative occurrences. However, known and reasonably potential risks to health and safety need to be considered along with the individual's personal outcomes. The individual and their unique circumstances should be at the center of considerations of living safely.
- Person Centered planning and services and outcomes reviewed throughout this protocol will provide information on whether strategies and supports (environmental, technological and human) are adequate and appropriate for the person. For example:
- Environmental fire safety: safe smoking and cooking practices, maintaining clear pathway, smoke detectors in home
- Emergency evacuation from premises (e.g. Fire evacuation planning, knowing where exits are and how to safely evacuate)
- Security to prevent unwanted entry by others (appropriate locking mechanisms, practices for safety when answering door; etc.)
    - o Other known health and safety issue which have resulted in negative consequences* for the person, or are likely to result in negative consequences; need to have been responsibly discussed with reasoned decisions regarding safeguards. The considerations in support of the decisions should be part of the documentation reviewed previously.
    - o This is not to say that all known risks need to be prevented. Risk needs to be balanced with the individual's informed expression of choice and mitigated when possible while still allowing the individual to be independent and take risks. Again the critical discussion and decision making regarding this balance needs to be evident and documented.

*Negative Consequences: e.g. Physical injury; hospitalization; serious medical conditions; physical harm to others; personal or financial exploitation; arrest/ law enforcement; etc.

SELECT "MET" If either of the following are evident:

- ✓ The person is effectively living safely and/or supported in the mitigation of risks associated with "home" and their individualized living environment and circumstances, free of serious sustained negative consequences.

SELECT "NOT MET" If One or more of the following is present:

- ✓ The person is not living safely and/or not receiving needed supports to live safely in their home, resulting in serious and/or negative occurrences.

Standard No.	Standard Text	Decision
11-7	The person lives safely in their community per their informed choices.	**Met/Not Met**

Guidance

GUIDANCE:

Using information gathered in all review activities make a determination regarding outcomes related to this standard statement.
It is possible for this standard to be met even if a regulatory requirement was not met.

REVIEW CONSIDERATIONS:

- This quality indicator involves the person's outcomes related to community life. The expectation is that the person has community skills and or supports necessary to participate in their community successfully. This may include navigation in the community and transportation, social skills and caution with strangers, conducting business in the community, for example.
- The person's perspective is paramount. However, their vulnerabilities should be adequately identified and addressed through education and supports. In addition to discussion about the person's experiences, a review of IRMA/incident reporting should contribute to the evaluation. Life happens so the intent is to use judgment and perspective when confirming that the person has a successful community life.

SELECT "MET" If either of the following are evident:

- ✓ The person is effectively living safely and/or supported in the mitigation of risks associated with "community" integration free of serious sustained negative consequences.

SELECT "NOT MET" If One or more of the following is present:

- ✓ The person is not living safely and/or not receiving needed supports to live safely in their community, resulting in serious and/or negative occurrences while in the community.

Standard No.	Standard Text	Decision
11-8	The person is satisfied with the supports they receive intended to achieve their outcomes.	**Met/Not Met**

Guidance

GUIDANCE:

- Ask and determine whether the person (or advocate) is pleased with the varied and coordinated services and supports arranged and provided and whether they agree that they are meeting their intended purpose. This is based upon their perception whether or not it is an accurate assessment of the situation.

SELECT "MET" If:

✓ The individual reports satisfaction with their complement of services and supports and effectiveness in their achievement of desired outcomes.

SELECT "NOT MET" If One or more of the following is present:

✓ The individual reports dissatisfaction with their complement of services and supports.

✓ The individual reports that the services/supports do not help them achieve their desired outcomes.

Standard No.	Standard Text	Decision
11-9	The person's service(s) in total, contribute to advancing toward or achieving their specified goals and personal outcomes.	**Met/Not Met**

Guidance

GUIDANCE:

- Using information gathered in all review activities make a determination whether the individual's complement of services is resulting in the intended and desired outcomes individualized for the person.
- It is possible for this standard to be met even if a regulatory requirement was not met.
- To make a determination, consider whether what is the person is maintain or achieving throughout their life, and if this aligns with their personal outcomes. This in an assessment of whether outcome achievement is being advanced.
- It is important to remember that sometimes a limited amount of time has elapsed since the identification of new or changed desired outcomes and the implementation related supports, or since identification that services/supports are ineffective and implementation of revised supports/services to improve effectiveness (e.g. < 6 months). In these cases, so long as the intended new supports are being provided, this should be considered advancement.
- Measurement of the outcome is defined by the person, i.e., person specific.
- Use information available through the survey process to inform your decision making. Agencies/programs are not expected to "chart" progress toward outcomes, although some may choose to do so. However formal arranged services (e.g. waiver services, residential services, etc.) should have documentation evidencing effectiveness to inform your overall decision making.

SELECT "MET" If either of the following are evident:

- ✓ The individual for the most part is advancing toward or achieving their individualized desired outcomes.
- ✓ The individual has not advanced toward or achieved their individualized desired outcomes, but this was identified timely, recently and addressed.

SELECT "NOT MET" If One or more of the following is present:

- ✓ The individual is not advancing toward or achieving their desired outcomes.
- ✓ The individual is not advancing toward or achieving their desired outcomes and this is not identified, analyzed or addressed.

Regulatory References

Standard No.	Standard Text	Decision	Regulatory References
1-10	Assessments needed by the individual or required by program regulation were completed to inform the individual's plan development.	Met/Not Met	**676.6(a)** Core diagnostic and evaluation services are mandatory for each person admitted to the clinic for the comprehensive evaluation; these services are available discretely for any person admitted for a particular diagnostic and evaluation service under subparagraph (a)(4)(ii) of section 676.5 of this Part. It shall be mandatory that each person receiving the package of core diagnostic and evaluation services shall also have the services specified in subdivisions (e) and (f) of this section. **676.6(f)(3)** During the interdisciplinary team conference, each professional's findings in their particular disciplines shall be coordinated and integrated so that a single and unified profile of the person emerges. This unified profile shall include at least written statements concerning the person's: (i) etiology; (ii) symptomatology; (iii) classification according to activities of daily life; (iv) central nervous system process; (v) functional and behavioral skills and deficits; or (vi) diagnostic conclusion.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**676.10(a)(1)-(13)** The diagnostic and research clinic shall maintain a comprehensive record of each person referred and admitted to the clinic. Each record shall be organized in the manner and contain the information specified by OPWDD for inclusion. Each individual's record shall contain the following types of information: (1) person identification information, including, if applicable, a Medicaid or Medicare number, a developmental disabilities information survey profile, etc.; (2) information regarding the person's medical and developmental history; (3) copies of previous diagnoses or tentative diagnoses, assessments, progress notes, and, if possible, copies of individual program plans or service

			plans previously developed for the person at other programs or agencies; (4) descriptions of treatment and medications previously administered; (5) name and address of person or organization referring the individual to the diagnostic and research clinic and reason for such referral; (6) criteria for admission eligibility and itemized lists of diagnostic and evaluation services, specialized clinical laboratory services, need for residential services and any other optional services required by the person. This section of the record shall include written authorizations by clinicians for diagnosis, evaluation or clinical laboratory services; (7) authorizations signed by the clinic's attending physicians and/or clinicians who have designated that the person receive other optional services in addition to the core or optional services initially authorized by the admission committee; (8) written authorizations by a physician or other clinician to admit a person for short-term residential care; such record should include date of admission, projected date of discharge, actual date of discharge, services received while in the residential unit, and a report of any significant occurrence in the life and experience of the person while staying at the clinic; (9) discipline specific diagnostic summaries, evaluations and findings and recommendations for services; and (10) minutes and decisions made by the interdisciplinary team including copies of the individual's recommended treatment plan in which at least the following shall be stated: (i) primary and secondary diagnoses; (ii) integrated evaluations, and statements concerning the severity of the disability; (iii) prioritized long-range goals and short-range objectives that are matched to prioritized needs and areas of behavioral and medical deficits; (iv) services and methods of interventions recommended to address the person's deficits; and (v) recommendations for follow-up visits and/or recommendations to have the person receive services at other specialized diagnostic and evaluation programs; (11) minutes of conferences conducted between clinical staff and the person and/or his or her correspondent in which the clinician's findings and

			recommendations are explained and discussed; (12) minutes of conferences, meetings, discussions, etc., between clinical staff at the diagnostic and research clinic and the referring agency and/or the agency who has been or will be delivering the recommended services to the person; and (13) notes and correspondence between clinic staff and referring agents, family, family physicians, advocacy organization, and programs providing services to the person or programs considering the person for admission.
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**676.6(f)(1)** Each person admitted to the clinic for any or all of the services specified in subdivision (a), (b), (c) or (d) of this section shall be afforded, in addition to a discipline summary stipulated in subdivision (e), an interdisciplinary team treatment planning conference conducted by the professionals who have assessed the person with developmental disabilities in specific disciplines. This group of professionals, working as an interdisciplinary team, shall develop an individualized recommended treatment plan for the person and shall follow the provisions in paragraphs (2) through (7) of this subdivision in so doing.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**676.6(f)(2)** Each recommended treatment plan shall include the diagnostic and evaluation service summaries written by each clinician evaluating the person with developmental disabilities. **676.6(f)(4)** Based on this unified profile, the interdisciplinary team shall develop a written recommended treatment plan in which the team states the person's behavioral and/or medical goals and short-range objectives, methods of intervention and correlative services oriented toward ameliorating the effects of the person's developmental disability(ies).
2-11	The person's services are delivered by competent	Met/Not Met	**633.4(a)(4)(ix)**

	staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.		No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-15	The person is satisfied with the specific service.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii)** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)**

			OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)** No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4)** OMRDD shall verify that staff are aware of the rights of persons in the facility.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual.

			625.5(c)(2) The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)**

			When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)

10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate. **624.5(h)(3)** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16)

			employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)

10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).

10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1) -(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual	Met/Not Met	**625.3(b)(1-6)**

	involved in reported 625 event/situations.		The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c -QQ	INCIDENT MANAGEMENT: Not Reported in IRMA - There are Minor Notable Occurrence reported through	Yes/No	**If "YES" continue complete Section 10-c** **If "NO" review and submit.**

	the agency process but not entered into IRMA.		
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16)

			624.5(g)(3) When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3)** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or

			contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written

			recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3):** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated, or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency investigate and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD;

			or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Regulatory References – Free Standing Respite (19/27) and IRA - Large and Small (19/84)

Standard No.	Standard Text	Decision	Regulatory References
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**ADM 2005-02 :** In addition to the "Respite Documentation Record," the Respite provider must have a copy of the consumer's current Individualized Service Plan (ISP) on file.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**ADM 2005-02 :** A contemporaneous entry must be made on the Respite Documentation Record for each day a Respite service is delivered and billed for a consumer.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **635-10(g)(4)** : Respite care services in the person's home shall be delivered by parties who are qualified to provide the level of care specified in the person's individualized service plan.
2-15	The person is satisfied with the specific service.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)** : No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**686.16(b)(3) :** OPWDD shall verify that each person has a plan for protective oversight, based on an analysis of the person's need for same, and that such need has periodically, but at least annually, been reviewed, revised as appropriate, and integrated, as appropriate, with other services received.
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**686.16(b)(4)(ii)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following:... (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**686.16(b)(4)(ii)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: … (ii) any parties with supervision responsibilities are aware of the specifics of each

			person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**686.16(b)(4)(ii)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: ... (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met	**ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **686.16(b)(4)(ii)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: ... (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for

			protective oversight is being implemented as specified in the person's individualized service plan.
7-6	The individual's needs for support and assistance related to fire safety and evacuation are documented according to service/setting requirements.	Met/Not Met	**686.16(b)(2) :** For individualized residential alternatives of eight or fewer beds, OMRDD shall verify that each person's individualized services plan (see glossary) contains a current evaluation of the fire evacuation capacity of the person based on actual performance. OMRDD shall verify the accuracy of the information in each person's individualized services plan relative to fire evacuation performance.
7-7	The individual is provided the necessary supports and assistance related to fire safety and evacuation.	Met/Not Met	**686.16(b)(1) :** OMRDD shall verify that each individualized residential alternative has implemented a facility evacuation plan. OMRDD shall verify that staff and persons residing in the facility are trained and evaluated regarding their performance of said plan. **686.16(b)(4)(i)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (i) any parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid; (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
8d-1	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s) addressed during services at the site.	Met/Not Met/NA	**686.15(a)(1)(i)(b)(3) :** In providing respite, the facility shall assume the daily responsibilities of the primary caregiver, limited to:. health and self-care services including overseeing routine medical care and managing any medical emergency; **686.16(b)(4)(ii)-(iii) :** 686.16(b)(4) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: ... (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.

8d-2	The individual receives the needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met	**686.15(a)(1)(i)(b)(3) :** In providing respite, the facility shall assume the daily responsibilities of the primary caregiver, limited to:. health and self-care services including overseeing routine medical care and managing any medical emergency; **686.16(b)(4)(ii)-(iii) :** 686.16(b)(4) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: ... (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
8d-3	The individual's service record/service plan is maintained to reflect current status of the individual's health needs being addressed.	Met/Not Met	**686.15(a)(1)(i)(b)(3) :** In providing respite, the facility shall assume the daily responsibilities of the primary caregiver, limited to: ..(3) health and self-care services including overseeing routine medical care and managing any medical emergency;
8d-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**ADM 2003-01 :** A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities… **686.16(a)(6)(i) :** A facility receiving an operating certificate as an individualized residential alternative, shall develop a site specific written plan for protective oversight. The plan shall include provisions for ensuring: (i) The assessment of each person's need for the amount and type of supervision necessary including both staff and/or technology as appropriate to the person and circumstance.
8d-5	The individual and/or their support(s) report the individual's health concerns/symptoms to	Met/Not Met/NA	**633.4(a)(4)(x)** : No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through

	appropriate parties as needed or directed.		parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8e-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met/NA	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person,
8e-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8e-3	The individual receives medications and treatments safely as prescribed.	Met/Not Met/NA	**633.17(b)(3) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. **633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8e-4	Problems or errors with administration of the individual's medication are	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to

	reported and remediated per agency processes.		policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ... **633.17(a)(7) :** All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling. **ADM 2003-01 :** The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)**

			The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4) :** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)

10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)

10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate. **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)

10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n) (1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).

10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(j)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l) :** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the

			Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** : Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16)

			624.5(g)(3) : When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)

10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met	**624.7(b)(2): :** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3): :** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial

			action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(j)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met	**625.4(b)(2)(i-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(b)(1) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions;
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the

			individual's life that are most important to him or her (e.g., health, relationships, work, and home). **ADM 2012-01 :** The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**636-1.2(b)(3) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-16	The individual's goals and priorities regarding meaningful relationships are	Met/Not Met	**636-1.2(a) :**

	identified in the person centered plan.		A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**636-1.3(b)(8) :** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed;

1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**636-1.2(b)(3) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**ADM 2012-01 :** Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or his/her advocate.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**636-1.2(b)(4) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the

	HCBS Waiver Service providers.		person for whom the record is kept, and which includes a plan of services (by whatever name known). **635-10.4(b) :** Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments.
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). **633.4(a)(4))(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and

			community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2012-01 :** Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: an ISP review date, or the date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action	Met/Not Met	**ADM 2012-10 Habilitation Plan Requirements : pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one

	expected by service provider and the individual.		of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. ... c. Exploration of new experiences is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ...

			633.4(a)(4) ; No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(b)(1)** : For Residential Habilitation Services: Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments. Habilitation services are directed toward acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. services offered are designed to correspond to the person's strengths and needs. These services include activities and tasks required to design, implement and support the individualized service plan. ... (1) Residential habilitation services are generally provided in the person's home, and include assistance with acquisition, retention or improvement in skills related to life safety and fire evacuation; to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food; and social and adaptive skills necessary to enable the person to reside in a noninstitutional setting. ... **633.4(a)(4)(viii)-(ix)** : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity

2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**636-1.2(a)(3)(ii) :** The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**ADM 2014-01 :** The required service documentation format for the daily Supervised IRA-RH service is a Daily Narrative Note format or a checklist with a monthly summary note, which must be completed by the staff person who delivers the service or is knowledgeable of service delivery.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative,	Met/Not Met	**ADM 2014-04 :** Habilitation Supports and services are focused on the development of skills that are needed in order to facilitate greater degrees of choice, independence, autonomy and full participation in community life….

	autonomy, independence, and dignity.		**441.301 4 (C)(4)(iii) :** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint. **441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers.

			635-99.1(bl) : If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives.....Each Habilitation Plan must be

			reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii) :** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1) :** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.

3-4	The individual is informed of their HCBS rights.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5) :** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3) :** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-7	The individual is supported to express themselves through personal choices/decisions on style of dress and grooming preferences.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-8	The individual is supported to participate in cultural/religious/associational practices, educuation, celebrations and experiences	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.

	per their interests and preferences.		
3-9	The individual is supported to have visitors of their choosing according their preferences.	Met/Not Met	**636-1.4(b)(4) :** Each individual is able to have visitors of his or her choosing at any time.
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support.	Met/Not Met	**636-1.4(b)(2) :** Each individual has privacy in his or her sleeping or living unit. **633.4(a)(xx) :** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
3-11	The individual is aware that he/she is not required to follow a particular schedule for waking up, going to bed, eating, leisure activities, etc.	Met/Not Met	**636-1.4(b)(3) :** Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs.	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-13	The individual can choose to eat meals when they want to, even if mealtimes occur at routine or scheduled times.	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each

			individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-14	The individual has access/is supported to have access to food at any time and to store their own food and snack choices for their use at any time as desired, similar to people without disabilities.	Met/Not Met	**636-1.4(b)(3)** : (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-15	The individual is supported to have independent access to the site/service setting with freedom to come and go as desired, similar to people without disabilities.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-17	The setting reflects the individual's needs and preferences including the presence of any necessary physical modifications, if applicable.	Met/Not Met	**441.301(C)(4)(ii) :** The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board. **441.430 (c)(4)(vi)(E) :** The setting is physically accessible to the individual.

3-18	The individual has a lease or other written occupancy agreement that provides eviction protections and due process/appeals and specifies the circumstances when he/she could be required to relocate.	Met/Not Met	**636-1.4(b)(1) :** Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.
3-19	There is evidence that the individual and/or their representative knows/understands their right to due process/appeals and when he/she could be required to relocate.	Met/Not Met	**636-1.4(b)(1) :** Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-21	The individual controls their personal resources and decides how to spend their personal discretionary funds.	Met/Not Met	**633.15(c)(5)-(6) :** The expenditure of personal allowance must personally benefit the person and reflect his/her personal spending choices. The person shall be involved in all decisions regarding the use of his/her personal allowance funds. OMRDD assumes that all people with developmental disabilities have some capacity for self-advocacy and decision making related to the expenditure of personal allowance.

3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii) :** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)** : No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a-1	When interventions that restrict or modify the individual's rights are used (not part of a behavior support plan), the individual's service plan includes a description of the positive and less intrusive approaches that have been tried but have not been successful.	Met/Not Met	**636-1.4(c)(2)-(3) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (2) the positive interventions and supports used prior to any modifications; (3) less intrusive methods of meeting the need that were tried but did not work. Pathway to employment if activities occur at in agency setting.
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan),	Met/Not Met	**636-1.4 (c)(1) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan; (1) a specific and individualized assessed need underlying the reason for the modification.

	The individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights modification (clinical justification).		**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.	Met/Not Met	**636-1.4(b) :** Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: **441.430 (c)(4) (vi)(F) :** any modification of the additional conditions, under 441.301 (C)(4)(vi)(A)-(D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan. …4. include a clear description of the condition that is directly proportionate to the specific assessed need 5. Include a regular collection and review of data to measure the ongoing effectiveness of the modification. … 8. Include an assurance that interventions and supports will cause no harm to the individual.
3a-5	The individual has given informed consent to the rights limitations/restrictions in place.	Met/Not Met	**441.430 (c)(4) (vi)(F) :** Any modification of the additional conditions, under 441.301 (C)(4)(vi)(A)-(D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in

			the person-centered service plan. … 7. Include the informed consent of the individual.
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community.	Met/Not Met	**441.301 (C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.	Met/Not Met	**441.301(C)(4)(vi)(C):** : Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time. **441.301(C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are meaningful to them for the period of time desired.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes. **636-1.2(3)(ii) :** supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and

6-1	The individual is satisfied with their living situation and does not express a desire (when questioned) to move to another living setting and/or with another roommate.	Met/Not Met	**636-1.3(b)(7) :** if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life); **636-1.4(b)(2)(ii) :** The individual sharing a unit has a choice of roommates in that setting.
6-2	If the individual is NOT satisfied with living situation, there is evidence that the staff is proactively working to find an alternate arrangement based on the person's needs, choices and preferences in a timely manner.	Met/Not Met	**636-1.3(b)(7) :** … if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life); **636-1.4(b)(2)(ii) :** The individual sharing a unit has a choice of roommates in that setting. **633.4(a)(4)(xxii) :** No person shall be denied the opportunity to request an alternative residential setting, whether a new residence or change of room, and involvement in the decisions regarding such changes.

6-3	The individual's personal living spaces(s) reflect their individualized interest and tastes.	Met/Not Met	**636-1.4(b)(2)(iii) :** No person shall be denied the opportunity to request an alternative residential setting, whether a new residence or change of room, and involvement in the decisions regarding such changes.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**686.16(b)(3) :** OPWDD shall verify that each person has a plan for protective oversight, based on an analysis of the person's need for same, and that such need has periodically, but at least annually, been reviewed, revised as appropriate, and integrated, as appropriate, with other services received. **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (i) An assessment of functional capacity. (ii) Review and evaluation of the person's written plan of services and his or her progress in relation to that plan; **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation;

			Day Habilitation (in certified day habilitation sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY.
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x):**: No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **686.16(b)(4)(ii)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following:… (ii) any parties with supervision responsibilities are aware of the specifics of

			each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and

			guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services. **686.16(b)(4)(ii)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: … (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
7-5	The individual is provided dining supports for consistency, assistance, and	Met/Not Met	**ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train

	monitoring per his/her written plan and as needed.		Applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and

			guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **686.16(b)(4)(ii)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: … (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan. **635.10.4(b)(xvi) :** Effective October 1, 2015, residential habilitation services in a supervised IRA include the following clinical services delivered to an individual that are directly related to the individual's residential habilitation plan: (a) nutrition services that consist of meal planning and monitoring, assessment of dietary needs and weight changes, development of specialized diets, diet education, and food safety and sanitation training,
7-6	The individual's needs for support and assistance related to fire safety and evacuation are documented according to service/setting requirements.	Met/Not Met	**686.16(b)(2) :** For individualized residential alternatives of eight or fewer beds, OMRDD shall verify that each person's individualized services plan (see glossary) contains a current evaluation of the fire evacuation capacity of the person based on actual performance. OMRDD shall verify the accuracy of the information in each person's individualized services plan relative to fire evacuation performance.
7-7	The individual is provided the necessary supports and assistance related to fire safety and evacuation.	Met/Not Met	**686.16(b)(1) :** OMRDD shall verify that each individualized residential alternative has implemented a facility evacuation plan. OMRDD shall verify that staff and persons residing in the facility are trained and evaluated regarding their performance of said plan. **686.16(b)(4)(i)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: (i) any

			parties with supervision responsibilities have received training appropriate to the protective oversight needs of the persons in the facility including, but not limited to, first aid; (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan. **ADM 2012-02 Fire Safety** Attachment: Essential El : Fire drills and evacuation drills are also essential to ensure that all staff on all shifts are trained to perform their assigned tasks outlined in the facility's evacuation plan and to ensure that all staff on all shifts are familiar with the use of the facility's fire protection equipment. In addition, individuals who are capable should be trained to participate and respond to fires or other emergency conditions. Drills also serve to provide agencies with a mechanism for evaluating the effectiveness of evacuation and disaster plans on an on-going basis and to capture information on changes in consumer status. Changes such as those resulting from advancing age, medical changes or new admissions may result in the need to modify the physical environment of the facility, revise the evacuation plan or provide additional staff resources to the facility to meet consumer needs.
7-8	The individuals is provided necessary supports necessary to facilitate financial stability and freedom from financial exploitation.	Met/Not Met	**633.4(a)(4)(xvi) :** No person shall be denied: … the use of his or her personal money and property, including regular notice of his or her financial status and the provision of assistance in the use of his or her resources, as appropriate. **633-15(j)(1)-(2) :** (1)The agency or sponsoring agency shall ensure that expenditure planning for personal allowance is conducted on at least an annual basis for each person for whom it is managing personal allowance. Documentation of the expenditure planning shall be incorporated into a personal expenditure plan (PEP). (2) Expenditure planning shall be done by an individual's expenditure planning team which includes the person, his or her advocate and service coordinator, if applicable; and relevant agency staff and the family care provider. **633-15(d)(1);** :

			Each agency which operates a residential facility or sponsors a family care home and manages personal allowance; or operates a non-residential facility or service and accepts responsibility for handling the personal allowance of residents of residential facilities; shall develop and implement policies and procedures to ensure safeguarding and accurate accounting of such personal allowance. **633-15(d)(4) :** Policies and procedures shall indicate that the use of personal allowance is to benefit the person only and shall reflect the person's personal spending choices in expenditures made. Policies and procedures shall include a process for individual personal expenditure planning and the implementation of a personal expenditure plan (PEP).
8a-1	A health assessment which identifies the individual's health care needs has been completed by a physician, PA, NP or RN.	Met/Not Met	**633.10(a)(2)(iii)** : (2) In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (iii) For persons in a residential facility, at least a medical/dental evaluation by a physician or registered physician's assistant addressing the person's need for an examination or specific medical/dental services; or by a dentist for dental services. The determination of the basis for such evaluation (e.g., appraisal of the person through records and previous contacts) shall be that of the qualified professional.
8a-2	The individual has someone chosen/delegated to support them in coordinating their health care.	Met/Not Met	**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.

			ADM 2003-01 : A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities….The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition.
8a-3	The individual's service plan identifies the services and supports necessary to access and receive routine professional medical care and evaluation.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: …(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;… **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-4	The individual's routine health care providers are identified and known to the person and/or their supports.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	Met/Not Met	**633.10(b)(3) :** OPWDD shall verify that staff have been made aware of their responsibilities in accordance with the agency/facility plan. [Context: 633.10(2) States:" There is a written plan specifying how the agency/facility will deal with life

			threatening emergencies. Such a plan shall address: (i) First aid. (ii) CPR. (iii) Access to emergency medical services."]
8a-6	The individual receives routine medical exams/medical appointments per his/her health care professionals' recommendations.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-7	The individual receives diagnostic evaluation/testing per his/her health care professionals' recommendations and standard safe practice (e.g. Lab work, x-rays, scans, MRIs, etc.)	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-8	The individual receives preventative testing and/or care based on recommended professional guidelines for	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;

	medical conditions, gender and age.		**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-9	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender, and age.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-10	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met/NA	**ADM 2003-01 :** The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition.
8a-11	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;

	NOT APPLY TO MEDICATION.		**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **686.16(b)(4)(ii)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: … (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
8a-12	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **633.17(a)(15)(i)-(ii) :** Supervision and monitoring of staff. (i) Medical or nursing supervision of those staff responsible for administering medication shall be provided. (ii) Supervision and monitoring shall be in accordance with agency/facility policies/procedures. **ADM 2003-01 :** A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities.
8a-13	The individual and/or their support(s) report the individual's health concerns/symptoms to	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:…(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;

	appropriate parties as needed or directed**.**		**ADM 2003-01 :** The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.
8a-14	The individual's emerging signs/symptoms are reported to a health care professional, and monitored and addressed appropriately.	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:…(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-15	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met/NA	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person,
8a-16	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.

8a-17	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA	**633.17(b)(3) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication.
8a-18	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. … **633.17(a)(7) :** All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling. **ADM 2003-01 :** The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.
8a-19	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**633.17(b)(8) :** OPWDD shall verify that the medication regimen of each person in a residential facility has been reviewed at least semi-annually by a registered nurse, physician, physician's assistant, or pharmacist.
8a-20	The individual exhibits a healthy lifestyle and/or receives support(s) to replace	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes**.**

	The unhealthy behaviors with healthier actions.		
8a-21	The individual is provided choice in health care providers.	Met/Not Met	**633.4(a)(4)(x) :** (4) No person shall be denied:. (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-22	The individual is supported to advocate and is included in informed decision-making related to medical care and treatment.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-23	Individuals have been given the opportunity to have advanced directives in place (DNR order, healthcare proxy, or living will).	Met/Not Met	**633.4(a)(4)(xxv)-(xxvi) :** (4) No person shall be denied: .(xxv) the opportunity to make, or have made on his or her behalf, an informed decision regarding cardiopulmonary resuscitation (see glossary), in accordance with the provisions of article 29-B of the Public Health Law, and any other applicable law or regulation. Each developmental center (see glossary) shall adopt policies/procedures to actualize this right. (xxvi) the opportunity, if the person is residing in an OPWDD operated or certified facility, to create a health care proxy (see glossary) in accordance with 14 NYCRR 633.20.
8a-24	For those that have advanced directives, they are completed properly in accordance with the Healthcare Decisions Act.	Met/Not Met	**633.10(a)(7)(ii) :** Upon receipt of notification of a decision to withdraw or withhold life-sustaining treatment in accordance with section 1750-b(4)(e)(ii) of the Surrogate's Court Procedure Act (SCPA), the chief executive officer (see glossary, section 633.99 of this Part) of the agency (see glossary, section 633.99 of this Part) shall confirm that the person's condition meets all of the criteria set forth in SCPA section 1750-b(4)(a) and (b). In the event that the chief executive officer is not convinced that all of the necessary criteria are

			met, he or she may object to the decision and/or initiate a special proceeding to resolve such dispute in accordance with SCPA section 1750-b(5) and (6).
8a-25	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA	**633.4(a)(4)(x) :** (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-27	The individual is given access to family planning resources and sexuality education and/or counseling if desired.	Met/Not Met/NA	**633.4(a)(4)(xi) :** (4) No person shall be denied:...(xi) access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated.
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall	Met/Not Met	**Quality Indicator**

	with the medical care that the individual receives.		This is an indicator of quality outcomes.
9-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	Met/Not Met	**633.16(d)(1)-(2) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive

			services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	Met/Not Met	**633.16(d)(1)(i - v)** : Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other

			data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.

9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii):** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional

			components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.

9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(j)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive

			intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation

			of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to	Met/Not Met	**633.16(e)(4)(i):** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section.

	implementation and approval is current.		**633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an	Met/Not Met/NA	**633.16(j)(2)(ii) :**

	emergency is documented in the individual's record.		In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.

9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90

			days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.

9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(i)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a

	supervision of a senior member of the staff.		senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(j)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(j)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(j)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person’s behavior which

	timeframes or if he/she appeared physically at risk.		necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program

	period resulted in a comprehensive review.		planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.

9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)** : Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9e-1	Medication to address the individual's challenging behavior or a symptom of a diagnosed co-occurring psychiatric disorder is administered only as a part of a BSP or Monitoring Plan which includes additional interventions.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9e-2	Written Informed Consent for use of medication by the individuals has been obtained and is current.	Met/Not Met	**633.16(j)(5)(ii)(b) :** Written informed consent shall be obtained prior to the use of the medication. If it is necessary for the medication to be administered before written informed consent can reasonably be obtained, verbal consent may be accepted for only the period of time before written informed consent can be obtained. Verbal consent must be witnessed by two members of the staff and documented in the person's record. This verbal consent may be considered valid for a period of up to 45 days.

9e-3	When the plan includes the medication the Individual's service record includes a semi-annual medication regimen review that is used to evaluate the benefits/risk of continuation.	Met/Not Met	**633.16(j)(5)(i)(d) :** A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
9e-4	The Individual's service record includes evidence that the prescriber was consulted regarding administration and continued effectiveness of the medication.	Met/Not Met	**633.16(j)(5)(i)(e)** : At least semi-annually, and more frequently as needed, staff shall consult with the prescriber regarding the administration and continued effectiveness of the medication.
9e-5	The Individual's service record includes evidence that the use of medication is having a positive effect on his/her behavior or target symptoms.	Met/Not Met	**633.16(j)(5)(ii)(c) :** The use of medication shall have a documented positive effect on the person's behavior or target symptoms to justify its ongoing use.
9e-6	The Individual's service record includes evidence that the effectiveness of the medication has been re-evaluated at least semi-annually at the program plan review with required service attendees.	Met/Not Met	**633.16(j)(5)(ii)(d)** : The effectiveness of the medication shall be re-evaluated at least semi-annually at the program plan reviews by the program planning team in consultation with a licensed psychologist, licensed clinical social worker, or behavior intervention specialist, and a health care professional. The goal(s) of this aspect of the plan review include: ensuring that medication is at the minimum and most effective dose; identifying a potential need for a medication with fewer or less intrusive side effects; evaluating the evidence

			presented to support continuation of the medication at a maintenance level, or recommending reduction or discontinuation of medication use if clinically indicated and authorized by the prescriber.
9e-7	Medications were administered in accordance with requirements.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9f-1	When prn medication is prescribed to address behavior or symptoms of a psychiatric disorder, this strategy is included in the Individual's Behavioral Support or Monitoring Plan.	Met/Not Met/NA	**633.16(j)(5)(iii)(a) :** As-needed (also known as PRN) orders for medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, are considered planned use and must be incorporated in and documented as part of a behavior support plan or a monitoring plan.
9f-2	The Individual's service record includes evidence of the display of the behavior(s) or symptom(s) for which the PRN medication is being prescribed in the past 12 months.	Met/Not Met/NA	**633.16(j)(5)(iii)(b) :** Planned use of as-needed orders for medication: The person shall have a recent documented history of displaying the behavior(s) or symptoms (occurring in the last 12 months) for which the as-needed medication is being prescribed.
9f-3	The Individual's Behavioral Support or Monitoring Plan provides instruction and guidance for administration of the PRN medication,	Met/Not Met/NA	**633.16(j)(5)(iii)(c)(1-3) :** The behavior support plan or monitoring plan, consistent with the prescriber's order, shall clearly state: (1) the conditions under which the as-needed medication is to be administered, including the nature and degree of the individual's behavior(s) or symptoms, and the prescriber's recommendations

	consistent with the prescriber's order.		regarding proximity to any scheduled medication administration; (2) the expected therapeutic effects; and (3) if applicable, the conditions under which the medication can be re-administered, and the allowable frequency of re-administration.
9f-4	The Individual's service record must include a summary, in behavioral terms, of the results of the PRN medication administration.	Met/Not Met/NA	**633.16(j)(5)(iii)(d) :** Planned use of as-needed orders for medication: The staff person or family care provider who is responsible for support and supervision of a person who has a behavior support plan or monitoring plan must document in the person's clinical record a summary of the results of the medication use in behavioral terms.
9f-5	The Individual's service record includes evidence that any adverse or unexpected side effects were reported to the PRN prescriber immediately and the planning team by the next business day.	Met/Not Met/NA	**633.16(j)(5)(iii)(e) :** ~~Planned use of as-~~needed orders for medication: Results that are substantively different from the intended effect, and any adverse side effects, shall be reported to the prescriber immediately and the person's program planning team no later than the next business day.
9f-6	Use of PRN Medications on more than four (4) separate days in a 14-day period resulted in consideration of a recommendation for incorporation into a regular drug regimen.	Met/Not Met/NA	**633.16(j)(5)(iii)(f) :** If any as-needed medication is administered on more than four separate days (one day equals 24 hours) in a 14-day period, the individual's program planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist and healthcare professional, must reassess the appropriateness of continuing the as-needed medication, or consider recommending that it be incorporated into the individual's regular drug regimen.
9f-7	Lack of use of a PRN medication during a six-month period resulted in a review of the BSP and a	Met/Not Met/NA	**633.16(j)(5)(iii)(h) :** If the as-needed medication is not administered during a six-month period, the program planning team, in consultation with the licensed psychologist,

	recommendation to the prescriber.		licensed clinical social worker, or behavioral intervention specialist, must review the behavior support plan and develop a recommendation to the prescriber regarding the appropriateness of continuing the as-needed medication as part of the plan. If the order is continued, a clear justification is to be documented in the record.
9f-8	Effectiveness of the medication ordered in an emergency is documented in the Individual's record.	Met/Not Met/NA	**633.16(J)(5)(iv)(c) :** Emergency use of medication: The use of the medication, along with the prescription/order and a note on its effectiveness, shall be documented in the person's record.
9f-9	Emergency use of medication in more than 4 instances in a 14-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(J)(5)(iv)(d) :** Emergency use of medication. The emergency use of medication to control challenging behavior or acute symptoms of a co-occurring diagnosed psychiatric disorder in more than four instances in a 14-day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, a licensed clinical social worker or behavioral intervention specialist within three business days of the fifth medication administration.
9f-10	Use of PRN medications in conjunction with a restrictive physical intervention technique were reported electronically to OPWDD.	Met/Not Met/NA	**633.16(j)(5)(iii)(g) :** Each use of an as-needed medication when used in conjunction with a restrictive physical intervention technique to prevent, modify, or control challenging behavior shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9g-1	The Individual's record identifies the symptoms he/she exhibits and each co-occurring psychiatric disorder diagnosis.	Met/Not Met	**633.16(j)(5)(vi)(e) :** Medication use to treat a co-occurring diagnosed psychiatric disorder. Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such

			circumstances, the following requirement must be met. (e) The symptoms and diagnosis of the co-occurring psychiatric disorder must be documented.
9g-2	The Individual's Monitoring Plan clearly identifies target symptoms associated with each medication prescribed for a psychiatric disorder.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented.
9g-3	The Individual's Monitoring Plan includes the method to measure and document symptom reduction and functional improvement.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.

9g-4	The Individual's Monitoring Plan includes alternative interventions (other than medication).	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-5	The individual's Monitoring Plan is developed by a qualified clinician.	Met/Not Met	**633.16(b)(29) :** Plan, monitoring. A plan developed by a licensed psychologist, licensed psychiatric nurse practitioner, licensed clinical social worker, or a behavioral intervention specialist that identifies the target symptoms of a co-occurring diagnosed psychiatric disorder that are to be prevented, reduced, or eliminated.
9g-6	The effectiveness of the individual's Monitoring Plan in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(j)(5)(j)(d)** : A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person’s program planning team

			and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.

10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4) :** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)

10b-3	Investigations of Reportable Incidents and Notable	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate.

	Occurrences involving the individual are thorough and documented.		**624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)

10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).

10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(j)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l) :** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a

			report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** : Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3) :**

			When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)

10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met	**624.7(b)(2): :** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3): :** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial

			action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(j)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met	**625.4(b)(2)(i-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(b)(1) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions;
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports

			to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **ADM 2012-01 :** The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**636-1.2(b)(3) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-16	The individual's goals and priorities regarding	Met/Not Met	**636-1.2(a) :**

	meaningful relationships are identified in the person centered plan.		A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**636-1.3(b)(8) :** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed;
1-28	The plan is written in plain language, in a manner that is	Met/Not Met	**636-1.2(b)(3) :**

	accessible to the individual and parties responsible for the implementation of the plan.		A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**ADM 2012-01 :** Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or his/her advocate.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**636-1.2(b)(4) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). **635-10.4(b) :**

	HCBS Waiver Service providers.		Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments.
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). **633.4(a)(4))(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible.

2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2012-01 :** Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: an ISP review date, or the date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**ADM 2012-10 Habilitation Plan Requirements : pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has

			been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. ... c. Exploration of new experiences is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ... **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(b)(1)** : For Residential Habilitation Services: Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments. Habilitation services are directed toward acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. services offered are designed to correspond to the person's strengths and needs. These services include activities and tasks required to design, implement and support the individualized service plan. ... (1) Residential habilitation services are generally provided in the

			person's home, and include assistance with acquisition, retention or improvement in skills related to life safety and fire evacuation; to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food; and social and adaptive skills necessary to enable the person to reside in a noninstitutional setting. ... **633.4(a)(4)(viii)-(ix)**: No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**636-1.2(a)(3)(ii) :** The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**ADM 2014-01 :** The required service documentation format for the daily Supervised IRA-RH service is a Daily Narrative Note format or a checklist with a monthly summary note, which must be completed by the staff person who delivers the service or is knowledgeable of service delivery.

2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**ADM 2014-04 :** Habilitation Supports and services are focused on the development of skills that are needed in order to facilitate greater degrees of choice, independence, autonomy and full participation in community life…. **441.301 4 (C)(4)(iii) :** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint. **441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress

	are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.		and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers. **635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include

			recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives.....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of

			a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii) :** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1) :** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-4	The individual is informed of their HCBS rights.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5) :** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3) :** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.

3-7	The individual is supported to express themselves through personal choices/decisions on style of dress and grooming preferences.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-8	The individual is supported to participate in cultural/religious/associational practices, educuation, celebrations and experiences per their interests and preferences.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-9	The individual is supported to have visitors of their choosing according their preferences.	Met/Not Met	**636-1.4(b)(4) :** Each individual is able to have visitors of his or her choosing at any time.
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support.	Met/Not Met	**636-1.4(b)(2) :** Each individual has privacy in his or her sleeping or living unit. **633.4(a)(xx) :** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
3-11	The individual is aware that he/she is not required to follow a particular schedule for waking up, going to bed, eating, leisure activities, etc.	Met/Not Met	**636-1.4(b)(3) :** Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-12	The individual is encouraged and supported to make their own scheduling choices and	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed

	changes according to their preferences and needs.		need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-13	The individual can choose to eat meals when they want to, even if mealtimes occur at routine or scheduled times.	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-14	The individual has access/is supported to have access to food at any time and to store their own food and snack choices for their use at any time as desired, similar to people without disabilities.	Met/Not Met	**636-1.4(b)(3)** : (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-15	The individual is supported to have independent access to the site/service setting with freedom to come and go as desired, similar to people without disabilities.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

3-17	The setting reflects the individual's needs and preferences including the presence of any necessary physical modifications, if applicable.	Met/Not Met	**441.301(C)(4)(ii) :** The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board. **441.430 (c)(4)(vi)(E) :** The setting is physically accessible to the individual.
3-18	The individual has a lease or other written occupancy agreement that provides eviction protections and due process/appeals and specifies the circumstances when he/she could be required to relocate.	Met/Not Met	**636-1.4(b)(1) :** Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.
3-19	There is evidence that the individual and/or their representative knows/understands their right to due process/appeals and when he/she could be required to relocate.	Met/Not Met	**636-1.4(b)(1) :** Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.

3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-21	The individual controls their personal resources and decides how to spend their personal discretionary funds.		**633.15(c)(5)-(6) :** The expenditure of personal allowance must personally benefit the person and reflect his/her personal spending choices. The person shall be involved in all decisions regarding the use of his/her personal allowance funds. OMRDD assumes that all people with developmental disabilities have some capacity for self-advocacy and decision making related to the expenditure of personal allowance.
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii) :** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)** : No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a-1	When interventions that restrict or modify the individual's rights are used (not part of a behavior support plan), the individual's service plan includes a	Met/Not Met	**636-1.4(c)(2)-(3) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (2) the positive interventions and supports used prior to any modifications; (3) less intrusive methods of meeting the need that were tried but did not work. Pathway to employment if activities occur at in agency setting.

	description of the positive and less intrusive approaches that have been tried but have not been successful.		
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights modification (clinical justification).	Met/Not Met	**636-1.4 (c)(1) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan; (1) a specific and individualized assessed need underlying the reason for the modification. **633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.	Met/Not Met	**636-1.4(b) :** Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: **441.430 (c)(4) (vi)(F) :** any modification of the additional conditions, under 441.301 (C)(4)(vi)(A)-(D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan. ...4. include a clear description of the

			condition that is directly proportionate to the specific assessed need 5. include a regular collection and review of data to measure the ongoing effectiveness of the modification. ... 8. include an assurance that interventions and supports will cause no harm to the individual.
3a-5	The individual has given informed consent to the rights limitations/restrictions in place.	Met/Not Met	**441.430 (c)(4) (vi)(F) :** Any modification of the additional conditions, under 441.301 (C)(4)(vi)(A)-(D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan. ... 7. include the informed consent of the individual.
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community.	Met/Not Met	**441.301 (C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.	Met/Not Met	**441.301(C)(4)(vi)(C):**: Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time. **441.301(C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	meaningful to them for the period of time desired.		
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes. **636-1.2(3)(ii) :** supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and
6-1	The individual is satisfied with their living situation and does not express a desire (when questioned) to move to another living setting and/or with another roommate.	Met/Not Met	**636-1.3(b)(7) :** if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life); **636-1.4(b)(2)(ii) :** The individual sharing a unit has a choice of roommates in that setting.
6-2	If the individual is NOT satisfied with living situation, there is evidence that the staff is proactively working to find an alternate arrangement based on the person's needs, choices and preferences in a timely manner.	Met/Not Met	**636-1.3(b)(7) :** ... if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life);

			636-1.4(b)(2)(ii) : The individual sharing a unit has a choice of roommates in that setting. **633.4(a)(4)(xxii) :** No person shall be denied the opportunity to request an alternative residential setting, whether a new residence or change of room, and involvement in the decisions regarding such changes.
6-3	The individual's personal living spaces(s) reflect their individualized interest and tastes.	Met/Not Met	**636-1.4(b)(2)(iii) :** No person shall be denied the opportunity to request an alternative residential setting, whether a new residence or change of room, and involvement in the decisions regarding such changes.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**686.8(a)(1) :** Each person in a supportive community residence shall have sufficient oversight and guidance to ensure that his or her health, safety and welfare are addressed. The amount and type of oversight and guidance provided shall be directly related to systematic formal assessment and ongoing review of all persons' need for such supervision. A person requiring long-term residential oversight and guidance in excess of an average 21 hours per week is considered inappropriate for placement in a supportive community residence. **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (i) An assessment of functional capacity. (ii) Review and evaluation of the person's written plan of services and his or her progress in relation to that plan; **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while

			participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation; Day Habilitation (in certified day habilitation sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY.
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x):** : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons

			receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **686.7(b)(3)-(4) :** (3) OPWDD shall verify that the plan of services, on an overall basis, is being implemented as developed ; (4) OMRDD shall verify that the staff in the community residence having program and/or supervision responsibilities for a specific person know what their role and/or responsibilities are in carrying out the person's plan of services. **671.6(a)(7) :** The plan of services shall be delivered by appropriately trained and supervised staff of the facility.
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons

			receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **686.7(b)(3)-(4) :** "(3) OPWDD shall verify that the plan of services, on an overall basis, is being implemented as developed. (4) OMRDD shall verify that the staff in the community residence having program and/or supervision responsibilities for a specific person know what their role and/or responsibilities are in carrying out the person's plan of services."
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons

			receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services. **686.7(b)(3)-(4) :** (3) OPWDD shall verify that the plan of services, on an overall basis, is being implemented as developed (4) OMRDD shall verify that the staff in the community residence having program and/or supervision responsibilities for a specific person know what their role and/or responsibilities are in carrying out the person's plan of services. **671.6(a)(7) :** The plan of services shall be delivered by appropriately trained and supervised staff of the facility.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met	**ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified

			applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **ADM 2012-01 Habilitation Plan Requirements ; Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **633.4(a)(4)(viii)-(ix) ;** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **686.7(b)(3)-(4) ;** (3) OPWDD shall verify that the plan of services, on an overall basis, is being implemented as developed (4) OMRDD shall verify that the staff in the community residence having program and/or supervision responsibilities for a specific person know what their role and/or responsibilities are in carrying out the person's plan of services. **671.6(a)(7) :**

			The plan of services shall be delivered by appropriately trained and supervised staff of the facility.
7-6	The individual's needs for support and assistance related to fire safety and evacuation are documented according to service/setting requirements.	Met/Not Met	**ADM 2012-01 Habilitation Plan Requirements :** Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-7	The individual is provided the necessary supports and assistance related to fire safety and evacuation.	Met/Not Met	**686.7(b)(3)-(4) :** (3) OPWDD shall verify that the plan of services, on an overall basis, is being implemented as developed. (4) OMRDD shall verify that the staff in the community residence having program and/or supervision responsibilities for a specific person know what their role and/or responsibilities are in carrying out the person's plan of services. **ADM 2012-02 Fire Safety** Attachment: Essential El : Fire drills and evacuation drills are also essential to ensure that all staff on all shifts are trained to perform their assigned tasks outlined in the facility's evacuation plan and to ensure that all staff on all shifts are familiar with the use of the facility's fire protection equipment. In addition, individuals who are capable should be trained to participate and respond to fires or other emergency conditions. Drills also serve to provide agencies with a mechanism for evaluating the effectiveness of evacuation

			and disaster plans on an on-going basis and to capture information on changes in consumer status. Changes such as those resulting from advancing age, medical changes or new admissions may result in the need to modify the physical environment of the facility, revise the evacuation plan or provide additional staff resources to the facility to meet consumer needs.
7-8	The individuals is provided necessary supports necessary to facilitate financial stability and freedom from financial exploitation.	Met/Not Met	**633.4(a)(4)(xvi) :** No person shall be denied: … the use of his or her personal money and property, including regular notice of his or her financial status and the provision of assistance in the use of his or her resources, as appropriate. **633-15(j)(1)-(2) :** (1)The agency or sponsoring agency shall ensure that expenditure planning for personal allowance is conducted on at least an annual basis for each person for whom it is managing personal allowance. Documentation of the expenditure planning shall be incorporated into a personal expenditure plan (PEP). (2) Expenditure planning shall be done by an individual's expenditure planning team which includes the person, his or her advocate and service coordinator, if applicable; and relevant agency staff and the family care provider. **633-15(d)(1):** : Each agency which operates a residential facility or sponsors a family care home and manages personal allowance; or operates a non-residential facility or service and accepts responsibility for handling the personal allowance of residents of residential facilities; shall develop and implement policies and procedures to ensure safeguarding and accurate accounting of such personal allowance. **633-15(d)(4) :** Policies and procedures shall indicate that the use of personal allowance is to benefit the person only and shall reflect the person's personal spending choices in expenditures made. Policies and procedures shall include a process for individual personal expenditure planning and the implementation of a personal expenditure plan (PEP).

8a-1	A health assessment which identifies the individual's health care needs has been completed by a physician, PA, NP or RN.	Met/Not Met	**633.10(a)(2)(iii)**: (2) In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (iii) For persons in a residential facility, at least a medical/dental evaluation by a physician or registered physician's assistant addressing the person's need for an examination or specific medical/dental services; or by a dentist for dental services. The determination of the basis for such evaluation (e.g., appraisal of the person through records and previous contacts) shall be that of the qualified professional.
8a-2	The individual has someone chosen/delegated to support them in coordinating their health care.	Met/Not Met	**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **ADM 2003-01 :** A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities….The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition.
8a-3	The individual's service plan identifies the services and supports necessary to access and receive routine	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: ...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;...

	professional medical care and evaluation.		**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-4	The individual's routine health care providers are identified and known to the person and/or their supports.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	Met/Not Met	**633.10(b)(3) :** OPWDD shall verify that staff have been made aware of their responsibilities in accordance with the agency/facility plan. [Context: 633.10(2) States:" There is a written plan specifying how the agency/facility will deal with life threatening emergencies. Such a plan shall address: (i) First aid. (ii) CPR. (iii) Access to emergency medical services."]
8a-6	The individual receives routine medical exams/medical appointments per his/her health care professionals' recommendations.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.

8a-7	The individual receives diagnostic evaluation/testing per his/her health care professionals' recommendations and standard safe practice (e.g. Lab work, x-rays, scans, MRIs, etc.)	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-8	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender and age.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-9	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender, and age.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;

			633.10(a)(1) : Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-10	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met/NA	**ADM 2003-01 :** The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition.
8a-11	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **686.16(b)(4)(ii)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: ... (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
8a-12	The individual's health care services are competently	Met/Not Met	**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully,

	overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.		safely and humanely administered with full respect to his or her dignity and personal integrity. **633.17(a)(15)(i)-(ii) :** Supervision and monitoring of staff. (i) Medical or nursing supervision of those staff responsible for administering medication shall be provided. (ii) Supervision and monitoring shall be in accordance with agency/facility policies/procedures. **ADM 2003-01 :** A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities.
8a-13	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed**.**	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2003-01 :** The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.
8a-14	The individual's emerging signs/symptoms are reported to a health care professional, and monitored and addressed appropriately.	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-15	The individual's current medications are correctly documented as prescribed	Met/Not Met/NA	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which

	when support for administration is needed/provided.		documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person,
8a-16	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8a-17	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA	**633.17(b)(3) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication.
8a-18	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ... **633.17(a)(7) :** All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling.

			ADM 2003-01 : The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.
8a-19	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**633.17(b)(8) :** OPWDD shall verify that the medication regimen of each person in a residential facility has been reviewed at least semi-annually by a registered nurse, physician, physician's assistant, or pharmacist.
8a-20	The individual exhibits a healthy lifestyle and/or receives support(s) to replace the unhealthy behaviors with healthier actions.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes**.**
8a-21	The individual is provided choice in health care providers.	Met/Not Met	**633.4(a)(4)(x) :** (4) No person shall be denied:. (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-22	The individual is supported to advocate and is included in informed decision-making related to medical care and treatment.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes**.**
8a-23	Individuals have been given the opportunity to have advanced directives in place	Met/Not Met	**633.4(a)(4)(xxv)-(xxvi) :** (4) No person shall be denied: .(xxv) the opportunity to make, or have made on his or her behalf, an informed decision regarding cardiopulmonary

	(DNR order, healthcare proxy, or living will).		resuscitation (see glossary), in accordance with the provisions of article 29-B of the Public Health Law, and any other applicable law or regulation. Each developmental center (see glossary) shall adopt policies/procedures to actualize this right. (xxvi) the opportunity, if the person is residing in an OPWDD operated or certified facility, to create a health care proxy (see glossary) in accordance with 14 NYCRR 633.20.
8a-24	For those that have advanced directives, they are completed properly in accordance with the Healthcare Decisions Act.	Met/Not Met	**633.10(a)(7)(ii) :** Upon receipt of notification of a decision to withdraw or withhold life-sustaining treatment in accordance with section 1750-b(4)(e)(ii) of the Surrogate's Court Procedure Act (SCPA), the chief executive officer (see glossary, section 633.99 of this Part) of the agency (see glossary, section 633.99 of this Part) shall confirm that the person's condition meets all of the criteria set forth in SCPA section 1750-b(4)(a) and (b). In the event that the chief executive officer is not convinced that all of the necessary criteria are met, he or she may object to the decision and/or initiate a special proceeding to resolve such dispute in accordance with SCPA section 1750-b(5) and (6).
8a-25	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA	**633.4(a)(4)(x) :** (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-27	The individual is given access to family planning resources	Met/Not Met/NA	**633.4(a)(4)(xi) :** (4) No person shall be denied:...(xi) access to clinically sound instructions on the topic of sexuality and family planning services and information about the

	and sexuality education and/or counseling if desired.		existence of these services, including access to medication or devices to regulate conception, when clinically indicated.
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall with the medical care that the individual receives.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
9-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	Met/Not Met	**633.16(d)(1)-(2) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct

			observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	Met/Not Met	**633.16(d)(1)(i - v)** : Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric

	environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.		disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.

	clinician as determined by the interventions in the plan.		
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive

	and reinforcing alternative skills and adaptive behaviors.		(replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii):** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no

	effectiveness of the interventions included in the behavior support plan.		less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(j)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers,

			respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or

			applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights

			included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(i):** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a

			household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.

	required when the device is used.		
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must

			incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :**

	accordance with the Behavior Support Plan.		Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(j)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.

9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(i)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(i)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(i)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid

			pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in

			an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the

			following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)** : Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9e-1	Medication to address the individual's challenging behavior or a symptom of a diagnosed co-occurring psychiatric disorder is administered only as a part of a BSP or Monitoring Plan which includes additional interventions.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9e-2	Written Informed Consent for use of medication by the	Met/Not Met	**633.16(j)(5)(ii)(b) :**

	individuals has been obtained and is current.		Written informed consent shall be obtained prior to the use of the medication. If it is necessary for the medication to be administered before written informed consent can reasonably be obtained, verbal consent may be accepted for only the period of time before written informed consent can be obtained. Verbal consent must be witnessed by two members of the staff and documented in the person's record. This verbal consent may be considered valid for a period of up to 45 days.
9e-3	When the plan includes the medication the Individual's service record includes a semi-annual medication regimen review that is used to evaluate the benefits/risk of continuation.	Met/Not Met	**633.16(j)(5)(i)(d) :** A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
9e-4	The Individual's service record includes evidence that the prescriber was consulted regarding administration and continued effectiveness of the medication.	Met/Not Met	**633.16(j)(5)(i)(e)** : At least semi-annually, and more frequently as needed, staff shall consult with the prescriber regarding the administration and continued effectiveness of the medication.
9e-5	The Individual's service record includes evidence that the use of medication is having a positive effect on his/her behavior or target symptoms.	Met/Not Met	**633.16(j)(5)(ii)(c) :** The use of medication shall have a documented positive effect on the person's behavior or target symptoms to justify its ongoing use.
9e-6	The Individual's service record includes evidence that	Met/Not Met	**633.16(j)(5)(ii)(d)** :

	the effectiveness of the medication has been re-evaluated at least semi-annually at the program plan review with required service attendees.		The effectiveness of the medication shall be re-evaluated at least semi-annually at the program plan reviews by the program planning team in consultation with a licensed psychologist, licensed clinical social worker, or behavior intervention specialist, and a health care professional. The goal(s) of this aspect of the plan review include: ensuring that medication is at the minimum and most effective dose; identifying a potential need for a medication with fewer or less intrusive side effects; evaluating the evidence presented to support continuation of the medication at a maintenance level, or recommending reduction or discontinuation of medication use if clinically indicated and authorized by the prescriber.
9e-7	Medications were administered in accordance with requirements.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9f-1	When prn medication is prescribed to address behavior or symptoms of a psychiatric disorder, this strategy is included in the Individual's Behavioral Support or Monitoring Plan.	Met/Not Met/NA	**633.16(j)(5)(iii)(a) :** As-needed (also known as PRN) orders for medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, are considered planned use and must be incorporated in and documented as part of a behavior support plan or a monitoring plan.
9f-2	The Individual's service record includes evidence of the display of the behavior(s) or symptom(s) for which the PRN medication is being	Met/Not Met/NA	**633.16(j)(5)(iii)(b) :** Planned use of as-needed orders for medication: The person shall have a recent documented history of displaying the behavior(s) or symptoms (occurring in the last 12 months) for which the as-needed medication is being prescribed.

	prescribed in the past 12 months.		
9f-3	The Individual's Behavioral Support or Monitoring Plan provides instruction and guidance for administration of the PRN medication, consistent with the prescriber's order.	Met/Not Met/NA	**633.16(j)(5)(iii)(c)(1-3) :** The behavior support plan or monitoring plan, consistent with the prescriber's order, shall clearly state: (1) the conditions under which the as-needed medication is to be administered, including the nature and degree of the individual's behavior(s) or symptoms, and the prescriber's recommendations regarding proximity to any scheduled medication administration; (2) the expected therapeutic effects; and (3) if applicable, the conditions under which the medication can be re-administered, and the allowable frequency of re-administration.
9f-4	The Individual's service record must include a summary, in behavioral terms, of the results of the PRN medication administration.	Met/Not Met/NA	**633.16(j)(5)(iii)(d) :** Planned use of as-needed orders for medication: The staff person or family care provider who is responsible for support and supervision of a person who has a behavior support plan or monitoring plan must document in the person's clinical record a summary of the results of the medication use in behavioral terms.
9f-5	The Individual's service record includes evidence that any adverse or unexpected side effects were reported to the PRN prescriber immediately and the planning team by the next business day.	Met/Not Met/NA	**633.16(j)(5)(iii)(e) :** Planned use of as-needed orders for medication: Results that are substantively different from the intended effect, and any adverse side effects, shall be reported to the prescriber immediately and the person's program planning team no later than the next business day.
9f-6	Use of PRN Medications on more than four (4) separate days in a 14-day period resulted in consideration of a recommendation for	Met/Not Met/NA	**633.16(j)(5)(iii)(f) :** If any as-needed medication is administered on more than four separate days (one day equals 24 hours) in a 14-day period, the individual's program planning team, in consultation with the licensed psychologist, licensed

	incorporation into a regular drug regimen.		clinical social worker, or behavioral intervention specialist and healthcare professional, must reassess the appropriateness of continuing the as-needed medication, or consider recommending that it be incorporated into the individual's regular drug regimen.
9f-7	Lack of use of a PRN medication during a six-month period resulted in a review of the BSP and a recommendation to the prescriber.	Met/Not Met/NA	**633.16(j)(5)(iii)(h) :** If the as-needed medication is not administered during a six-month period, the program planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist, must review the behavior support plan and develop a recommendation to the prescriber regarding the appropriateness of continuing the as-needed medication as part of the plan. If the order is continued, a clear justification is to be documented in the record.
9f-8	Effectiveness of the medication ordered in an emergency is documented in the Individual's record.	Met/Not Met/NA	**633.16(J)(5)(iv)(c) :** Emergency use of medication: The use of the medication, along with the prescription/order and a note on its effectiveness, shall be documented in the person's record.
9f-9	Emergency use of medication in more than 4 instances in a 14-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(J)(5)(iv)(d) :** Emergency use of medication. The emergency use of medication to control challenging behavior or acute symptoms of a co-occurring diagnosed psychiatric disorder in more than four instances in a 14-day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, a licensed clinical social worker or behavioral intervention specialist within three business days of the fifth medication administration.
9f-10	Use of PRN medications in conjunction with a restrictive physical intervention technique were reported electronically to OPWDD.	Met/Not Met/NA	**633.16(j)(5)(iii)(g) :** Each use of an as-needed medication when used in conjunction with a restrictive physical intervention technique to prevent, modify, or control

			challenging behavior shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9g-1	The Individual's record identifies the symptoms he/she exhibits and each co-occurring psychiatric disorder diagnosis.	Met/Not Met	**633.16(j)(5)(vi)(e) :** Medication use to treat a co-occurring diagnosed psychiatric disorder. Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirement must be met. (e) The symptoms and diagnosis of the co-occurring psychiatric disorder must be documented.
9g-2	The Individual's Monitoring Plan clearly identifies target symptoms associated with each medication prescribed for a psychiatric disorder.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented.
9g-3	The Individual's Monitoring Plan includes the method to measure and document symptom reduction and functional improvement.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address

			challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-4	The Individual's Monitoring Plan includes alternative interventions (other than medication).	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-5	The individual's Monitoring Plan is developed by a qualified clinician.	Met/Not Met	**633.16(b)(29) :** Plan, monitoring. A plan developed by a licensed psychologist, licensed psychiatric nurse practitioner, licensed clinical social worker, or a behavioral intervention specialist that identifies the target symptoms of a co-occurring diagnosed psychiatric disorder that are to be prevented, reduced, or eliminated.

9g-6	The effectiveness of the individual's Monitoring Plan in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(j)(5)(i)(d)** : A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.

10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.

10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4) :** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)

10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate. **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16). **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)

10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).

10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16) **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l) :** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a

			report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** : Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3) :**

			When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30	Met/Not Met	**624.5(n)(1-2) :**

	calendar days after the incident or notable occurrence is reported.		Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met	**624.7(b)(2): ;** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3):** : (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16)

			624.5(i)(2)(j)-(ii) : When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met	**625.4(b)(2)(j-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(b)(1) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions;
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).

			ADM 2012-01 : The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**636-1.2(b)(3) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-16	The individual's goals and priorities regarding meaningful relationships are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the

			individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**636-1.3(b)(8) :** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed;
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**636-1.2(b)(3) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information

			in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**ADM 2012-01 :** Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or his/her advocate.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**636-1.2(b)(4) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). **635-10.4(b) :** Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments.

2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). **633.4(a)(4))(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2012-01 :** Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: an ISP review date, or the

			date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**ADM 2012-10 Habilitation Plan Requirements ; pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. ... c. Exploration of new experiences is an acceptable component of the Habilitation Plan when based on an

			appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ... **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(b)(1)** : For Residential Habilitation Services: Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments. Habilitation services are directed toward acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. services offered are designed to correspond to the person's strengths and needs. These services include activities and tasks required to design, implement and support the individualized service plan. ... (1) Residential habilitation services are generally provided in the person's home, and include assistance with acquisition, retention or improvement in skills related to life safety and fire evacuation; to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food; and social and adaptive skills necessary to enable the person to reside in a noninstitutional setting. ... **633.4(a)(4)(viii)-(ix)** :

			No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**636-1.2(a)(3)(ii) :** The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**ADM 2014-01 :** The required service documentation format for the daily Supervised IRA-RH service is a Daily Narrative Note format or a checklist with a monthly summary note, which must be completed by the staff person who delivers the service or is knowledgeable of service delivery.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs,	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	preferences, and desired outcomes.		
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**ADM 2014-04 :** Habilitation Supports and services are focused on the development of skills that are needed in order to facilitate greater degrees of choice, independence, autonomy and full participation in community life…. **441.301 4 (C)(4)(iii) :** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint. **441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a

			minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers. **635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this

	advancement/achievement of his/her goals/outcomes.		point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives.....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii) :** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1) :** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.

3-4	The individual is informed of their HCBS rights.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5) :** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3) :** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-7	The individual is supported to express themselves through personal choices/decisions on style of dress and grooming preferences.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-8	The individual is supported to participate in cultural/religious/associational practices, educuation, celebrations and experiences	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.

	per their interests and preferences.		
3-9	The individual is supported to have visitors of their choosing according their preferences.	Met/Not Met	**636-1.4(b)(4) :** Each individual is able to have visitors of his or her choosing at any time.
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support.	Met/Not Met	**636-1.4(b)(2) :** Each individual has privacy in his or her sleeping or living unit. **633.4(a)(xx) :** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
3-11	The individual is aware that he/she is not required to follow a particular schedule for waking up, going to bed, eating, leisure activities, etc.	Met/Not Met	**636-1.4(b)(3) :** Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs.	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-13	The individual can choose to eat meals when they want to, even if mealtimes occur at routine or scheduled times.	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each

			individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-14	The individual has access/is supported to have access to food at any time and to store their own food and snack choices for their use at any time as desired, similar to people without disabilities.	Met/Not Met	**636-1.4(b)(3)** : (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-15	The individual is supported to have independent access to the site/service setting with freedom to come and go as desired, similar to people without disabilities.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-17	The setting reflects the individual's needs and preferences including the presence of any necessary physical modifications, if applicable.	Met/Not Met	**441.301(C)(4)(ii) :** The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board. **441.430 (c)(4)(vi)(E) :** The setting is physically accessible to the individual.

3-18	The individual has a lease or other written occupancy agreement that provides eviction protections and due process/appeals and specifies the circumstances when he/she could be required to relocate.	Met/Not Met	**636-1.4(b)(1) :** Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.
3-19	There is evidence that the individual and/or their representative knows/understands their right to due process/appeals and when he/she could be required to relocate.	Met/Not Met	**636-1.4(b)(1) :** Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-21	The individual controls their personal resources and decides how to spend their personal discretionary funds.		**633.15(c)(5)-(6) :** The expenditure of personal allowance must personally benefit the person and reflect his/her personal spending choices. The person shall be involved in all decisions regarding the use of his/her personal allowance funds. OMRDD assumes that all people with developmental disabilities have some capacity for self-advocacy and decision making related to the expenditure of personal allowance.
3-22	The individual is encouraged and supported to advocate for	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	themselves and to increase their self-advocacy skills.		
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii) :** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)** : No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a-1	When interventions that restrict or modify the individual's rights are used (not part of a behavior support plan), the individual's service plan includes a description of the positive and less intrusive approaches that have been tried but have not been successful.	Met/Not Met	**636-1.4(c)(2)-(3) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (2) the positive interventions and supports used prior to any modifications; (3) less intrusive methods of meeting the need that were tried but did not work. Pathway to employment if activities occur at in agency setting.
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies	Met/Not Met	**636-1.4 (c)(1) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan; (1) a specific and individualized assessed need underlying the reason for the modification. **633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and

	the rights restriction or rights modification (clinical justification).		specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.	Met/Not Met	**636-1.4(b) :** Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: **441.430 (c)(4) (vi)(F) :** any modification of the additional conditions, under 441.301 (C)(4)(vi)(A)-(D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan. ...4. include a clear description of the condition that is directly proportionate to the specific assessed need 5. include a regular collection and review of data to measure the ongoing effectiveness of the modification. ... 8. include an assurance that interventions and supports will cause no harm to the individual.
3a-5	The individual has given informed consent to the rights limitations/restrictions in place.	Met/Not Met	**441.430 (c)(4) (vi)(F) :** Any modification of the additional conditions, under 441.301 (C)(4)(vi)(A)-(D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan. ... 7. include the informed consent of the individual.
4-1	The individual is encouraged and supported to have full access to the community based on their	Met/Not Met	**441.301 (C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal

	interests/preferences/priorities for meaningful activities to the same degree as others in the community.		resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.	Met/Not Met	**441.301(C)(4)(vi)(C):** : Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time. **441.301(C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are meaningful to them for the period of time desired.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes. **636-1.2(3)(ii) :** supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and
6-1	The individual is satisfied with their living situation and does not express a desire (when questioned) to move to another living setting and/or with another roommate.	Met/Not Met	**636-1.3(b)(7) :** if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated

			settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life); **636-1.4(b)(2)(ii) :** The individual sharing a unit has a choice of roommates in that setting.
6-2	If the individual is NOT satisfied with living situation, there is evidence that the staff is proactively working to find an alternate arrangement based on the person's needs, choices and preferences in a timely manner.	Met/Not Met	**636-1.3(b)(7) :** ... if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life); **636-1.4(b)(2)(ii) :** The individual sharing a unit has a choice of roommates in that setting. **633.4(a)(4)(xxii) :** No person shall be denied the opportunity to request an alternative residential setting, whether a new residence or change of room, and involvement in the decisions regarding such changes.
6-3	The individual's personal living spaces(s) reflect their individualized interest and tastes.	Met/Not Met	**636-1.4(b)(2)(iii) :** No person shall be denied the opportunity to request an alternative residential setting, whether a new residence or change of room, and involvement in the decisions regarding such changes.
7-1	The individual's specific safeguarding needs and related interventions	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the

	(including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.		person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (i) An assessment of functional capacity. (ii) Review and evaluation of the person's written plan of services and his or her progress in relation to that plan; **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation; Day Habilitation (in certified day habilitation sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY. **686.8(a)(1) :** Each person in a supportive community residence shall have sufficient oversight and guidance to ensure that his or her health, safety and welfare are addressed. The amount and type of oversight and guidance provided shall be directly related to systematic formal assessment and ongoing review of all persons' need for such supervision. A person requiring long-term residential oversight and guidance in excess of an average 21 hours per week is considered inappropriate for placement in a supportive community residence.

7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x):**: No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **671.6(a)(7) :** The plan of services shall be delivered by appropriately trained and supervised staff of the facility.
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful

			recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **686.8(b)(8) :** (8) OPWDD shall verify that scheduled oversight and guidance visitations by the designated party or substitute are being made as scheduled.
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;

			ADM 2012-01 Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services. **671.6(a)(7) :** The plan of services shall be delivered by appropriately trained and supervised staff of the facility.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met	**ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid

			Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **671.6(a)(7) :** The plan of services shall be delivered by appropriately trained and supervised staff of the facility.
7-6	The individual's needs for support and assistance related to fire safety and	Met/Not Met	**686.8(b)(1) :**

	evacuation are documented according to service/setting requirements.		OMRDD shall verify for each individual (other than those 17 years of age or under) newly admitted since the last survey, that such person(s); prior to admission: …(iii) had the ability to evacuate the premises without staff assistance in the event of a fire emergency, or take other appropriate action in such emergency;
7-7	The individual is provided the necessary supports and assistance related to fire safety and evacuation.	Met/Not Met	**686.8(b)(1) :** OMRDD shall verify for each individual (other than those 17 years of age or under) newly admitted since the last survey, that such person(s); prior to admission: …(iii) had the ability to evacuate the premises without staff assistance in the event of a fire emergency, or take other appropriate action in such emergency; **ADM 2012-02 Fire Safety** Attachment: Essential El : Fire drills and evacuation drills are also essential to ensure that all staff on all shifts are trained to perform their assigned tasks outlined in the facility's evacuation plan and to ensure that all staff on all shifts are familiar with the use of the facility's fire protection equipment. In addition, individuals who are capable should be trained to participate and respond to fires or other emergency conditions. Drills also serve to provide agencies with a mechanism for evaluating the effectiveness of evacuation and disaster plans on an on-going basis and to capture information on changes in consumer status. Changes such as those resulting from advancing age, medical changes or new admissions may result in the need to modify the physical environment of the facility, revise the evacuation plan or provide additional staff resources to the facility to meet consumer needs.
7-8	The individuals is provided necessary supports necessary to facilitate financial stability and freedom from financial exploitation.	Met/Not Met	**633.4(a)(4)(xvi) :** No person shall be denied: … the use of his or her personal money and property, including regular notice of his or her financial status and the provision of assistance in the use of his or her resources, as appropriate. **633-15(j)(1)-(2) :** (1)The agency or sponsoring agency shall ensure that expenditure planning for personal allowance is conducted on at least an annual basis for each person for whom it is managing personal allowance. Documentation of the expenditure planning shall be incorporated into a personal expenditure plan (PEP). (2) Expenditure planning shall be done by an individual's expenditure planning team which includes the person, his or her advocate and service

			coordinator, if applicable; and relevant agency staff and the family care provider. **633-15(d)(1):** : Each agency which operates a residential facility or sponsors a family care home and manages personal allowance; or operates a non-residential facility or service and accepts responsibility for handling the personal allowance of residents of residential facilities; shall develop and implement policies and procedures to ensure safeguarding and accurate accounting of such personal allowance. **633-15(d)(4) :** Policies and procedures shall indicate that the use of personal allowance is to benefit the person only and shall reflect the person's personal spending choices in expenditures made. Policies and procedures shall include a process for individual personal expenditure planning and the implementation of a personal expenditure plan (PEP).
8a-1	A health assessment which identifies the individual's health care needs has been completed by a physician, PA, NP or RN.	Met/Not Met	**633.10(a)(2)(iii)** : (2) In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (iii) For persons in a residential facility, at least a medical/dental evaluation by a physician or registered physician's assistant addressing the person's need for an examination or specific medical/dental services; or by a dentist for dental services. The determination of the basis for such evaluation (e.g., appraisal of the person through records and previous contacts) shall be that of the qualified professional.
8a-2	The individual has someone chosen/delegated to support	Met/Not Met	**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully,

	them in coordinating their health care.		safely and humanely administered with full respect to his or her dignity and personal integrity. **ADM 2003-01 :** A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities….The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition.
8a-3	The individual's service plan identifies the services and supports necessary to access and receive routine professional medical care and evaluation.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: ...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;... **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-4	The individual's routine health care providers are identified and known to the person and/or their supports.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	Met/Not Met	**633.10(b)(3) :** OPWDD shall verify that staff have been made aware of their responsibilities in accordance with the agency/facility plan. [Context: 633.10(2) States:" There is a written plan specifying how the agency/facility will deal with life

			threatening emergencies. Such a plan shall address: (i) First aid. (ii) CPR. (iii) Access to emergency medical services."]
8a-6	The individual receives routine medical exams/medical appointments per his/her health care professionals' recommendations.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-7	The individual receives diagnostic evaluation/testing per his/her health care professionals' recommendations and standard safe practice (e.g. Lab work, x-rays, scans, MRIs, etc.)	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-8	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender and age.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :**

			Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-9	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender, and age.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-10	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met/NA	**ADM 2003-01 :** The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition.
8a-11	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully,

			safely and humanely administered with full respect to his or her dignity and personal integrity. **686.16(b)(4)(ii)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: ... (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.
8a-12	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **633.17(a)(15)(i)-(ii) :** Supervision and monitoring of staff. (i) Medical or nursing supervision of those staff responsible for administering medication shall be provided. (ii) Supervision and monitoring shall be in accordance with agency/facility policies/procedures. **ADM 2003-01 :** A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities.
8a-13	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed**.**	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2003-01 :**

			The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.
8a-14	The individual's emerging signs/symptoms are reported to a health care professional, and monitored and addressed appropriately.	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-15	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met/NA	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person,
8a-16	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8a-17	The individual receives or self-administers medications	Met/Not Met/NA	**633.17(b)(3) :**

	and treatments safely as prescribed.		Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication.
8a-18	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ... **633.17(a)(7) :** All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling. **ADM 2003-01 :** The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.
8a-19	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**633.17(b)(8) :** OPWDD shall verify that the medication regimen of each person in a residential facility has been reviewed at least semi-annually by a registered nurse, physician, physician's assistant, or pharmacist.
8a-20	The individual exhibits a healthy lifestyle and/or receives support(s) to replace the unhealthy behaviors with healthier actions.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes**.**

8a-21	The individual is provided choice in health care providers.	Met/Not Met	**633.4(a)(4)(x) :** (4) No person shall be denied:. (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-22	The individual is supported to advocate and is included in informed decision-making related to medical care and treatment.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-23	Individuals have been given the opportunity to have advanced directives in place (DNR order, healthcare proxy, or living will).	Met/Not Met	**633.4(a)(4)(xxv)-(xxvi) :** (4) No person shall be denied: .(xxv) the opportunity to make, or have made on his or her behalf, an informed decision regarding cardiopulmonary resuscitation (see glossary), in accordance with the provisions of article 29-B of the Public Health Law, and any other applicable law or regulation. Each developmental center (see glossary) shall adopt policies/procedures to actualize this right. (xxvi) the opportunity, if the person is residing in an OPWDD operated or certified facility, to create a health care proxy (see glossary) in accordance with 14 NYCRR 633.20.
8a-24	For those that have advanced directives, they are completed properly in accordance with the Healthcare Decisions Act.		**633.10(a)(7)(ii) :** Upon receipt of notification of a decision to withdraw or withhold life-sustaining treatment in accordance with section 1750-b(4)(e)(ii) of the Surrogate's Court Procedure Act (SCPA), the chief executive officer (see glossary, section 633.99 of this Part) of the agency (see glossary, section 633.99 of this Part) shall confirm that the person's condition meets all of the criteria set forth in SCPA section 1750-b(4)(a) and (b). In the event that the chief executive officer is not convinced that all of the necessary criteria are met, he or she may object to the decision and/or initiate a special proceeding to resolve such dispute in accordance with SCPA section 1750-b(5) and (6).
8a-25	The individual's service record/service plan is maintained to reflect current	Met/Not Met	**633.10(a)(2) :**

	status of the individual's health.		In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA	**633.4(a)(4)(x) :** (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-27	The individual is given access to family planning resources and sexuality education and/or counseling if desired.	Met/Not Met/NA	**633.4(a)(4)(xi) :** (4) No person shall be denied:..(xi) access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated.
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall with the medical care that the individual receives.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
9-1	A Functional Behavioral Assessment is completed for	Met/Not Met	**633.16(d)(1)-(2) :**

	the individual prior to the development of the Behavior Support Plan.		Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging	Met/Not Met	**633.16(d)(1)(i - v)**: Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric

	behaviors and all contextual factors as required.		disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain

			relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.

9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii):** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.

	person's plan and the specific interventions included.		
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(j)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive

			comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be

			inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use

			of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(i):** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on	Met/Not Met	**633.16(g)(3) :**

	the individual's rights and/or a restrictive/intrusive intervention.		Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :**

	Mechanical Restraining device specifies the facts justifying the use of the device.		The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.

9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :**

	documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.		Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(i)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be

			provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(j)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(j)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the	Met/Not Met	**633.16(j)(1)(i)(a-d) :**

	individual's Behavior Support Plans.		(1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated

	notification to appropriate parties within two business days.		with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :**

	during time-outs to monitor the Individual's safety.		The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)** : Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9e-1	Medication to address the individual's challenging behavior or a symptom of a diagnosed co-occurring psychiatric disorder is administered only as a part of a BSP or Monitoring Plan	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging

	which includes additional interventions.		behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9e-2	Written Informed Consent for use of medication by the individuals has been obtained and is current.	Met/Not Met	**633.16(j)(5)(ii)(b) :** Written informed consent shall be obtained prior to the use of the medication. If it is necessary for the medication to be administered before written informed consent can reasonably be obtained, verbal consent may be accepted for only the period of time before written informed consent can be obtained. Verbal consent must be witnessed by two members of the staff and documented in the person's record. This verbal consent may be considered valid for a period of up to 45 days.
9e-3	When the plan includes the medication the Individual's service record includes a semi-annual medication regimen review that is used to evaluate the benefits/risk of continuation.	Met/Not Met	**633.16(j)(5)(i)(d) :** A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
9e-4	The Individual's service record includes evidence that the prescriber was consulted regarding administration and continued effectiveness of the medication.	Met/Not Met	**633.16(j)(5)(i)(e)** : At least semi-annually, and more frequently as needed, staff shall consult with the prescriber regarding the administration and continued effectiveness of the medication.
9e-5	The Individual's service record includes evidence that the use of medication is having a positive effect on	Met/Not Met	**633.16(j)(5)(ii)(c) :** The use of medication shall have a documented positive effect on the person's behavior or target symptoms to justify its ongoing use.

	his/her behavior or target symptoms.		
9e-6	The Individual's service record includes evidence that the effectiveness of the medication has been re-evaluated at least semi-annually at the program plan review with required service attendees.	Met/Not Met	**633.16(j)(5)(ii)(d)**: The effectiveness of the medication shall be re-evaluated at least semi-annually at the program plan reviews by the program planning team in consultation with a licensed psychologist, licensed clinical social worker, or behavior intervention specialist, and a health care professional. The goal(s) of this aspect of the plan review include: ensuring that medication is at the minimum and most effective dose; identifying a potential need for a medication with fewer or less intrusive side effects; evaluating the evidence presented to support continuation of the medication at a maintenance level, or recommending reduction or discontinuation of medication use if clinically indicated and authorized by the prescriber.
9e-7	Medications were administered in accordance with requirements.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9f-1	When prn medication is prescribed to address behavior or symptoms of a psychiatric disorder, this strategy is included in the Individual's Behavioral Support or Monitoring Plan.	Met/Not Met/NA	**633.16(j)(5)(iii)(a) :** As-needed (also known as PRN) orders for medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, are considered planned use and must be incorporated in and documented as part of a behavior support plan or a monitoring plan.
9f-2	The Individual's service record includes evidence of the display of the behavior(s)	Met/Not Met/NA	**633.16(j)(5)(iii)(b) :**

	or symptom(s) for which the PRN medication is being prescribed in the past 12 months.		Planned use of as-needed orders for medication: The person shall have a recent documented history of displaying the behavior(s) or symptoms (occurring in the last 12 months) for which the as-needed medication is being prescribed.
9f-3	The Individual's Behavioral Support or Monitoring Plan provides instruction and guidance for administration of the PRN medication, consistent with the prescriber's order.	Met/Not Met/NA	**633.16(j)(5)(iii)(c)(1-3) :** The behavior support plan or monitoring plan, consistent with the prescriber's order, shall clearly state: (1) the conditions under which the as-needed medication is to be administered, including the nature and degree of the individual's behavior(s) or symptoms, and the prescriber's recommendations regarding proximity to any scheduled medication administration; (2) the expected therapeutic effects; and (3) if applicable, the conditions under which the medication can be re-administered, and the allowable frequency of re-administration.
9f-4	The Individual's service record must include a summary, in behavioral terms, of the results of the PRN medication administration.	Met/Not Met/NA	**633.16(j)(5)(iii)(d) :** Planned use of as-needed orders for medication: The staff person or family care provider who is responsible for support and supervision of a person who has a behavior support plan or monitoring plan must document in the person's clinical record a summary of the results of the medication use in behavioral terms.
9f-5	The Individual's service record includes evidence that any adverse or unexpected side effects were reported to the PRN prescriber immediately and the planning team by the next business day.	Met/Not Met/NA	**633.16(j)(5)(iii)(e) :** Planned use of as-needed orders for medication: Results that are substantively different from the intended effect, and any adverse side effects, shall be reported to the prescriber immediately and the person's program planning team no later than the next business day.
9f-6	Use of PRN Medications on more than four (4) separate days in a 14-day period resulted in consideration of a	Met/Not Met/NA	**633.16(j)(5)(iii)(f) :** If any as-needed medication is administered on more than four separate days (one day equals 24 hours) in a 14-day period, the individual's program

	recommendation for incorporation into a regular drug regimen.		planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist and healthcare professional, must reassess the appropriateness of continuing the as-needed medication, or consider recommending that it be incorporated into the individual's regular drug regimen.
9f-7	Lack of use of a PRN medication during a six-month period resulted in a review of the BSP and a recommendation to the prescriber.	Met/Not Met/NA	**633.16(j)(5)(iii)(h) :** If the as-needed medication is not administered during a six-month period, the program planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist, must review the behavior support plan and develop a recommendation to the prescriber regarding the appropriateness of continuing the as-needed medication as part of the plan. If the order is continued, a clear justification is to be documented in the record.
9f-8	Effectiveness of the medication ordered in an emergency is documented in the Individual's record.	Met/Not Met/NA	**633.16(J)(5)(iv)(c) :** Emergency use of medication: The use of the medication, along with the prescription/order and a note on its effectiveness, shall be documented in the person's record.
9f-9	Emergency use of medication in more than 4 instances in a 14-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(J)(5)(iv)(d) :** Emergency use of medication. The emergency use of medication to control challenging behavior or acute symptoms of a co-occurring diagnosed psychiatric disorder in more than four instances in a 14-day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, a licensed clinical social worker or behavioral intervention specialist within three business days of the fifth medication administration.
9f-10	Use of PRN medications in conjunction with a restrictive physical intervention	Met/Not Met/NA	**633.16(j)(5)(iii)(g) :** Each use of an as-needed medication when used in conjunction with a restrictive physical intervention technique to prevent, modify, or control

	technique were reported electronically to OPWDD.		challenging behavior shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9g-1	The Individual's record identifies the symptoms he/she exhibits and each co-occurring psychiatric disorder diagnosis.	Met/Not Met	**633.16(j)(5)(vi)(e) :** Medication use to treat a co-occurring diagnosed psychiatric disorder. Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirement must be met. (e) The symptoms and diagnosis of the co-occurring psychiatric disorder must be documented.
9g-2	The Individual's Monitoring Plan clearly identifies target symptoms associated with each medication prescribed for a psychiatric disorder.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented.
9g-3	The Individual's Monitoring Plan includes the method to measure and document symptom reduction and functional improvement.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology.

			The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-4	The Individual's Monitoring Plan includes alternative interventions (other than medication).	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-5	The individual's Monitoring Plan is developed by a qualified clinician.	Met/Not Met	**633.16(b)(29) :** Plan, monitoring. A plan developed by a licensed psychologist, licensed psychiatric nurse practitioner, licensed clinical social worker, or a behavioral intervention specialist that identifies the target symptoms of a co-occurring diagnosed psychiatric disorder that are to be prevented, reduced, or eliminated.
9g-6	The effectiveness of the individual's Monitoring Plan in improving the quality of	Met/Not Met	**633.16(j)(5)(i)(d)** :

	his/her life is reviewed as identified in the plan.		A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.

10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.

10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1) :** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16) **624.5(g)(4) :** Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)

10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate. **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)

10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).

10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l) :** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)

10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** : Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)

10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information

			in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met	**624.7(b)(2): :** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3): **: (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(j)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation,

			submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met	**625.4(b)(2)(i-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(b)(1) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions;
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the

			individual's life that are most important to him or her (e.g., health, relationships, work, and home). **ADM 2012-01 :** The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**636-1.2(b)(3) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-16	The individual's goals and priorities regarding meaningful relationships are	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and

	identified in the person centered plan.		makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**636-1.3(b)(8) :** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed;
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for	Met/Not Met	**636-1.2(b)(3) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen

	the implementation of the plan.		by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**ADM 2012-01 :** Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or his/her advocate.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**636-1.2(b)(4) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). **635-10.4(b) :** Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments.

2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). **633.4(a)(4))(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2012-01 :** Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service

			coordinator no more than 30 days after either: an ISP review date, or the date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**ADM 2012-10 Habilitation Plan Requirements ; pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. ... c. Exploration of new experiences

			is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ... **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(b)(1)** : For Residential Habilitation Services: Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments. Habilitation services are directed toward acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. services offered are designed to correspond to the person's strengths and needs. These services include activities and tasks required to design, implement and support the individualized service plan. ... (1) Residential habilitation services are generally provided in the person's home, and include assistance with acquisition, retention or improvement in skills related to life safety and fire evacuation; to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food; and social and adaptive skills necessary to enable the person to reside in a noninstitutional setting. ... **633.4(a)(4)(viii)-(ix)** :

			No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**636-1.2(a)(3)(ii) :** The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**ADM 2014-01 :** The required service documentation format for the daily Supervised IRA-RH service is a Daily Narrative Note format or a checklist with a monthly summary note, which must be completed by the staff person who delivers the service or is knowledgeable of service delivery.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs,	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	preferences, and desired outcomes.		
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**ADM 2014-04 :** Habilitation Supports and services are focused on the development of skills that are needed in order to facilitate greater degrees of choice, independence, autonomy and full participation in community life…. **441.301 4 (C)(4)(iii) :** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint. **441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a

			minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers. **635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this

	advancement/achievement of his/her goals/outcomes.		point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives.....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii) :** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1) :** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.

3-4	The individual is informed of their HCBS rights.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5) :** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3) :** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-7	The individual is supported to express themselves through personal choices/decisions on style of dress and grooming preferences.	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.
3-8	The individual is supported to participate in cultural/religious/associational practices, educuation, celebrations and experiences	Met/Not Met	Quality Indicator : This is an indicator of quality outcomes.

	per their interests and preferences.		
3-9	The individual is supported to have visitors of their choosing according their preferences.	Met/Not Met	**636-1.4(b)(4) :** Each individual is able to have visitors of his or her choosing at any time.
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support.	Met/Not Met	**636-1.4(b)(2) :** Each individual has privacy in his or her sleeping or living unit. **633.4(a)(xx) :** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
3-11	The individual is aware that he/she is not required to follow a particular schedule for waking up, going to bed, eating, leisure activities, etc.	Met/Not Met	**636-1.4(b)(3) :** Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs.	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-13	The individual can choose to eat meals when they want to, even if mealtimes occur at routine or scheduled times.	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each

			individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-14	The individual has access/is supported to have access to food at any time and to store their own food and snack choices for their use at any time as desired, similar to people without disabilities.	Met/Not Met	**636-1.4(b)(3)** : (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-15	The individual is supported to have independent access to the site/service setting with freedom to come and go as desired, similar to people without disabilities.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-17	The setting reflects the individual's needs and preferences including the presence of any necessary physical modifications, if applicable.	Met/Not Met	**441.301(C)(4)(ii) :** The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board. **441.430 (c)(4)(vi)(E) :** The setting is physically accessible to the individual.

3-18	The individual has a lease or other written occupancy agreement that provides eviction protections and due process/appeals and specifies the circumstances when he/she could be required to relocate.	Met/Not Met	**636-1.4(b)(1) :** Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.
3-19	There is evidence that the individual and/or their representative knows/understands their right to due process/appeals and when he/she could be required to relocate.	Met/Not Met	**636-1.4(b)(1) :** Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-21	The individual controls their personal resources and decides how to spend their personal discretionary funds.		**633.15(c)(5)-(6) :** The expenditure of personal allowance must personally benefit the person and reflect his/her personal spending choices. The person shall be involved in all decisions regarding the use of his/her personal allowance funds. OMRDD assumes that all people with developmental disabilities have some capacity for self-advocacy and decision making related to the expenditure of personal allowance.
3-22	The individual is encouraged and supported to advocate for	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	themselves and to increase their self-advocacy skills.		
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii) :** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)** : No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a-1	When interventions that restrict or modify the individual's rights are used (not part of a behavior support plan), the individual's service plan includes a description of the positive and less intrusive approaches that have been tried but have not been successful.	Met/Not Met	**636-1.4(c)(2)-(3) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (2) the positive interventions and supports used prior to any modifications; (3) less intrusive methods of meeting the need that were tried but did not work. Pathway to employment if activities occur at in agency setting.
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies	Met/Not Met	**636-1.4 (c)(1) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan; (1) a specific and individualized assessed need underlying the reason for the modification. **633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and

	the rights restriction or rights modification (clinical justification).		specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.	Met/Not Met	**636-1.4(b) :** Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: **441.430 (c)(4) (vi)(F) :** any modification of the additional conditions, under 441.301 (C)(4)(vi)(A)-(D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan. ...4. include a clear description of the condition that is directly proportionate to the specific assessed need 5. include a regular collection and review of data to measure the ongoing effectiveness of the modification. ... 8. include an assurance that interventions and supports will cause no harm to the individual.
3a-5	The individual has given informed consent to the rights limitations/restrictions in place.	Met/Not Met	**441.430 (c)(4) (vi)(F) :** Any modification of the additional conditions, under 441.301 (C)(4)(vi)(A)-(D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan. ... 7. include the informed consent of the individual.
4-1	The individual is encouraged and supported to have full access to the community based on their	Met/Not Met	**441.301 (C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal

	interests/preferences/priorities for meaningful activities to the same degree as others in the community.		resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.	Met/Not Met	**441.301(C)(4)(vi)(C):** : Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time. **441.301(C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are meaningful to them for the period of time desired.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes. **636-1.2(3)(ii) :** supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and
6-1	The individual is satisfied with their living situation and does not express a desire (when questioned) to move to another living setting and/or with another roommate.	Met/Not Met	**636-1.3(b)(7) :** if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated

			settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life); **636-1.4(b)(2)(ii) :** The individual sharing a unit has a choice of roommates in that setting.
6-2	If the individual is NOT satisfied with living situation, there is evidence that the staff is proactively working to find an alternate arrangement based on the person's needs, choices and preferences in a timely manner.	Met/Not Met	**636-1.3(b)(7) :** ... if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life); **636-1.4(b)(2)(ii) :** The individual sharing a unit has a choice of roommates in that setting. **633.4(a)(4)(xxii) :** No person shall be denied the opportunity to request an alternative residential setting, whether a new residence or change of room, and involvement in the decisions regarding such changes.
6-3	The individual's personal living spaces(s) reflect their individualized interest and tastes.	Met/Not Met	**636-1.4(b)(2)(iii) :** No person shall be denied the opportunity to request an alternative residential setting, whether a new residence or change of room, and involvement in the decisions regarding such changes.
7-1	The individual's specific safeguarding needs and related interventions	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the

	(including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.		person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (i) An assessment of functional capacity. (ii) Review and evaluation of the person's written plan of services and his or her progress in relation to that plan; **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation; Day Habilitation (in certified day habilitation sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY.
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x):** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through

			parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **686.7(b)(3)-(4) :** (3) OPWDD shall verify that the plan of services, on an overall basis, is being implemented as developed ; (4) OMRDD shall verify that the staff in the community residence having program and/or supervision responsibilities for a specific person know what their role and/or responsibilities are in carrying out the person's plan of services. **671.6(a)(7) :** The plan of services shall be delivered by appropriately trained and supervised staff of the facility.
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and

			guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **686.7(b)(3)-(4) :** "(3) OPWDD shall verify that the plan of services, on an overall basis, is being implemented as developed. (4) OMRDD shall verify that the staff in the community residence having program and/or supervision responsibilities for a specific person know what their role and/or responsibilities are in carrying out the person's plan of services."
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through

			parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services. **686.7(b)(3)-(4) :** (3) OPWDD shall verify that the plan of services, on an overall basis, is being implemented as developed (4) OMRDD shall verify that the staff in the community residence having program and/or supervision responsibilities for a specific person know what their role and/or responsibilities are in carrying out the person's plan of services. **671.6(a)(7) :** The plan of services shall be delivered by appropriately trained and supervised staff of the facility.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met	**ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid

			consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **ADM 2012-01 Habilitation Plan Requirements ; Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **633.4(a)(4)(viii)-(ix) ;** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;

			<u>686.7(b)(3)-(4) :</u> (3) OPWDD shall verify that the plan of services, on an overall basis, is being implemented as developed (4) OMRDD shall verify that the staff in the community residence having program and/or supervision responsibilities for a specific person know what their role and/or responsibilities are in carrying out the person's plan of services. **<u>671.6(a)(7) :</u>** The plan of services shall be delivered by appropriately trained and supervised staff of the facility.
7-6	The individual's needs for support and assistance related to fire safety and evacuation are documented according to service/setting requirements.	Met/Not Met	**<u>ADM 2012-01 Habilitation Plan Requirements :</u>** Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-7	The individual is provided the necessary supports and assistance related to fire safety and evacuation.	Met/Not Met	**<u>686.7(b)(3)-(4) :</u>** (3) OPWDD shall verify that the plan of services, on an overall basis, is being implemented as developed. (4) OMRDD shall verify that the staff in the community residence having program and/or supervision responsibilities for a specific person know what their role and/or responsibilities are in carrying out the person's plan of services.

			ADM 2012-02 Fire Safety Attachment: Essential El : Fire drills and evacuation drills are also essential to ensure that all staff on all shifts are trained to perform their assigned tasks outlined in the facility's evacuation plan and to ensure that all staff on all shifts are familiar with the use of the facility's fire protection equipment. In addition, individuals who are capable should be trained to participate and respond to fires or other emergency conditions. Drills also serve to provide agencies with a mechanism for evaluating the effectiveness of evacuation and disaster plans on an on-going basis and to capture information on changes in consumer status. Changes such as those resulting from advancing age, medical changes or new admissions may result in the need to modify the physical environment of the facility, revise the evacuation plan or provide additional staff resources to the facility to meet consumer needs.
7-8	The individuals is provided necessary supports necessary to facilitate financial stability and freedom from financial exploitation.	Met/Not Met	**633.4(a)(4)(xvi) :** No person shall be denied: … the use of his or her personal money and property, including regular notice of his or her financial status and the provision of assistance in the use of his or her resources, as appropriate. **633-15(j)(1)-(2) :** (1)The agency or sponsoring agency shall ensure that expenditure planning for personal allowance is conducted on at least an annual basis for each person for whom it is managing personal allowance. Documentation of the expenditure planning shall be incorporated into a personal expenditure plan (PEP). (2) Expenditure planning shall be done by an individual's expenditure planning team which includes the person, his or her advocate and service coordinator, if applicable; and relevant agency staff and the family care provider. **633-15(d)(1):** : Each agency which operates a residential facility or sponsors a family care home and manages personal allowance; or operates a non-residential facility or service and accepts responsibility for handling the personal allowance of residents of residential facilities; shall develop and implement policies and procedures to ensure safeguarding and accurate accounting of such personal allowance. **633-15(d)(4) :**

			Policies and procedures shall indicate that the use of personal allowance is to benefit the person only and shall reflect the person's personal spending choices in expenditures made. Policies and procedures shall include a process for individual personal expenditure planning and the implementation of a personal expenditure plan (PEP).
8a-1	A health assessment which identifies the individual's health care needs has been completed by a physician, PA, NP or RN.	Met/Not Met	**633.10(a)(2)(iii)**: (2) In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (iii) For persons in a residential facility, at least a medical/dental evaluation by a physician or registered physician's assistant addressing the person's need for an examination or specific medical/dental services; or by a dentist for dental services. The determination of the basis for such evaluation (e.g., appraisal of the person through records and previous contacts) shall be that of the qualified professional.
8a-2	The individual has someone chosen/delegated to support them in coordinating their health care.	Met/Not Met	**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **ADM 2003-01 :** A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities….The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition.

8a-3	The individual's service plan identifies the services and supports necessary to access and receive routine professional medical care and evaluation.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: ...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;... **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-4	The individual's routine health care providers are identified and known to the person and/or their supports.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	Met/Not Met	**633.10(b)(3) :** OPWDD shall verify that staff have been made aware of their responsibilities in accordance with the agency/facility plan. [Context: 633.10(2) States:" There is a written plan specifying how the agency/facility will deal with life threatening emergencies. Such a plan shall address: (i) First aid. (ii) CPR. (iii) Access to emergency medical services."]
8a-6	The individual receives routine medical exams/medical appointments per his/her health care professionals' recommendations.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :**

			Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-7	The individual receives diagnostic evaluation/testing per his/her health care professionals' recommendations and standard safe practice (e.g. Lab work, x-rays, scans, MRIs, etc.)	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-8	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender and age.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-9	The individual receives preventative testing and/or care based on recommended professional guidelines for	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through

	medical conditions, gender, and age.		parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-10	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met/NA	**ADM 2003-01 :** The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition.
8a-11	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **686.16(b)(4)(ii)-(iii) :** OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: ... (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan.

8a-12	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **633.17(a)(15)(i)-(ii) :** Supervision and monitoring of staff. (i) Medical or nursing supervision of those staff responsible for administering medication shall be provided. (ii) Supervision and monitoring shall be in accordance with agency/facility policies/procedures. **ADM 2003-01 :** A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities.
8a-13	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed**.**	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2003-01 :** The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.
8a-14	The individual's emerging signs/symptoms are reported to a health care professional, and monitored and addressed appropriately.	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the

			choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-15	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met/NA	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person,
8a-16	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8a-17	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA	**633.17(b)(3) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication.
8a-18	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ... **633.17(a)(7) :**

			All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling. **ADM 2003-01 :** The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.
8a-19	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**633.17(b)(8) :** OPWDD shall verify that the medication regimen of each person in a residential facility has been reviewed at least semi-annually by a registered nurse, physician, physician's assistant, or pharmacist.
8a-20	The individual exhibits a healthy lifestyle and/or receives support(s) to replace the unhealthy behaviors with healthier actions.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-21	The individual is provided choice in health care providers.	Met/Not Met	**633.4(a)(4)(x) :** (4) No person shall be denied:. (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-22	The individual is supported to advocate and is included in informed decision-making related to medical care and treatment.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.

8a-23	Individuals have been given the opportunity to have advanced directives in place (DNR order, healthcare proxy, or living will).	Met/Not Met	**633.4(a)(4)(xxv)-(xxvi) :** (4) No person shall be denied: .(xxv) the opportunity to make, or have made on his or her behalf, an informed decision regarding cardiopulmonary resuscitation (see glossary), in accordance with the provisions of article 29-B of the Public Health Law, and any other applicable law or regulation. Each developmental center (see glossary) shall adopt policies/procedures to actualize this right. (xxvi) the opportunity, if the person is residing in an OPWDD operated or certified facility, to create a health care proxy (see glossary) in accordance with 14 NYCRR 633.20.
8a-24	For those that have advanced directives, they are completed properly in accordance with the Healthcare Decisions Act.	Met/Not Met	**633.10(a)(7)(ii) :** Upon receipt of notification of a decision to withdraw or withhold life-sustaining treatment in accordance with section 1750-b(4)(e)(ii) of the Surrogate's Court Procedure Act (SCPA), the chief executive officer (see glossary, section 633.99 of this Part) of the agency (see glossary, section 633.99 of this Part) shall confirm that the person's condition meets all of the criteria set forth in SCPA section 1750-b(4)(a) and (b). In the event that the chief executive officer is not convinced that all of the necessary criteria are met, he or she may object to the decision and/or initiate a special proceeding to resolve such dispute in accordance with SCPA section 1750-b(5) and (6).
8a-25	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA	**633.4(a)(4)(x) :** (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;

8a-27	The individual is given access to family planning resources and sexuality education and/or counseling if desired.	Met/Not Met/NA	**633.4(a)(4)(xi) :** (4) No person shall be denied:...(xi) access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated.
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall with the medical care that the individual receives.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
9-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	Met/Not Met	**633.16(d)(1)-(2) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a

			contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	Met/Not Met	**633.16(d)(1)(i - v)** : Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment	Met/Not Met	**633.16(d)(1)(vi-ix) :**

	includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.		Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.

	clinician as determined by the interventions in the plan.		
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive

			(replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii):** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no

	interventions included in the behavior support plan.		less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(j)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.

9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.

9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be

			documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(j):** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(j) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(j)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and

			for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :**

	Mechanical Restraining device specifies criteria for the application, removal and duration of device use.		The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a

	extremities or total immobilization.		written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by

			OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(i)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :**

	supervision of a senior member of the staff.		A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(i)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(i)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(i)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had	Met/Not Met	**633.16(j)(1)(iv) :**

	diminished significantly, within timeframes or if he/she appeared physically at risk.		The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six

	period resulted in a comprehensive review.		month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.

9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)** : Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9e-1	Medication to address the individual's challenging behavior or a symptom of a diagnosed co-occurring psychiatric disorder is administered only as a part of a BSP or Monitoring Plan which includes additional interventions.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9e-2	Written Informed Consent for use of medication by the individuals has been obtained and is current.	Met/Not Met	**633.16(j)(5)(ii)(b) :** Written informed consent shall be obtained prior to the use of the medication. If it is necessary for the medication to be administered before written informed consent can reasonably be obtained, verbal consent may be accepted for only the period of time before written informed consent can be obtained. Verbal consent must be witnessed by two members of the staff and documented in the person's record. This verbal consent may be considered valid for a period of up to 45 days.
9e-3	When the plan includes the medication the Individual's	Met/Not Met	**633.16(j)(5)(i)(d) :**

	service record includes a semi-annual medication regimen review that is used to evaluate the benefits/risk of continuation.		A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
9e-4	The Individual's service record includes evidence that the prescriber was consulted regarding administration and continued effectiveness of the medication.	Met/Not Met	**633.16(j)(5)(i)(e)** : At least semi-annually, and more frequently as needed, staff shall consult with the prescriber regarding the administration and continued effectiveness of the medication.
9e-5	The Individual's service record includes evidence that the use of medication is having a positive effect on his/her behavior or target symptoms.	Met/Not Met	**633.16(j)(5)(ii)(c) :** The use of medication shall have a documented positive effect on the person's behavior or target symptoms to justify its ongoing use.
9e-6	The Individual's service record includes evidence that the effectiveness of the medication has been re-evaluated at least semi-annually at the program plan review with required service attendees.	Met/Not Met	**633.16(j)(5)(ii)(d)** : The effectiveness of the medication shall be re-evaluated at least semi-annually at the program plan reviews by the program planning team in consultation with a licensed psychologist, licensed clinical social worker, or behavior intervention specialist, and a health care professional. The goal(s) of this aspect of the plan review include: ensuring that medication is at the minimum and most effective dose; identifying a potential need for a medication with fewer or less intrusive side effects; evaluating the evidence presented to support continuation of the medication at a maintenance level, or recommending reduction or discontinuation of medication use if clinically indicated and authorized by the prescriber.

9e-7	Medications were administered in accordance with requirements.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9f-1	When prn medication is prescribed to address behavior or symptoms of a psychiatric disorder, this strategy is included in the Individual's Behavioral Support or Monitoring Plan.	Met/Not Met/NA	**633.16(j)(5)(iii)(a) :** As-needed (also known as PRN) orders for medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, are considered planned use and must be incorporated in and documented as part of a behavior support plan or a monitoring plan.
9f-2	The Individual's service record includes evidence of the display of the behavior(s) or symptom(s) for which the PRN medication is being prescribed in the past 12 months.	Met/Not Met/NA	**633.16(j)(5)(iii)(b) :** Planned use of as-needed orders for medication: The person shall have a recent documented history of displaying the behavior(s) or symptoms (occurring in the last 12 months) for which the as-needed medication is being prescribed.
9f-3	The Individual's Behavioral Support or Monitoring Plan provides instruction and guidance for administration of the PRN medication, consistent with the prescriber's order.	Met/Not Met/NA	**633.16(j)(5)(iii)(c)(1-3) :** The behavior support plan or monitoring plan, consistent with the prescriber's order, shall clearly state: (1) the conditions under which the as-needed medication is to be administered, including the nature and degree of the individual's behavior(s) or symptoms, and the prescriber's recommendations regarding proximity to any scheduled medication administration; (2) the expected therapeutic effects; and (3) if applicable, the conditions under which the medication can be re-administered, and the allowable frequency of re-administration.

9f-4	The Individual's service record must include a summary, in behavioral terms, of the results of the PRN medication administration.	Met/Not Met/NA	**633.16(j)(5)(iii)(d) :** Planned use of as-needed orders for medication: The staff person or family care provider who is responsible for support and supervision of a person who has a behavior support plan or monitoring plan must document in the person's clinical record a summary of the results of the medication use in behavioral terms.
9f-5	The Individual's service record includes evidence that any adverse or unexpected side effects were reported to the PRN prescriber immediately and the planning team by the next business day.	Met/Not Met/NA	**633.16(j)(5)(iii)(e) :** Planned use of as-needed orders for medication: Results that are substantively different from the intended effect, and any adverse side effects, shall be reported to the prescriber immediately and the person's program planning team no later than the next business day.
9f-6	Use of PRN Medications on more than four (4) separate days in a 14-day period resulted in consideration of a recommendation for incorporation into a regular drug regimen.	Met/Not Met/NA	**633.16(j)(5)(iii)(f) :** If any as-needed medication is administered on more than four separate days (one day equals 24 hours) in a 14-day period, the individual's program planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist and healthcare professional, must reassess the appropriateness of continuing the as-needed medication, or consider recommending that it be incorporated into the individual's regular drug regimen.
9f-7	Lack of use of a PRN medication during a six-month period resulted in a review of the BSP and a recommendation to the prescriber.	Met/Not Met/NA	**633.16(j)(5)(iii)(h) :** If the as-needed medication is not administered during a six-month period, the program planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist, must review the behavior support plan and develop a recommendation to the prescriber regarding the appropriateness of continuing the as-needed medication as part of the plan. If the order is continued, a clear justification is to be documented in the record.

9f-8	Effectiveness of the medication ordered in an emergency is documented in the Individual's record.	Met/Not Met/NA	**633.16(J)(5)(iv)(c) :** Emergency use of medication: The use of the medication, along with the prescription/order and a note on its effectiveness, shall be documented in the person's record.
9f-9	Emergency use of medication in more than 4 instances in a 14-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(J)(5)(iv)(d) :** Emergency use of medication. The emergency use of medication to control challenging behavior or acute symptoms of a co-occurring diagnosed psychiatric disorder in more than four instances in a 14-day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, a licensed clinical social worker or behavioral intervention specialist within three business days of the fifth medication administration.
9f-10	Use of PRN medications in conjunction with a restrictive physical intervention technique were reported electronically to OPWDD.	Met/Not Met/NA	**633.16(j)(5)(iii)(g) :** Each use of an as-needed medication when used in conjunction with a restrictive physical intervention technique to prevent, modify, or control challenging behavior shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9g-1	The Individual's record identifies the symptoms he/she exhibits and each co-occurring psychiatric disorder diagnosis.	Met/Not Met	**633.16(j)(5)(vi)(e) :** Medication use to treat a co-occurring diagnosed psychiatric disorder. Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirement must be met. (e) The symptoms and diagnosis of the co-occurring psychiatric disorder must be documented.
9g-2	The Individual's Monitoring Plan clearly identifies target symptoms associated with each medication prescribed for a psychiatric disorder.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of

			medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented.
9g-3	The Individual's Monitoring Plan includes the method to measure and document symptom reduction and functional improvement.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-4	The Individual's Monitoring Plan includes alternative interventions (other than medication).	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional

			behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-5	The individual's Monitoring Plan is developed by a qualified clinician.	Met/Not Met	**633.16(b)(29) :** Plan, monitoring. A plan developed by a licensed psychologist, licensed psychiatric nurse practitioner, licensed clinical social worker, or a behavioral intervention specialist that identifies the target symptoms of a co-occurring diagnosed psychiatric disorder that are to be prevented, reduced, or eliminated.
9g-6	The effectiveness of the individual's Monitoring Plan in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(j)(5)(i)(d)** : A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.

10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4) :** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)

10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)

10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate. **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)

10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies;

			624.5(k)(1)-(3): Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(j)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l) :** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from	Met/Not Met	**624.5(g)(1)** : Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she

	harm and abuse, were implemented immediately.		must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must

			make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met	**624.7(b)(2): :** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16)

			624.5(k)(1)-(3): : (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(j)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met	**625.4(b)(2)(i-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(b)(1) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions;
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports

			to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **ADM 2012-01 :** The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**636-1.2(b)(3) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-16	The individual's goals and priorities regarding	Met/Not Met	**636-1.2(a) :**

	meaningful relationships are identified in the person centered plan.		A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**636-1.3(b)(8) :** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed;
1-28	The plan is written in plain language, in a manner that is	Met/Not Met	**636-1.2(b)(3) :**

	accessible to the individual and parties responsible for the implementation of the plan.		A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**ADM 2012-01 :** Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or his/her advocate.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**636-1.2(b)(4) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). **635-10.4(b) :**

	HCBS Waiver Service providers.		Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments.
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2012-01 :** Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: an ISP review date, or the

			date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**ADM 2012-10 Habilitation Plan Requirements ; pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. ... c. Exploration of new experiences

			is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ... **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(b)(1)** : For Residential Habilitation Services: Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments. Habilitation services are directed toward acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. services offered are designed to correspond to the person's strengths and needs. These services include activities and tasks required to design, implement and support the individualized service plan. ... (1) Residential habilitation services are generally provided in the person's home, and include assistance with acquisition, retention or improvement in skills related to life safety and fire evacuation; to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food; and social and adaptive skills necessary to enable the person to reside in a noninstitutional setting. ...

			633.4(a)(4)(viii)-(ix) : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**636-1.2(a)(3)(ii) :** The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**635-10.5(b)(14) :** To bill for each day that family care residential habilitation services are provided, the family care provider shall deliver and daily document at least one face-to-face individualized residential habilitation service to the individual.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	to the individual's needs, preferences, and desired outcomes.		
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**ADM 2014-04 :** Habilitation Supports and services are focused on the development of skills that are needed in order to facilitate greater degrees of choice, independence, autonomy and full participation in community life….
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP

			meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers. **635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and

			establish agreement on those objectives.....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii) :** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1) :** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.

3-4	The individual is informed of their HCBS rights.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5) :** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3) :** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3-7	The individual is supported to express themselves through personal choices/decisions on style of dress and grooming preferences.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3-8	The individual is supported to participate in cultural/religious/associational practices, educuation, celebrations and experiences	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	per their interests and preferences.		
3-9	The individual is supported to have visitors of their choosing according their preferences.	Met/Not Met	**636-1.4(b)(4) :** Each individual is able to have visitors of his or her choosing at any time.
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support.	Met/Not Met	**636-1.4(b)(2) :** Each individual has privacy in his or her sleeping or living unit. **633.4(a)(xx) :** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
3-11	The individual is aware that he/she is not required to follow a particular schedule for waking up, going to bed, eating, leisure activities, etc.	Met/Not Met	**636-1.4(b)(3) :** Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs.	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-13	The individual can choose to eat meals when they want to, even if mealtimes occur at routine or scheduled times.	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each

			individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-14	The individual has access/is supported to have access to food at any time and to store their own food and snack choices for their use at any time as desired, similar to people without disabilities.	Met/Not Met	**636-1.4(b)(3)** : (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-15	The individual is supported to have independent access to the site/service setting with freedom to come and go as desired, similar to people without disabilities.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-17	The setting reflects the individual's needs and preferences including the presence of any necessary physical modifications, if applicable.	Met/Not Met	**441.301(C)(4)(ii) :** The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board. **441.430 (c)(4)(vi)(E) :** The setting is physically accessible to the individual.

3-18	The individual has a lease or other written occupancy agreement that provides eviction protections and due process/appeals and specifies the circumstances when he/she could be required to relocate.	Met/Not Met	**636-1.4(b)(1) :** Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.
3-19	There is evidence that the individual and/or their representative knows/understands their right to due process/appeals and when he/she could be required to relocate.	Met/Not Met	**636-1.4(b)(1) :** Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-21	The individual controls their personal resources and decides how to spend their personal discretionary funds.		**633.15(c)(5)-(6) :** The expenditure of personal allowance must personally benefit the person and reflect his/her personal spending choices. The person shall be involved in all decisions regarding the use of his/her personal allowance funds. OMRDD assumes that all people with developmental disabilities have some capacity for self-advocacy and decision making related to the expenditure of personal allowance.
3-22	The individual is encouraged and supported to advocate for	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	themselves and to increase their self-advocacy skills.		
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii) :** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)** : No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a-1	When interventions that restrict or modify the individual's rights are used (not part of a behavior support plan), the individual's service plan includes a description of the positive and less intrusive approaches that have been tried but have not been successful.	Met/Not Met	**636-1.4(c)(2)-(3) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (2) the positive interventions and supports used prior to any modifications; (3) less intrusive methods of meeting the need that were tried but did not work. Pathway to employment if activities occur at in agency setting.
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need	Met/Not Met	**636-1.4 (c)(1) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan; (1) a specific and individualized assessed need underlying the reason for the modification. **633.4(b)(6) :**

	and/or behavior that justifies the rights restriction or rights modification (clinical justification).		For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.	Met/Not Met	**636-1.4(b) :** Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: **441.430 (c)(4) (vi)(F) :** any modification of the additional conditions, under 441.301 (C)(4)(vi)(A)-(D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan. ...4. include a clear description of the condition that is directly proportionate to the specific assessed need 5. include a regular collection and review of data to measure the ongoing effectiveness of the modification. ... 8. include an assurance that interventions and supports will cause no harm to the individual.
3a-5	The individual has given informed consent to the rights limitations/restrictions in place.	Met/Not Met	**441.430 (c)(4) (vi)(F) :** Any modification of the additional conditions, under 441.301 (C)(4)(vi)(A)-(D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan. ... 7. include the informed consent of the individual.

4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community.	Met/Not Met	**441.301 (C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.	Met/Not Met	**441.301(C)(4)(vi)(C):** : Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time. **441.301(C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are meaningful to them for the period of time desired.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**636-1.2(3)(ii) :** supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and
6-1	The individual is satisfied with their living situation and does	Met/Not Met	**636-1.3(b)(7) :** if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative

	not express a desire (when questioned) to move to another living setting and/or with another roommate.		residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life); **636-1.4(b)(2)(ii) :** The individual sharing a unit has a choice of roommates in that setting.
6-2	If the individual is NOT satisfied with living situation, there is evidence that the staff is proactively working to find an alternate arrangement based on the person's needs, choices and preferences in a timely manner.	Met/Not Met	**636-1.3(b)(7) :** ... if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life); **636-1.4(b)(2)(ii) :** The individual sharing a unit has a choice of roommates in that setting. **633.4(a)(4)(xxii) :** No person shall be denied the opportunity to request an alternative residential setting, whether a new residence or change of room, and involvement in the decisions regarding such changes.
6-3	The individual's personal living spaces(s) reflect their	Met/Not Met	**636-1.4(b)(2)(iii) :**

	individualized interest and tastes.		No person shall be denied the opportunity to request an alternative residential setting, whether a new residence or change of room, and involvement in the decisions regarding such changes.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (i) An assessment of functional capacity. (ii) Review and evaluation of the person's written plan of services and his or her progress in relation to that plan; **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation; Day Habilitation (in certified day habilitation sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY.
7-2	The individual is provided necessary safeguards/supports per	Met/Not Met	**633.4(a)(4)(viii)-(x);** : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his

	his/her written plan and as needed (excludes supervision, mobility and dining supports).		or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01**

			Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2012-01** Habilitation Plan Requirements : Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons

			receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met	**ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **ADM 2012-01 Habilitation Plan Requirements ; Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be

			addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
7-6	The individual's needs for support and assistance related to fire safety and evacuation are documented according to service/setting requirements.	Met/Not Met	**ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]

7-7	The individual is provided the necessary supports and assistance related to fire safety and evacuation.	Met/Not Met	**687.8(o) :** A family care provider shall develop a fire evacuation plan which shall be practiced periodically.
7-8	The individuals is provided necessary supports necessary to facilitate financial stability and freedom from financial exploitation.	Met/Not Met	**633.4(a)(4)(xvi) :** No person shall be denied: … the use of his or her personal money and property, including regular notice of his or her financial status and the provision of assistance in the use of his or her resources, as appropriate. **633-15(j)(1)-(2) :** (1)The agency or sponsoring agency shall ensure that expenditure planning for personal allowance is conducted on at least an annual basis for each person for whom it is managing personal allowance. Documentation of the expenditure planning shall be incorporated into a personal expenditure plan (PEP). (2) Expenditure planning shall be done by an individual's expenditure planning team which includes the person, his or her advocate and service coordinator, if applicable; and relevant agency staff and the family care provider. **633-15(d)(1):** : Each agency which operates a residential facility or sponsors a family care home and manages personal allowance; or operates a non-residential facility or service and accepts responsibility for handling the personal allowance of residents of residential facilities; shall develop and implement policies and procedures to ensure safeguarding and accurate accounting of such personal allowance. **633-15(d)(4) :** Policies and procedures shall indicate that the use of personal allowance is to benefit the person only and shall reflect the person's personal spending choices in expenditures made. Policies and procedures shall include a process for individual personal expenditure planning and the implementation of a personal expenditure plan (PEP).
8a-1	A health assessment which identifies the individual's health care needs has been	Met/Not Met	**633.10(a)(2)(iii)** :

	completed by a physician, PA, NP or RN.		(2) In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (iii) For persons in a residential facility, at least a medical/dental evaluation by a physician or registered physician's assistant addressing the person's need for an examination or specific medical/dental services; or by a dentist for dental services. The determination of the basis for such evaluation (e.g., appraisal of the person through records and previous contacts) shall be that of the qualified professional.
8a-2	The individual has someone chosen/delegated to support them in coordinating their health care.	Met/Not Met	**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-3	The individual's service plan identifies the services and supports necessary to access and receive routine professional medical care and evaluation.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: ...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;... **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-4	The individual's routine health care providers are identified	Met/Not Met	**633.10(a)(2) :**

	and known to the person and/or their supports.		In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	Met/Not Met	**633.10(b)(3) :** OPWDD shall verify that staff have been made aware of their responsibilities in accordance with the agency/facility plan. [Context: 633.10(2) States:" There is a written plan specifying how the agency/facility will deal with life threatening emergencies. Such a plan shall address: (i) First aid. (ii) CPR. (iii) Access to emergency medical services."]
8a-6	The individual receives routine medical exams/medical appointments per his/her health care professionals' recommendations.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-7	The individual receives diagnostic evaluation/testing per his/her health care professionals' recommendations and standard safe practice (e.g. Lab work, x-rays, scans, MRIs, etc.)	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :**

			Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-8	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender and age.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-9	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender, and age.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-10	There is a written plan/instruction to address routine care/monitoring to be	Met/Not Met/NA	**633.10(a)(2) :**

	provided related to the individual's specific medical condition(s).		In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment:
8a-11	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-12	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **633.17(a)(15)(i)-(ii) :** Supervision and monitoring of staff. (i) Medical or nursing supervision of those staff responsible for administering medication shall be provided. (ii) Supervision and monitoring shall be in accordance with agency/facility policies/procedures.
8a-13	The individual and/or their support(s) report the individual's health concerns/symptoms to	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;

	appropriate parties as needed or directed**.**		
8a-14	The individual's emerging signs/symptoms are reported to a health care professional, and monitored and addressed appropriately.	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-15	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met/NA	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person,
8a-16	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8a-17	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA	**633.17(b)(3) :**

			Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication.
8a-18	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ... **633.17(a)(7) :** All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling.
8a-19	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**633.17(b)(8) :** OPWDD shall verify that the medication regimen of each person in a residential facility has been reviewed at least semi-annually by a registered nurse, physician, physician's assistant, or pharmacist.
8a-20	The individual exhibits a healthy lifestyle and/or receives support(s) to replace the unhealthy behaviors with healthier actions.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-21	The individual is provided choice in health care providers.	Met/Not Met	**633.4(a)(4)(x) :** (4) No person shall be denied:. (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the

			choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-22	The individual is supported to advocate and is included in informed decision-making related to medical care and treatment.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-23	Individuals have been given the opportunity to have advanced directives in place (DNR order, healthcare proxy, or living will).	Met/Not Met	**633.4(a)(4)(xxv)-(xxvi) :** (4) No person shall be denied: .(xxv) the opportunity to make, or have made on his or her behalf, an informed decision regarding cardiopulmonary resuscitation (see glossary), in accordance with the provisions of article 29-B of the Public Health Law, and any other applicable law or regulation. Each developmental center (see glossary) shall adopt policies/procedures to actualize this right. (xxvi) the opportunity, if the person is residing in an OPWDD operated or certified facility, to create a health care proxy (see glossary) in accordance with 14 NYCRR 633.20.
8a-24	For those that have advanced directives, they are completed properly in accordance with the Healthcare Decisions Act.	Met/Not Met	**633.10(a)(7)(ii) :** Upon receipt of notification of a decision to withdraw or withhold life-sustaining treatment in accordance with section 1750-b(4)(e)(ii) of the Surrogate's Court Procedure Act (SCPA), the chief executive officer (see glossary, section 633.99 of this Part) of the agency (see glossary, section 633.99 of this Part) shall confirm that the person's condition meets all of the criteria set forth in SCPA section 1750-b(4)(a) and (b). In the event that the chief executive officer is not convinced that all of the necessary criteria are met, he or she may object to the decision and/or initiate a special proceeding to resolve such dispute in accordance with SCPA section 1750-b(5) and (6).
8a-25	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the

			person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA	**633.4(a)(4)(x) :** (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-27	The individual is given access to family planning resources and sexuality education and/or counseling if desired.	Met/Not Met/NA	**633.4(a)(4)(xi) :** (4) No person shall be denied:...(xi) access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated.
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall with the medical care that the individual receives.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
9-1	A Functional Behavioral Assessment is completed for the individual prior to the	Met/Not Met	**633.16(d)(1)-(2) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric

	development of the Behavior Support Plan.		disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging	Met/Not Met	**633.16(d)(1)(i - v)** : Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a

	behaviors and all contextual factors as required.		clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain

			relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.

9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii):** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.

	person's plan and the specific interventions included.		
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(j)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year

			before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and

			a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use

			of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(i):** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan	Met/Not Met	**633.16(g)(3) :**

	that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.		Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.

9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.

	is expected to be reduced and eventually eliminated.		
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a

			commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician’s order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person’s clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50	Met/Not Met	**633.16(j)(4)(ii)(i)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a

	minutes intervals or according to physician's orders.		period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(i)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.

9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(i)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(i)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD

			or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.

			Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9e-1	Medication to address the individual's challenging behavior or a symptom of a diagnosed co-occurring psychiatric disorder is administered only as a part of a BSP or Monitoring Plan which includes additional interventions.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9e-2	Written Informed Consent for use of medication by the individuals has been obtained and is current.	Met/Not Met	**633.16(j)(5)(ii)(b) :** Written informed consent shall be obtained prior to the use of the medication. If it is necessary for the medication to be administered before written informed consent can reasonably be obtained, verbal consent may be ~~accepted for only th~~e period of time before written informed consent can be obtained. Verbal consent must be witnessed by two members of the staff and documented in the person's record. This verbal consent may be considered valid for a period of up to 45 days.
9e-3	When the plan includes the medication the Individual's service record includes a semi-annual medication regimen review that is used to evaluate the benefits/risk of continuation.	Met/Not Met	**633.16(j)(5)(j)(d) :** A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.

9e-4	The Individual's service record includes evidence that the prescriber was consulted regarding administration and continued effectiveness of the medication.	Met/Not Met	**633.16(j)(5)(i)(e)** : At least semi-annually, and more frequently as needed, staff shall consult with the prescriber regarding the administration and continued effectiveness of the medication.
9e-5	The Individual's service record includes evidence that the use of medication is having a positive effect on his/her behavior or target symptoms.	Met/Not Met	**633.16(j)(5)(ii)(c) :** The use of medication shall have a documented positive effect on the person's behavior or target symptoms to justify its ongoing use.
9e-6	The Individual's service record includes evidence that the effectiveness of the medication has been re-evaluated at least semi-annually at the program plan review with required service attendees.	Met/Not Met	**633.16(j)(5)(ii)(d)** : The effectiveness of the medication shall be re-evaluated at least semi-annually at the program plan reviews by the program planning team in consultation with a licensed psychologist, licensed clinical social worker, or behavior intervention specialist, and a health care professional. The goal(s) of this aspect of the plan review include: ensuring that medication is at the minimum and most effective dose; identifying a potential need for a medication with fewer or less intrusive side effects; evaluating the evidence presented to support continuation of the medication at a maintenance level, or recommending reduction or discontinuation of medication use if clinically indicated and authorized by the prescriber.
9e-7	Medications were administered in accordance with requirements.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging

			behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9f-1	When prn medication is prescribed to address behavior or symptoms of a psychiatric disorder, this strategy is included in the Individual's Behavioral Support or Monitoring Plan.	Met/Not Met/NA	**633.16(j)(5)(iii)(a) :** As-needed (also known as PRN) orders for medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, are considered planned use and must be incorporated in and documented as part of a behavior support plan or a monitoring plan.
9f-2	The Individual's service record includes evidence of the display of the behavior(s) or symptom(s) for which the PRN medication is being prescribed in the past 12 months.	Met/Not Met/NA	**633.16(j)(5)(iii)(b) :** Planned use of as-needed orders for medication: The person shall have a recent documented history of displaying the behavior(s) or symptoms (occurring in the last 12 months) for which the as-needed medication is being prescribed.
9f-3	The Individual's Behavioral Support or Monitoring Plan provides instruction and guidance for administration of the PRN medication, consistent with the prescriber's order.	Met/Not Met/NA	**633.16(j)(5)(iii)(c)(1-3) :** The behavior support plan or monitoring plan, consistent with the prescriber's order, shall clearly state: (1) the conditions under which the as-needed medication is to be administered, including the nature and degree of the individual's behavior(s) or symptoms, and the prescriber's recommendations regarding proximity to any scheduled medication administration; (2) the expected therapeutic effects; and (3) if applicable, the conditions under which the medication can be re-administered, and the allowable frequency of re-administration.
9f-4	The Individual's service record must include a summary, in behavioral terms, of the results of the PRN medication administration.	Met/Not Met/NA	**633.16(j)(5)(iii)(d) :** Planned use of as-needed orders for medication: The staff person or family care provider who is responsible for support and supervision of a person who has a behavior support plan or monitoring plan must document in the

			person's clinical record a summary of the results of the medication use in behavioral terms.
9f-5	The Individual's service record includes evidence that any adverse or unexpected side effects were reported to the PRN prescriber immediately and the planning team by the next business day.	Met/Not Met/NA	**633.16(j)(5)(iii)(e) :** Planned use of as-needed orders for medication: Results that are substantively different from the intended effect, and any adverse side effects, shall be reported to the prescriber immediately and the person's program planning team no later than the next business day.
9f-6	Use of PRN Medications on more than four (4) separate days in a 14-day period resulted in consideration of a recommendation for incorporation into a regular drug regimen.	Met/Not Met/NA	**633.16(j)(5)(iii)(f) :** If any as-needed medication is administered on more than four separate days (one day equals 24 hours) in a 14-day period, the individual's program planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist and healthcare professional, must reassess the appropriateness of continuing the as-needed medication, or consider recommending that it be incorporated into the individual's regular drug regimen.
9f-7	Lack of use of a PRN medication during a six-month period resulted in a review of the BSP and a recommendation to the prescriber.	Met/Not Met/NA	**633.16(j)(5)(iii)(h) :** If the as-needed medication is not administered during a six-month period, the program planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist, must review the behavior support plan and develop a recommendation to the prescriber regarding the appropriateness of continuing the as-needed medication as part of the plan. If the order is continued, a clear justification is to be documented in the record.
9f-8	Effectiveness of the medication ordered in an	Met/Not Met/NA	**633.16(J)(5)(iv)(c) :**

	emergency is documented in the Individual's record.		Emergency use of medication: The use of the medication, along with the prescription/order and a note on its effectiveness, shall be documented in the person's record.
9f-9	Emergency use of medication in more than 4 instances in a 14-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(J)(5)(iv)(d) :** Emergency use of medication. The emergency use of medication to control challenging behavior or acute symptoms of a co-occurring diagnosed psychiatric disorder in more than four instances in a 14-day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, a licensed clinical social worker or behavioral intervention specialist within three business days of the fifth medication administration.
9f-10	Use of PRN medications in conjunction with a restrictive physical intervention technique were reported electronically to OPWDD.	Met/Not Met/NA	**633.16(j)(5)(iii)(g) :** Each use of an as-needed medication when used in conjunction with a restrictive physical intervention technique to prevent, modify, or control challenging behavior shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9g-1	The Individual's record identifies the symptoms he/she exhibits and each co-occurring psychiatric disorder diagnosis.	Met/Not Met	**633.16(j)(5)(vi)(e) :** Medication use to treat a co-occurring diagnosed psychiatric disorder. Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirement must be met. (e) The symptoms and diagnosis of the co-occurring psychiatric disorder must be documented.
9g-2	The Individual's Monitoring Plan clearly identifies target symptoms associated with each medication prescribed for a psychiatric disorder.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a

			written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented.
9g-3	The Individual's Monitoring Plan includes the method to measure and document symptom reduction and functional improvement.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-4	The Individual's Monitoring Plan includes alternative interventions (other than medication).	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional

			behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-5	The individual's Monitoring Plan is developed by a qualified clinician.	Met/Not Met	**633.16(b)(29) :** Plan, monitoring. A plan developed by a licensed psychologist, licensed psychiatric nurse practitioner, licensed clinical social worker, or a behavioral intervention specialist that identifies the target symptoms of a co-occurring diagnosed psychiatric disorder that are to be prevented, reduced, or eliminated.
9g-6	The effectiveness of the individual's Monitoring Plan in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(j)(5)(i)(d)** : A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.

10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4) :** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)

10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)
			624.5(g)(2) : When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)

10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate. **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16)\ **624.5(h)(5) :**

			The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);**

			Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(j)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l) :** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** : Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to

			immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16)

			624.5(h)(5) : The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met	**624.7(b)(2): :** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16)

			624.5(k)(1)-(3): : (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(j)(2)(j)-(jj) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met	**625.4(b)(2)(j-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-10	Assessments needed by the individual or required by program regulation were completed to inform the individual's plan development.	Met/Not Met	**676.6(a) :** Core diagnostic and evaluation services are mandatory for each person admitted to the clinic for the comprehensive evaluation; these services are available discretely for any person admitted for a particular diagnostic and evaluation service under subparagraph (a)(4)(ii) of section 676.5 of this Part. It shall be mandatory that each person receiving the package of core diagnostic and evaluation services shall also have the services specified in subdivisions (e) and (f) of this section. **676.6(f)(3) :** During the interdisciplinary team conference, each professional's findings in their particular disciplines shall be coordinated and integrated so that a single and unified profile of the person emerges. This unified profile shall include at least written statements concerning the person's: (i) etiology; (ii) symptomatology; (iii) classification according to activities of daily life; (iv) central nervous system process; (v) functional and behavioral skills and deficits; or (vi) diagnostic conclusion.
1-25	The person-centered plan identifies the provider(s) of the individual's supports and services.	Met/Not Met	**679.4(j)(2) :** OPWDD shall verify that there is a clinical record maintained in a confidential manner for each person admitted to the facility which contains at least: ….and the name of the party responsible for treatment coordination; **679.4(g) :** OPWDD shall verify that the facility has assigned a staff member to each person admitted for service, to perform the functions of treatment coordinator and who is the contact point for the person's service coordinator (if applicable). The person's clinical record reflects the activities of this treatment coordination.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service	Met/Not Met	**679.4(j)(1)-(6) :** Clinic Treatment: (j) OPWDD shall verify that there is a clinical record maintained in a confidential manner for each person admitted to the facility which contains at least: (1) identification information about the applicant/service recipient and his or her family and services received

	providers.		outside of the clinic (including identification of practitioner or responsible entity); (2) source of referral, date commencing service/treatment, and the name of the party responsible for treatment coordination; (3) initial, interim, and/or final diagnosis(es), as applicable, set forth in appropriate official terminology, including those related to the person's developmental disability, other mental disability(ies) if present, and medical condition/diagnoses; (4) reports of all known, recent (i.e., within the last two years) diagnostic examinations and assessments including findings and conclusions, regardless of source, including reports of any special studies and/or laboratory procedures performed at the clinic's recommendation; (5) the individual written plan of services for all treatments being recommended and delivered by the clinic; and (6) treatment notes signed by the professional staff member or treatment coordinator making the note.
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**679.4(j)(5) :** (j) OPWDD shall verify that there is a clinical record maintained in a confidential manner for each person admitted to the facility which contains at least: ...(5) the individual written plan of services for all treatments being recommended and delivered by the clinic;
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**679.4(j)(5) :** OPWDD shall verify that there is a clinical record maintained in a confidential manner for each person admitted to the facility which contains at least: ...(5) the individual written plan of services for all treatments being recommended and delivered by the clinic; 679.4(k) There shall be a written plan of services which also documents that the outcomes and/or course of treatment has been reviewed as to the achievement of said outcomes and the need for continued course of treatment... **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live

			as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**679.3(i) :** The facility shall have sufficient professional (see glossary) staff to deliver the services offered in accordance with the intensity, duration and frequency recommended by the treating clinician(s) for persons admitted to the facility. **679.7(a)(3) :** Clinic services shall be delivered in accordance with the person's clinic treatment plan (see section 679.4[j] and [k] of this Part), except for a clinic intake and diagnostic and evaluation services. **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**679.3(m):** All services shall be provided so as to maximize each person's continuity of care…. **633.4(a)(4)(viii):** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely

	expectations specific to the service type.		and humanely, with full respect for the individual's dignity and personal integrity; **679.4(e) :** OPWDD shall verify that the facility's staffing plan and actual day-to-day allocation of staff includes provisions for all services to be delivered by or under the direct supervision (see glossary) of practitioners of the healing arts or otherwise herein authorized parties. **679.4(h) :** OPWDD shall verify that all treatment has been given upon the written order of a physician or dentist, at least annually or when there are significant changes to the ongoing treatment plan, and is delivered under the supervision of a physician, dentist or practitioner of the healing arts (see glossary) subsequent to an intake visit assessment documenting the need for admission to the clinic.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**679.4(k)(1)-(2) :** (k) There shall be a written plan of services which also documents that the outcomes and/or course of treatment has been reviewed as to the achievement of said outcomes and the need for continued course of treatment pursuant to the following schedule: (1) as specified by the treating physician or dentist, for medical or dental treatment; and (2) at least semi-annually by the treating practitioner or treatment coordinator in consultation with the person receiving the service and/or his/her collaterals (unless the person is an adult, has the capacity to object, and does so object to the provision of such services), for all other ongoing rehabilitation/habilitation services (see section 79.3[j][2] of this Part) or health care services (see section 679.3[j][4] of this Part) of six months or longer duration.
2-13	There is a review summary	Met/Not Met	**679.4(k)(1)-(2) :**

	note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.		There shall be a written plan of services which also documents that the outcomes and/or course of treatment has been reviewed as to the achievement of said outcomes and the need for continued course of treatment pursuant to the following schedule: (1) as specified by the treating physician or dentist, for medical or dental treatment; and (2) at least semi-annually by the treating practitioner or treatment coordinator in consultation with the person receiving the service and/or his/her collaterals (unless the person is an adult, has the capacity to object, and does so object to the provision of such services), for all other ongoing rehabilitation/habilitation services (see section 79.3[j][2] of this Part) or health care services (see section 679.3[j][4] of this Part) of six months or longer duration.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**679.4(k)(1)-(2) :** (k) There shall be a written plan of services which also documents that the outcomes and/or course of treatment has been reviewed as to the achievement of said outcomes and the need for continued course of treatment pursuant to the following schedule: (1) as specified by the treating physician or dentist, for medical or dental treatment; and (2) at least semi-annually by the treating practitioner or treatment coordinator in consultation with the person receiving the service and/or his/her collaterals (unless the person is an adult, has the capacity to object, and does so object to the provision of such services), for all other ongoing rehabilitation/habilitation services (see section 79.3[j][2] of this Part) or health care services (see section 679.3[j][4] of this Part) of six months or longer duration.
2-15	The person is satisfied with the specific service.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such

			information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii) :** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1) :** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5) :** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3) :** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-24	The individual's rights are respected and staff	Met/Not Met	**633.4(a)(4)(ix)** :

	support/advocate for the individual's rights as needed.		No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4) :**

			If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate. **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or

			operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16)\ **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to	Met/Not Met/NA	**624.7(b)(2);**

	prevent future similar events involving the individual were planned and implemented.		An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i)

			implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l) :** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** : Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to

			immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must

			make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met	**624.7(b)(2); :** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16)

			624.5(k)(1)-(3); : (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met	**625.4(b)(2)(i-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**690.5(d)(3)(ii) :** The person shall be given the opportunity to invite additional parties of his/her choice to participate in the program planning process. The facility shall make reasonable efforts for said invitees to actually participate.
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**690.5(d)(3)(i)-(iv) :** (l) Treatment planning and review. (3) Each person in a day treatment facility shall have an individual program plan. (i) The person shall participate (unless the person is a capable adult and chooses not to participate), and the person's correspondent shall be invited to actively participate in the development of the individual program plan, unless the person is a capable adult who objects to such correspondents' participation. (ii) The person shall be given the opportunity to invite additional parties of his/her choice to participate in the program planning process. The facility shall make reasonable efforts for said invitees to actually participate. (iii) If no correspondent is available, and if the person does not have the capacity himself/herself to knowledgeably select an outside party to participate in the program planning process, an advocate (see glossary) shall be appointed who shall be invited to actively participate. (iv) The coordinator at the person's residential facility, if applicable, or case manager shall also be invited to attend and participate in all interdisciplinary treatment team meetings. **690.6(l)(2) :** (l) OPWDD shall verify that the annual interdisciplinary treatment team review process includes: (2) participation by the person, the person's correspondent (which includes invitation, if not actual attendance), and advocate (if appropriate), unless the person is an adult capable of objecting to such participation and has so objected;
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-10	Assessments needed by the individual or required by program regulation were completed to inform the individual's plan development.	Met/Not Met	**690.5(d)(4)(i)-(ii) :** (4) The initial individual program plan shall be developed by an interdisciplinary treatment team which shall: (i) review current assessments and/or an existing individual program plan, if available. Assessments or plans developed within twelve months by another agency or certified facility prior to enrollment shall be considered acceptable, based on review and approval by the interdisciplinary treatment team; and (ii) in the absence of current and acceptable assessments and/or an individual program plan, conduct a preliminary screening of the person. **690.6(l)(1) :** (l) OPWDD shall verify that the annual interdisciplinary treatment team review process includes: (1) such reassessments of the person's capabilities, capacities, needs, and preferences as may be indicated;
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**690.5(d)(6)(i)(f) :** (6) Each person's individual program plan shall include, but not be limited to, the following: (i) A comprehensive functional assessment which addresses the persons capacities and capabilities in the areas of communication, mobility, learning, independent living, self-care, health care and self-direction. The comprehensive functional assessment shall: (f) identify the person's preferences (see section 690.99[ab] of this Part) with respect to the activities, interventions, and outcomes which will become components of or be taken into account in the design of his/her individual program plan.

1-12	The individual's strengths and preferences are documented in the service plan.	Met/Not Met	**690.5(d)(6)(i)(b) :** 6) Each person's individual program plan shall include, but not be limited to, the following: (i) A comprehensive functional assessment which addresses the persons capacities and capabilities in the areas of communication, mobility, learning, independent living, self-care, health care and self-direction. The comprehensive functional assessment shall: (b) identify the person's specific developmental strengths; **690.5(d)(6)(i)(f) :** (6) Each person's individual program plan shall include, but not be limited to, the following: (i) A comprehensive functional assessment which addresses the persons capacities and capabilities in the areas of communication, mobility, learning, independent living, self-care, health care and self-direction. The comprehensive functional assessment shall: (f) identify the person's preferences (see section 690.99[ab] of this Part) with respect to the activities, interventions, and outcomes which will become components of or be taken into account in the design of his/her individual program plan.
1-13	The individual's identified needs for clinical and/or functional support are documented in the service plan.	Met/Not Met	**690.5(d)(6)(i)(c)-(d) :** (6) Each person's individual program plan shall include, but not be limited to, the following: (i) A comprehensive functional assessment which addresses the persons capacities and capabilities in the areas of communication, mobility, learning, independent living, self-care, health care and self-direction. The comprehensive functional assessment shall: ...(c) identify the person's specific developmental and behavioral management needs; (d) identify the person's need for services within the day treatment facility without regard for availability of the services needed;
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-16	The individual's goals and priorities regarding meaningful relationships are identified in the person centered plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-18	The individual's goals and priorities related to health concerns and medical needs are identified in the person centered plan.	Met/Not Met	**690.5(d)(6)(i)(e) :** (6) Each person's individual program plan shall include, but not be limited to, the following: (i) A comprehensive functional assessment which addresses the persons capacities and capabilities in the areas of communication, mobility, learning, independent living, self-care, health care and self-direction. The comprehensive functional assessment shall: (e) include physical development, health and nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the person to be able to function in the community, and vocational skills if applicable; ... **690.5(d)(6)(ii) :** 6) Each person's individual program plan shall include, but not be limited to, the following: (ii) Treatment plans for a coordinated program of individually

			designed activities, experiences and services necessary to achieve individual program objectives written in the form of outcomes (see glossary). These plans shall contain, as appropriate, specific medical prescriptions or written direction (i.e., interventions, (see glossary). These plans shall contain, as appropriate, specific medical prescriptions or written direction (i.e., interventions, methodologies or strategies) from the interdisciplinary treatment team for all specified services. Such services, interventions, and methodologies shall be described in terms sufficiently clear to be understood by all parties participating in the implementation of the individual program plan. **690.5(d)(9)(iii) :** 9) Review of each individual program plan shall take place at intervals determined by the agency/facility, but with sufficient responsiveness to ensure review whenever a person has completed an objective/goal, is regressing or losing skills already gained, is failing to progress toward identified objectives after reasonable efforts have been made, when a person is being considered for training towards new objectives or when the person or their correspondent requests. (iii) If the physician is not present, a registered nurse must attend at least the annual review (and any other interdisciplinary treatment team meetings) where it is necessary to interpret the medical assessment and integrate the person's identified health care needs into the individual program plan.
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-34	The individual has been informed that they can	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	request a change to the plan and understands how to do so.		
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**690.6(r)(1-6) :** (r) OPWDD shall verify that individual program plans are maintained in a confidential manner and that the plans contain at least: (1) identification information about the person and his or her family, and services received outside of the day treatment facility (including identification of practitioner or responsible entity); (2) source of referral, date service commenced, and the name of the party responsible for treatment coordination; (3) initial, interim, and/or final diagnosis(es), as applicable, set forth in appropriate official terminology, including those related to the person's developmental disability, other mental disability(ies) if present, and medical condition/diagnoses; (4) reports of all known, recent (i.e., within the last year) diagnostic examinations and assessments, including findings and conclusions, regardless of source, including reports of any special studies and/or laboratory procedures performed at the day treatment facility's recommendation; (5) the individual written plan of services for all services being recommended and delivered by the facility; and (6) treatment notes signed by the professional staff member or treatment coordinator making the note. **690.99(y) :** (y) Plan, individual program. A record system, by whatever name known, which documents the process of developing, implementing, coordinating, reviewing and modifying a person's total plan of care. It is maintained as the functional record, indicating all planning as well as services and interventions delivered to the person. It contains, at a minimum, identification data, diagnostic reports, assessments, the comprehensive functional assessment, service plans, medical data, activity schedules, interdisciplinary team minutes and reports, and staff action records. The overall responsibility for maintenance of the individual program plan rests with the treatment coordinator of the person's individual program plan.

2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**690.5(d)(6)(ii) :** 6) Each person's individual program plan shall include, but not be limited to, the following: (ii) Treatment plans for a coordinated program of individually designed activities, experiences and services necessary to achieve individual program objectives written in the form of outcomes (see glossary). These plans shall contain, as appropriate, specific medical prescriptions or written direction (i.e., interventions, (see glossary). These plans shall contain, as appropriate, specific medical prescriptions or written direction (i.e., interventions, methodologies or strategies) from the interdisciplinary treatment team for all specified services. Such services, interventions, and methodologies shall be described in terms sufficiently clear to be understood by all parties participating in the implementation of the individual program plan. **690.99(z) :** (z) Plan, treatment. A component of the individual program plan which specifies outcomes, records to be kept, those responsible for delivery of activities, interventions and therapies, and review schedules. These written plans of activities, interventions, and therapies are developed on the basis of assessment findings with input of the service providers, the person and, as appropriate, the person's correspondent.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**690.5(d)(5)(iii)(b)-(d) :** Within the 21 working days after the date of admission, the following shall have completed:... (b) a comprehensive functional assessment; (c) a summary clinical statement(s) by the Interdisciplinary Team that can be used for comprehensive programming; and (d) at least a preliminary individual program plan, which shall then be finalized within the next 30 days. **690.5(d)(7) :** The day treatment facility shall provide to each person a range of allowable services to meet that person's needs, as identified by the comprehensive functional assessment, and which are directed toward the acquisition of the behaviors and skills necessary for the person to function with as much self determination and independence as possible, including, as appropriate, the prevention or deceleration of regression or loss of current optimal functional status.

2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**690.5(d)(6)(ii) :** 6) Each person's individual program plan shall include, but not be limited to, the following: (ii) Treatment plans for a coordinated program of individually designed activities, experiences and services necessary to achieve individual program objectives written in the form of outcomes (see glossary). These plans shall contain, as appropriate, specific medical prescriptions or written direction (i.e., interventions, (see glossary). These plans shall contain, as appropriate, specific medical prescriptions or written direction (i.e., interventions, methodologies or strategies) from the interdisciplinary treatment team for all specified services. Such services, interventions, and methodologies shall be described in terms sufficiently clear to be understood by all parties participating in the implementation of the individual program plan. **690.99(z) :** (z) Plan, treatment. A component of the individual program plan which specifies outcomes, records to be kept, those responsible for delivery of activities, interventions and therapies, and review schedules. These written plans of activities, interventions, and therapies are developed on the basis of assessment findings with input of the service providers, the person and, as appropriate, the person's correspondent. **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;…
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**690.5(d)(8) :** The individual program plan and processes for its development and monitoring shall document conformity with the definition of active treatment and ensure its provision. **690.99(ar) :** Treatment, active. An active and organized process of service delivery, designed to maximize each person's development and well-being. It

			has as its aim the implementation of an approach of specialized and generic training, treatment, health services and related services as described in this Part. Nothing shall prohibit the delivery of interventions/therapies through group activities as opposed to individually delivered services. The active treatment process results in an integrated, individually tailored plan of activities, interventions, and therapies directed toward achieving individual specific outcomes (see subdivision [v] of this section) in an environment approximating as closely as possible that of persons without disabilities. Active treatment provided in a day treatment facility does not include services to maintain persons who may be considered generally independent, and who are able to function with little supervision or in the absence of a planned program of targeted activities, interventions and therapies. The active treatment process includes: (1) a comprehensive functional assessment of the person that, at least annually, is reviewed by the interdisciplinary treatment team for relevancy and updated as needed. This comprehensive functional assessment is based on assessments in developmental areas, and not, necessarily on discipline specific assessments, unless the comprehensive functional assessment shows a need for a full professional discipline-specific assessment. It includes an analysis and synthesis by the interdisciplinary team of the person's developmental disability and skills and deficits in all areas of adaptive behavior (see subdivision [i] of this section); and (2) preparation of a written service plan which is directed toward the acquisition of the behaviors and skills necessary for a person to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**690.6(k) :** OPWDD shall verify that the activities and services engaged in by the person are consistent with, and generally reflect the values associated with individualization, inclusion, independence and productivity.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality	Met/Not Met	**690.6(r)(6) :** (r) OPWDD shall verify that individual program plans are maintained in a confidential manner and that the plans contain at least: ...(6) treatment notes

	expectations specific to the service type.		signed by the professional staff member or treatment coordinator making the note.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her	Met/Not Met	**690.6(l)(1)-(7) :** OPWDD shall verify that the annual interdisciplinary treatment team review process includes: (1) such reassessments of the person's capabilities, capacities, needs, and preferences as may be indicated; (2) participation by the person, the person's correspondent (which includes invitation, if not actual attendance), and advocate (if appropriate), unless the person is an adult capable of objecting to such participation and has so objected; (3) review of a person's comprehensive functional assessment for relevancy,

	goals, priorities, needed safeguards and outcomes.		updating it as necessary, and revising the individual program plan as appropriate; (4) a review of the outcome of the services delivered; (5) establishment of modified or new outcomes, if need or preference is indicated; (6) a listing of all parties who attended the review, by name and title or role; and (7) notification, at least semi-annually, of the person's status and progress sent to the person's correspondent and the certified residential facility, if applicable, unless the person is an adult with the capacity to object to such notification and does object. **690.6(s)(1)-(3) :** OPWDD shall verify that individual program plans of persons admitted to the day facility include: (1) progress notes describing the person's response in terms of the established objectives; (2) written notations regarding significant changes in the person's performance, attitudes, feelings and physical condition; (3) summaries specific to the person's goals and objectives prepared or reviewed and approved by qualified professionals providing or supervising services and reviewed by the treatment coordinator of the person's program plan; or a summarization, by the treatment coordinator, of all services being provided to the person;
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**690.6(s)(1)-(3) :** OPWDD shall verify that individual program plans of persons admitted to the day facility include: (1) progress notes describing the person's response in terms of the established objectives; (2) written notations regarding significant changes in the person's performance, attitudes, feelings and physical condition; (3) summaries specific to the person's goals and objectives prepared or reviewed and approved by qualified professionals providing or supervising services and reviewed by the treatment coordinator of the person's program plan; or a summarization, by the treatment coordinator, of all services being provided to the person;
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person	Met/Not Met	**690.6(l)(3)-(5) :** (l) OPWDD shall verify that the annual interdisciplinary treatment team review process includes:...(3) review of a person's comprehensive functional assessment for relevancy, updating it as necessary, and revising the

	to foster the advancement/achievement of his/her goals/outcomes.		individual program plan as appropriate; (4) a review of the outcome of the services delivered; (5) establishment of modified or new outcomes, if need or preference is indicated;
2-15	The person is satisfied with the specific service.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2q-1	The individual is receiving active treatment.	Met/Not Met/NA	**690.5(d)(8) :** The individual program plan and processes for its development and monitoring shall document conformity with the definition of active treatment and ensure its provision. **690.5(ar) :** Treatment, active. An active and organized process of service delivery, designed to maximize each person's development and well-being. It has as its aim the implementation of an approach of specialized and generic training, treatment, health services and related services as described in this Part. Nothing shall prohibit the delivery of interventions/therapies through group activities as opposed to individually delivered services. The active treatment process results in an integrated, individually tailored plan of activities, interventions, and therapies directed toward achieving individual specific outcomes (see subdivision [v] of this section) in an environment approximating as closely as possible that of persons without disabilities. Active treatment provided in a day treatment facility does not include services to maintain persons who may be considered generally independent, and who are able to function with little supervision or in the absence of a planned program of targeted activities, interventions and therapies. The active treatment process includes: (1) a comprehensive functional assessment of the person that, at least annually, is reviewed by the interdisciplinary treatment team for relevancy and updated as needed. This comprehensive functional assessment is based on assessments in developmental areas, and not, necessarily on discipline specific assessments, unless the comprehensive functional assessment shows a need for a full professional discipline-specific assessment. It includes an analysis and synthesis by the interdisciplinary team of the person's developmental disability and skills and deficits in all areas of adaptive behavior (see subdivision [i] of this section); and (2) preparation of a written service plan which is directed toward the acquisition of the behaviors and skills necessary for a person to function with as much self-determination and

			independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.
2q-2	Coordination with the individual's residential provider is evident.	Met/Not Met/NA	**690.6(j)(3) :** OMRDD shall verify that individual program plans reflect: (3) coordination of day treatment services with the person's services provided in a certified residence; **690.5(d)(3)(iv) :** The coordinator at the person's residential facility, if applicable, or case manager shall also be invited to attend and participate in all interdisciplinary treatment team meetings.
2q-3	When the individual's services include therapeutic prevocational services, he/she must be compensated in compliance with New York wage and hour laws.	Met/Not Met/NA	**690.3(a)(2) :** Where clinically appropriate, and incorporated into the person's individual program plan (see glossary), a day treatment facility may elect to provide, as part of the allowable services in the area of independent living or other category, active treatment-based activities of a therapeutic prevocational nature. Included here, for example, might be training in the performance of an assembly task to improve manipulation skills, training in the performance of a sorting task to improve cognitive discrimination skills, etc. However, this excludes those activities/interventions which have a purely vocational (i.e., work-for-pay) purpose. Therapeutic prevocational activities are eligible for reimbursement through the Medical Assistance Program as part of a day treatment facility's allowable services if: (i) The activities/interventions are documented in a written individual program plan and conform to the requirements for the provision of active treatment (see glossary). (ii) The activities in which persons are engaged are primarily therapeutic and individualized in nature (i.e., the treatment goal is the amelioration of a developmental skill deficit, or developmental skill enhancement, rather than the production of a product), and the activities are chosen, approved or developed by the interdisciplinary treatment team (see glossary) on the basis of clinical judgement related to the person's needs. (iii) The activities engaged in are not performed as part of contract work (see glossary) for

			which the day treatment facility in particular, has made any commitments for itself, its staff, or the participants. (iv) The activities engaged in by persons at the facility do not generate any outside income which accrues to the day treatment facility. (v) In accordance with the Department of Labor regulations, if the therapeutic activity/intervention results in a saleable product or an economic benefit to any party, the person(s) must be recompensed in accordance with New York State's Wage and Hour Law requirements.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii) :** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1) :** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.

3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5) :** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them.
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support.	Met/Not Met	**633.4(a)(xx) :** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)** : No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights modification (clinical justification).	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-4	The individual's service plan identifies specific	Met/Not Met	**Quality Indicator:**

	actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.		This is an indicator of quality outcomes.
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**690.6(r) :** OPWDD shall verify that individual program plans are maintained in a confidential manner and that the plans contain at least: … (5) the individual written plan of services for all services being recommended and delivered by the facility; **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (i) An assessment of functional capacity. (ii) Review and evaluation of the person's written plan of services and his or her progress in relation to that plan …;
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x):** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the

			opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. 690.3(a)(3) : As part of the day treatment facility's reimbursement, allowable services shall be provided as needed on a regular basis (though not necessarily on a daily basis), to person(s)/people attending the day treatment facility in accordance with an individual program plan and, in the case of occupational and physical therapy, by specific written medical prescription. (i) The frequency and intensity of service delivery shall be based on the needs indicated in each person's comprehensive functional assessment…
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity …
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
7-5	The individual is provided dining supports for	Met/Not Met	**ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable

	consistency, assistance, and monitoring per his/her written plan and as needed.		parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
8d-1	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s) addressed during services at the site.	Met/Not Met/NA	**633.10(a)(2)(iii)** : (2) In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (iii) For persons in a residential facility, at least a medical/dental evaluation by a

			physician or registered physician's assistant addressing the person's need for an examination or specific medical/dental services; or by a dentist for dental services. The determination of the basis for such evaluation (e.g., appraisal of the person through records and previous contacts) shall be that of the qualified professional.
8d-2	The individual receives the needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8d-3	The individual's service record/service plan is maintained to reflect current status of the individual's health needs being addressed.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). ...
8d-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8d-5	The individual and/or their support(s) report the individual's health concerns/symptoms to	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through

	appropriate parties as needed or directed.		parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8e-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person
8e-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8e-3	The individual receives medications and treatments safely as prescribed.	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.17(b)(3)** : Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication.
8e-4	Problems or errors with administration of the	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as

	individual's medication are reported and remediated per agency processes**.**		is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ... **633.17(a)(7) :** All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling.
9-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	Met/Not Met	**633.16(d)(1)-(2) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency,

			duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	Met/Not Met	**633.16(d)(1)(i - v)** : Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii)

			include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.

	and/or other parties involved with implementation of the plan.		
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports	Met/Not Met	**633.16(e)(2)(vii):** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :**

	designed to address the challenging behavior.		A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the

	his/her life is reviewed as identified in the plan.		frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(i)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's

	intervention(s) and/or limitation on rights.		behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize

			and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to	Met/Not Met	**633.16(e)(4)(i):** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section.

	implementation and approval is current.		**633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an	Met/Not Met/NA	**633.16(j)(2)(ii) :**

	emergency is documented in the individual's record.		In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.

9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or

			immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.

9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(j)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a

	supervision of a senior member of the staff.		senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(i)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(i)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(i)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly,	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person’s behavior which necessitated application of the intervention has diminished sufficiently or has

	within timeframes or if he/she appeared physically at risk.		ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed

			clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :**

	review of the Behavior Support Plan within three business days.		The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)**: Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.

10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4) :** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an

	Occurrences involving the individual are thorough and documented.		investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate. **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16)\ **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2):** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for

			completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(j)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be

			undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l) :** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives

	needed was provided to the individual.		any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** : Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or

	involving the individual are thorough and documented.		occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to):

			(i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met	**624.7(b)(2): ;** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3):** : (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(j)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met	**625.4(b)(2)(i-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-34	The individual has been informed that they can	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	request a change to the plan and understands how to do so.		
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**85.6(d) :** (d) A single case record which contains current information regarding diagnosis, treatment and evaluation of results of care or treatment for each person served shall be available to all professional staff involved in the care or treatment of that person.
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**85.6(b) :** (b) All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**85.6(b) :** b) All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**85.6(b) :** (b) All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. **85.6(d) :** A single case record which contains current information regarding diagnosis, treatment and evaluation of results of care or treatment for each person served shall be available to all professional staff involved in the care or treatment of that person.

2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**85.6(d) :** A single case record which contains current information regarding diagnosis, treatment and evaluation of results of care or treatment for each person served shall be available to all professional staff involved in the care or treatment of that person.

2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**85.6(d) :** A single case record which contains current information regarding diagnosis, treatment and evaluation of results of care or treatment for each person served shall be available to all professional staff involved in the care or treatment of that person.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
2-15	The person is satisfied with the specific service.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2p-1	When the individual's services include vocational services, services must be in compliance with federal and state laws regarding labor wages and safety.	Met/Not Met	**25.4(a)-(d) :** Vocational training is the process of providing a patient [individual receiving services] with job training through on- and off-job instructions and performance of actual work tasks designed and supervised to increase the patient's [his or her] ability to work, (b) No patient [individual] may participate in work involved in vocational training unless the facility has first obtained a Federal Labor Department certificate. This certificate is issued by the Facilities Division of the Office of Vocational Rehabilitation of the New York State Education Department as an agent of the Federal Labor Department and any such participation shall be in accordance with the terms and conditions of the certificate. (c) Compensation for work performed in vocational training shall be paid in accordance with the terms and conditions of the certificate. (d) Facilities shall provide or arrange for the provision of relevant services for the mentally disabled for patients [individuals] involved in vocational training as provided in this section as necessary to their total habilitation or rehabilitation. **25.5(a)-(b) :**

			Work by a patient [an individual receiving services] may be an appropriate part of the patient's [his or her] overall service plan only in accordance with this section. (b) Sheltered work may be provided to patients [individuals receiving services] only in workshops having appropriate certification in accordance with applicable Federal and State laws and regulations. Such work shall be provided, supervised and compensated in accordance with the certificate issued; **25.5(g) :** Under no circumstances shall any patient [individual receiving services] be allowed to perform work tasks under conditions, in facilities, or on machines or equipment which are not in full compliance with all applicable Federal and State laws and regulations.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii) :** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1) :**

			OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5) :** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them.
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support.	Met/Not Met	**633.4(a)(xx) :** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3-17	The setting reflects the individual's needs and preferences including the presence of any necessary	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	physical modifications, if applicable.		
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)** : No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights modification (clinical justification).	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)

	imposition and review of continued necessity.		
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**85.6(b)** : From Operation of Outpatient Facilities regulations applicable to Day Training and Day Training/Sheltered Workshop facilities. All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (i) An assessment of functional capacity. (ii) Review and evaluation of the person's written plan of services and his or her progress in relation to that plan;

7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x):** : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **85.6(b):** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and

			rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met	**ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an

			overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
8d-1	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s) addressed during services at the site.	Met/Not Met/NA	**633.10(a)(2)(iii)** : (2) In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (iii) For persons in a residential facility, at least a medical/dental evaluation by a physician or registered physician's assistant addressing the person's need for an examination or specific medical/dental services; or by a dentist for dental services. The determination of the basis for such evaluation (e.g.,

			appraisal of the person through records and previous contacts) shall be that of the qualified professional.
8d-2	The individual receives the needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8d-3	The individual's service record/service plan is maintained to reflect current status of the individual's health needs being addressed.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). ...
8d-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8d-5	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8e-1	The individual's current medications are correctly	Met/Not Met	**633.17(b)(3)(i)-(ii) :**

	documented as prescribed when support for administration is needed/provided.		Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person
8e-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8e-3	The individual receives medications and treatments safely as prescribed.	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.17(b)(3)** : Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication.
8e-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ...

			633.17(a)(7) : All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling.
9-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	Met/Not Met	**633.16(d)(1)-(2) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed

			or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	Met/Not Met	**633.16(d)(1)(i - v)**: Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service

			providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.

9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii):** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional

			components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.

9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(i)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive

			intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less

			intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(i):** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.

9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the

			person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :**

	Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.		The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order

			and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :**

	use of the Mechanical Restraining device.		A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(i)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred.	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider

			or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(i)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(i)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(i)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical

			intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the

			exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the

	Support Plan within three business days.		behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)** : Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and	Met/Not Met	**624.5(g)(1) :**

	needed was provided to the individual.		A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4) :** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate.

			624.5(h)(3) : When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16)\ **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2):** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an

			outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l) :** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable

			and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** : Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and

			specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity

			(e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met	**624.7(b)(2): ;** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3): **: (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii) ;** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met	**625.4(b)(2)(i-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met	**25.1(c)(1) :** Work Activities-Sheltered Work: c) Vocational rehabilitation services shall be available to patients, as appropriate to their developmental levels, and in accordance with their overall service plans. When indicated, the following vocational rehabilitation services shall be provided as part of the patient's overall service plan: (1) the fullest possible participation of the patient in the formulation of this plan;
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**25.1(c)(2) :** (c) Vocational rehabilitation services shall be available to patients, as appropriate to their developmental levels, and in accordance with their overall service plans. When indicated, the following vocational rehabilitation services shall be provided as part of the patient's overall service plan: (2) vocational evaluation, including written comprehensive interdisciplinary evaluation (medical, psychological, social, vocational and educational) that generates information relevant to vocational objectives and goals; **25.3(a) :**

			(a) Prevocational training is the process of developing the patient's functional competence to be able to participate effectively in vocational training or work. This process includes the development of appropriate attitudes toward work, social and personal habits necessary to job performance and interactions with coworkers, and physical skills and performance necessary to the performance of job tasks. Prevocational evaluation is the process of identifying and assessing an individual's assets, interests and limitations and developing from them appropriate vocational goals and objectives and means for their attainment.
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**85.6(d) :** (d) A single case record which contains current information regarding diagnosis, treatment and evaluation of results of care or treatment for each person served shall be available to all professional staff involved in the care or treatment of that person.

2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**25.1(c)(4) :** (c) Vocational rehabilitation services shall be available to patients, as appropriate to their developmental levels, and in accordance with their overall service plans. When indicated, the following vocational rehabilitation services shall be provided as part of the patient's overall service plan: (4) a written plan to achieve the stated objectives including the assignment of responsibilities. **85.6(b) :** (b) All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. **633.4(a)(4))(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**25.1(c)(3)-(4) :** (c) Vocational rehabilitation services shall be available to patients, as appropriate to their developmental levels, and in accordance with their overall service plans. When indicated, the following vocational rehabilitation services shall be provided as part of the patient's overall service plan: (3) written vocational objectives for each patient; and (4) a written plan to achieve the stated objectives including the assignment of responsibilities. **85.6(b) :** b) All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the

			nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**85.6(b) :** (b) All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**25.1(d)(1)-(4) :** Implementation of the plan should take into consideration the developmental level of the patient and include, but not be limited to: (1) prevocational programs to promote work readiness, including relevant vocational academic instruction, the development of work attitudes, self-help and social skills, and practice in job tasks; (2) vocational training provided through on-the-job training, transitional sheltered workshops, work-study programs, and classroom trade training; (3) vocational placement in competitive employment, sheltered workshops or trade training programs; (4) assistance in vocational placement, including such job-related factors as living arrangements, social, recreational and religious activities, medical and educational services, transportation, legal and financial affairs; ... **85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality	Met/Not Met	**25.1(d)(5) :** Implementation of the plan should take into consideration the developmental level of the patient and include, but not be limited to: (5) completion of reports on a timely basis documenting the services provided and the patient's progress in relation to these services. These reports shall be included in the patient's clinical record.

	expectations specific to the service type.		**85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. **85.6(d) :** A single case record which contains current information regarding diagnosis, treatment and evaluation of results of care or treatment for each person served shall be available to all professional staff involved in the care or treatment of that person.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely

	plan and the person's needs, preferences and goals related to the service.		and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**25.1(d)(5) :** Implementation of the plan should take into consideration the developmental level of the patient and include, but not be limited to: (5) completion of reports on a timely basis documenting the services provided and the patient's progress in relation to these services. These reports shall be included in the patient's clinical record. **25.1(e) :** Follow-up evaluation shall be provided to determine the effectiveness of the rehabilitation program. **85.6(d) :** A single case record which contains current information regarding diagnosis, treatment and evaluation of results of care or treatment for each person served shall be available to all professional staff involved in the care or treatment of that person.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**25.1(d)(5) :** Implementation of the plan should take into consideration the developmental level of the patient and include, but not be limited to: (5) completion of reports on a timely basis documenting the services provided and the patient's progress in relation to these services. These reports shall be included in the patient's clinical record. **85.6(d) :** A single case record which contains current information regarding diagnosis, treatment and evaluation of results of care or treatment for each person served shall be available to all professional staff involved in the care or treatment of that person.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired	Met/Not Met	**85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of

	in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.		the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
2-15	The person is satisfied with the specific service.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2p-1	When the individual's services include vocational services, services must be in compliance with federal and state laws regarding labor wages and safety.	Met/Not Met	**25.4(a)-(d) :** Vocational training is the process of providing a patient [individual receiving services] with job training through on- and off-job instructions and performance of actual work tasks designed and supervised to increase the patient's [his or her] ability to work, (b) No patient [individual] may participate in work involved in vocational training unless the facility has first obtained a Federal Labor Department certificate. This certificate is issued by the Facilities Division of the Office of Vocational Rehabilitation of the New York State Education Department as an agent of the Federal Labor Department and any such participation shall be in accordance with the terms and conditions of the certificate. (c) Compensation for work performed in vocational training shall be paid in accordance with the terms and conditions of the certificate. (d) Facilities shall provide or arrange for the provision of relevant services for the mentally disabled for patients [individuals] involved in vocational training as provided in this section as necessary to their total habilitation or rehabilitation. **25.5(a)-(b) :** Work by a patient [an individual receiving services] may be an appropriate part of the patient's [his or her] overall service plan only in accordance with this section. (b) Sheltered work may be provided to patients [individuals receiving services] only in workshops having appropriate certification in accordance with applicable Federal and State laws and regulations. Such work shall be provided, supervised and compensated in accordance with the certificate issued; **25.5(g) :** Under no circumstances shall any patient [individual receiving services] be allowed to perform work tasks under conditions, in facilities, or on machines or equipment which are not in full compliance with all applicable Federal and State laws and regulations.

3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii) :** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii) :** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1) :** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5) :** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them.
3-6	The individual knows who to contact/how to make a complaint including	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	anonymous complaints if desired.		
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support.	Met/Not Met	**633.4(a)(xx) :** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3-17	The setting reflects the individual's needs and preferences including the presence of any necessary physical modifications, if applicable.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)** : No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.

3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights modification (clinical justification).	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or	Met/Not Met	**85.6(b)** : From Operation of Outpatient Facilities regulations applicable to Day Training and Day Training/Sheltered Workshop facilities. All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.

	attachment according to service/setting requirements.		**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (i) An assessment of functional capacity. (ii) Review and evaluation of the person's written plan of services and his or her progress in relation to that plan;
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x):**: No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and

			guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision.
7-5	The individual is provided dining supports for consistency, assistance, and	Met/Not Met	**ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train

	monitoring per his/her written plan and as needed.		applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **85.6(b) :** All direct services shall be provided in accordance with an individual written plan of care, treatment, and rehabilitation or training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and rehabilitation or training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
8d-1	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical	Met/Not Met/NA	**633.10(a)(2)(iii)**: (2) In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by

	condition(s) addressed during services at the site.		whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (iii) For persons in a residential facility, at least a medical/dental evaluation by a physician or registered physician's assistant addressing the person's need for an examination or specific medical/dental services; or by a dentist for dental services. The determination of the basis for such evaluation (e.g., appraisal of the person through records and previous contacts) shall be that of the qualified professional.
8d-2	The individual receives the needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8d-3	The individual's service record/service plan is maintained to reflect current status of the individual's health needs being addressed.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). ...
8d-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8d-5	The individual and/or their support(s) report the individual's health	Met/Not Met	**633.4(a)(4)(x) :**

	concerns/symptoms to appropriate parties as needed or directed.		No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8e-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person
8e-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8e-3	The individual receives medications and treatments safely as prescribed.	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.17(b)(3)** : Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication.

8e-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ... **633.17(a)(7) :** All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling.
9-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	Met/Not Met	**633.16(d)(1)-(2) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual’s record and other sources; (ix) not be based solely

			on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	Met/Not Met	**633.16(d)(1)(i - v)**: Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a

	reduce or eliminate behaviors.		contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.

	and/or other parties involved with implementation of the plan.		
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports	Met/Not Met	**633.16(e)(2)(vii):** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :**

	designed to address the challenging behavior.		A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the

			frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(j)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive

	intervention(s) and/or limitation on rights.		intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication

			to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(i):** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.

9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.

9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a

	monitoring his/her needs, comfort, and safety.		mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.

9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician’s order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The

			order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(j)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred.	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the

			person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(j)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(j)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(j)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.

9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.

9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.

9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)** : Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)

			624.5(g)(4) : If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate. **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At

			its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16)\ **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).

10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l) :** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)

10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** : Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review

			by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met	**624.7(b)(2): :** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16)

			624.5(k)(1)-(3): : (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(j)(2)(j)-(jj) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met	**625.4(b)(2)(j-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**FIDA IDT Policy IV.A. para 2:** The FIDA-IDD Plan, through the Care Manager and in consultation with the Participant (and/or the Participant's representative or designee), must identify the individuals who will be on the Participant's IDT. The Care Manager must offer to invite any providers or individuals with a caregiving relationship or clinical history with the Participant and must invite any individual requested by the Participant (and/or the Participant's representative or designee).
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**FIDA IDT Policy IV.C:** A Participant's IDT must be comprised of the following individuals: 1. Participant and/or, his or her representative or designee; 2. The FIDA-IDD Plan Care Manager; 3. Participant's primary provider(s) of Developmental Disability services, who has knowledge of the Participant's desired outcomes and service needs; **FIDA IDT Policy IV.D:** All current IDT members must actively participate in the IDT service planning and care management process. … The IDT members who elect to participate in the meeting must attend in person or via means of real-time, two-way communication (such as by telephone or videoconference) .... **FIDA IDT Policy VI.E:** … The Care Manager shall come prepared to present information he/she has available about prior service plans, current needs, and more, and can come to the meetings with a proposed or draft LP to present to the IDT members for their review. During the service planning meetings, the Care Manager will request that each IDT member explicitly communicate his or her thoughts on questions being considered, including his/her recommendations and/or preferred course(s) of action. ... **WPI Appendix I Section II.3.a**:

			The case manager shall make every effort to ensure that all appropriate parties, including the class member, the correspondent, the Mental Hygiene Legal Services ("MHLS") and the CAB representative to the extent it represents a class member, are invited and in attendance at interdisciplinary treatment team meetings.
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met	**FIDA IDT Policy IV.H. Para3**: In scheduling and arranging meetings for the IDT members, the Care Manager and other IDT members must reasonably accommodate the needs, communication needs and schedule of the Participant (and Home Care Aide(s)) to help ensure that he/she can be available to attend IDT meetings. ... **FIDA IDT Policy VI.E. Para1:** The Care Manager will schedule the meeting at a time that is conducive to Participant participation and convenient to the members of the IDT. The Care Manager should also take into consideration the primary goals of Participant attendance and timeliness of LP planning.
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met	**FIDA IDT Policy IV.H: H.** Participant Involvement on IDT: Participants shall be involved in care planning. Participants must be asked to express their preferences about care, and his or her expression must be respected and incorporated into care decisions, as appropriate. Providers on the IDT must work with the Participant (and his or her Designee and/or his or her Authorized Representative) and consider his or her preferences in making care decisions. ... **FIDA IDT Policy IV.J.1-2**: The IDT must: 1. Educate, empower and facilitate the Participant to make choices within the parameters of the FIDA-IDD Demonstration and to exercise his or her rights and responsibilities, including the opportunity to

			participate in self-direction and be employed in the Participant's community; 2. Involve the Participant as an active team member, including providing information and explanations using plain language understandable to the Participant and/or representative or designee, and stress Participant-centered collaborative goal setting;
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**FIDA IDT Policy IV.E:** ... The IDT is encouraged to work collaboratively, soliciting input from all members and reaching consensus regarding specific treatment decisions that consider the Participant's specific preferences and needs across multiple domains. Where consensus is not possible, the IDT members should strive for a workable compromise. When a care decision is required to be made by a provider with a certain licensure and/or certification under the applicable laws and regulations of New York State, the ultimate decision always rests with the appropriately licensed and/or certified treating member(s) of the IDT or the FIDA-IDD Plan.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**FIDA IDT Policy IV.J.1-**2: The IDT must: 1. Educate, empower and facilitate the Participant to make choices within the parameters of the FIDA-IDD Demonstration and to exercise his or her rights and responsibilities, including the opportunity to participate in self-direction and be employed in the Participant's community; 2. Involve the Participant as an active team member, including providing information and explanations using plain language understandable to the Participant and/or representative or designee, and stress Participant-centered collaborative goal setting; **FIDA IDT Policy VI.G.18:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by

			the FIDA-IDD Plan. The LP must specify: ... 18. Participant choice of service providers;
1-8	The individual's service planning includes consideration of natural supports as well as paid supports.	Met/Not Met	**CMS/NYS FIDA MOU III.E.1: Choice of Plan and Providers:** Participants will maintain their choice of providers from amongst those that participate in the FIDA-IDD Plan's network. Participants may also exercise the right to disenroll from the FIDA-IDD Plan at any time, effective the first calendar day of the following month. As an alternative to the FIDA-IDD Plan, Participants have the right to choose to receive their Medicare benefits through a Medicare Advantage plan or Medicare Fee-for-Service (FFS) and to receive their Medicaid benefits through Medicaid FFS and any available Medicaid managed care options for which they are eligible. **FIDA IDT Policy IV.J.6:** The IDT must: ...6. Identify the Participant's informal support systems/networks in relationship to his or her functional and safety needs; **FIDA IDT Policy VI.G.21:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: ... 21. Participant's informal support network and services; Participant's need for and plan to access community resources and non-covered services;
1-9	The individual has made informed choice of residential setting and alternative options considered by the individual are recorded in his/her written plan.	Met/Not Met	**FIDA IDT Policy VI.E.13**: During each IDT meeting, the IDT members should: 13. When a Participant is determined to be likely to require a level of care provided in a nursing facility or ICF-IID, inform the Participant and/or his/her designee of any feasible alternatives and offer the choice of either institutional or home and community-based services;

			FIDA IDT Policy IV.J.12: The IDT must: 12. Provide information about and assist Participant with housing and transportation issues and other community benefits and services;
1-10	Assessments needed by the individual or required by program regulation were completed to inform the individual's plan development.	Met/Not Met	**FIDA IDT Policy III.A:** As outlined in the Three-way Contract, each participant shall receive an Office for People with Developmental Disabilities (OPWDD) Approved Assessment (OAA), a FIDA-IDD Comprehensive Service Planning Assessment (CSPA), and ongoing Comprehensive Reassessments (CR). ... **FIDA IDT Policy III.B:** The OAA will be performed by OPWDD and the most recent results will be provided to the FIDA-IDD Plan. After this initial OAA is provided to the FIDA-IDD Plan, the OAA elements will be incorporated into the CR which will be completed in its entirety by the FIDA-IDD Plan. ... **FIDA IDT Policy III.C:** Each Participant will receive, and actively participate in, a timely CSPA of his/her medical, behavioral health, long-term services and supports (LTSS), and social needs. The CSPA shall be completed by a RN on staff, or under contract with, the FIDA-IDD Plan. **FIDA IDT Policy VI.E.4:** During each IDT meeting, the IDT members should: … 4. Provide information about the Participant specific to each discipline and expertise; **FIDA IDT Policy X.A:** The FIDA-IDD Plan must conduct a CR on an annual basis based on the completion date of the initial CSPA. The OAA elements of the CR must be

			administered by the QIDP and the CSPA elements of the CR must be administered by an FIDA-IDD Plan employed or contracted RN.
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**FIDA IDT Policy III.C.1:** … The CSPA must cover at least the following domains: social, functional, medical, behavioral, wellness and prevention domains, representative and/or designee status and capabilities, as well as the Participants' preferences, strengths, and goals. The RN shall use relevant and comprehensive data sources when completing the CSPA, including the Participant, providers, and caregivers/guardians or designees input. The FIDA-IDD Plan Care Manger will use the CSPA results, in addition to the results of the OAA, as the basis for developing the integrated, Person-Centered Life Plan called the Life Plan (LP) with the Participant. ... **FIDA IDT Policy IV.J.7:** The IDT must: 7. Assess and assist the Participant in identifying and addressing quality of life issues; **FIDA IDT Policy VI.A:** … The Participant is the center of the person-centered service planning process. The process must be tailored to the Participant's culture, communication style, physical requirements and personal preferences…. **FIDA IDT Policy VI.E.15:** During each IDT meeting, the IDT members should: ... 15. In addition to the above, during service plan meetings, the IDT should also review and discuss: Feedback from each IDT member about how the Participant's needs and preferences are being met under the current service plan and any suggested changes. ... **FIDA IDT Policy VI.G.7**: The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the

			OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: ... 7. Participant's goals and preferences and how they will be addressed, taking into consideration the Participant's expectations, characteristics, and previous daily routines;
1-12	The individual's strengths and preferences are documented in the service plan.	Met/Not Met	**FIDA IDT Policy IV.H:** Participants shall be involved in care planning. Participants must be asked to express their preferences about care, and his or her expression must be respected and incorporated into care decisions, as appropriate. Providers on the IDT must work with the Participant (and his or her Designee and/or his or her Authorized Representative) and consider his or her preferences in making care decisions. ... **FIDA IDT Policy VI.A:** … The Participant is the center of the person-centered service planning process. The process must be tailored to the Participant's culture, communication style, physical requirements and personal preferences…. **FIDA IDT Policy VI.E.15:** During each IDT meeting, the IDT members should: ... 15. In addition to the above, during service plan meetings, the IDT should also review and discuss: Feedback from each IDT member about how the Participant's needs and preferences are being met under the current service plan and any suggested changes. ... **FIDA IDT Policy III.C.1:** … The CSPA must cover at least the following domains: social, functional, medical, behavioral, wellness and prevention domains, representative and/or designee status and capabilities, as well as the Participants' preferences, strengths, and goals. The RN shall use relevant and comprehensive data sources when completing the CSPA, including the Participant, providers, and caregivers/guardians or designees input. The FIDA-IDD Plan Care Manger will use the CSPA results, in addition to the results of the OAA, as the basis

			for developing the integrated, Person-Centered Life Plan called the Life Plan (LP) with the Participant. ...
1-13	The individual's identified needs for clinical and/or functional support are documented in the service plan.	Met/Not Met	**FIDA IDT Policy III.C.1: C. FIDA-IDD Comprehensive Service Planning Assessment (CSPA):** Each Participant will receive, and actively participate in, a timely CSPA of his/her medical, behavioral health, long-term services and supports (LTSS), and social needs. The CSPA shall be completed by a RN on staff, or under contract with, the FIDA-IDD Plan. 1. CSPA & Initial Enrollment in the FIDA-IDD Plan: A FIDA-IDD Plan Registered Nurse (RN) must review and incorporate the results of the OAA that is provided to the Plan by OPWDD within ten (10) days of the enrollment transaction. The FIDA-IDD Plan will complete a CSPA as part of the care planning process. The CSPA must cover at least the following domains: social, functional, medical, behavioral, wellness and prevention domains, representative and/or designee status and capabilities, as well as the Participants' preferences, strengths, and goals. The RN shall use relevant and comprehensive data sources when completing the CSPA, including the Participant, providers, and caregivers/guardians or designees input. The FIDA-IDD Plan Care Manger will use the CSPA results, in addition to the results of the OAA, as the basis for developing the integrated, Person-Centered Life Plan called the Life Plan (LP) with the Participant. ... **FIDA IDT Policy IV.J.3-6:** The IDT must: ... 3. Provide the supports necessary for the Participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active; 4. Establish a set of guidelines or care responsibilities for the entire team and distribute these to Participant; 5. Provide education to the Participants and families regarding health and social needs; 6. Identify the Participant's informal support systems/networks in relationship to his or her functional and safety needs; **FIDA IDT Policy VI.A:** Person-centered service planning is the process of creating and implementing a written LP with and for the Participant. Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Participant, as well as the

			Participant's functional level, behavioral health needs, language, culture, and support systems. Person-centered service planning is completed by the Participant and his/her IDT members. LPs must contain measurable goals, interventions, and expected outcomes with completion timeframes. The Participant is the center of the person-centered service planning process. The process must be tailored to the Participant's culture, communication style, physical requirements and personal preferences. **FIDA IDT Policy.VI.G :** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. ... **FIDA IDT Policy.VI. G.3**: The LP must specify: 3. For each need identified, the LP must state the problem, interventions to resolve or mitigate the problem, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes;
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**FIDA IDT Policy VI.G.7:** The LP must specify: 7. Participant's goals and preferences and how they will be addressed, taking into consideration the Participant's expectations, characteristics, and previous daily routines; **FIDA IDT Policy VI.A:** Person-centered service planning is the process of creating and implementing a written LP with and for the Participant. Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems. Person-centered service planning is completed by the

			Participant and his/her IDT members. LPs must contain measurable goals, interventions, and expected outcomes with completion timeframes. The Participant is the center of the person-centered service planning process. The process must be tailored to the Participant's culture, communication style, physical requirements and personal preferences. **FIDA IDT Policy VI.E.3:** During each IDT meeting, the IDT members should: ... 3. Identify Participant requests, including those that accord with the Participant's religious or cultural beliefs;
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person-centered plan.	Met/Not Met	**FIDA IDT Policy IV.J.1:** The IDT must: 1. Educate, empower and facilitate the Participant to make choices within the parameters of the FIDA-IDD Demonstration and to exercise his or her rights and responsibilities, including the opportunity to participate in self-direction and be employed in the Participant's community; **FIDA IDT Policy IV.J.3**: The IDT must: ... 3. Provide the supports necessary for the Participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active; **FIDA IDT Policy IV.J.7**: The IDT must: ... 7. Assess and assist the Participant in identifying and addressing quality of life issues; **FIDA IDT Policy IV.J.10:** The IDT must: … 10. Provide information about and assist Participant in maintaining and establishing community links; **FIDA IDT Policy IV.J.12:**

			The IDT must: ...12. Provide information about and assist Participant with housing and transportation issues and other community benefits and services; **FIDA IDT Policy VI.G.7:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: ... 7. Participant's goals and preferences and how they will be addressed, taking into consideration the Participant's expectations, characteristics, and previous daily routines.
1-16	The individual's goals and priorities regarding meaningful relationships are identified in the person-centered plan.	Met/Not Met	**FIDA IDT Policy IV.J.3:** The IDT must: ... 3. Provide the supports necessary for the Participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active; **FIDA IDT Policy IV.J.7:** The IDT must: … 7. Assess and assist the Participant in identifying and addressing quality of life issues; **FIDA IDT Policy VI.A:** Person-centered service planning is the process of creating and implementing a written LP with and for the Participant. Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems. Person-centered service planning is completed by the Participant and his/her IDT members. LPs must contain measurable goals, interventions, and expected outcomes with completion timeframes. The Participant is the center of the person-centered service planning process. The process must be tailored to the Participant's culture, communication style, physical requirements and personal preferences.

			FIDA IDT Policy VI.G.7: The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: ... 7. Participant's goals and preferences and how they will be addressed, taking into consideration the Participant's expectations, characteristics, and previous daily routines;
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person-centered plan.	Met/Not Met	**FIDA IDT Policy IV.J.3:** The IDT must: … 3. Provide the supports necessary for the Participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active; **FIDA IDT Policy IV.J.7:** The IDT must: 7. Assess and assist the Participant in identifying and addressing quality of life issues; **FIDA IDT Policy VI.G.7:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: ... 7. Participant's goals and preferences and how they will be addressed, taking into consideration the Participant's expectations, characteristics, and previous daily routines;
1-18	The individual's goals and priorities related to health concerns and medical needs	Met/Not Met	**FIDA IDT Policy IV.J.3:**

	are identified in the person-centered plan.		The IDT must: … 3. Provide the supports necessary for the Participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active; **FIDA IDT Policy VI.A:** Person-centered service planning is the process of creating and implementing a written LP with and for the Participant. Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems. Person-centered service planning is completed by the Participant and his/her IDT members. LPs must contain measurable goals, interventions, and expected outcomes with completion timeframes. The Participant is the center of the person-centered service planning process. The process must be tailored to the Participant's culture, communication style, physical requirements and personal preferences. **FIDA IDT Policy VI.G.1-2, 14-15:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: 1. All active chronic problems, current non-chronic problems, and problems that were previously controlled and or classified as maintenance care but have been exacerbated by disease progression and/or other intervening conditions; 2. All current medications taken by the Participant. ...14. Known needed physical and behavioral health care and services; 15. Continuation of ongoing course of medical treatment (e.g. chemotherapy, chiropractic care, etc.);
1-19	The individual's known food, medication, and/or environmental allergies and the corresponding	Met/Not Met/NA	**FIDA IDT Policy VI.G.1:** The LP must specify: 1. All active chronic problems, current non-chronic problems, and problems that were previously controlled and or classified as

	precautions are identified in the person-centered plan.		maintenance care but have been exacerbated by disease progression and/or other intervening conditions;
1-20	Individualized considerations and safeguards regarding fire safety are identified in the person-centered service plan.	Met/Not Met	**Quality Indicator:** This is an indicator of quality service planning and identification.
1-21	The person-centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person-centered plan.	Met/Not Met	**FIDA IDT Policy VI.G.9:** The LP must specify: … 9. Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the Participant's highest feasible level of well-being;
1-23	The individual's written plan documents each specific service and support to be provided to address his/her needs and achieve his/her identified desired outcomes, short term and long term goals.	Met/Not Met	**FIDA IDT Policy IV.F:** Implementation of the LP requires that the IDT members must either directly deliver services or arrange and confirm delivery of services required under the LP. Precise tasks for ensuring implementation will be assigned during service planning meetings or accomplished by the Care Manager. IDT members must work with the Care Manager and collaborate with each other in order to facilitate timely access to appropriate services and the effective and efficient monitoring of the Participant's health and wellness. **FIDA IDT Policy VI.A:**

			Person-centered service planning is the process of creating and implementing a written LP with and for the Participant. Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems. Person-centered service planning is completed by the Participant and his/her IDT members. LPs must contain measurable goals, interventions, and expected outcomes with completion timeframes. The Participant is the center of the person-centered service planning process. The process must be tailored to the Participant's culture, communication style, physical requirements and personal preferences. **FIDA IDT Policy VI.E.7-8:** During each IDT meeting, the IDT members should: … 7. Summarize problems, approaches and goals and incorporate into the LP; 8. Specify goals for the six (6) months/duration of the care plan; **FIDA IDT Policy VI.G.3-7:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: ... 3. For each need identified, the LP must state the problem, interventions to resolve or mitigate the problem, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes; 4. Reasonable long-term and/or short-term goals for all problems identified; 5. All services authorized and the scope and duration of the services authorized; 6. A schedule of preventive service needs or requirements; 7. Participant's goals and preferences and how they will be addressed, taking into consideration the Participant's expectations, characteristics, and previous daily routines; **FIDA IDT Policy VI.G.14-15:**

			The LP must specify: … 14. Known needed physical and behavioral health care and services; 15. Continuation of ongoing course of medical treatment (e.g. chemotherapy, chiropractic care, etc.);
1-24	The individual's written plan identifies the amount, frequency and duration of each HCBS waiver service he/she receives, as applicable.	Met/Not Met/NA	**FIDA IDT Policy VI.G.5-7:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: ... 5. All services authorized and the scope and duration of the services authorized; 6. A schedule of preventive service needs or requirements; 7. Participant's goals and preferences and how they will be addressed, taking into consideration the Participant's expectations, characteristics, and previous daily routines; **FIDA IDT Policy VI.G.12:** The LP must specify: … 12. How frequently specific services will be provided;
1-25	The person-centered plan identifies the provider(s) of the individual's supports and services.	Met/Not Met	**FIDA IDT Policy IV.F:** Implementation of the LP requires that the IDT members must either directly deliver services or arrange and confirm delivery of services required under the LP. Precise tasks for ensuring implementation will be assigned during service planning meetings or accomplished by the Care Manager. IDT members will have to work with the Care Manager and collaborate with each other in order to facilitate timely access to appropriate services and the effective and efficient monitoring of the Participant's health and wellness. **FIDA IDT Policy VI.E.10:** During each IDT meeting, the IDT members should: ... 10. Identify who is responsible for implementation of each element of the care plan;

			FIDA IDT Policy VI.G.18-21: The LP must specify: ...18. Participant choice of service providers; 19. Individualized back-up plans; 20. The person(s)/providers responsible for specific interventions/services; 21. Participant's informal support network and services; Participant's need for and plan to access community resources and non-covered services;
1-26	The person-centered plan evidences that informed choice is made regarding self-direction; and if chosen, identifies the services that the individual elects to self-direct.	Met/Not Met	**FIDA IDT Policy III.C.1:** The FIDA-IDD Plan must inform Participants of the option to self-direct their own services at a minimum when the CSPA and CR are completed and when the IDT meets to create or update **FIDA IDT Policy VI.E.14** During each IDT meeting, the IDT members should: … 14. Discuss with the Participant his/her choice to direct their own services through self-directed services. The discussion will include a review of how this could work and if the Participant has chosen to self-direct the Participant obligations related to this choice; **FIDA IDT Policy VI.G.10** The LP must specify: … 10. Participant decisions around self-directed care and whether the Participant is participating in CDPAS or home and community-based services (HCBS) self-directed services;
1-27	For FIDA-IDD, the Life Plan identifies the services the individual is responsible to schedule and the support needed to do so.	Met/Not Met	**FIDA IDT Policy IV.H.:** ... To the extent that the Participant is able, willing, and agreeable to be responsible for scheduling his/her own appointments and services, the LP must clearly outline which services the Participant will be responsible for scheduling, how the Care Manager will support the Participant in these activities, and what monitoring the Care Manager will do to ensure that necessary appointments, tests, etc. are obtained as called for in the LP. ... **FIDA IDT Policy V.D. para 9**:

			To the extent that the Participant is able, willing, and agreeable to be responsible for scheduling his/her own appointments and services, the LP must clearly outline which services the Participant will be responsible for scheduling, how the Care Manager will support the Participant in these activities, and what monitoring the Care Manager will do to ensure that necessary appointments, tests, etc. are authorized and obtained as called for in the LP.
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**FIDA 3-Way Contract, Appendix B,3rd bullet:** Specifically, each Participant must be guaranteed the right: To request and receive written and oral information about the FIDA-IDD Plan, it's Participating Providers, its benefits and services and the Participants' rights and responsibilities in a manner the Participant understands.
1-29	The person-centered service plan is signed by the individual as indicator of written informed consent or approval.	Met/Not Met	**FIDA IDT Policy VI.D, para2:** … Each individual who prospectively agrees to participate on the IDT as a member (including the Participant) or review/approve the LP must approve the LP. … The FIDA-IDD Plan may confirm the Participant's approval by using a signature page at the IDT meeting or sent to the Participant after the meeting to obtain a wet or electronic signature. The form should make it clear that the signature is an attestation that said member was involved in the IDT process, and not necessarily that they agreed with the ultimate care plan that was reached. In addition, the Care Manager must document and attest that the LP accurately reflects the scope of what the Participant approved. The Participant may approve the LP before or after any necessary UM process but the Care Manager must explain to the Participant any changes in the final LP from the version drafted during the IDT meeting. **FIDA IDT Policy XI.C:** The IDT must generate a new printable LP, or update an existing one (as long as the final form will be an easily readable, understandable document), for any LP update or revision. Each individual who prospectively agrees to participate on an IDT member (including the Participant) or review/approve the LP must approve the updated or revised LP. ... The FIDA-IDD Plan may

			confirm the Participant's approval by using a signature page at the IDT meeting or sent to the Participant after the meeting to obtain a wet or electronic signature. The form should make it clear that the signature is an attestation that said member was involved in the IDT process, and not necessarily that they agreed with the ultimate care plan that was reached. In addition, the Care Manager must document and attest that the LP accurately reflects the scope of what the Participant approved.
1-30	The individual's person centered service plan is agreed to by services providers and/or members of the team as required.	Met/Not Met	**FIDA IDT Policy VI. D.para2**: Each individual who prospectively agrees to participate on the IDT as a member (including the Participant) or review/approve the LP must approve the LP. Acceptable methods of approvals from IDT members, other than the Participant, are (1) verbal, but noted in the LP with a date the verbal approval is given, (2) email or electronic signature, (3) wet signature on a separate signature page in person or (4) wet signature on the LP. **FIDA IDT Policy XI.C**: Each individual who prospectively agrees to participate on an IDT member (including the Participant) or review/approve the LP must approve the updated or revised LP. Acceptable methods of approvals from IDT members, other than the Participant, are (1) verbal, but noted in the LP with a date the verbal approval is given, (2) email or electronic signature, (3) wet signature on a separate signature page in person or (4) wet signature on the LP.
1-31	The individual's FIDA-IDD Life Plan is authorized as required per the services in the plan.	Met/Not Met	**FIDA IDT Policy IV.B. para1:** All items and services included in the finalized LP serve as authorizations up to the extent allowed under the licensure of the professionals who agree to participate in its development subject to medical necessity review when applicable. Before the initial LP is developed by the IDT, authorizations for items and services not subject to the continuity of care provisions must be made by the FIDA-IDD Plan through the utilization management (UM) process. If the Participant's PCP elects to participate in the IDT meeting or review/approve the LP, all services requiring a physician's order, included therein act as service authorizations', with the exception of the services described below in VII.F which must go through the FIDA-IDD plan's UM process. All Home and Community Based waiver services, ICF-IDD and day

			treatment services may be authorized by the Participant's duly convened IDT and are not subject to the FIDA-IDD Plan's UM process. If the PCP does not elect to participate in the IDT meeting or review/approve the LP, some ordered services and care decisions included therein may act as service authorizations up to the extent allowed under the licensure of the professionals who agreed to participate in that IDT. Service authorizations made via the LP may not be modified by the FIDA-IDD Plan except in cases where the participant (or providers, representatives or designees on behalf of the participant) appeals the IDT service authorizations. In these cases, the Plan may modify the service authorizations consistent with the appeal decision. **FIDA IDT Policy VI.D. para1:** Once a service or treatment has been agreed to by the IDT and/or FIDA-IDD Plan, and entered into the LP, that service or treatment is authorized until the LP is changed. The FIDA-IDD Plan may not disallow any service or treatment authorized in the final LP. Any additional services needed that are not addressed by the IDT are subject to the FIDA-IDD Plan's UM process, as more fully described in Section VII. If an appropriately licensed physician does not participate in the IDT, any physician ordered services included in the Life Plan must be authorized by the FIDA-IDD Plan's UM process. All Home and Community Based waiver services, ICF-IDD and day treatment services may be authorized by the Participant's duly convened IDT and are not subject to the Plan's UM process. **FIDA IDT Policy VI.E.9:** During each IDT meeting, the IDT members should: ... 9. Authorize care/services for the six (6) months/duration of the care plan;
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**FIDA IDT Policy VI.F para2:**

			Each member of the IDT, including the Participant, representative and designee(s) must each receive a signed written copy (hard copy or electronic) of the final LP.
1-33	The person-centered service plan includes all relevant and applicable attachments.	Met/Not Met	**Quality Indicator:** This is an indicator of quality service planning.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**FIDA IDT Policy VI.D. para5:** The LP must be printed and provided to the Participant and his/her representative or designee along with language clearly specifying the right of the Participant to appeal a LP update or revision, including the steps for how to request an appeal. **FIDA IDT Policy VI.F:** The FIDA-IDD Plan must develop a LP form to be used by all IDTs in developing a Participant's LP. The form must include a space for the IDT members to sign and date the LP and must include language clearly specifying the following: 1. The right of the Participant to appeal a LP; 2. That signing the LP does not preclude appeal; 3. Instructions for requesting an appeal; and 4. Contact information for the FIDA-IDD Ombudsman. ... **FIDA IDT Policy VIII: VIII. RIGHT TO APPEAL** To the extent that the Participant does not agree with the LP or any coverage determination the Participant may appeal in accordance with the appeal process outlined in the Three-Way Contract. The LP form must include language clearly specifying the right of the Participant to appeal a LP, including the steps for how to request an appeal.
1-35	The Individual's written person centered service plan is reviewed with regular required frequency.	Met/Not Met	**FIDA IDT Policy IV.B. para3:** The Care Manager must review the Participant's LP at least every six (6) calendar months from the previous LP review. This LP review must coincide with a meeting with the IDT at least annually (no more than twelve (12) calendar months from the previous IDT meeting). These IDT meetings may

			occur more frequently, as the IDT must reconvene after a CR, which may be triggered by certain events, as described in Section X, or if the Participant (and/or the Participant's representative or designee) requests a meeting. **FIDA IDT Policy IV.D. para2:** As described in Section VI.B, the IDT must create and complete the LP within sixty (60) calendar days (or sooner if required by the circumstances or clinically indicated) of the initial Assessment. Thereafter, the IDT must meet to evaluate the LP no more than six (6) calendar months after the date of the last LP. Certain trigger events, as described in Section X, will necessitate a CR, which will require the IDT to reconvene and may require revisions to the LP. The Care Manager must reconvene the IDT within thirty (30) calendar days of the CR. Note that if the IDT is required to convene sooner than twelve (12) calendar months due to a trigger event or at the request of the Participant, the IDT meeting schedule will reset and the next routine IDT meeting will not need to occur until twelve (12) calendar months from the date of that meeting or until another trigger event, whichever is sooner. **FIDA IDT Policy XI.A: A. LP Updates** The LP must be reviewed at least every six (6) calendar months from the previous LP review. This LP review must coincide with a meeting with the IDT at least annually (no more than twelve (12) months from the previous IDT meeting). These IDT meetings may occur more frequently, as the IDT must reconvene after a CR, which may be triggered by certain events, as described in Section X or if the Participant requests a more frequent meeting LP updates must occur within six (6) months of the previous LP authorization or sooner in accordance with the timeframes outlined above in Section X. The Participant's IDT will meet in person, telephonically, or by video-conference to discuss and review the Participant's status, existing LP, and Comprehensive CR and, if necessary, will revise the Participant's LP.
1-36	Review of the plan includes the individual's status/progress towards the	Met/Not Met	**636-1.2(a)(3)(i) -(iii) - 3)** The person-centered planning process requires that: (i) supports and services are based on the individual's interests, preferences, strengths, capacities, and needs; (ii) supports and services are designed to empower

	achievement of his/her goals, priorities and outcomes.		the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and (iii) the individual is satisfied with activities, supports, and services. **ADM 2010-04 –** The ISP must be reviewed and updated as necessary and required (i.e., at least twice annually). The purpose of ISP reviews is for the Service Coordinator and the person and others involved with the person to assess the ongoing appropriateness and adequacy of the services and supports identified in the ISP and to review that the services are consistent with and responsive to the individual's needs, preferences, informed choices, and valued outcomes. During ISP reviews, Service Coordinators work with individuals to review their valued outcomes and to choose and/or amend valued outcomes as goals and aspirations change through the progression of the person's life.
1-37	The individual's person centered service plan is revised whenever changes are necessary and warranted and/or as directed/preferred by the individual.	Met/Not Met/NA	**FIDA IDT Policy IV.B. para3:** … These IDT meetings may occur more frequently, as the IDT must reconvene after a CR, which may be triggered by certain events, as described in Section X, or if the Participant (and/or the Participant's representative or designee) requests a meeting. **FIDA IDT Policy IV.D. para2:** … Certain trigger events, as described in Section X, will necessitate a CR, which will require the IDT to reconvene and may require revisions to the LP. The Care Manager must reconvene the IDT within thirty (30) calendar days of the CR. Note that if the IDT is required to convene sooner than twelve (12) calendar months due to a trigger event or at the request of the Participant, the IDT meeting schedule will reset and the next routine IDT meeting will not need to occur until twelve (12) calendar months from the date of that meeting or until another trigger event, whichever is sooner. **FIDA IDT Policy V.D. para9:**

			Upon the occurrence of a trigger event, as described in Section X, the Care Manager must notify the IDT, and ensure that a CR will be conducted within the appropriate timeframe. **FIDA IDT Policy XI.B: B. LP Update/Revision Process:** As described above in Section VI.E, updates to the LP are made through service planning meetings. These meetings should be fully attended in person with the Participant, where possible. Where in-person meetings are not possible, those IDT members should participate telephonically or by video conference. Updates are made directly to the service plan in a way that preserves the history of care and enables the team to trace the effectiveness of interventions over time. New problems are added as they are identified, and resolved problems should be retained for monitoring. The rationale for eliminating or relocating a resolved problem to maintenance care must be documented in the LP. The LP is routinely updated as the IDT monitors the Participant's health status. The IDT members meet for updates and revisions and complete service planning steps as outlined above.
1-38	Revisions to the individual's written plan are documented in the form and format required.	Met/Not Met/NA	**FIDA IDT Policy XI.B. para2:** Updates are made directly to the service plan in a way that preserves the history of care and enables the team to trace the effectiveness of interventions over time. New problems are added as they are identified, and resolved problems should be retained for monitoring. The rationale for eliminating or relocating a resolved problem to maintenance care must be documented in the LP. **FIDA IDT Policy XI.C:** The IDT must generate a new printable LP, or update an existing one (as long as the final form will be an easily readable, understandable document), for any LP update or revision.
1-39	Decisions made by FIDA-IDD outside of IDT meeting, are recorded in the	Met/Not Met	**FIDA IDT Policy IV.G. para2:**

	Comprehensive Participant Health Record and communicated to all IDT members within one business day.		When decisions are made by the FIDA-IDD Plan outside of the IDT meetings, such decisions must be communicated to the Care Manager and recorded in the shared, accessible Participant record Comprehensive Participant Health Record and then must be communicated to all IDT members within one business day of the decision.
1-40	The SC/CM/CC competently assures person centered planning as evidenced by the individual's written plan for services and supports and interview.	Met/Not Met	**Quality Indicator:** This is an indicator of quality service planning.
1-41	CAS findings were reviewed with the individual within 30 days	Met/Not Met	**Quality Indicator** – This is an indicator of quality service planning.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**WPI Appendix I Section II.4.a: 4. Recordkeeping:** a. The case manager shall ensure that the individual's record is maintained including the individual's plan for needs and services, persons responsible, and plans for date maintenance and monitoring. b. The case manager shall prepare monthly case notes reflecting visits and progress. c. The case manager shall ensure written notifications to the class member and correspondent as required by OMRDD's [sic] Client Placement Procedures. **FIDA IDT Policy IX.B.1-12:** In addition to the LP, the Care Manager on behalf of the FIDA-IDD Plan must maintain a single, comprehensive health record for each Participant in accordance with accepted professional standards.

2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**FIDA IDT Policy VI.A:** A. LP is Required: Person-centered service planning is the process of creating and implementing a written LP with and for the Participant. Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems. Person-centered service planning is completed by the Participant and his/her IDT members. LPs must contain measurable goals, interventions, and expected outcomes with completion timeframes. The Participant is the center of the person-centered service planning process. The process must be tailored to the Participant's culture, communication style, physical requirements and personal preferences. **FIDA IDT Policy XI.C:** The IDT must generate a new printable LP, or update an existing one (as long as the final form will be an easily readable, understandable document), for any LP update or revision.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**FIDA IDT Policy IV.A, para3:** The Participant's initial CSPA will occur no later than thirty (30) calendar days after enrollment (as per Section III.C), and the LP must be finalized no fewer than sixty (60) calendar days following the completion of the initial CSPA (as per Section VI.B). **FIDA IDT Policy VI.C:** A LP must be completed for each Participant by and with that Participant's IDT within sixty (60) calendar days of the FIDA-IDD Plan completing the CSPA and within thirty (30) calendar days of the FIDA-IDD Plan completing the CR. Prior to the initial IDT meeting, service authorizations related to new needs for service may be made by, and only by, the FIDA-IDD Plan via the Utilization Management (UM) process.

2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**FIDA IDT Policy VI.A:** Person-centered service planning is the process of creating and implementing a written LP with and for the Participant. Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems. Person-centered service planning is completed by the Participant and his/her IDT members. LPs must contain measurable goals, interventions, and expected outcomes with completion timeframes. The Participant is the center of the person-centered service planning process. The process must be tailored to the Participant's culture, communication style, physical requirements and personal preferences. **FIDA IDT Policy VI.F:** The FIDA-IDD Plan must develop a LP form to be used by all IDTs in developing a Participant's LP. The form must include a space for the IDT members to sign and date the LP and must include language clearly specifying the following: 1. The right of the Participant to appeal a LP; 2. That signing the LP does not preclude appeal; 3. Instructions for requesting an appeal; and 4. Contact information for the FIDA-IDD Ombudsman. ... **FIDA IDT Policy VI.G:** LP and Electronic Care Coordination Record Content: The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: 1. All active chronic problems, current non-chronic problems, and problems that were previously controlled and or classified as maintenance care but have been exacerbated by disease progression and/or other intervening conditions; 2. All current medications taken by the Participant.;3. For each need identified, the LP must state the problem, interventions to resolve or mitigate the problem, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for

			conducting the interventions and monitoring the outcomes; 4. Reasonable long-term and/or short-term goals for all problems identified; 5. All services authorized and the scope and duration of the services authorized; 6. A schedule of preventive service needs or requirements; 7. Participant's goals and preferences and how they will be addressed, taking into consideration the Participant's expectations, characteristics, and previous daily routines; 8. Method and frequency of evaluating progress towards goals and documentation of progress toward the goals including success, barriers, or obstacles; 9. Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the Participant's highest feasible level of well-being; 10. Participant decisions around self-directed care and whether the Participant is participating in CDPAS or home and community-based services (HCBS) self-directed services; 11. Communications plan; 12. How frequently specific services will be provided; 13. How technology and tele-health will be used; 14. Known needed physical and behavioral health care and services; 15. Continuation of ongoing course of medical treatment (e.g. chemotherapy, chiropractic care, etc.); 16. Right of the Participant to appeal a LP, including the steps for how to request an appeal; 17. The Participant's consent to Money Follows the Person participation; 18. Participant choice of service providers; 19. Individualized back-up plans; 20. The person(s)/providers responsible for specific interventions/services; 21. Participant's informal support network and services; Participant's need for and plan to access community resources and non-covered services; and 22. A record of all reasonable accommodations and policy modifications required for the Participant; and anything else appropriate for the needs of the Participant. **FIDA IDT Policy VI.H:** "The LP is a comprehensive care plan. For this reason, the IDT should include items and services in the LP as noted in Section VI.G above, as well as any appropriate items and services listed in section VII.B and/or VII.C, even though these items and services do not require authorization." **NOTE:** VII.B includes Items and Services That a Participant May Access Directly (and Without Prior Authorization or Approval). VII.C includes Services that Must Be Authorized by a Specialist (not the IDT or FIDA-IDD Plan)

2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**FIDA IDT Policy IV.F. para3:** Implementation of the LP requires that the IDT members must either directly deliver services or arrange and confirm delivery of services required under the LP. Precise tasks for ensuring implementation will be assigned during service planning meetings or accomplished by the Care Manager. IDT members will have to work with the Care Manager and collaborate with each other in order to facilitate timely access to appropriate services and the effective and efficient monitoring of the Participant's health and wellness. **FIDA IDT Policy V.D. para5:** The Care Manager must ensure that all IDT responsibilities are being met, and must assist the IDT members where possible or necessary. Implementation of the LP means that the IDT members must either directly deliver or arrange and confirm delivery of services required under the LP. The precise tasks involved with carrying out the LP will be assigned during the IDT meeting, and supervised, coordinated, and/or directly accomplished by the Care Manager. **FIDA IDT Policy IX.A:** While the Care Manager is the facilitator of the IDT activities, the whole IDT is required to manage care and take all steps necessary to ensure that the Participant receives the items and services the Participant needs, including those called for in his/her LP.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**FIDA IDT Policy IX.B.:** In addition to the LP, the Care Manager on behalf of the FIDA-IDD Plan must maintain a single, comprehensive health record for each Participant in accordance with accepted professional standards. At a minimum, the comprehensive health record must contain the following documentation of all care and services rendered to the Participant by providers, and must be made available to all IDT members: .... NOTE: Please refer to guidance for additional requirements.

2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**FIDA IDT Policy IV.A:** … For each Participant, an individually tailored IDT, led by a Care Manager employed by or under contract with the FIDA-IDD Plan, will ensure the integration of the Participant's medical, behavioral health, community-based or facility-based LTSS, and social needs as part of the CSPA. The IDT will be person-centered, built on the Participant's specific preferences and needs, and deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity. **FIDA IDT Policy XII:** … Plans are expected to monitor the quality of the care management services being provided by the Care Manager and any other similar concerns raised by the IDT process.
2a-1	The individual was provided a choice of service/care manager/coordinator.	Met/Not Met	**FIDA IDT Policy: V.A:** Participants will be assigned a FIDA-IDD Plan staff or contract Care Manager who has the appropriate experience and qualifications to address the Participant's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers). A Participant has the right to choose a different Care Manager and change her/his Care Manager at any time. Again, choice of Care Manager is limited to those Care Managers available within the FIDA-IDD Plan care management staff and those that have room in their caseload to handle care management responsibilities for additional Participants.
2a-5	The Willowbrook class member's Notice of Rights is placed in the SC /CM/CC service record.	Met/Not Met	**WPI Item. 17: 17. Notice of Rights.** The OMRDD [sic] defendants shall place the following information describing the rights and entitlements under the permanent injunction in the permanent record of each class member, shall retain such information on record for so long as the class member is alive, and shall enter such information in the class member's file maintained by all providers of residential and habilitative services to class members: (a). designation of membership in the

			Willowbrook class; (b). notation that class membership results in rights and services guaranteed by this permanent injunction issued by the United States District Court, Eastern District, and a summary of those rights; and (c). the name, address and telephone number of plaintiffs' counsel, MHLS and the Consumer Advisory Board
2a-6	The SC/CM/CC advocates/ensures that rights limitations occur only with required protections, justifications and approvals in place.	Met/Not Met/NA	**FIDA IDD Contract Appendix B:** ... Specifically, each Participant must be guaranteed the right: · To be treated with consideration, respect and full recognition of his or her dignity, privacy, and individuality; … • To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation; **WPI Appendix I, Section II, 1.a; 1. Advocacy:** a. The case manager shall protect and uphold the rights and entitlements of the class member in the residential program, in the day or work program, and in all spheres of the class member's life. ... **FIDA IDT Policy: IV.A. para1:** ... The IDT will be person-centered, built on the Participant's specific preferences and needs, and deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity. **3 Way Contract 2.9.6.4.5.1.**: The FIDA-IDD Plan shall make reasonable efforts to detect unauthorized use of restraint or seclusion. The FIDA-IDD Plan shall require that events involving the use of restraint or seclusion are reported to the FIDA-IDD Plan as a reportable incident, and reported to the investigating authority as indicated if it rises to the level of suspected Abuse, Neglect, or Financial Exploitation. **3 Way Contract 2.9.6.4.5.2.:** The FIDA-IDD Plan shall make reasonable efforts to detect unauthorized use of restrictive interventions. The FIDA-IDD Plan shall require that events

			involving the use of restrictive interventions are reported to the FIDA-IDD Plan as a reportable incident, and reported to the investigating authority if it rises to the level of Abuse, Neglect, or Financial Exploitation. **3 Way Contract Appendix B bullets 6, 7, 8:** Specifically, each Participant must be guaranteed the right: To be treated with consideration, respect and full recognition of his or her dignity, privacy, and individuality; To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation; Not to be neglected, intimidated, physically or verbally abused, mistreated or exploited;
2a-8	The individual enrolled in FIDA-IDD is provided a set of guidelines and care responsibilities of the entire IDT.	Met/Not Met	**FIDA IDT Policy IV.J.4.:** The IDT must: 4. Establish a set of guidelines or care responsibilities for the entire team and distribute these to Participant; **FIDA IDT Policy V.D.:** … The Care Manager must communicate and provide the Participant with written (or in an alternative format chosen by the Participant) educational materials outlining the IDT policy including opportunities available to self-direct using employer and/or budget authority models. These materials must include the roles and responsibilities for the Participant and or their representative or designee.
2a-9	The individual and designees, as applicable are given required contact information.	Met/Not Met	**FIDA IDT Policy IV.G. para3:** Participants and their representative or designees (who are current IDT members) must be provided with contact information (which is regularly updated) for all other members of the IDT.
2a-11	The SC/CM/CC solicits input from/among members of the person's "circle"/team as part of the review of the person's	Met/Not Met	**FIDA IDT Policy: IV.F. Para1:** … The IDT must maintain regular communication as and when required and agreed upon by the other members, and must participate in service planning and oversight.

	services and status as needed.		**FIDA IDT Policy: V.D. Para4:** During the initial and subsequent IDT meetings, Care Managers must ask each IDT member to give their thoughts on the questions or topics being discussed. This includes the members' preferences or recommendations regarding their preferred course(s) of action. The Care Manager must then summarize the discussion and any conflicts. **FIDA IDT Policy VI.E. Para 2:** During the service planning meetings, the Care Manager will request that each IDT member explicitly communicate his or her thoughts on questions being considered, including his/her recommendations and/or preferred course(s) of action.
2a-12	Meetings for the review of the person-centered service plan must be face to face as required by the service type.	Met/Not Met	**WPI Appendix I Section II.3.a.:** The case manager shall make every effort to ensure that all appropriate parties, including the class member, the correspondent, the Mental Hygiene Legal Services ("MHLS") and the CAB representatives to the extent it represents a class member, are invited and in attendance at the interdisciplinary treatment team meetings.
2a-14	The SC/CM/CC notes indicate that the service coordinator/case manager has contact with the individual in the frequency and manner required by service and when needed.	Met/Not Met	**FIDA 3-Way Contract 2.5.2.7.1.:** Care Manager Contact Standards. Care Managers shall maintain contact with Participants as frequently as outlined in the LP but not less than one telephone contact per month.
2a-15	The service coordinator/case manager meets with the individual in his/her home at least quarterly with a	Met/Not Met	**2011 Vendor Manual Pg. 36**

	Willowbrook Class Member, annually with a non-class member, and when needed.		For Willowbrook Class members, a face-to-face service meeting in the person's home is required at least once during each three-month quarter of a calendar year.
2a-18	SC/CC/CC has taken action to affirm that all allegations of abuse and/or neglect were reported to appropriate	Met/Not Met/NA	**FIDA 3-Way Contract 2.9.6.4.3.:** The FIDA-IDD Plan shall have processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and issues that are identified must be routed to the appropriate department

	parties and investigated as appropriate.		within the FIDA-IDD Plan and, when required or otherwise appropriate, to the investigating authority. **FIDA 3-Way Contract 2.9.6.4.5.:** The FIDA-IDD Plan shall have systems in place to report, monitor, track, and resolve critical incidents and reports of Abuse, Neglect, or Financial Exploitation for Participants receiving Community-based or Facility-based LTSS and concerning restraints and restrictive interventions in accordance with 14 NYCRR Parts 633 and 624. **FIDA 3-Way Contract Appendix B:** ... Specifically, each Participant must be guaranteed the right: ... To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation; Not to be neglected, intimidated, physically or verbally abused, mistreated or exploited; **WPI Appendix I. Section II.8.c:** The case manager shall ensure reporting, investigation, implementation of preventive actions, and other needed follow-up on incidents which pose a risk to the health and safety of the class member or to others in the class member's immediate environment.
2a-19	If abuse was substantiated, SC/CM/CC advocates for the safety and protection of the individual.	Met/Not Met/NA	**FIDA 3-Way Contract 2.9.6.4.3.:** The FIDA-IDD Plan shall have processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and issues that are identified must be routed to the appropriate department within the FIDA-IDD Plan and, when required or otherwise appropriate, to the investigating authority. **FIDA 3-Way Contract 2.9.6.4.5.**: The FIDA-IDD Plan shall have systems in place to report, monitor, track, and resolve critical incidents and reports of Abuse, Neglect, or Financial Exploitation for Participants receiving Community-based or Facility-based

			LTSS and concerning restraints and restrictive interventions in accordance with 14 NYCRR Parts 633 and 624. **WPI Appendix I. Section II.8.c**: The case manager shall ensure reporting, investigation, implementation of preventive actions, and other needed follow-up on incidents which pose a risk to the health and safety of the class member or to others in the class member's immediate environment.
2a-20	The SC/CM/CC monitors that the individual is linked to and receiving the services he/she wants and that the services are helping the individual to attain his/her valued outcomes and life goals.	Met/Not Met	**FIDA IDT Policy: V.D. Para5:** The Care Manager must ensure that all IDT responsibilities are being met, and must assist the IDT members where possible or necessary. Implementation of the LP means that the IDT members must either directly deliver or arrange and confirm delivery of services required under the LP. The precise tasks involved with carrying out the LP will be assigned during the IDT meeting, and supervised, coordinated, and/or directly accomplished by the Care Manager. **FIDA IDT Policy: VI.I.:** Monitoring of the LP requires that the IDT members must monitor the Participant's medical, functional, social, and cognitive status. IDT members monitor status by direct observation when providing services, informal observation of the Participant, self-report by Participants, feedback from representatives or designees, reports from network providers, or communication among IDT members. The FIDA-IDD Plans will monitor the LPs and any gaps in care will be addressed in an integrated manner with the IDT. The IDT must monitor the Participant's representative or designee's ability to fulfill the Participant's responsibilities under the self-direction program and make changes in the Participant's authorization and reauthorization as needed. **WPI Appendix I. Section II.5.b: 5. Coordination:** …

			b. The case manager shall coordinate among the diverse providers of service required by the class member, including their day and residential programs. **WPI Appendix I. Section II.8.a: 8. Monitoring/Follow-Up:** a. The case manager shall assure that the class member is receiving appropriate services in accordance with their plans of needs and goals, and periodic reassessment of the class member's progress
2a-21	The WCS Coordinator or WSC assists the QIDP, treatment Coordinator and/or IDT members in linking to services and/or in support during crisis intervention, as needed.	Met/Not Met	**WPI Appendix I. Section II.6.a: Linking**: a. The case manager shall ensure that the class member is linked to new services, as needed. In doing so, the case manager shall, as needed, make referrals for the new services, arrange services at generic agencies, accompany the class member to agencies providing services or arrange for a person familiar with the class member and his or her needs to do so, assist in completing forms and applications, and perform other related duties. **WPI Appendix I. Section II.7.a: Support:** a. The case manager shall assist the class member and/or their family with unanticipated crisis intervention.
2a-23	The SC/CM/CC monitors that individuals receive the health care services identified in their service plan.	Met/Not Met	**FIDA IDT Policy: V.D. para5:** The Care Manager must ensure that all IDT responsibilities are being met, and must assist the IDT members where possible or necessary. Implementation of the LP means that the IDT members must either directly deliver or arrange and confirm delivery of services required under the LP. The precise tasks involved with carrying out the LP will be assigned during the IDT meeting, and supervised, coordinated, and/or directly accomplished by the Care Manager. **FIDA IDT Policy: IV.F. para3:**

			Implementation of the LP requires that the IDT members must either directly deliver services or arrange and confirm delivery of services required under the LP. Precise tasks for ensuring implementation will be assigned during service planning meetings or accomplished by the Care Manager. IDT members will have to work with the Care Manager and collaborate with each other in order to facilitate timely access to appropriate services and the effective and efficient monitoring of the Participant's health and wellness. **FIDA IDT Policy: IX.A.**: While the Care Manager is the facilitator of the IDT activities, the whole IDT is required to manage care and take all steps necessary to ensure that the Participant receives the items and services the Participant needs, including those called for in his/her LP. ...
2a-24	Care/Case/Service Coordinator/Manager advocates for the rights and entitlements of the individual in the home, day and work environments and in all spheres of his/her life.	Met/Not Met	**WPI Appendix I. Section II. 1.a.** Advocacy: a. The case manager shall protect and uphold the rights and entitlements of the class member in the residential program, in the day or work program, and in all spheres of the class member's life. ...
2a-25	The Care/Case/Service Coordinator/Manager ensures that procedural and substantive due process requirements are met.	Met/Not Met/NA	**WPI Appendix I. Section II. 1.a.:** Advocacy: a. … The case manager shall ensure the procedural and substantive due process requirements are met with regard to the class members and the class member's representatives.
2a-26	The WCS Coordinator or WSC ensures active representation, either by the class member, the correspondent or Consumer Advisory Board (CAB)	Met/Not Met	**WPI Appendix I Section II.1.b** The case manager shall ensure active representation either by the class member or by a correspondent or Consumer Advisory Board ("CAB") representative.

2a-27	The person is satisfied with the coordination/case management services he/she receives.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2b Qualifier	Does the individual Self-Direct by exercising budget authority?	Yes/No	
2b-1	The individual is supported to exercise budget authority over how his or her resources are budgeted and managed within the Personal Resources Account (PRA).	Met/Not Met	**ADM 2015-06 Service Documentation for Support Broker**: "A Start-up Broker assists the individual to develop a complete and approvable self-direction budget within the individual's Personal Resource Account (PRA) amount. This assistance may also include helping the individual to develop a planning team. Additional activities such as hiring staff, assisting with service documentation, and other tasks are allowed and need to be outlined in the support brokerage agreement." A Support Broker also "provides support and training to individuals and their families regarding the ongoing decisions and tasks associated with self-direction. …The Support Broker provides assistance and practical skills training to the individual in the areas of: understanding and managing the responsibilities involved with self-direction, community inclusion and independent living; developing daily implementation of and managing the self-directed budget; monitoring expenditures; negotiating terms and service arrangements with providers; employer responsibilities such as recruiting, supervising, and training of individual hired staff; service documentation requirements to ensure agreement with program and Medicaid standards; planning and ensuring safeguards are identified and met. The extent of the assistance provided is determined by the individual and is specified in a written agreement signed by the individual and Support Broker. **ADM #2015-04 Service Documentation for Fiscal Intermediary:** "Fiscal Intermediary services (FI Services) are HCBS Waiver services that include tasks performed by a Fiscal Intermediary (FI) which support a participant who self directs an individualized budget. Such tasks include billing and payment of approved goods and services, fiscal accounting and reporting, Medicaid and corporate compliance, and general administrative supports. The FI is the employer of record for staff hired by the participant

			[where applicable]. … A participant must choose an FI to handle billing if any of the following services is included in his or her budget: Individual Directed Goods and Services; Live-in Caregiver; Brokerage Services; Community Transition Services; Any type of 100% state-funded service(s) that is listed in the participant's individualized budget; or Any self-hired staff for Community Habilitation, Supported Employment (SEMP), and/or Respite."
3-2	The individual is informed of their rights as a FIDA-IDD member and availability of the FIDA-IDD Ombudsman.	Met/Not Met	**FIDA IDD IDT IV.J.14:** The IDT Must: Ensure that the Participant, representative and designee are knowledgeable about his/her rights as a FIDA-IDD member and the availability of assistance from the FIDA-IDD Ombudsman.
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**FIDA IDT Policy: VI.D. para5:** The LP must be printed and provided to the Participant and his/her representative or designee along with language clearly specifying the right of the Participant to appeal a LP update or revision, including the steps for how to request an appeal. **FIDA IDT Policy: VI.F.1-4:** The FIDA-IDD Plan must develop a LP form to be used by all IDTs in developing a Participant's LP. The form must include a space for the IDT members to sign and date the LP and must include language clearly specifying the following: 1. The right of the Participant to appeal a LP; 2. That signing the LP does not preclude appeal; 3. Instructions for requesting an appeal; and 4. Contact information for the FIDA-IDD Ombudsman. **FIDA IDT Policy VI.G.16:** The LP must specify: 16. Right of the Participant to appeal a LP, including the steps for how to request an appeal; **FIDA IDT Policy VIII:** To the extent that the Participant does not agree with the LP or any coverage determination the Participant may appeal in accordance with the appeal

			process outlined in the Three-Way Contract. The LP form must include language clearly specifying the right of the Participant to appeal a LP, including the steps for how to request an appeal.
3-5	The individual is provided with information about their rights in plain language and in a way, that is accessible to them.	Met/Not Met	**FIDA IDT Policy: IV.J.2:** The IDT must: Involve the Participant as an active team member, including providing information and explanations using plain language understandable to the Participant and/or representative or designee, and stress Participant-centered collaborative goal setting; **FIDA 3-Way Contract Appendix B:** Specifically, each Participant must be guaranteed the right: To request and receive written and oral information about the FIDA-IDD Plan, it's Participating Providers, its benefits and services and the Participants' rights and responsibilities in a manner the Participant understands.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**FIDA IDT Policy IV.J.1:** The IDT must: 1. Educate, empower and facilitate the Participant to make choices within the parameters of the FIDA-IDD Demonstration and to exercise his or her rights and responsibilities, including the opportunity to participate in self-direction and be employed in the Participant's community; **FIDA IDT Policy IV. J.13**: The IDT must: ...13. Assist the Participant and/or designated representative to realize his/her role as the daily self-manager;

3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**FIDA 3-Way Contract Appendix B:** Specifically, each Participant must be guaranteed the right: To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)**: No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4):** OMRDD shall verify that staff are aware of the rights of persons in the facility.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**FIDA IDT Policy IV.J.3:** The IDT must: … 3. Provide the supports necessary for the Participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active; **FIDA IDT Policy VI.G.9:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: ... 9. Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the Participant's highest feasible level of well-being;
8a-1	A health assessment which identifies the individual's health care needs has been	Met/Not Met	**FIDA IDT Policy VI.G.1:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and

	completed by a physician, PA, NP or RN.		anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: 1. All active chronic problems, current non-chronic problems, and problems that were previously controlled and or classified as maintenance care but have been exacerbated by disease progression and/or other intervening conditions;
8a-2	The individual has someone chosen/delegated to support them in coordinating their health care.	Met/Not Met	**FIDA IDT Policy IV.F. para3:** Implementation of the LP requires that the IDT members must either directly deliver services or arrange and confirm delivery of services required under the LP. Precise tasks for ensuring implementation will be assigned during service planning meetings or accomplished by the Care Manager. IDT members will have to work with the Care Manager and collaborate with each other to facilitate timely access to appropriate services and the effective and efficient monitoring of the Participant's health and wellness. **FIDA IDT Policy V.D. para5:** The Care Manager must ensure that all IDT responsibilities are being met, and must assist the IDT members where possible or necessary. Implementation of the LP means that the IDT members must either directly deliver or arrange and confirm delivery of services required under the LP. The precise tasks involved with carrying out the LP will be assigned during the IDT meeting, and supervised, coordinated, and/or directly accomplished by the Care Manager. ...
8a-3	The individual's service plan identifies the services and supports necessary to access and receive routine professional medical care and evaluation.	Met/Not Met	**FIDA IDT Policy VI.G.1-3:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: 1. All active chronic problems, current non-chronic problems, and problems that were previously controlled and or classified as maintenance care but have been exacerbated by

			disease progression and/or other intervening conditions; 2. All current medications taken by the Participant; 3. For each need identified, the LP must state the problem, interventions to resolve or mitigate the problem, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes; **FIDA IDT Policy VI.G.6:** The LP must specify: ... 6. A schedule of preventive service needs or requirements; **FIDA IDT Policy VI.G.13-15:** The LP must specify: ... 13. How technology and tele-health will be used; 14. Known needed physical and behavioral health care and services; 15. Continuation of ongoing course of medical treatment (e.g. chemotherapy, chiropractic care, etc.); ...
8a-4	The individual's routine health care providers are identified and known to the person and/or their supports.	Met/Not Met	**FIDA IDT Policy VI.G.20:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: 20. The person(s)/providers responsible for specific interventions/services;
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-6	The individual receives routine medical exams/medical appointments	Met/Not Met	**633.4(a)(4)(x):**

	per his/her health care professionals' recommendations.		No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **FIDA IDT Policy IX.B.2:** In addition to the LP, the Care Manager on behalf of the FIDA-IDD Plan must maintain a single, comprehensive health record for each Participant in accordance with accepted professional standards. At a minimum, the comprehensive health record must contain the following documentation of all care and services rendered to the Participant by providers, and must be made available to all IDT members: ... 2. Documentation of all services furnished, including the following: A summary of emergency care and other inpatient or long-term care services; Items and services furnished by Network and Out-Of-Network providers;
8a-7	The individual receives diagnostic evaluation/testing per his/her health care professionals' recommendations and standard safe practice (e.g. Lab work, x-rays, scans, MRIs, etc.)	Met/Not Met	**633.4(a)(4)(x):** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **FIDA IDT Policy IX.B.4:** In addition to the LP, the Care Manager on behalf of the FIDA-IDD Plan must maintain a single, comprehensive health record for each Participant in accordance with accepted professional standards. At a minimum, the comprehensive health record must contain the following documentation of all care and services rendered to the Participant by providers, and must be made available to all IDT members: ... 4. Laboratory, radiological and other diagnostic test reports;
8a-8	The individual receives preventative testing and/or care based on recommended	Met/Not Met	**633.4(a)(4)(x):**

	professional guidelines for medical conditions, gender and age.		No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **FIDA IDT Policy IX.B.2:** In addition to the LP, the Care Manager on behalf of the FIDA-IDD Plan must maintain a single, comprehensive health record for each Participant in accordance with accepted professional standards. At a minimum, the comprehensive health record must contain the following documentation of all care and services rendered to the Participant by providers, and must be made available to all IDT members: ... 2. Documentation of all services furnished, including the following: A summary of emergency care and other inpatient or long-term care services; Items and services furnished by Network and Out-Of-Network providers;
8a-9	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender, and age.	Met/Not Met	**633.4(a)(4)(x):** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-10	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met/NA	**FIDA IDT Policy VI.G.3:** The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify: ...3. For each need identified, the LP must state the problem, interventions to resolve or mitigate the problem, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes;

8a-20	The individual exhibits a healthy lifestyle and/or receives support(s) to replace the unhealthy behaviors with healthier actions.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-21	The individual is provided choice in health care providers.	Met/Not Met	**FIDA 3-Way Contract Appendix B:** Specifically, each Participant must be guaranteed the right: ... To make decisions about Providers and coverage, which includes the right to choose and change Providers within the FIDA-IDD Plan's network and to choose and change coverage (including how one receives his/her Medicare and/or Medicaid coverage – whether by changing to another FIDA-IDD Plan or making other changes in coverage); **FIDA IDT Policy VI.G.18:** The LP must specify: … 18. Participant choice of service providers;
8a-22	The individual is supported to advocate and is included in informed decision-making related to medical care and treatment.	Met/Not Met	**FIDA IDT Policy IV.J.1-2:** The IDT must: 1. Educate, empower and facilitate the Participant to make choices within the parameters of the FIDA-IDD Demonstration and to exercise his or her rights and responsibilities, including the opportunity to participate in self-direction and be employed in the Participant's community; 2. Involve the Participant as an active team member, including providing information and explanations using plain language understandable to the Participant and/or representative or designee, and stress Participant-centered collaborative goal setting;.
8a-23	Individuals have been given the opportunity to have advanced directives in place (DNR order, healthcare proxy, or living will).	Met/Not Met	**FIDA 3-Way Contract Appendix B:** ... Specifically, each Participant must be guaranteed the right: ... To be informed at the time of enrollment and at LP update or revision meetings of the explanation of what is an Advance Directive and the right to make an Advance Directive – giving instructions about what is to be done if the

			Participant is not able to make medical decisions for him/herself - and to have the FIDA-IDD Plan and its Participating Providers honor it;
8a-25	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**FIDA IDT Policy IX.B.**: In addition to the LP, the Care Manager on behalf of the FIDA-IDD Plan must maintain a single, comprehensive health record for each Participant in accordance with accepted professional standards. At a minimum, the comprehensive health record must contain the following documentation of all care and services rendered to the Participant by providers, and must be made available to all IDT members: .... NOTE: Please refer to guidance for additional requirements. **FIDA IDT Policy XI.B. para2-3**: Updates are made directly to the service plan in a way that preserves the history of care and enables the team to trace the effectiveness of interventions over time. New problems are added as they are identified, and resolved problems should be retained for monitoring. The rationale for eliminating or relocating a resolved problem to maintenance care must be documented in the LP. The LP is routinely updated as the IDT monitors the Participant's health status. The IDT members meet for updates and revisions and complete service planning steps as outlined above.
8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA	**FIDA 3-Way Contract 2.7.1.20.:** The FIDA-IDD Plan provides for a second opinion for diagnosis of a condition, treatment, or surgical procedure by a qualified Physician or appropriate specialist, including one affiliated with a specialty care center. In the event that the FIDA-IDD Plan determines that it does not have a Participating Provider in its Provider Network with appropriate training and experience qualifying the Participating Provider to provide a second opinion, the FIDA-IDD Plan shall authorize the Participant to access services from an appropriate Non-Participating Provider. The FIDA-IDD Plan shall pay for the cost of the services associated with obtaining a second opinion regarding

			medical or surgical care, including diagnostic and evaluation services, provided by the Non-Participating Provider.
8a-27	The individual is given access to family planning resources and sexuality education and/or counseling if desired.	Met/Not Met/NA	**633.4(a)(4)(xi):** (4) No person shall be denied:(xi) access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated. **FIDA IDT Policy IV.K.3:** As appropriate, the IDT shall coordinate care for Participants with: 3. Family planning clinics, community health centers, migrant health centers, rural health centers and prenatal care providers;
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall with the medical care that the individual receives.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.

10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
11-1	The person has the resources to obtain possessions and supplies necessary for comfortable daily living.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-2	The individual is living as independently as able in the home/living environment they choose.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-3	The person is maintaining/improving and/or developing meaningful relationship(s).	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.

11-4	The person is employed, doing volunteer work or participating in other integrated meaningful activities, per their desires/life goals.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-5	The person is maintaining their desired role in their community.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-6	The individual is living safely/receiving supports to live safely in their home/living environment, according to informed choices and responsible consideration.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-7	The person lives safely in their community per their informed choices.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-8	The person is satisfied with the supports they receive intended to achieve their outcomes.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-9	The person's service(s) in total, contribute to advancing toward or achieving their specified goals and personal outcomes.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**636-1.2(a)(1)-(2) :** (1) The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met	**636-1.2(b)(2)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen

			by the individual. The person centered planning process involves: scheduling with the individual at times and locations of convenience to the individual.
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met	**636-1.2(b)(1)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**636-1.2(b)(5)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (5) developing strategies that address conflicts or disagreements in the process, including clear conflict of interest guidelines for individuals, and communicating such strategies to the individual who is receiving services as appropriate.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(a)(2**) A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the

			individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences. **636-1.2(b)(1) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **ADM 2012-01** : ADM 2012-01 The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen

	included in person centered planning/plan.		by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk,	Met/Not Met	**ADM 2012-01 :**

	including specific back-up plans, are identified in the person centered plan.		The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ...For all other habilitation services...safeguards must be included in the Habilitation Plan or the plan must reference other documentation that specifies the safeguards. Information on the safeguards must be readily available to the habilitation service provider staff. **636-1.3(b)(8)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed; and
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**ADM 2012-01 :** Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties

			including other Waiver Service Providers, the individual being served and/or his/her advocate.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**636-1.2(b)(4) -** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**635-10.5(ag)(2)(i) :** Reimbursement of site based prevocational services (where allowed) shall be contingent on prior OPWDD approval for individuals who enroll in such service on and after July 1, 2015. OPWDD approval will be based on the following criteria: (i) the individual must have a goal to develop pre-employment skills, which must be identified in the individual's individualized service plan (ISP);
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :**.. If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. **635-10.4(ag)(8)(iii) :**

			The service provider must develop a service delivery plan in the form and format specified by OPWDD that guides the delivery of the service for each individual receiving services. The plan must be documented, reviewed, and updated in accordance with section 635-99.1 of this Part.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2012-01 :** Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: an ISP review date, or the date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**ADM 2012-10 Habilitation Plan Requirements : pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff

			support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. ... c. Exploration of new experiences is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ... **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately,

			skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(k)(1) :** Site based prevocational services are habilitation services that assist individuals to develop employment readiness skills and that are provided in non-residential facilities certified by OPWDD. The services consist of learning and work experiences that are not job-task specific but contribute to an individual's ability to attain paid employment in the community. **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**636-1.2(a)(3)(ii) :** The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**635-10.5(ag)(8)(iv) :** The service provider shall maintain documentation that the individual receiving site based prevocational services has received the services in accordance with the individual's ISP and service delivery plan. **635-10.5(ag)(8)(v) :** For each continuous site based prevocational service period/session, the service provider shall document the service start time and the service stop

			time, and the provision of at least one allowable activity that was delivered in accordance with the service delivery plan.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**441.301 4 (C)(4)(iii) :** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint. **441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or

	goals, priorities, needed safeguards and outcomes.		methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers. **635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the

	conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.		individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives.....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2k-1	When the individual's services include site-based prevocational services, the individual must have a demonstrated or assessed earning capacity relative to the prevocational task(s) involved, of less than 50 percent of the current State minimum wage, Federal minimum wage or prevailing wage, whichever is greatest, and be expected to have such an earning capacity while participating in the services.	Met/Not Met	**635-10.4(k)(3) :** To participate in site based prevocational services, the individual must have a demonstrated or assessed earning capacity relative to the prevocational task(s) involved, of less than 50 percent of the current State minimum wage, Federal minimum wage or prevailing wage, whichever is greatest, and be expected to have such an earning capacity while participating in such services.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such

			information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii)** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-4	The individual is informed of their HCBS rights.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5)** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3)** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including

			the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-8	The individual is supported to participate in cultural/religious/associational practices, educuation, celebrations and experiences per their interests and preferences.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-9	The individual is supported to have visitors of their choosing according their preferences.	Met/Not Met	**636-1.4(b)(4) :** Each individual is able to have visitors of his or her choosing at any time.
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support.	Met/Not Met	**633.4(a)(xx) :** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs..	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each

			individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-13	The individual can choose to eat meals when they want to, even if mealtimes occur at routine or scheduled times.	Met/Not Met	**636-1.4(b)(3) :** (b) Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan: (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.
3-14	The individual has access/is supported to have access to food at any time and to store their own food and snack choices for their use at any time as desired, similar to people without disabilities.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-15	The individual is supported to have independent access to the site/service setting with freedom to come and go as desired, similar to people without disabilities.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met	**441.301 (C)(4)(iv) :** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-17	The setting reflects the individual's needs and preferences including the	Met/Not Met	**441.301(C)(4)(ii) :**

	presence of any necessary physical modifications, if applicable.		The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii)** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4)** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a-1	When interventions that restrict or modify the individual's rights are used (not part of a behavior support plan), the individual's service plan includes a description of the positive and less intrusive approaches that	Met/Not Met	**636-1.4(c)(2)-(3) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (2) the positive interventions and supports used prior to any modifications; (3) less intrusive methods of meeting the need that were tried but did not work. Pathway to employment if activities occur at in agency setting.

	have been tried but have not been successful.		
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights modification (clinical justification).	Met/Not Met	**636-1.4 (c)(1) :** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan; (1) a specific and individualized assessed need underlying the reason for the modification. **633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm .	Met/Not Met	**636-1.4(b) :** Modifications to the rights identified in paragraphs (1)-(4) of this subdivision of an individual receiving services in a setting described in subdivision (a) of this section must be supported by a specific assessed need and justified in the individual's person-centered service plan:
3a-5	The individual has given informed consent to the rights	Met/Not Met	**636-1.4(c)(8) :**

	limitations/restrictions in place.		The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (8) the informed consent of the individual.
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community**.**	Met/Not Met	**441.301 (C)(4)(i)** : The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.	Met/Not Met	**441.301(C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are meaningful to them for the period of time desired.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or	Met/Not Met	**ADM 2012-01 – Habilitation Plan Requirements ; Safeguards**. The safeguards delineated in the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except

	attachment according to service/setting requirements.		that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation; Day Habilitation (in certified day habilitation sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY. **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (i) An assessment of functional capacity. (ii) Review and evaluation of the person's written plan of services and his or her progress in relation to that plan
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x):** : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through

			parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight

			must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.

7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with

			14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-6	The individual's needs for support and assistance related to fire safety and evacuation are documented according to service/setting requirements.	Met/Not Met	**ADM 2012-01 Habilitation Plan Requirements ; Safeguards**. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **635-7.5(e) :** An evacuation and safety plan specific to the certified premises shall be developed and implemented that is designed with consideration of the capabilities of the persons receiving services, the staffing of the premises, and the physical plant configuration. A description of the evacuation and safety training for individual participants and staff shall be included in the plan.
7-7	The individual is provided the necessary supports and assistance related to fire safety and evacuation.	Met/Not Met	**635-7.5(e) :** An evacuation and safety plan specific to the certified premises shall be developed and implemented that is designed with consideration of the capabilities of the persons receiving services, the staffing of the premises, and the physical plant configuration. A description of the evacuation and

			safety training for individual participants and staff shall be included in the plan. **ADM 2012-02 Fire Safety… Attachment: Essential El**: Fire drills and evacuation drills are also essential to ensure that all staff on all shifts are trained to perform their assigned tasks outlined in the facility's evacuation plan and to ensure that all staff on all shifts are familiar with the use of the facility's fire protection equipment. In addition, individuals who are capable should be trained to participate and respond to fires or other emergency conditions. Drills also serve to provide agencies with a mechanism for evaluating the effectiveness of evacuation and disaster plans on an on-going basis and to capture information on changes in consumer status. Changes such as those resulting from advancing age, medical changes or new admissions may result in the need to modify the physical environment of the facility, revise the evacuation plan or provide additional staff resources to the facility to meet consumer needs.
8d-1	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s) addressed during services at the site.	Met/Not Met/NA	**633.10(a)(2)(iii)**: (2) In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (iii) For persons in a residential facility, at least a medical/dental evaluation by a physician or registered physician's assistant addressing the person's need for an examination or specific medical/dental services; or by a dentist for dental services. The determination of the basis for such evaluation (e.g., appraisal of the person through records and previous contacts) shall be that of the qualified professional.
8d-2	The individual receives the needed care/support/interventions, through arranged supports or	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through

	independent delivery. DOES NOT APPLY TO MEDICATION.		parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8d-3	The individual's service record/service plan is maintained to reflect current status of the individual's health needs being addressed.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). ...
8d-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8d-5	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8e-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person

8e-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8e-3	The individual receives medications and treatments safely as prescribed.	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.17(b)(3)** : Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication.
8e-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes**.**	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ... **633.17(a)(7) :** All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling.
9-1	A Functional Behavioral Assessment is completed for the individual prior to the	Met/Not Met	**633.16(d)(1)-(2) :**

	development of the Behavior Support Plan.		Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging	Met/Not Met	**633.16(d)(1)(i - v)** : Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric

	behaviors and all contextual factors as required.		disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain

			relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.

9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii):** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.

	person's plan and the specific interventions included.		
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(j)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive

			comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be

			inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use

			of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(i):** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on	Met/Not Met	**633.16(g)(3) :**

	the individual's rights and/or a restrictive/intrusive intervention.		Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :**

	Mechanical Restraining device specifies the facts justifying the use of the device.		The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.

9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :**

	documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.		Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician’s order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person’s clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(i)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be

			provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(j)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(j)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the	Met/Not Met	**633.16(j)(1)(i)(a-d) :**

	individual's Behavior Support Plans.		(1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated

	notification to appropriate parties within two business days.		with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :**

	during time-outs to monitor the Individual's safety.		The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)** : Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving	Met/Not Met/NA	**625.4(a)**

	the individual that are required to be reported have been reported to OPWDD.		The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and	Met/Not Met	**624.5(g)(1)**

	abuse, were implemented immediately.		A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3**) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that

			are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events	Met/Not Met/NA	**624.7(b)(2);**

	involving the individual were planned and implemented.		An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6)

			educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16:

	harm and abuse, were implemented immediately.		624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3**) 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the

			VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary

			investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3):** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(j)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be

			undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**636-1.2(a)(1)-(2) :** (1) The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met	**636-1.2(b)(2)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: scheduling with the individual at times and locations of convenience to the individual.
1-5	The individual is supported to direct the planning process to	Met/Not Met	**636-1.2(b)(1)** A person-centered planning process is required for developing the person-

	the maximum extent possible and desired.		centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**636-1.2(b)(5)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (5) developing strategies that address conflicts or disagreements in the process, including clear conflict of interest guidelines for individuals, and communicating such strategies to the individual who is receiving services as appropriate.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(a)(2**) A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences. **636-1.2(b)(1) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she

			receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **ADM 2012-01** : ADM 2012-01 The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-16	The individual's goals and priorities regarding meaningful relationships are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum

	regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.		extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**ADM 2012-01 :** The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ...For all other habilitation services...safeguards must be included in the Habilitation Plan or the plan must reference other documentation that specifies the safeguards. Information on the safeguards must be readily available to the habilitation service provider staff. **636-1.3(b)(8)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed; and
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-32	The person-centered plan is distributed to the individual	Met/Not Met	**ADM 2012-01 :** Revised Habilitation Plans, which are also written by the habilitation service

	and service providers.		provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or his/her advocate.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**636-1.2(b)(4) -** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**2006-01 Group Day Habilitation :** Group Day Habilitation: In addition to the service note(s) supporting Group Day Habilitation or Supplemental Group Day Habilitation... agency must maintain the following documentation: A copy of the consumer's Individualized Service Plan ISP), developed by the consumer's Medicaid Service Coordinator (MSC) or Plan of Care Support Services (PCSS) service coordinator. **635-10.4(b) :** Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments.

2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :**.. If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2012-01 :** Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: an ISP review date, or the date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**ADM 2012-10 Habilitation Plan Requirements: pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed

			below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. ... c. Exploration of new experiences is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ... **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;

2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(b)(2) :** Day habilitation services are delivered primarily in a nonresidential setting separate from the person's home/residence with exceptions allowed to promote transition or adaptation. Such services shall provide assistance with acquisition, retention or improvement of self-help, socialization, adaptive skills and development of manual and perceptual motor skills. **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**636-1.2(a)(3)(ii) :** The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**ADM 2006-02 :** The acceptable format for the service documentation ... is either a narrative note or a checklist/chart with an entry made at the same time each Individual Day Habilitation service is delivered and billed. **ADM 2006-01:** The acceptable format for the service documentation ... is either a narrative note or a checklist/chart with an entry made at the same time each Group Day Habilitation service is delivered and billed.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix)** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers.

			635-99.1(bl) : If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives.....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and

			responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii)** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-4	The individual is informed of their HCBS rights.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5)** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3)** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-8	The individual is supported to participate in cultural/religious/associational practices, educuation,	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

	celebrations and experiences per their interests and preferences.		
3-9	The individual is supported to have visitors of their choosing according their preferences.	Met/Not Met	**636-1.4(b)(4) :** Each individual is able to have visitors of his or her choosing at any time.
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support.	Met/Not Met	**633.4(a)(xx):** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs..	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-14	The individual has access/is supported to have access to food at any time and to store their own food and snack choices for their use at any time as desired, similar to people without disabilities.	Met/Not Met	**441.301 (C)(4)(iv)** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-15	The individual is supported to have independent access to the site/service setting with freedom to come and go as desired, similar to people without disabilities.	Met/Not Met	**441.301 (C)(4)(iv):** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met	**441.301 (C)(4)(iv):** The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
3-17	The setting reflects the individual's needs and preferences including the presence of any necessary physical modifications, if	Met/Not Met	**441.301(C)(4)(ii):** The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences,

	applicable.		and for residential settings, resources available for room and board.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii)** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4)** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3aQQ	The individual is subjected to restrictions or limitations to their rights not associated with a Behavior Support Plan (e.g. HCBS Rights Limitations)	Yes/No	
3a-1	When interventions that restrict or modify the individual's rights are used (not part of a behavior support plan), the individual's service plan includes a description of the positive and less intrusive approaches that have been tried but have not been successful.	Met/Not Met	**636-1.4(c)(2)-(3):** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (2) the positive interventions and supports used prior to any modifications; (3) less intrusive methods of meeting the need that were tried but did not work.
3a-2	When interventions that restrict or modify rights the individual's rights are used (not part of a behavior support plan), the individual's written service plan includes a description of the individualized assessed need	Met/Not Met	**636-1.4 (c)(1)** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan; (1) a specific and individualized assessed need underlying the reason for the modification. **633.4(b)(6)** For the person who has had limitations placed on any rights, there is

	and/or behavior that justifies the rights restriction or rights modification (clinical justification).		documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When Interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**633.4(b)(6):** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm .	Met/Not Met	**636-1.4(c) (4), (5), (7)** The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (4) a clear description of the condition that is directly proportionate to the specific assessed need; (5) a regular collection and review of data to measure the ongoing effectiveness of the modification; (7) an assurance that interventions and supports will cause no harm to the individual;
3a-5	The individual has given informed consent to the rights limitations/restrictions in place.	Met/Not Met	**636-1.4(c)(8):** The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (8) the informed consent of the individual.
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community**.**	Met/Not Met	**441.301 (C)(4)(i)** : The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.	Met/Not Met	**441.301(C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are meaningful to them for the period of time desired.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**636-1.2(3)(ii) :** supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect;
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**ADM 2012-01 – Habilitation Plan Requirements: Safeguards**. The safeguards delineated in the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation; Day Habilitation (in certified day habilitation sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY.
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x);** : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and

			personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01 Habilitation Plan Requirements: Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01 Habilitation Plan Requirements: Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight

			must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met/NA	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2012-01 Habilitation Plan Requirements: Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written	Met/Not Met/NA	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful

	plan and as needed.		recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-6	The individual's needs for support and assistance related to fire safety and evacuation are documented according to service/setting requirements.	Met/Not Met	**ADM 2012-01 Habilitation Plan Requirements** Safeguards. The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] **635-7.5(e)**

			An evacuation and safety plan specific to the certified premises shall be developed and implemented that is designed with consideration of the capabilities of the persons receiving services, the staffing of the premises, and the physical plant configuration. A description of the evacuation and safety training for individual participants and staff shall be included in the plan.
7-7	The individual is provided the necessary supports and assistance related to fire safety and evacuation.	Met/Not Met	**635-7.5(e):** An evacuation and safety plan specific to the certified premises shall be developed and implemented that is designed with consideration of the capabilities of the persons receiving services, the staffing of the premises, and the physical plant configuration. A description of the evacuation and safety training for individual participants and staff shall be included in the plan.
8dQQ	The individual receives supports related to health care delivered by the site/program staff.	Yes/No	
8d-1	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s) addressed during services at the site.	Met/Not Met/NA	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8d-2	The individual receives the needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met	**686.15(a)(1)(i)(b)(3) :** In providing respite, the facility shall assume the daily responsibilities of the primary caregiver, limited to:. health and self-care services including overseeing routine medical care and managing any medical emergency; **686.16(b)(4)(ii)-(iii) :** 686.16(b)(4) OPWDD shall verify that persons living in the facility are receiving appropriate protective oversight in accordance with the following: ... (ii) any parties with supervision responsibilities are aware of the specifics of each person's plan for protective oversight; and (iii) each person's plan for protective oversight is being implemented as specified in the person's individualized service plan. **633.4(a)(4)(x) :** No person shall be denied:. (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through

			parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8d-3	The individual's service record/service plan is maintained to reflect current status of the individual's health needs being addressed.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8d-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8d-5	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8eQQ	Does the person receive support for medication administration during delivery of this service?	Yes/No	
8e-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met/NA	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person,
8e-2	The individual is assessed regarding ability to self	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential

	administer medications, when medication administration is associated with the service or service environment.		facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8e-3	The individual receives medication and treatments safely as prescribed.	Met/Not Met/NA	**633.17(b)(3) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. **633.4(a)(4)(x) :** No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8e-4	Problems or errors with administration of the individuals medications are reported and remediated per agency processes.	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ... **633.17(a)(7) :** All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling.
9QQ	The individual receives behavior supports/the program/service includes implementation of a Behavior Support Plan.	Yes/No	
9-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	Met/Not Met	**633.16(d)(1)-(2) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain

			relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	Met/Not Met	**633.16(d)(1)(i - v)** : Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;

9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.

	and/or other parties involved with implementation of the plan.		
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii);** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.

9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(i)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to

			implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9aQQ	Restrictive/Intrusive Interventions used and/or Limitations on the individual's rights are used to address behavior and/or part of the individual's Behavior Support Plan.	Yes/No	
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must

	applicable.		include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to	Met/Not Met	**633.16(e)(4)(i);** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section.

	implementation and approval is current.		**633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team

			shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9bQQ	Mechanical restraining devices are used with the individual to address behavior and/or included in their BSP.	Yes/No	
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :**

	record contains a current physician's order for the use of the Mechanical Restraining device.		A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use.

			Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(i)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.

9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(i)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(i)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9cQQ	Physical interventions are used with the individual and/or included in their Behavior Support Plan?	Yes/No	
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(i)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.

9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d QQ	Time out is used with the individual and/or included in the Behavior Support Plan.	Yes/No	
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any

			time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)** : Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment	Met/Not Met	**624.5(g)(1)**

	identified and needed was provided to the individual.		A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3**) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional

			information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or

			neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)

10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)

10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3)** 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16)

			624.5(h)(5) 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial

			action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-1	The individual was provided written notice of their right to a person-centered planning process.	Met/Not Met	**636-1.5(a)(1)-(2)** The service coordinator must give notice of the individual's right to a person-centered planning process in accordance with section 636-1.2 of this Subpart and to a person-centered plan in accordance with section 636-1.3 of this Subpart, and of the right to object to services pursuant to section 633.12 of this Title, to the individual and the person upon whom decision-making authority is conferred by State law (see section 636-1.2[a][1] of this Subpart), if any, in the following manner: (1) for individuals who do not have an ISP in place on November 1, 2015, the service coordinator must give written notice prior to the initiation of the person-centered planning process and development of the plan; or (2) for individuals who have an ISP in place on November 1, 2015, the service coordinator must give written notice at the time of the individual's next ISP review.
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-3	The individual's planning process/planning meetings	Met/Not Met	**636-1.2(a)(1)-(2) :**

	include participation and input from required parties.		(1) The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met	**636-1.2(b)(2)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: scheduling with the individual at times and locations of convenience to the individual.
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met	**636-1.2(b)(1)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**636-1.2(b)(5)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (5) developing strategies that address conflicts or disagreements in the process, including clear conflict of interest guidelines for individuals, and

			communicating such strategies to the individual who is receiving services as appropriate.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(a)(2)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences. **636-1.2(b)(1) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions
1-8	The individual's service planning includes consideration of natural supports as well as paid supports.	Met/Not Met	**636-1.3(b)(4)** The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (4) the necessary and appropriate services and supports (paid and unpaid) that are based on the individual's preferences and needs (as identified through an assessment of functional and health-related needs) and that will assist the individual to achieve his or her identified goals.

1-9	The individual has made informed choice of residential setting and alternative options considered by the individual are recorded in his/her written plan.	Met/Not Met	**636-1.3(b)(7)** The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (7) if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life); **441.301(C)(2)(i)** Commensurate with the level of need of the individual, and the scope of services and supports available under the state's 1915(c) HCBS waiver, the written plan must: reflect that the setting in which the individual resides is chosen by the individual. The state must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving services Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
1-10	Assessments needed by the individual or required by program regulation were completed to inform the individual's plan development.	Met/Not Met	**636-1.3(b)(1)-(4) b)** The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (1) the individual's goals and desired outcomes; (2) the individual's strengths and preferences; (3) the individual's clinical and support needs as identified through an assessment of functional and health-related needs; (4) the

			necessary and appropriate services and supports (paid and unpaid) that are based on the individual's preferences and needs (as identified through an assessment of functional and health-related needs) and that will assist the individual to achieve his or her identified goals;
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **636-1.3(b)(1)** b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (1) the individual's goals and desired outcomes;
1-12	The individual's strengths and preferences are documented in the service plan.	Met/Not Met	**636-1.3(b)(2)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ….(2) the individual's strengths and preferences;
1-13	The individual's identified needs for clinical and/or functional support are documented in the service plan.	Met/Not Met	**636-1.3(b)(3)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ...(3) the individual's clinical and support needs as identified through an assessment of functional and health-related needs;
1-14	The individual's cultural/religious and other personalized associational interests/preferences are	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the

	included in person centered planning/plan.		HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-16	The individual's goals and priorities regarding meaningful relationships are identified in the person centered plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).

1-18	The individual's goals and priorities related to health concerns and medical needs are identified in the person centered plan.	Met/Not Met	**636-1.3(b)(3)-(4)** "(b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (3) the individual's clinical and support needs as identified through an assessment of functional and health-related needs; (4) the necessary and appropriate services and supports (paid and unpaid) that are based on the individual's preferences and needs (as identified through an assessment of functional and health-related needs) and that will assist the individual to achieve his or her identified goals;" **ADM 2010-04 Addendum-ISP instructions** ISP Instructions revised 12/10/10 Pg. 2: State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. … In addition, the following areas should be considered: chronic medical conditions, allergies, ability to self-administer medications, special dietary needs, ability to manage finances, ability to give consent, level of supervision required in the home and community, ability to travel independently, and safety awareness. **ADM 2012-06 :** Service Coordinators providing PCSS must also perform the following tasks: … Assuring that necessary safeguards have been identified to protect the health and welfare of the individual.
1-19	The individual's known food, medication, and/or environmental allergies and the corresponding precautions are identified in the person centered plan.	Met/Not Met/NA	**ADM 2010-04 Addendum-ISP instructions** ISP Instructions revised 12/10/10 Pg. 2: State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. … In addition, the following areas should be considered: chronic medical conditions, allergies, ability to self-administer medications, special dietary needs, ability to manage

			finances, ability to give consent, level of supervision required in the home and community, ability to travel independently, and safety awareness. **ADM 2012-06 :** Service Coordinators providing PCSS must also perform the following tasks: … Assuring that necessary safeguards have been identified to protect the health and welfare of the individual.
1-20	Individualized considerations and safeguards regarding fire safety are identified in the person centered service plan.	Met/Not Met	**ADM 2010-04 Addendum-ISP instructions** State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. … Fire safety must be discussed in the safeguard section of all ISPs unless it is discussed in the attached Individual Plan for Protective Oversight for people who live in IRAs. The service coordinator must ensure that there is a current and reasonable assessment of the person's specific needs relative to his/her capacity to evacuate the home in a timely manner in the event of a fire emergency. If the person lives in a non-certified site, the service coordinator must ensure that actions and recommendations relative to addressing a person's assessed fire safety needs are specified in the ISP.
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up	Met/Not Met	**636-1.3(b)(8)**

	plans, are identified in the person centered plan.		(b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed; and
1-23	The individual's written plan documents each specific service and support to be provided to address his/her needs and achieve his/her identified desired outcomes, short term and long term goals.	Met/Not Met	**ADM 2010-04 Addendum-ISP instructions** The ISP identifies the waiver services as well as other services and supports that a person needs in order to live successfully in the community, and therefore, avoid institutionalization. Each person enrolled in the HCBS Waiver must have an ISP that includes a listing of all of the person's current authorized HCBS waiver services. The ISP should also reflect the full range of the person's service needs including State Medicaid Plan Services, non-Medicaid services, informal supports, and other community resources. **ADM 2012-06 :** The Service coordinator: a. Uses a person centered planning approach to develop the ISP. The Service coordinator identifies the desired goals and valued outcomes of the person and the supports and services that person wants and needs to achieve those outcomes. ... c. Documents in the ISP the supports , services, community resources needed and chosen by the person with developmental disabilities and the entities that will supply them.
1-24	The individual's written plan identifies the amount, frequency and duration of each HCBS waiver service he/she receives, as applicable.	Met/Not Met/NA	**ADM 2010-04 Addendum-ISP instructions** Required Information for HCBS Waiver Services: Name of the waiver service provider or agency; Type of waiver service (e.g., residential habilitation, supported employment, consolidated supports and services, respite); Frequency of the support or service. The frequency of an HCBS Waiver Service must correspond to the billing unit of service (e.g., day, month, hour, or one time expenditure). See the Frequency of HCBS Waiver Services Appendix at the end of these instructions; Duration of the support or service. This means for how long the assistance is expected to last. If the service does not have an expected end date, write "ongoing."; Effective date of the support or service. This is the date the current provider first provided the service. Waiver services must have the exact and correct effective date

			and this date must be on or before the date the provider began delivering the service. A waiver service provider's billing will be jeopardized if the date the provider billed for the service is prior to the effective date on the ISP. For a one time service or purchase, such as environmental modifications and adaptive devices, the anticipated purchase/completion date is used as the effective date. Note: The above information (name and type of provider, frequency, duration, and effective date) must be accurate for HCBS Waiver Services since the ISP substantiates the payment of these services.
1-25	The person-centered plan identifies the provider(s) of the individual's supports and services.	Met/Not Met	**636-1.3(b)(6)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (6) the providers of those services and supports specified in paragraph (4) and (5) of this subdivision; ...
1-26	The person-centered plan evidences that informed choice is made regarding self-direction; and if chosen, identifies the services that the individual elects to self-direct.	Met/Not Met	**636-1.3(b)(5)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: … (5) the services that the individual elects to self-direct;
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual. **636-1.3(c)** The service coordinator must develop the person-centered service plan in a way that is understandable to the individual and parties chosen by the

			individual. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to the individual, to the extent possible, and parties chosen by the individual.
1-29	The person-centered service plan is signed by the individual as indicator of written informed consent or approval.	Met/Not Met	**636-1.3(d)** The plan must be finalized and agreed to with the individual's written informed consent and signed by the provider(s) responsible for implementing the person-centered service plan.
1-30	The individual's person centered service plan is agreed to by services providers and/or members of the team as required.	Met/Not Met	**636-1.3(d)** The plan must be finalized and agreed to with the individual's written informed consent and signed by the provider(s) responsible for implementing the person-centered service plan.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**636-1.3(e)** The service coordinator must distribute the person-centered service plan to the individual and parties involved in the implementation of the plan.
1-33	The person-centered service plan includes all relevant and applicable attachments.	Met/Not Met	**635.99.1(bk) -** "… The ISP shall include or contain as attachments the following: (1) all relevant habilitation plans (for individuals receiving habilitation services); (2) all relevant plans or documents pursuant to section 636-1.4(c) and (d) of this Title that support modification to an individual's rights specified in section 636-1.4(b)(1)-(4) of this Title; and (3) the individual plan for protective oversight for residents of an individualized residential alternative (IRA) (see section 686.16[a][6] of this Title). " **ADM 2012-06 :** The contents of the ISP section of the individual's PCSS record contain the ISP with appropriate attachments. The ISP, with its required attachments, constitutes the "plan of care" for purposes of the HCBS waiver. The attachments include: HCBS Waiver habilitation plans (...) for HCBS Waiver

			enrollees.; The Individual Plan for Protective Oversight if the person lives in an Individualized Residential Alternative (IRA).
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	636-1.2(b)(4) - A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
1-35	The Individual's written person centered service plan is reviewed with regular required frequency .	Met/Not Met	**636-1.3(f)(1) - (f)** The individual, parties chosen by the individual, the service provider, and service coordinator must review the person-centered service plan described in subdivision (b) of this section and subdivisions 636-1.4(c) and (d) of this Subpart, and the service coordinator must revise such plan if necessary, as follows: (1) at least semi-annually;
1-36	Review of the plan includes the individual's status/progress towards the achievement of his/her goals, priorities and outcomes.	Met/Not Met	**636-1.2(a)(3)(i)-(iii) - 3)** The person-centered planning process requires that: (i) supports and services are based on the individual's interests, preferences, strengths, capacities, and needs; (ii) supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and (iii) the individual is satisfied with activities, supports, and services. **ADM 2012-06 :** Service coordinators providing PCSS must also perform the following tasks: 1. Maintaining a current ISP in consultation with the individual, and completing a review at least twice within a twelve month period. … 2. Making whatever contacts with the individual's advocate, if any, and major service providers necessary to accurately review and update the ISP if needed.

1-37	The individual's person centered service plan is revised whenever changes are necessary and warranted and/or as directed/preferred by the individual.	Met/Not Met/NA	**636-1.3(f)(1)-(5) - "(f)** The individual, parties chosen by the individual, the service provider, and service coordinator must review the person-centered service plan described in subdivision (b) of this section and subdivisions 636-1.4(c) and (d) of this Subpart, and the service coordinator must revise such plan if necessary, as follows: (1) at least semi-annually; (2) when the capabilities, capacities, or preferences of the individual have changed and warrant a review; (3) at the request of the individual and/or parties chosen by the individual; (4) when it is determined that the existing plan (or portions of the plan) is/are ineffective; and (5) upon reassessment of the individual's functional need."
1-38	Revisions to the individual's written plan are documented in the form and format required.	Met/Not Met/NA	**ADM 2012-06 :** For two months within any twelve month period, PCSS should be provided for the purpose of reviewing and updating the person's individualized service plan, related records, and ensuring that the annually required HCBS waiver level of care eligibility determination is completed. During these two service months, PCSS service coordinators must meet and document all of the following first set of criteria: 1. Conduct a face-to-face service meeting with the individual. 2. Review (which may include the creation of the initial ISP) and/or update (addendum) the ISP. ..... Evidence that the person's ISP has been reviewed twice within a twelve month period. Evidence of a review may include, but is not limited to, a review sign-in sheet, a monthly service note indicating that the ISP was updated or revised, and ISP addendum, a revised ISP, or a review section on the ISP.
1-40	The SC/CM/CC competently assures person centered planning as evidenced by the individual's written plan for services and supports and interview.	Met/Not Met	**636-1.2(a)(3)(i)-(iii) - (3)** The person-centered planning process requires that: (i) supports and services are based on the individual's interests, preferences, strengths, capacities, and needs; (ii) supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and (iii) the individual is satisfied with activities, supports, and services."

			636-1.3(a) – The person-centered service plan is created using the planning process described in section 636-1.2 of this Subpart. The person-centered service plan may also be known as the individualized service plan (ISP, see definition in section 635-99.1 of this Title).
1-41	CAS findings were reviewed with the individual within 30 days	Met/Not Met	**Quality Indicator –** This is an indicator of quality service planning
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**ADM 2012-06 :** Individual's PCSS Record: The first section of an individual's PCSS record contains the eligibility and enrollment documentation for the individual with developmental disabilities.... For people enrolled in the HCBS Waiver, the following HCBS Waiver enrollment information/documents should also be included in this section: Waiver Enrollment forms ... Current redetermination of ICF/DD Level of Care eligibility. ... Name of the person's advocate or statement that the person is self-advocating. ... The written evaluations section of the individual's PCSS record contains written, professional evaluations regarding the person. ... The contents of the ISP section of the individual's PCSS record containing the ISP with appropriate attachments.

2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**ADM 2012-06 :** Service coordinators providing PCSS must also perform the following tasks: 1. Maintaining a current ISP in consultation with the individual, and completing a review at least twice within a twelve month period.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2010-04** If an ISP review results in a rewritten ISP, the service coordinator signs the ISP (first) with his or her full signature and date. The service coordinator's signature and date should be within 45 days of the date of the review which resulted in the rewritten ISP. **ADM 2012-06 :** An individual's first ISP must be written an signed by the service coordinator within 60 days of the HCBS enrollment date or of the PCSS enrollment date whichever comes first.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**ADM 2012-06 :** Documentation of each service required for monthly billing must include the following monthly servcie note elements: 1. the individual's name. 2. …. Service provided. 3. ….agency providing PCSS. 4. The month and year that the PCSS service was provided. 5. The location of the servic meeting for the ISP review only. 6. A description of the activities that count... 7. The full name, title, and signature of teh PCSS service coordinator delivering the servcie. Initials are permitted if a "key" is provided, which identifies the title,

			signature and full name associated with the staff initials. 8. The date the note was written (i.e. the signature date) which must include the day, the month, and the year.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix)** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **2011 MSC Vendor Manual pg. 24** In order to help a person determine and access necessary and available supports and services, a service coordinator performs person centered activities related to: assessment; service plan development; implementation; maintenance and monitoring; linkages and referrals; monitoring and follow up; advocacy; and record keeping.
2a-1	The individual was provided a choice of service/care manager/coordinator.	Met/Not Met	**2011 Vendor Manual Pg. 22** It is important to remember that the service coordination provider and the service coordinator (to the greatest extent possible) are chosen by the person with developmental disabilities. … **2011 Vendor Manual Pg. 67** All MSC participants have a choice of MSC Vendors, within available options. The selected MSC Vendor or regional office must be identified in the person's ISP. The Service Coordination Agreement explains a person's right to change vendors. The MSC service coordinator must ensure the person with developmental disabilities is aware of his or her right to choose a different vendor.
2a-2	An initial Level of Care determination (LCED) was completed indicating OPWDD determination that the	Met/Not Met/NA	**2011 Vendor Manual Pg. 73 :** The HCBS Waiver provider delivering PCSS must maintain a PCSS Record for all individuals receiving PCSS. The PCSS Record contains: SECTION I:

	individual is eligible for services (when individuals receive HCBS Waiver Services).		Waiver Enrollment Forms ... Initial, current, and each annual (re-determination) of ICF/MR Level of Care; … (See Also ADM# 2012-06)
2a-3	The level of care is reevaluated at least annually (within 365 days) as evidenced by a current LCED in the SC/CC record.	Met/Not Met/NA	**2011 Vendor Manual Pg. 37** The service coordinator ensures that there is timely completion of annual LCEDs for all HCBS waiver enrolled individuals. **2011 Vendor Manual Pg. 72 :** Plan of Care Support Services (PCSS) is a separate and distinct HCBS Waiver service. It supports individuals enrolled in the HCBS Waiver by ensuring that each participant who is not enrolled in MSC continues to have: ... A current Level of Care Eligibility Determination (LCED). **2011 Vendor Manual Pg. 73 :** The HCBS Waiver provider delivering PCSS must maintain a PCSS Record for all individuals receiving PCSS. The PCSS Record contains: SECTION I: Waiver Enrollment Forms ... Initial, current, and each annual (re-determination) of ICF/MR Level of Care; … (See Also ADM# 2012-06) **ADM# 2011-01** Level of Care Redetermination: A qualified person is able to review the information on the form and, if there are no changes that impact the person's level of care, to complete the ICF/MR (sic) Level of Care Eligibility Redetermination section on the same form as the last redetermination. The redetermination must be completed and signed annually, i.e. within 365 days of the previous authorization (i.e. effective) date.
2a-4	The service plan record contains a correctly completed Documentation of Choices form.	Met/Not Met	**2011 Vendor Manual Pg. 73 :** The HCBS Waiver provider delivering PCSS must maintain a PCSS Record for all individuals receiving PCSS. The PCSS Record contains: SECTION I: Waiver Enrollment Forms: ... Documentation of Choices; …(See also ADM# 2012-06).

2a-6	The SC/CM/CC advocates/ensures that rights limitations occur only with required protections, justifications and approvals in place.	Met/Not Met/NA	**636-1.4(c)** The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (1) a specific and individualized assessed need underlying the reason for the modification; (2) the positive interventions and supports used prior to any modifications; (3) less intrusive methods of meeting the need that were tried but did not work; (4) a clear description of the condition that is directly proportionate to the specific assessed need; (5) a regular collection and review of data to measure the ongoing effectiveness of the modification; (6) established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; (7) an assurance that interventions and supports will cause no harm to the individual; and (8) the informed consent of the individual. **633.4(a)(3)** (3) The rights set forth in this section are intended to establish the living and/or program environment that protects individuals and contributes to providing an environment in keeping with the community at large, to the extent possible, given the degree of the disabilities of those individuals. Rights that are self-initiated or involve privacy or sexuality issues may need to be adapted to meet the need of certain persons with the most severe disabilities and/or persons whose need for protection, safety and health care will justify such adaptation. It is the responsibility of the agency/facility or the sponsoring agency to ensure that rights are not arbitrarily denied. Rights limitations must be documented and must be on an individual basis, for a specific period of time, and for clinical purposes only. (Note: See section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
2a-9	The individual and designees, as applicable are given required contact information.	Met/Not Met	**2011 Vendor Manual Pg31** MSC vendors must provide a 24-hour emergency telephone number to each individual served. The emergency number must be answered by either an MSC agency staff person or an answering service who contacts an MSC agency staff person. An answering machine cannot be used unless it

			provides a forwarding number that is answered by an MSC agency staff person. ... MSC vendors should have a reliable system in place to ensure that each individual has been provided with this number and that this number is reviewed with the person at least annually and their advocates, family members.
2a-10	The individual can reach the service coordinator when needed in a timely manner.	Met/Not Met/NA	**2011 Vendor Manual Pg31** MSC vendors must provide a 24-hour emergency telephone number to each individual served. The emergency number must be answered by either an MSC agency staff person or an answering service who contacts an MSC agency staff person. An answering machine cannot be used unless it provides a forwarding number that is answered by an MSC agency staff person.
2a-11	The SC/CM/CC solicits input from/among members of the person's "circle"/team as part of the review of the person's services and status as needed.	Met/Not Met	**2011 MSC Vendor Manual pgs. 27-28** The service coordinator: Uses a person centered planning process to review the ISP at least twice annually (at least once annually through a face-to-face meeting with the individual and major service providers) and makes any necessary revisions to ensure the ISP is up-to-date and supports and service are consistent with the needs and goals of the person; Works with the person and others as appropriate to assess the person's satisfaction with his or her ISP and the services, supports, valued outcomes/goals therein and related service coordination activities and makes adjustments as necessary; Continuously supports the person with developmental disabilities to make informed choices and achieve his/her valued outcomes; Establishes and maintains an effective communication network with service providers and others involved with the person with developmental disabilities; Keeps up to date with changes, choices, temporary setbacks and accomplishments related to the ISP and incorporates changes to the ISP as needed; and Advocates for the person with developmental disabilities when his or her rights, protections, or health and safety needs and safeguards are not being met. **ADM# 2012-06 :**

			2...The service coordinator: … g. Facilitates visits and interview with family members, service providers, housing options, etc. and h. Ensures essential information is made available to the person and providers and others with the consent of the individual with developmental disabilities. Service coordinators providing PCSS must also perform the following tasks:...2. Making whatever contacts with the individual's advocate, if any, and major service providers necessary to accurately review and update the ISP if needed.
2a-12	Meetings for the review of the person centered service plan must be face to face as required by the service type.	Met/Not Met	**ADM# 2012-06 :** Service coordinators providing PCSS must also perform the following tasks: 1. Maintaining a current ISP in consultation with the individual, and completing a review at least twice within a twelve month period. Both reviews must include a face-to-face contact with the individual a the individual's residence or at a n alternative site mutually agreed to by the individual and the service coordinator.

2a-14	The SC/CM/CC notes indicate that the service coordinator/case manager has contact with the individual in the frequency and manner required by service and when needed.	Met/Not Met	**ADM #2012-06 :** … Maintaining a current ISP in consultation with the individual, and completing a review at least twice within a twelve month period. Both reviews must include a face-to-face contact with the individual at the individual's residence or at an alternate site mutually agreed to by the individual and the service coordinator **2011 Vendor Manual Pg. 38-39** The MSC record keeping responsibility focuses activity on keeping accurate and current records on service coordination activities and other services provided to the person. The documents and notes within the person's service coordination record should provide a chronological, ongoing written record of relevant information about the person and his or her life that helps a service coordinator provide person centered quality services. Additionally, high quality professional notes demonstrate the service coordinator's comprehensive and personal knowledge of the individual and his or her ISP along with substantiating billing for service coordination and key quality indicators. The service coordinator's record keeping should be clear and comprehensive enough to enable effective transition of service coordination services to another service coordinator or vendor if necessary. The records should be organized and clear to ensure that oversight entities can obtain a complete picture of the person and the MSC activities that are being provided on behalf of the person.

2a-18	SC/CC/CC has taken action to affirm that all allegations of abuse and/or neglect were reported to appropriate parties and investigated as appropriate.	Met/Not Met/NA	**ADM# 2012-06 :** Service coordinators providing PCSS must also perform the following tasks: … 3. Assuring that necessary safeguards have been identified to protect the health and welfare of the individual. **2011 Vendor Manual Pg. 15** While the extent of involvement by a service coordinator and the exact tasks he or she undertakes in providing MSC services to each individual will vary, the objectives and focus of every service coordinator in every instance should be the same. Service coordinators must always: ... Take all reasonable steps to ensure the health and safety of the person with developmental disabilities, ... **2011 Vendor Manual Pg. 29**

			A critical role of the service coordinator is monitoring the health and safety needs of the person and working to improve the quality and safety of the person's living environment if necessary (e.g., through advocacy). … **2011 Vendor Manual Pg. 29-30** The health and safety reporting requirements and standards are different for individuals who live in OPWDD certified residences and for individuals who live independently or with family members. Regardless of where the individual lives, MSCs must inform the appropriate regional office of any dangerous situations and of any reports made to outside state or law enforcement agencies. This includes reporting any suspected child abuse to the State Central Register of Child Abuse and Maltreatment at 1-800-342-3720. To fulfill responsibilities related to health and safety monitoring for individuals living in OPWDD certified settings, an MSC must: • Report any suspected unmet health or safety needs to the applicable regional office, • Report suspected unmet health or safety needs for any Willowbrook Class member living in any OPWDD certified residential setting using the Service Coordination Observation Report (MSC7-SCOR) (See Appendix Three), • Ensure that IRA residents have Individual Plans of Protective Oversight (IPOP), • For people living in CRs, IRAs, or Family Care, document in the safeguard section of the ISP the supports needed to keep the person safe from harm and actions to be taken when the health or welfare of the person is at risk, including any fire safety actions or provisions necessary, • Comply with Part 624 (Reportable Incidents, Serious Reportable Incidents and Abuse in Facilities Operated or Certified by OPWDD) and take reasonable steps to prevent violation of Part 633 (Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD), and subpart 635-9 (Provision of Required Services). For individuals who live independently, with others, or at home with family, the service coordinator must: ... Report suspected child abuse to the State Register of Child Abuse and Maltreatment at 1-800-342-3720.; Address other suspected abuse, neglect, and financial exploitation of children or adults, including situations where an individual cannot care for him or herself. This may require a call to the local adult protective service system. In New York City, suspected abuse or neglect of adults is reported to Protective Services

			for Adults. Outside New York City, the local county department of social services should be contacted to determine which office has responsibility for this function in the county where the individual lives, ...
2a-19	If abuse was substantiated, SC/CM/CC advocates for the safety and protection of the individual.	Met/Not Met/NA	**ADM# 2012-06 :** Service coordinators providing PCSS must also perform the following tasks: … 3. Assuring that necessary safeguards have been identified to protect the health and welfare of the individual. **2011 Vendor Manual Pg. 15** While the extent of involvement by a service coordinator and the exact tasks he or she undertakes in providing MSC services to each individual will vary, the objectives and focus of every service coordinator in every instance should be the same. Service coordinators must always: ... Take all reasonable steps to ensure the health and safety of the person with developmental disabilities, ... **2011 Vendor Manual Pg. 29** A critical role of the service coordinator is monitoring the health and safety needs of the person and working to improve the quality and safety of the person's living environment if necessary (e.g., through advocacy). …
2a-20	The SC/CM/CC monitors that the individual is linked to and receiving the services he/she wants and that the services are helping the individual to attain his/her valued outcomes and life goals.	Met/Not Met	**2011 Vendor Manual Pg.27-28** The service coordinator: Uses knowledge of the community and available resources to support the person with developmental disabilities to make informed choices regarding how to achieve his or her valued outcomes, Coordinates access to and the delivery of supports and services identified in the ISP, ... The service coordinator: Uses a person centered planning process to review the ISP at least twice annually (at least once annually through a face-to-face meeting with the individual and major service providers) and makes any necessary revisions to ensure the ISP is up-to-date and supports and service are consistent with the needs and goals of the person,; Works with the person and others as appropriate to assess the person's satisfaction with his

			or her ISP and the services, supports, valued outcomes/goals therein and related service coordination activities and makes adjustments as necessary; Continuously supports the person with developmental disabilities to make informed choices and achieve his/her valued outcomes, Establishes and maintains an effective communication network with service providers and others involved with the person with developmental disabilities, Keeps up to date with changes, choices, temporary setbacks and accomplishments related to the ISP and incorporates changes to the ISP as needed, and Advocates for the person with developmental disabilities when his or her rights, protections, or health and safety needs and safeguards are not being met. .
2a-22	The SC/CM/CC monitors that the fire safety safeguard identified in the Person Centered Plan are in place/provided.	Met/Not Met	**2011 Vendor Manual Pg.30 :** To fulfill responsibilities related to health and safety monitoring for individuals living in OPWDD certified settings, an MSC must: Report any suspected unmet health or safety needs to the applicable regional office, Report suspected unmet health or safety needs for any Willowbrook Class member living in any OPWDD certified residential setting using the Service Coordination Observation Report (MSC7-SCOR) (See Appendix Three), Ensure that IRA residents have Individual Plans of Protective Oversight (IPOP), For people living in CRs, IRAs, or Family Care, document in the safeguard section of the ISP the supports needed to keep the person safe from harm and actions to be taken when the health or welfare of the person is at risk, including any fire safety actions or provisions necessary,... **ADM# 2012-06** : Service Coordinators providing PCSS must also perform the following tasks: … 3. Assuring that necessary safeguards have been identified to protect the health and welfare of the individual. **2011 Vendor Manual Pg.30 :** For individuals who live independently, with others, or at home with family, the service coordinator must: Document in the safeguards section of the ISP that there are safeguards in place to protect the person's health and safety, including a summary of fire safety needs,
2a-23	The SC/CM/CC monitors that individuals receive the health	Met/Not Met	**ADM# 2012-06 :**

	care services identified in their service plan.		Service Coordinators providing PCSS must also perform the following tasks: … 3. Assuring that necessary safeguards have been identified to protect the health and welfare of the individual. **2011 Vendor Manual Pg. 27-28** The service coordinator: Uses knowledge of the community and available resources to support the person with developmental disabilities to make informed choices regarding how to achieve his or her valued outcomes, Coordinates access to and the delivery of supports and services identified in the ISP, ... The service coordinator: Advocates for the person with developmental disabilities when his or her rights, protections, or health and safety needs and safeguards are not being met. ...
2a-27	The person is satisfied with the coordination/case management services he/she receives.	Met/Not Met	**636-1.2(a)(3)(iii)** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities; **2011 Vendor Manual Pg. 46** The first section of a Service Coordination Record contains the eligibility and enrollment documentation for the individual with developmental disabilities and should include: ... Notice of individual rights and responsibilities per Part 633.4. (For Willowbrook Class members, there must be the Notice of Rights for Willowbrook Class members only).

3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii)** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-4	The individual is informed of their HCBS rights.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5)** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3)** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3)

			taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-21	The individual controls their personal resources and decides how to spend their personal discretionary funds.	Met/Not Met	**2011 MSC Vendor Manual pg. 29** ... Another example of advocacy is when a service coordinator who serves individuals residing in certified residences actively seeks to ensure that the individual's right to a monthly personal allowance is maintained. Any individual with income, including Social Security Disability and SSI benefits, is entitled to a personal allowance. An individual's personal funds should be used to support the person's preferences, choices and interests and the service coordinator's advocacy in this area helps ensure the person's rights are upheld....
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii)** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff	Met/Not Met	**633.4(a)(4)(ix) :**

	support/advocate for the individual's rights as needed.		No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4)** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a - QQ	The individual is subjected to restrictions or limitations to their rights not associated with a Behavior Support Plan (e.g. HCBS Rights Limitations)	Met/Not Met	
3a-1	When interventions that restrict or modify the individual's rights are used (not part of a behavior support plan), the individual's service plan includes a description of the positive and less intrusive approaches that have been tried but have not been successful.	Met/Not Met	**636-1.4(c)(2)-(3)** "Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (2) the positive interventions and supports used prior to any modifications; (3) less intrusive methods of meeting the need that were tried but did not work. Pathway to employment if activities occur at in agency setting."
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights	Met/Not Met	**633.4(b)(6)** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.) **636-1.4 (c)(1)** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's

	modification (clinical justification).		person-centered service plan; (1) a specific and individualized assessed need underlying the reason for the modification.
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**636-1.4 (c)(6)** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan; (6)established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm .	Met/Not Met	**636-1.4(c)(4),(5),(7)** The service coordinator must ensure documentation of the following in the individual's person-centered service plan:... (4) a clear description of the condition that is directly proportionate to the specific assessed need; (5) a regular collection and review of data to measure the ongoing effectiveness of the modification; ...(7) an assurance that interventions and supports will cause no harm to the individual;
3a-5	The individual has given informed consent to the rights limitations/restrictions in place.	Met/Not Met	**636-1.4(c)(8)** The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (8) the informed consent of the individual.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**636-1.3(b)(3), (4), and (8)** "The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (3) the individual's clinical and support needs as identified through an assessment of functional and health-related needs; (4) the necessary and appropriate services and supports (paid and unpaid) that are based on the individual's preferences and needs (as identified through an assessment of functional and health-related needs) and that will assist the individual to

			achieve his or her identified goals; …(8)the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed" **ADM 2010-04** Program Standards: Individualized Service Plan (ISP) Program Standards: Individualized Service Plan (ISP)… Attachment: ISP Instructions (9/2015 update). Applicable to MSC and PCSS: Safeguards: State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. The habilitation plans, or referenced documents, will provide greater detail about how safeguards are ensured within the context of the respective service environment. The "Individual Plan for Protective Oversight" can be referenced in the safeguards section for people who live in an Individualized Residential Alternative (IRA). However, the service coordinator should also include safeguards that pertain to other environments where the person spends time.
7-8	The individuals is provided necessary supports necessary to facilitate financial stability and freedom from financial exploitation.	Met/Not Met	**ADM 2010-04** Program Standards: Individualized Service Plan (ISP)… Attachment: ISP Instructions (9/2015 update) Safeguards: …state the safeguards that must be in place to keep the person safe from harm. … the following areas should be considered:… ability to manage finances …
8a-2	The individual has someone chosen/delegated to support them in coordinating their health care.	Met/Not Met	**2011 MSC Vendor Manual pg. 26** The service coordinator: Uses a person centered planning approach to develop the ISP. The service coordinator identifies the desired goals and valued outcomes of the person and the supports and services that person wants and needs to achieve those outcomes, Helps a person with developmental disabilities plan by promoting and supporting informed choices and developing a personal network of activities, supports, services, and community resources based on the person's needs and desires, Documents in the ISP the supports, services, community resources needed

			and chosen by the person with developmental disabilities and the entities that will supply them, ...
8a-3	The individual's service plan identifies the services and supports necessary to access and receive routine professional medical care and evaluation.	Met/Not Met	**2011 MSC Vendor Manual pg. 26** The service coordinator: Uses a person centered planning approach to develop the ISP. The service coordinator identifies the desired goals and valued outcomes of the person and the supports and services that person wants and needs to achieve those outcomes, Helps a person with developmental disabilities plan by promoting and supporting informed choices and developing a personal network of activities, supports, services, and community resources based on the person's needs and desires, Documents in the ISP the supports, services, community resources needed and chosen by the person with developmental disabilities and the entities that will supply them, ...
8a-4	The individual's routine health care providers are identified and known to the person and/or their supports.	Met/Not Met	**ADM 2010-04 ISP Instructions** "Medicaid State Plan Services are those services that a person can access with his or her Medicaid card. These services include Medicaid Service Coordination, physician, pharmacy, laboratory, hospital, dental, physical therapy, audiology, durable medical equipment, day treatment, and psychology. Services provided in Article 16, 28, or 31 Clinics should also be described in this section. These services may include Physical, Occupational, Speech, Rehabilitation Counseling, Nutrition, Psychology, Social Work, Psychiatry, nursing, or dental. Indicate what type of Clinic (16, 28, or 31) and the specific service being provided."
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-11	The individual receives needed care/support/interventions,	Met/Not Met/NA	**2011 MSC Vendor Manual pgs. 27-28**

	through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.		The service coordinator: Uses a person centered planning process to review the ISP at least twice annually (at least once annually through a face-to-face meeting with the individual and major service providers) and makes any necessary revisions to ensure the ISP is up-to-date and supports and service are consistent with the needs and goals of the person, ... Advocates for the person with developmental disabilities when his or her rights, protections, or health and safety needs and safeguards are not being met..
8a-20	The individual exhibits a healthy lifestyle and/or receives support(s) to replace the unhealthy behaviors with healthier actions.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-21	The individual is provided choice in health care providers.	Met/Not Met	**633.4(a)(4)(x)** (4) No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-22	The individual is supported to advocate and is included in informed decision-making related to medical care and treatment.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-23	Individuals have been given the opportunity to have advanced directives in place (DNR order, healthcare proxy, or living will).	Met/Not Met	**633.4(a)(4)(xxv)-(xxvi)** "(4) No person shall be denied: (xxv) the opportunity to make, or have made on his or her behalf, an informed decision regarding cardiopulmonary resuscitation (see glossary), in accordance with the provisions of article 29-B of the Public Health Law, and any other applicable law or regulation. Each developmental center (see glossary) shall adopt policies/procedures to actualize this right.

			(xxvi) the opportunity, if the person is residing in an OPWDD operated or certified facility, to create a health care proxy (see glossary) in accordance with 14 NYCRR 633.20."
8a-25	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**2011 MSC Vendor Manual** The service coordinator: ... Uses a person centered planning process to review the ISP at least twice annually (at least once annually through a face-to-face meeting with the individual and major service providers) and makes any necessary revisions to ensure the ISP is up-to-date and supports and service are consistent with the needs and goals of the person, ... Keeps up to date with changes, choices, temporary setbacks and accomplishments related to the ISP and incorporates changes to the ISP as needed,
8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA	**633.4(a)(4)(x)** (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-27	The individual is given access to family planning resources and sexuality education and/or counseling if desired.	Met/Not Met/NA	**633.4(a)(4)(xi)** (4) No person shall be denied:...(xi) access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated.
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.

8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall with the medical care that the individual receives.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and	Met/Not Met	**624.5(g)(1)**

	needed was provided to the individual.		A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)

10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate. **624.5(h)(3)** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)

10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies;

			624.5(k)(1)-(3): Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning

	to recommendations were implemented as reported.		any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect

			individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3**) 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified

			and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."

10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3):** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address	Met/Not Met/NA	**625.4(b)(2)(i-ii)**

	recommendations resulting from the investigation findings and incident review.		When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
11-1	The person has the resources to obtain possessions and supplies necessary for comfortable daily living.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-2	The individual is living as independently as able in the home/living environment they choose.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-3	The person is maintaining/improving and/or developing meaningful relationship(s).	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-4	The person is employed, doing volunteer work or participating in other integrated meaningful activities, per their desires/life goals.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.

11-5	The person is maintaining their desired role in their community.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-6	The individual is living safely/receiving supports to live safely in their home/living environment, according to informed choices and responsible consideration.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-7	The person lives safely in their community per their informed choices.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-8	The person is satisfied with the supports they receive intended to achieve their outcomes.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-9	The person's service(s) in total, contribute to advancing toward or achieving their specified goals and personal outcomes.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**636-1.2(a)(1)-(2) :** (1) The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met	**636-1.2(b)(2)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: scheduling with the individual at times and locations of convenience to the individual.
1-5	The individual is supported to direct the planning process to	Met/Not Met	**636-1.2(b)(1)** A person-centered planning process is required for developing the person-

	the maximum extent possible and desired.		centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**636-1.2(b)(5)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (5) developing strategies that address conflicts or disagreements in the process, including clear conflict of interest guidelines for individuals, and communicating such strategies to the individual who is receiving services as appropriate.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(a)(2**) A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences. **636-1.2(b)(1) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions
1-8	The individual's service planning includes consideration of natural supports as well as paid	Met/Not Met	**636-1.3(b)(4)** The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (4) the necessary and appropriate services and supports (paid and unpaid)

	supports.		that are based on the individual's preferences and needs (as identified through an assessment of functional and health-related needs) and that will assist the individual to achieve his or her identified goals.
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **ADM 2015-07:** ADM2015-07, pg. 7: ...The service provider must develop a Pathway to Employment Career/Vocational plan for each individual receiving the service. The career/vocational plan must identify and focus on the individual's career/vocational and employment goals, employment needs, talents and natural supports. Pg. 9: The Pathway to Employment Service Delivery Plan developed by the agency providing Pathway to Employment services must conform to the Habilitation Plan requirements found in Administrative Memorandum #2012-01. **ADM 2012-01**: ADM 2012-01 The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.

1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**ADM 2012-01:** The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ...For all other habilitation services...safeguards must be included in the Habilitation Plan or the plan must reference other documentation that specifies the safeguards. Information on the safeguards must be readily available to the habilitation service provider staff. **636-1.3(b)(8)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed; and
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.

1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**ADM 2012-01:** Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or his/her advocate.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	636-1.2(b)(4) - A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**ADM 2015-07 Service Documentation for Pathway to E** : Service Documentation for Pathway to Employment Service...In addition to the chart and monthly summary ... the agency providing Pathway to Employment services must maintain the following documentation: • A copy of the individual's ISP, developed by the individual's Medicaid Service Coordinator (MSC) or Plan of Care Support Services (PCSS) Service Coordinator.... **635-10.4(h)(2)(i) :** To receive the pathway to employment service, the following criteria must be met: the individual must express an interest in competitive employment or self employment. Competitive employment or self employment must be identified as a goal in the individual's individualized service plan (ISP);

2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :**.. If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. **635-10.4(h)(5) :** Pathway to employment service delivery plan. The service provider shall develop an individual-specific pathway to employment service delivery plan that guides the delivery of the service. **635-10.4(h)(6) :** Pathway to employment career/vocational plan. The service provider shall develop a pathway to employment career/vocational plan for each individual receiving the service.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2015-07;** The Pathway to Employment Service Delivery Plan developed by the agency providing Pathway to Employment services must conform to the Habilitation Plan requirements found in Administrative Memorandum #2012-01. **635-10.4(h)(6)(iii) :** Unless OPWDD authorizes an extension in accordance with section 635-10.5(ad)(5) of this Subpart that specifies a later timeframe for the completion of the plan, the pathway to employment provider shall develop the career/vocational plan no later than 12 months after the date the individual started receiving the service, or the date as of which the individual received 278 hours of the service, whichever occurs first. The pathway to employment provider shall give the career/vocational plan to the individual upon completion of the service.

			ADM 2012-01 : Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: an ISP review date, or the date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**635-10.4(h)(5)(i)-(ii) :** Pathway to employment service delivery plan. The service provider shall develop an individual-specific pathway to employment service delivery plan that guides the delivery of the service. Such service delivery plan shall: (i) list the individual's objectives and the relevant allowable activities that are necessary to achieve the individual's career/vocational and employment goals and to prepare the individual to receive supported employment services provided under this Subpart or under another State or Federal program; and (ii) outline the responsibilities of the individual and the service provider necessary to facilitate the successful delivery of the service and the achievement of the individual's career/vocational and employment goals. **635-10.4(h)(6)(i)-(ii)** : Pathway to employment career/vocational plan. The service provider shall develop a pathway to employment career/vocational plan for each individual receiving the service. (i) The career/vocational plan shall: (a) identify and focus on the individual's career/vocational and employment goals, employment needs, talents, and natural supports; and (b) serve as the individual's detailed career/vocational plan for guiding his or her employment supports. (ii) The pathway to employment provider must complete the career/vocational plan in the form and format specified by OPWDD to include interviews, action steps, career development activities, community-based volunteer experiences, work experiences, and recommendations for future employment related services. **ADM 2015-07:** The Pathway to Employment Service Delivery Plan developed by the agency providing Pathway to Employment services must conform to the Habilitation Plan requirements found in Administrative Memorandum #2012-01. **ADM 2012-10 Habilitation Plan Requirements: pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying

			information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. ... c. Exploration of new experiences is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All

			habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ... **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(h) :** Pathway to employment is a person-centered, comprehensive career/vocational employment planning and support service that provides assistance for individuals to obtain, maintain, or advance in competitive integrated employment or self-employment. This service combines an individualized career/vocational planning process that identifies the individual's support needs, with the provision of services that will strengthen the skills needed to obtain, maintain, or advance in competitive integrated employment or self-employment. It engages individuals in identifying a career/vocational direction, provides instruction and training in pre-employment skills, and develops a path for achieving self-employment or competitive integrated employment at or above the State or Federal minimum wage. ADM 2015-07 The Pathway to Employment service involves both the provision of direct and indirect services. 1. Direct service provision consists of activities involving interaction with the individual ... 2. Indirect service provision consists of activities that take place on behalf of the individual, but do not involve interaction with the individual... **633.4(a)(4)(viii)-(ix):** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;

2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**636-1.2(a)(3)(ii):** The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii):** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**ADM 2015-07: Service Documentation:** Medicaid rules require that service documentation is contemporaneous with the service provision.... Checklist and Monthly Summary: For each service session, a provider must document the direct and indirect Pathway to Employment services delivered by using a checklist prescribed or approved by OPWDD. A monthly summary is also required. The monthly summary must summarize the implementation of the individual's Pathway to Employment Service Delivery Plan during that month and address the individual's response to services provided along with any issues or concerns. The combination of the checklist and summary note must include all the service documentation elements listed above. **635-10.5(ad)(8)(i)-(iii) :** (i) The service provider shall maintain documentation that the individual receiving pathway to employment services has received the services in accordance with the individual's ISP and pathway to employment service delivery plan (see section 635-10.4[h][5] of this Subpart). (ii) For each continuous indirect service provision period/session, the service provider shall document the service start time and the service stop time, the ratio of individuals to staff at the time of the indirect service provision and the provision of all allowable activities that were delivered in accordance with the individual's pathway to employment service delivery plan. (iii) For each continuous direct service provision period/session, the service provider shall document the service start time and the service stop time, the ratio of individuals to staff at the time of the direct service provision and the provision of at least one allowable activity that was delivered in accordance with the individual's pathway to employment service delivery plan.
2-8	The person is participating in activities in the most natural	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

	context.		
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix)** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers.

			635-99.1(bl) : If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives.....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2i-1	The individual receives pathway to employment services individually or simultaneously in a group of	Met/Not Met	**635-10.4(h)(3) :** The number of individuals receiving pathway to employment services simultaneously from a service provider staff shall be limited to no more than four individuals, with the exception of job readiness training which shall be

	no more than 4 individuals.		limited to no more than 10 individuals.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii)** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-4	The individual is informed of their HCBS rights.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5)** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3)** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

	anonymous complaints if desired.		
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs..	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii)** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4)** OMRDD shall verify that staff are aware of the rights of persons in the facility.
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community**.**	Met/Not Met	**441.301 (C)(4)(i)** : The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**ADM 2012-01 – Habilitation Plan Requirements : Safeguards**. The safeguards delineated in the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight

			must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation; Day Habilitation (in certified day habilitation sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY.
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x);** : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01 Habilitation Plan Requirements: Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-3	The individual is provided	Met/Not Met	**633.4(a)(4)(viii)-(ix) :**

	supervision per his/her written plan and as needed.		No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01 Habilitation Plan Requirements: Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2012-01 Habilitation Plan Requirements: Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the

			person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **ADM #2012-04 OPWDD Choking Prevention Initiative:** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified

			applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **ADM 2012-01 Habilitation Plan Requirements: Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
8b-1	A medical assessment which identifies the individual's health care needs has been completed by a physician, PA, NP, or RN.	Met/Not Met	**ADM 2015-03: Page 4:** With respect to each new individual served by an approved provider, the approved provider, in collaboration with an RN employed by or under contract with the approved provider, shall review the individual's nursing needs, if any. If the RN determines that the individual requires nursing services, the RN shall complete a comprehensive assessment of the individual to determine whether nursing tasks, in whole or in part, can be delegated to DSPs with adequate training and nursing supervision. The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences; (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional; and (4) a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's

			condition warrants.
8b-2	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met	**ADM 2015-03: Pages 5-6:** The RN shall develop an individualized plan of nursing services based on the comprehensive nursing assessment of the individual, which identifies the nursing services to be provided to the individual, including delegated nursing tasks. An RN who delegates the performance of nursing tasks shall note in the individualized plan of nursing services a description of the nursing task, the name of the DSP(s) to whom the task is delegated, the date of delegation, the RN who will initially be assigned to supervise the DSP(s), and the RN's signature. The RN may include specific recommendations relating to the RN supervision of the delegated tasks. The RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. A delegating RN shall provide written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications to the qualified DSPs to whom the nursing task is delegated. An RN shall document in the plan of nursing services the delegation of nursing tasks to qualified DSPs as well as any changes in or termination of nursing tasks. The RN shall provide the DSP with written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 8 The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the individual's condition. The PONS shall identify the RN(s) who delegated each nursing task and the nursing tasks that were delegated.
8b-3	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**ADM 2015-03 Page 6:** An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 9: The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.

8b-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**ADM 2015-03 Page 5:** . It shall be the responsibility of the RN to determine, using professional nursing judgment, whether any and which nursing tasks can be delegated to DSPs and which DSPs will be authorized and trained to perform the delegated tasks. The RN shall exercise professional judgment as to when delegation is unsafe and/or not in the individual's best interest...Page 6: ...An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities... Page 6-7: ...The amount and type of nursing supervision required will be determined by the RN responsible for supervising the task or activity, and will depend upon:the complexity of the task; the skill, experience and training of the DSP; and the health conditions and health status of the individual being served.... Page 7: ...The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications... Page 8:... The frequency of visits to sites where DSPs provide nursing tasks shall be at the discretion of the RN responsible for supervision but in no case shall visits occur less frequently than once during the month in which such nursing tasks are delivered.... Page 9: ...The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.
8b-5	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8b-6	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**ADM 2015-03: Page 4:** An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants. Page 5: The RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. Page 8: The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the individual's condition.
8c-1	The individual's current medications are correctly	Met/Not Met	**ADM 2015-03 : Page 4**: The comprehensive nursing assessment must include the following

	documented as prescribed when support for administration is needed/provided.		information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8:The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii). **ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8: ...The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii).
8c-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences;
8c-3	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA	**ADM 2015-03 : Page 7:** .. The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications.
8c-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**ADM 2015-03 : Page 8:** The approved provider shall ensure that all supervising RNs (including supervising RNs working during off-hours or on-call), will be immediately notified of changes in medical orders for an individual and/or of changes in an individual's health status. This notification may be provided by the DSP or by other staff working with the individual at the time a change occurs (e.g., by

			the DSP who accompanied an individual to a medical appointment that resulted in a new medical order; an individual becomes ill or injured while under the care of the assigned DSP or other staff member, etc.)
8c-5	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (4) a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2) The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)

			624.5(g)(4) If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3)** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must

			make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee.

			624.5(i)(2)(i)-(ii) When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are

			not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been

			harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3)** 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)

10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter

			related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2d-1	There is a written summary of the specific Community Transition expenses paid on behalf of the individual by the FI, including the date and cost of each purchase or payment.	Met/Not Met	**635-10.5(ae)(2) :** CTS is administered by the FI services provider. The FI services provider must: (i) retain receipts to support allowable expenditures; and (ii) bill for allowable expenditures in $10 increments. **ADM #2015-02 Service Documentation for Community T :** "Medicaid rules require that service documentation be contemporaneous with the service provision. Required service documentation elements are: …4. A summary of expenses paid on behalf of the individual along with supporting receipts/documents. The documentation must include a list of expenses paid on behalf of the individual, the date it was paid for or purchased (e.g., the day the deposit was paid or the day the furniture was purchased), and the amount paid. Note, the date an expense included in the service was paid by the FI provider can be prior to the date the individual is enrolled in the HCBS waiver and prior to the date the individual moves into the non-certified location."
2d-2	There is evidence that the person is responsible for his/her own living expenses in the home.	Met/Not Met	**Regulatory Reference: 635-10.4(i)(1) :** CTS is a one-time service that funds non-recurring residential set-up expenses for an individual who is moving: (i) from: (a) an OPWDD operated or certified residential setting, including a family care home; (b) a State funded private residential school, or State operated residential school; or (c) a Medicaid funded institutional placement; (ii) to a non-certified community living arrangement within New York State where the individual will be responsible for his or her own living expenses. Note: CTS is not available to an individual who is moving into any type of State certified or State licensed residential setting.
10a-1	Events involving the individual that meet the definition of reportable	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or

	incident or notable occurrence have been reported.		situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps

	immediately.		to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3)** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16)

			624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency

			must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the

			Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps

	needed was provided to the individual.		to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16)

			624.5(h)(3) 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity

			(e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2o-1	FET is identified in the individual's ISP under Waiver services, with effective date, frequency, duration, and valued outcomes.	Met/Not Met	**635-99.1(bl) :** Plan, individualized service (ISP). The written document that is developed by an individual's chosen service coordinator, the individual and/or the parties chosen by the individual, often known as the person's circle of support, that describes the services, activities and supports, regardless of the funding source, and that constitutes the person's individualized service environment. This document may be known by a different name but it must comprise the elements described in this definition. The goal of the ISP is to ensure the provision of those things necessary to sustain the person in his/her chosen environment and preclude movement to an ICF/DD. These services, activities and supports, identified in the ISP, are to reflect the preferences, capabilities, and capacities of the person and emphasize the development of self-determination (i.e., making personal choices), independence, productivity, and integration into the community. The ISP identified by personal descriptive and identification information, contains at a minimum: … (2) an identification of each service, service provider (including type), the amount, frequency, and duration of each service, and effective dates for service delivery; **635-10.5(aa)(3)(x) :** Reimbursement for family education and training shall be contingent upon the services being delivered as specified in the person's individualized service plan.
2o-2	Documentation evidences that training was provided to the individual's family regarding the nature and impact of the person's disability and/or the service options**.**	Met/Not Met	**635-10.5(aa)(1)(iii) :** Family education and training services - The training provided by qualified personnel to the family of those who are under the age of 18, and who are enrolled HCBS waiver participants. Such training focuses on enhancing the family's decision making capacity through providing orientations regarding the nature and impact of the person's mental retardation or developmental disability upon the person and the family, and by educating the family regarding service alternatives (e.g., learning about the services in their community, dealing with transition to adult services, future planning and placement planning). The goal of any presentation shall not be to sell any product or service.

2o-3	Training provided to the individual's family was at least two (2) hours duration and provided by someone other than the person's MSC.	Met/Not Met	**635-10.5(aa)(3)(iii) :** Method of reimbursement and payment. (iii) A unit of service for a training session shall be a minimum of two hours. No more than two units of service per eligible person shall be provided on an annual basis to each family. **635-10.5(aa)(1)(iv) :** Qualified personnel - Those parties who are knowledgeable in the presentation topic (such as, but not limited to, self-advocacy, self-determination, family life with a child with disabilities) and who conduct the family education and training session. Such parties may include qualified service coordinators and clinicians with appropriate licensure/certification, or other recognized credentials appropriate to their discipline. It may also include those with expertise in such fields as law and/or finances and how the topics (consistent with the definition of family education and training services), pertain to persons with disabilities and their families.

Standard No.	Standard Text	Decision	Regulatory References
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**636-1.2(b)(4) -** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**ADM 2013-03 :** 'For each continuous period of service delivery (or “session”), the provider must document the delivery of at least one services(s)... This includes direct, face-to-face service time and other indirect time when IB Services staff is delivering the IB Service but the individual is not present." Staff members do not need to perform a face-to-face service during every service delivery, but must provide at least one of the services as described in the “Reimbursable Services” section and appropriately document the service delivery. Staff must complete a narrative note for each day of service. ...the following documentation must be maintained. A daily description of all of the services provided for the day... These services are individualized services based on the individual’s BSP... The individual’s response to the service. (Note: The response to service does not have to be recorded for every service session as long as the individual response is summarized at least monthly on one of the narrative notes).
2-11	The person’s services are delivered by competent staff/supports that	Met/Not Met	**633.4(a)(4)(ix)** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services

	understand their role, the service/service plan and the person's needs, preferences and goals related to the service.		adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2l-1	A functional behavioral assessment meeting content requirements is completed prior to development of the individual's behavior support plan.	Met/Not Met	**ADM #2013-03 :** The IB Services clinician must develop the FBA in accordance with the requirements of paragraph 63316(d)(1) as follows: (d) Functional behavioral assessment. (1) Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior;(iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s);(vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings,

			activities, people, and times of day.
2l-2	The individual has a behavior support plan (BSP) which meets content requirements.	Met/Not Met	**ADM #2013-03 :** The IB Services clinician must develop the BSP in accordance with the requirements of paragraphs 633.16(e)(2) and (e)(3) except as noted otherwise, as follows: (e) Behavior support plan. (2) All behavior support plans must: (i) be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; (ii) be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan; (iii) be developed on the basis of a functional behavioral assessment of the target behavior(s); (iv) include a concrete, specific description of the challenging behavior(s) targeted for intervention; (v) include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports; (vi) include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success; (vii) include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others; (viii) provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated; and (ix) include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors. For the purposes of IB Services, however, the schedule of reviews shall be no less frequently than every 60 days.
2l-3	There is a written, signed agreement between service provider and the person regarding nature, duration and scope of IB	Met/Not Met	**ADM #2013-03 :** Coordinating and Training of the BSP; There must be an agreement between providers and individuals and/or the Parent/Caregiver or family care provider regarding the nature, duration and scope of IB Services to be provided. The agreement must be signed by the

	services to be provided.		provider and individual or Parent/Caregiver or family care provider. (pg. 6 of 14)
2l-4	Written informed consent is obtained prior to implementation of the BSP.	Met/Not Met	**ADM #2013-03 :** Prior to implementation of a BSP, written informed consent must be obtained as specified in subdivision 633.16(g). Note that if IB services are provided on or after October 1, 2013 which implement a BSP developed prior to October 1, 2013, written informed consent must be obtained for that BSP. The requirement for written informed consent is not limited to plans containing restrictive/intrusive interventions. The consent-giver shall have the right to revoke approval of the BSP at any time, and request that a revised BSP be developed in accordance with the requirements of this ADM. The referenced 633.16(g) states: Informed consent. (1) Written informed consent shall be obtained in accordance with this subdivision. (i) Written informed consent is required prior to implementation any time that a restrictive/intrusive intervention is included in a behavior support plan to modify or control challenging behavior. However, if written informed consent cannot be obtained within a reasonable period of time prior to the initiation or continuance of a plan, verbal consent may be accepted only for the period of time before written informed consent can be reasonably obtained. Verbal consent must be witnessed by two members of the staff, and documented in the person's record. This verbal consent is valid for a period of up to 45 days and may not be renewed. (ii) Written informed consent is required prior to implementation of a physician's order for planned use of medication to treat a co-occurring diagnosed psychiatric disorder (see subparagraph [j][5][ii] of this section). However, if written informed consent cannot be obtained within a reasonable period of time prior to the initiation or continuance of a medication, verbal consent may be accepted only for the period of time before written informed consent can be reasonably obtained. Verbal consent must be witnessed by two members of the staff, and documented in the person's record. This verbal consent is valid for a period of up to 45 days and may not be renewed. (iii) Written informed consent is also required for short-term use of medication when there is no behavior support plan. If it is necessary for the medication to be administered before written informed consent can be reasonably obtained, verbal consent may be accepted for only the period of time

			before written informed consent can be reasonably obtained, but no longer than 45 days. Verbal consent must be witnessed by two members of the staff and documented in the person's record. (2) Written informed consent shall be documented in a person's clinical record. (3) Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year. (4) The agency shall ensure, in every case, that the person (or surrogate consent giver) be personally afforded an appropriate, clear explanation of the proposed plan. (5) When an emergency exists, restrictive/intrusive interventions may be applied to a person of any age without seeking informed consent if such use is permitted in accordance with this section; and – o 633.16(g)(6) - Hierarchy of parties appropriate to provide consent o 633.16(g)(7) – Determination of an individual's capacity to give informed consent o 633.16(g)(8) – Informed Consent Committee
2l-5	Upon conclusion of IB services, an evaluation of the service outcomes in increasing skill development and decreasing challenging behaviors must be completed.	Met/Not Met/NA	**ADM #2013-03 :** Evaluation; At the conclusion of IB Services, the agency must request that the individual or Parent/Caregiver or family care provider completes an Individual & Family Satisfaction Survey. The IB Services provider must also complete the CAANS-DD tool as a post-treatment assessment. Service outcomes must also be evaluated by the agency including increases in skill development for the individual and/or their Parent/Caregiver or family care provider or direct services professional(s) and decreases in challenging behaviors that precipitated the need for IB Services. Agencies may choose to include additional surveys into their evaluation of services for quality improvement. These evaluation measures will be reviewed by OPWDD for quality purposes on a random basis to ensure the IB Services delivered by the agency are demonstrating efficacy and meeting the intent of the service to reduce challenging behaviors and enable individuals to remain in the most community integrated residential option possible.
2l-6	The BSP describes the individual's behavior justifying the interventions and/or limitation(s).	Met/Not Met	**ADM #2013-03 :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph 633.16(c)(9)) shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a

			limitation on a person's rights must include the following additional components: (a) a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
2l-7	Previous strategies that have been tried and deemed ineffective are described with explanation regarding why use of less restrictive alternative would be insufficient/inappropriate.	Met/Not Met	**ADM #2013-03 :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph 633.16(c)(9)) shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: (b) a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
2l-8	The plan describes specific use of interventions as a hierarchy starting with most positive/least intrusive to most restrictive.	Met/Not Met	**ADM #2013-03 :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph 633.16(c)(9)) shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: (c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
2l-9	Interventions used/in the plan are only those permissible in IB services.	Met/Not Met	**ADM #2013-03 :** A BSP incorporating the use of a restrictive physical intervention, or exclusionary time-out (the placement of a person alone in a room from which his or her normal ability to leave is prevented by a staff's or care provider's direct and continuous physical action, or placement of a person in a secured room or area from which he or she cannot leave at will), is prohibited in IB Services. However, a BSP incorporating restrictive physical interventions to be implemented by Hourly Community Habilitation staff may be permitted if specifically authorized

			by OPWDD. Parents/Caregivers, Community Habilitation staff, and Family Care providers responsible for the support and supervision of a person whose BSP includes the use of a restrictive/intrusive intervention as defined in paragraph 633.16(b)(24), shall also be trained in the particular restrictive/intrusive intervention(s) to be utilized with a specific person, prior to their use. Community Habilitation staff and Family Care providers responsible for the support and supervision of a person whose BSP includes any use of physical interventions must have training consistent with the requirements of 633.16(i) and with the standards and procedures of the OPWDD training curriculum (e.g. SCIP-R). Parents/Caregivers may only be taught those specific protective interventions identified in the BSP created for the person for whom they provide care, as they cannot be certified at any level of the OPWDD training curriculum. Parents/Caregivers and Family Care providers must not be trained in restrictive physical interventions or use of exclusionary time-out as IB Services BSPs will not incorporate use of these interventions by Parents/Caregivers or Family Care Providers.
2l-10	There is a plan to fade/minimize/eliminate use of restrictive/limiting interventions.	Met/Not Met	**ADM #2013-03 :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph 633.16(c)(9)) shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: (e) a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
2l-11	The individual's BSP describes documentation necessary for implementation of each intervention and mandated reporting if applicable.	Met/Not Met	**ADM #2013-03:** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph 633.16(c)(9)) shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional

			components: (f) a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
2l-12	The BSP provides the schedule to review and analyze the use of restrictive/intrusive/limiting interventions, no less than every 60 days.	Met/Not Met	**ADM #2013-03 :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph 633.16(c)(9)) shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: (g) a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed. For the purposes of IB Services, however, the schedule of reviews shall be no less frequently than every 60 days.
2l-13	The review results are documented.	Met/Not Met	**ADM #2013-03 :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph 633.16(c)(9)) shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: (g) a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed. For the purposes of IB Services, however, the schedule of reviews shall be no less frequently than every 60 days.
2l-14	There is documentation that the individual is visually examined for injury and assessed for pain/discomfort following	Met/Not Met	**ADM #2013-03:** Immediately after the use of any physical intervention or emergency intervention by Community Habilitation staff or the family care provider, they shall visually examine the person for possible injury, ask the individual if they experience pain or discomfort, and document the

	physical interventions.		findings of such examination. Community Habilitation staff should report the results of their examination to their supervisor as soon as reasonably possible, and have the Parents/Caregivers co-sign the documentation completed by staff indicating their agreement with the results of the examination. The family care provider shall document the results of the examination and report the occurrence to their agency family care liaison as soon as reasonably possible. If an injury is suspected, appropriate medical care shall be provided or arranged for by staff or the family care provider. Any injury that meets the criteria in 14 NYCRR Section 624.4 (generally that the injury requires treatment more than first aid) must be reported in accordance with Part 624.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.

10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD

			or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3)** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law

			enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring

	resulting from the investigation findings and incident review.		agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant

			documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from

			harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3**) 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)**

			624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** (1)Within 10 days of the IRC review of a completed investigation, the

			agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-1	The individual was provided written notice of their right to a person-centered planning process.	Met/Not Met	**636-1.5(a)(1)-(2)** The service coordinator must give notice of the individual's right to a person-centered planning process in accordance with section 636-1.2 of this Subpart and to a person-centered plan in accordance with section 636-1.3 of this Subpart, and of the right to object to services pursuant to section 633.12 of this Title, to the individual and the person upon whom decision-making authority is conferred by State law (see section 636-1.2[a][1] of this Subpart), if any, in the following manner: (1) for individuals who do not have an ISP in place on November 1, 2015, the service coordinator must give written notice prior to the initiation of the person-centered planning process and development of the plan; or (2) for individuals who have an ISP in place on November 1, 2015, the service coordinator must give written notice at the time of the individual's next ISP review.
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**2011 MSC Vendor Manual pg.25** Service coordinators focus their planning for each individual on the needs and desires of the person with developmental disabilities, drawing input from the important people in the individual's life. Family members, friends, agency staff, and others who spend time with the person, along with the service coordinator, come together to form a "circle of support" to assist the person with developmental disabilities. Members of this circle communicate regularly together and with the individual with developmental disabilities to discuss and plan the best way to meet the individual's needs and fulfill his or her personal goals. Together, the circle of support and the individual with developmental disabilities work with the service coordinator to document a life plan for the individual.
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**2011 MSC Vendor Manual pg.25** Service coordinators focus their planning for each individual on the needs and desires of the person with developmental disabilities, drawing input from the important people in the individual's life. Family members, friends, agency staff, and others who spend time with the person, along with the service coordinator, come together to form a "circle of support" to assist the person

			with developmental disabilities. Members of this circle communicate regularly together and with the individual with developmental disabilities to discuss and plan the best way to meet the individual's needs and fulfill his or her personal goals. Together, the circle of support and the individual with developmental disabilities work with the service coordinator to document a life plan for the individual.
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met	**636-1.2(b)(2)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: scheduling with the individual at times and locations of convenience to the individual.
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met	**636-1.2(b)(1)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**636-1.2(b)(5)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (5) developing strategies that address conflicts or disagreements in the process, including clear conflict of interest guidelines for individuals, and

			communicating such strategies to the individual who is receiving services as appropriate.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(a)(2)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-8	The individual's service planning includes consideration of natural supports as well as paid supports.	Met/Not Met	**636-1.3(b)(4)** The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (4) the necessary and appropriate services and supports (paid and unpaid) that are based on the individual's preferences and needs (as identified through an assessment of functional and health-related needs) and that will assist the individual to achieve his or her identified goals.
1-9	The individual has made informed choice of residential setting and alternative options considered by the individual are recorded in his/her written plan.	Met/Not Met	**636-1.3(b)(7)** The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (7) if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: the setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated

			settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life); **441.301(C)(2)(i)** Commensurate with the level of need of the individual, and the scope of services and supports available under the state's 1915(c) HCBS waiver, the written plan must: reflect that the setting in which the individual resides is chosen by the individual. The state must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving services Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
1-10	Assessments needed by the individual or required by program regulation were completed to inform the individual's plan development.	Met/Not Met	**636-1.3(b)(1)-(4) b)** The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (1) the individual's goals and desired outcomes; (2) the individual's strengths and preferences; (3) the individual's clinical and support needs as identified through an assessment of functional and health-related needs; (4) the necessary and appropriate services and supports (paid and unpaid) that are based on the individual's preferences and needs (as identified through an assessment of functional and health-related needs) and that will assist the individual to achieve his or her identified goals;
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports

			to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **636-1.3(b)(1)** b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (1) the individual's goals and desired outcomes;
1-12	The individual's strengths and preferences are documented in the service plan.	Met/Not Met	**636-1.3(b)(2)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ….(2) the individual's strengths and preferences;
1-13	The individual's identified needs for clinical and/or functional support are documented in the service plan.	Met/Not Met	**636-1.3(b)(3)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ...(3) the individual's clinical and support needs as identified through an assessment of functional and health-related needs;
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and

	supports needed are identified in the person centered plan.		receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-16	The individual's goals and priorities regarding meaningful relationships are identified in the person centered plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-18	The individual's goals and priorities related to health concerns and medical needs are identified in the person centered plan.	Met/Not Met	**636-1.3(b)(3)-(4)** "(b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (3) the individual's clinical and support needs as identified through an assessment of functional and health-related needs; (4) the necessary and appropriate services and supports (paid and unpaid) that are based on the individual's preferences and needs (as identified through an assessment of functional and health-related needs) and that will assist the individual to achieve his or her identified goals;"

			ADM 2010-04 Addendum-ISP instructions ISP Instructions revised 12/10/10 Pg. 2: State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. … In addition, the following areas should be considered: chronic medical conditions, allergies, ability to self-administer medications, special dietary needs, ability to manage finances, ability to give consent, level of supervision required in the home and community, ability to travel independently, and safety awareness.
1-19	The individual's known food, medication, and/or environmental allergies and the corresponding precautions are identified in the person centered plan.	Met/Not Met/NA	**ADM 2010-04 Addendum-ISP instructions** ISP Instructions revised 12/10/10 Pg. 2: State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. … In addition, the following areas should be considered: chronic medical conditions, allergies, ability to self-administer medications, special dietary needs, ability to manage finances, ability to give consent, level of supervision required in the home and community, ability to travel independently, and safety awareness.
1-20	Individualized considerations and safeguards regarding fire safety are identified in the person centered service plan.	Met/Not Met	**ADM 2010-04 Addendum-ISP instructions** State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. … Fire safety must be discussed in the safeguard section of all ISPs unless it is discussed in the attached Individual Plan for Protective Oversight for people who live in IRAs. The service coordinator must ensure that there is a current and reasonable assessment of the person's specific needs relative to his/her capacity to evacuate the home in a timely manner in the event of a fire emergency. If the person lives in a non-certified site, the service coordinator must ensure that actions and recommendations relative to addressing a person's assessed fire safety needs are specified in the ISP.
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes

	when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.		
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**636-1.3(b)(8)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed; and
1-23	The individual's written plan documents each specific service and support to be provided to address his/her needs and achieve his/her identified desired outcomes, short term and long term goals.	Met/Not Met	**ADM 2010-04 Addendum-ISP instructions** The ISP identifies the waiver services as well as other services and supports that a person needs in order to live successfully in the community, and therefore, avoid institutionalization. Each person enrolled in the HCBS Waiver must have an ISP that includes a listing of all of the person's current authorized HCBS waiver services. The ISP should also reflect the full range of the person's service needs including State Medicaid Plan Services, non-Medicaid services, informal supports, and other community resources.
1-24	The individual's written plan identifies the amount, frequency and duration of each HCBS waiver service he/she receives, as applicable.	Met/Not Met/NA	**ADM 2010-04 Addendum-ISP instructions** Required Information for HCBS Waiver Services: Name of the waiver service provider or agency; Type of waiver service (e.g., residential habilitation, supported employment, consolidated supports and services, respite); Frequency of the support or service. The frequency of an HCBS Waiver Service must correspond to the billing unit of service (e.g., day, month, hour, or one time expenditure). See the Frequency of HCBS Waiver Services Appendix at the end of these instructions; Duration of the support or service. This means for how long the assistance is expected to last. If the service does not have an expected end date, write "ongoing."; Effective date of the support or service. This is the date the current provider first provided the service. Waiver services must have the exact and correct effective date

			and this date must be on or before the date the provider began delivering the service. A waiver service provider's billing will be jeopardized if the date the provider billed for the service is prior to the effective date on the ISP. For a one time service or purchase, such as environmental modifications and adaptive devices, the anticipated purchase/completion date is used as the effective date. Note: The above information (name and type of provider, frequency, duration, and effective date) must be accurate for HCBS Waiver Services since the ISP substantiates the payment of these services.
1-25	The person-centered plan identifies the provider(s) of the individual's supports and services.	Met/Not Met	**636-1.3(b)(6)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (6) the providers of those services and supports specified in paragraph (4) and (5) of this subdivision; ...
1-26	The person-centered plan evidences that informed choice is made regarding self-direction; and if chosen, identifies the services that the individual elects to self-direct.	Met/Not Met	**636-1.3(b)(5)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: … (5) the services that the individual elects to self-direct;
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual. **636-1.3(c)** The service coordinator must develop the person-centered service plan in a way that is understandable to the individual and parties chosen by the

			individual. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to the individual, to the extent possible, and parties chosen by the individual.
1-29	The person-centered service plan is signed by the individual as indicator of written informed consent or approval.	Met/Not Met	**636-1.3(d)** The plan must be finalized and agreed to with the individual's written informed consent and signed by the provider(s) responsible for implementing the person-centered service plan.
1-30	The individual's person centered service plan is agreed to by services providers and/or members of the team as required.	Met/Not Met	**636-1.3(d)** The plan must be finalized and agreed to with the individual's written informed consent and signed by the provider(s) responsible for implementing the person-centered service plan.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**636-1.3(e)** The service coordinator must distribute the person-centered service plan to the individual and parties involved in the implementation of the plan.
1-33	The person-centered service plan includes all relevant and applicable attachments.	Met/Not Met	**635.99.1(bk) -** "… The ISP shall include or contain as attachments the following: (1) all relevant habilitation plans (for individuals receiving habilitation services); (2) all relevant plans or documents pursuant to section 636-1.4(c) and (d) of this Title that support modification to an individual's rights specified in section 636-1.4(b)(1)-(4) of this Title; and (3) the individual plan for protective oversight for residents of an individualized residential alternative (IRA) (see section 686.16[a][6] of this Title). " **ADM 2010-04 –** The OPWDD ISP and required attachments (e.g., Habilitation Plans) is the "plan of care" (service plan) for purposes of meeting the requirements of the HCBS Waiver.

			ADM 2010-04 Addendum-ISP instructions - The following are required attachments to the ISP if the person is receiving the service: Any Waiver Habilitation Service Plans including residential habilitation, day habilitation, prevocational services, supported employment plan, community habilitation, consolidated supports and services; Individual Plan for Protective Oversight if the person lives in an IRA; Medicaid Service Coordination Activity Plan (if the person has requested one or is a Willowbrook Class Member); Clinic treatment plan recommendations for long-term therapies provided by Article 16 Clinics.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	636-1.2(b)(4) - A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
1-35	The Individual's written person centered service plan is reviewed with regular required frequency .	Met/Not Met	**636-1.3(f)(1) - (f)** The individual, parties chosen by the individual, the service provider, and service coordinator must review the person-centered service plan described in subdivision (b) of this section and subdivisions 636-1.4(c) and (d) of this Subpart, and the service coordinator must revise such plan if necessary, as follows: (1) at least semi-annually;
1-36	Review of the plan includes the individual's status/progress towards the achievement of his/her goals, priorities and outcomes.	Met/Not Met	**636-1.2(a)(3)(i)-(iii) - 3)** The person-centered planning process requires that: (i) supports and services are based on the individual's interests, preferences, strengths, capacities, and needs; (ii) supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and (iii) the individual is satisfied with activities, supports, and services.

			ADM 2010-04 – The ISP must be reviewed and updated as necessary and required (i.e., at least twice annually). The purpose of ISP reviews is for the Service Coordinator and the person and others involved with the person to assess the ongoing appropriateness and adequacy of the services and supports identified in the ISP and to review that the services are consistent with and responsive to the individual's needs, preferences, informed choices, and valued outcomes. During ISP reviews, Service Coordinators work with individuals to review their valued outcomes and to choose and/or amend valued outcomes as goals and aspirations change through the progression of the person's life.
1-37	The individual's person centered service plan is revised whenever changes are necessary and warranted and/or as directed/preferred by the individual.	Met/Not Met/NA	**636-1.3(f)(1)-(5) - "(f)** The individual, parties chosen by the individual, the service provider, and service coordinator must review the person-centered service plan described in subdivision (b) of this section and subdivisions 636-1.4(c) and (d) of this Subpart, and the service coordinator must revise such plan if necessary, as follows: (1) at least semi-annually; (2) when the capabilities, capacities, or preferences of the individual have changed and warrant a review; (3) at the request of the individual and/or parties chosen by the individual; (4) when it is determined that the existing plan (or portions of the plan) is/are ineffective; and (5) upon reassessment of the individual's functional need."
1-38	Revisions to the individual's written plan are documented in the form and format required.	Met/Not Met/NA	**ADM 2010-04 -** "ISP Reviews and Addendums: ...Only the Service Coordinator's signature is required on the ISP Addendum. A note in the MSC record must indicate the change was discussed with and agreed to by the individual and/or advocate. The completion of an ISP Addendum can be used to meet the review requirement outlined above, either as a face-to-face ISP review or a non-face-to-face ISP review." **ADM 2010-04 Addendum-ISP instructions: -**

			The service coordinator ensures that the ISP is kept current, adapted to the changing outcomes and priorities of the person as growth, temporary setbacks, and accomplishments occur.
1-40	The SC/CM/CC competently assures person centered planning as evidenced by the individual's written plan for services and supports and interview.	Met/Not Met	**636-1.2(a)(3)(i)-(iii) - (3)** The person-centered planning process requires that: (i) supports and services are based on the individual's interests, preferences, strengths, capacities, and needs; (ii) supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and (iii) the individual is satisfied with activities, supports, and services." **636-1.3(a) –** The person-centered service plan is created using the planning process described in section 636-1.2 of this Subpart. The person-centered service plan may also be known as the individualized service plan (ISP, see definition in section 635-99.1 of this Title). **2011 MSC Vendor Manual Pg. 15 –** While the extent of involvement by a service coordinator and the exact tasks he or she undertakes in providing MSC services to each individual will vary, the objectives and focus of every service coordinator in every instance should be the same. Service coordinators must always: Help the person with developmental disabilities make informed choices, Continually focus on the aspirations of the person with developmental disabilities and assist that person to reach his or her personal goals, Take all reasonable steps to ensure the health and safety of the person with developmental disabilities, Promote self-determination and community inclusion, and Make the satisfaction of the person with developmental disabilities a priority.
1-41	CAS findings were reviewed with the individual within 30 days	Met/Not Met	**Quality Indicator –** This is an indicator of quality service planning

2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**2011 MSC Vendor Manual Pg. 45** "The service coordinator is responsible for maintaining a separate record for each person receiving MSC. This record is known as the Service Coordination Record. The Service Coordination Record provides an ongoing written account of the service coordination activities needed by and provided to the person. The Service Coordination Record also contains the documents that verify the person's eligibility for various services. The Service Coordination Record has four main sections, each with minimum required information. Section I: Eligibility/Enrollment Documentation (including the Medicaid Service Coordination Agreement); Section 2: Written Evaluations; Section 3: The Individualized Service Plan (ISP) with Attachments (including the Service Coordination Activity Plan, if applicable); Section 4: Medicaid Service Coordination Notes Additional sections (such as a medical section) and additions to the sections listed above (such as vendor-specific forms) may be added at the discretion of the service coordinator, supervisor, vendor."

2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**2011 Vendor Manual Pg. 26** The service coordinator's most fundamental responsibility is to develop, implement and maintain the ISP—this activity is not static but is a continuous and ongoing process. **ADM 2010-04** The ISP is a readable and usable written personal plan that reflects the informed choices of individuals with developmental disabilities who are enrolled in PCSS or MSC. It summarizes the help a person wants and needs to live a successful life in the community and pursue his or her valued outcomes. The ISP is the blueprint for achieving a person's valued outcomes. It is a flexible information tool used to focus and direct efforts to assist the person with developmental disabilities throughout their lives. The ISP is reviewed at least twice annually with the individual and other persons close to the individual which may include service providers, family members, and others who can help the person to make informed choices and choose and amend valued outcomes when the person's needs, goals and/or aspirations change as life progresses.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2010-04** If an ISP review results in a rewritten ISP, the service coordinator signs the ISP (first) with his or her full signature and date. The service coordinator's signature and date should be within 45 days of the date of the review which resulted in the rewritten ISP.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**2011 MSC Vendor Manual Pg 35:** Service coordinators may comply with the documentation requirements for service coordination notes by completing the Medicaid Service Coordination Notes format. … The Medicaid Service Coordination Note must be completed by the 15th of the month following the month of service. This form must be signed and dated by the service coordinator.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service	Met/Not Met	**633.4(a)(4)(ix)** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely

	plan and the person's needs, preferences and goals related to the service.		and humanely, with full respect for the individual's dignity and personal integrity; **2011 MSC Vendor Manual pg. 24** In order to help a person determine and access necessary and available supports and services, a service coordinator performs person centered activities related to: assessment; service plan development; implementation; maintenance and monitoring; linkages and referrals; monitoring and follow up; advocacy; and record keeping.
2a-1	The individual was provided a choice of service/care manager/coordinator.	Met/Not Met	**2011 Vendor Manual Pg. 22** It is important to remember that the service coordination provider and the service coordinator (to the greatest extent possible) are chosen by the person with developmental disabilities. … **2011 Vendor Manual Pg. 67** All MSC participants have a choice of MSC Vendors, within available options. The selected MSC Vendor or regional office must be identified in the person's ISP. The Service Coordination Agreement explains a person's right to change vendors. The MSC service coordinator must ensure the person with developmental disabilities is aware of his or her right to choose a different vendor.
2a-2	An initial Level of Care determination (LCED) was completed indicating OPWDD determination that the individual is eligible for services (when individuals receive HCBS Waiver Services).	Met/Not Met/NA	**2011 Vendor Manual Pg. 46** The first section of a Service Coordination Record contains the eligibility and enrollment documentation for the individual with developmental disabilities and should include: ... For people enrolled in the HCBS Waiver, the following HCBS Waiver enrollment information/documents should also be included in this section: ... Initial Level of Care Eligibility Determination (LCED) and required documentation supporting the determination, ...
2a-3	The level of care is reevaluated at least annually	Met/Not Met/NA	**2011 Vendor Manual Pg. 37**

	(within 365 days) as evidenced by a current LCED in the SC/CC record.		The service coordinator ensures that there is timely completion of annual LCEDs for all HCBS waiver enrolled individuals. **ADM# 2011-01** Level of Care Redetermination: A qualified person is able to review the information on the form and, if there are no changes that impact the person's level of care, to complete the ICF/MR (sic) Level of Care Eligibility Redetermination section on the same form as the last redetermination. The redetermination must be completed and signed annually, i.e. within 365 days of the previous authorization (i.e. effective) date.
2a-4	The service plan record contains a correctly completed Documentation of Choices form.	Met/Not Met	**2011 Vendor Manual Pg. 46** "The first section of a Service Coordination Record contains the eligibility and enrollment documentation for the individual with developmental disabilities and should include: ...For people enrolled in the HCBS Waiver, the following HCBS Waiver enrollment information/documents should also be included in this section: Waiver Enrollment forms: ... Documentation of Choices..."
2a-5	The Willowbrook class member's Notice of Rights is placed in the SC /CM/CC service record.	Met/Not Met	**2011 Vendor Manual Pg. 46** The first section of a Service Coordination Record contains the eligibility and enrollment documentation for the individual with developmental disabilities and should include: ... Notice of individual rights and responsibilities per Part 633.4. (For Willowbrook Class members, there must be the Notice of Rights for Willowbrook Class members only).
2a-6	The SC/CM/CC advocates/ensures that rights limitations occur only with required protections, justifications and approvals in place.	Met/Not Met/NA	**636-1.4(c)** The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (1) a specific and individualized assessed need underlying the reason for the modification; (2) the positive interventions and supports used prior to any modifications; (3) less intrusive methods of meeting the need that were tried but did not work; (4) a clear description of the condition that is directly proportionate to the specific assessed need; (5) a regular collection and review of data to measure the

			ongoing effectiveness of the modification; (6) established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; (7) an assurance that interventions and supports will cause no harm to the individual; and (8) the informed consent of the individual. **633.4(a)(3)** (3) The rights set forth in this section are intended to establish the living and/or program environment that protects individuals and contributes to providing an environment in keeping with the community at large, to the extent possible, given the degree of the disabilities of those individuals. Rights that are self-initiated or involve privacy or sexuality issues may need to be adapted to meet the need of certain persons with the most severe disabilities and/or persons whose need for protection, safety and health care will justify such adaptation. It is the responsibility of the agency/facility or the sponsoring agency to ensure that rights are not arbitrarily denied. Rights limitations must be documented and must be on an individual basis, for a specific period of time, and for clinical purposes only. (Note: See section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
2a-7	The individual has a signed Service Coordination Agreement, which is reviewed annually.	Met/Not Met	**2011 MSC Vendor Manual pgs. 48-49** "All people enrolled in MSC must have a signed Medicaid Service Coordination Agreement (MSC5-SCA) (Appendix Two). The Medicaid Service Coordination Agreement describes the responsibilities of the MSC service coordinator, the MSC Vendor and the person receiving MSC. ... The Medicaid Service Coordination Agreement should be reviewed annually and this review is documented in the Medicaid Service Coordination Notes. It is recommended that this review occur during the annual face-to-face ISP review meeting. ..."
2a-9	The individual and designees, as applicable are given required contact information.	Met/Not Met	**2011 Vendor Manual Pg31** MSC vendors must provide a 24-hour emergency telephone number to each individual served. The emergency number must be answered by either an

			MSC agency staff person or an answering service who contacts an MSC agency staff person. An answering machine cannot be used unless it provides a forwarding number that is answered by an MSC agency staff person. ... MSC vendors should have a reliable system in place to ensure that each individual has been provided with this number and that this number is reviewed with the person at least annually and their advocates, family members.
2a-10	The individual can reach the service coordinator when needed in a timely manner.	Met/Not Met/NA	**2011 Vendor Manual Pg31** MSC vendors must provide a 24-hour emergency telephone number to each individual served. The emergency number must be answered by either an MSC agency staff person or an answering service who contacts an MSC agency staff person. An answering machine cannot be used unless it provides a forwarding number that is answered by an MSC agency staff person.
2a-11	The SC/CM/CC solicits input from/among members of the person's "circle"/team as part of the review of the person's services and status as needed.	Met/Not Met	**2011 MSC Vendor Manual pgs. 27-28** The service coordinator: Uses a person centered planning process to review the ISP at least twice annually (at least once annually through a face-to-face meeting with the individual and major service providers) and makes any necessary revisions to ensure the ISP is up-to-date and supports and service are consistent with the needs and goals of the person; Works with the person and others as appropriate to assess the person's satisfaction with his or her ISP and the services, supports, valued outcomes/goals therein and related service coordination activities and makes adjustments as necessary; Continuously supports the person with developmental disabilities to make informed choices and achieve his/her valued outcomes; Establishes and maintains an effective communication network with service providers and others involved with the person with developmental disabilities; Keeps up to date with changes, choices, temporary setbacks and accomplishments related to the ISP and incorporates changes to the ISP as needed; and Advocates for the person with developmental disabilities when his or her rights, protections, or health and safety needs and safeguards are not being met.

2a-12	Meetings for the review of the person centered service plan must be face to face as required by the service type.	Met/Not Met	**2011 Vendor Manual Pg. 34** ISP reviews must take place at least twice annually. One of these reviews must be a face-to-face review meeting with the individual and major service providers. The annual face-to-face meeting must occur within 365 days of the prior face-to-face meeting or by the end of the calendar month in which the 365th day occurs.
2a-13	The individual who is a Willowbrook class member has an activity plan.	Met/Not Met	**2011 Vendor Manual Pg. 50** All Willowbrook Class Members must have an MSC Activity Plan. … For Willowbrook Class Members, the Activity Plan must be reviewed and updated at least every six months. New activities that the individual with developmental disabilities would like to occur may be added at any time. This review should be documented in the service coordination notes.
2a-14	The SC/CM/CC notes indicate that the service coordinator/case manager has contact with the individual in the frequency and manner required by service and when needed.	Met/Not Met	**2011 Vendor Manual Pg. 32** Service coordinators are expected to meet face-to-face with all individuals on their caseloads as frequently as needed based upon each person's individualized needs and circumstances. However, there must be at least three face-to-face service meetings provided annually (based on the calendar year) to all non-Willowbrook Class Members. **2011 Vendor Manual Pg. 34** For non-Willowbrook Class members, a service coordinator must meet with the individual face-to-face at least three times in a calendar year. … This is the minimum number of face-to-face meetings required. As discussed above, if the needs of the individual warrant more face-to-face meetings, the service coordinator should meet with the individual more frequently. For Willowbrook Class members, a service coordinator must make every attempt to conduct a face-to-face meeting with every class member on his or her caseload during each calendar month. **2011 Vendor Manual Pg. 38-39**

			The MSC record keeping responsibility focuses activity on keeping accurate and current records on service coordination activities and other services provided to the person. The documents and notes within the person's service coordination record should provide a chronological, ongoing written record of relevant information about the person and his or her life that helps a service coordinator provide person centered quality services. Additionally, high quality professional notes demonstrate the service coordinator's comprehensive and personal knowledge of the individual and his or her ISP along with substantiating billing for service coordination and key quality indicators. The service coordinator's record keeping should be clear and comprehensive enough to enable effective transition of service coordination services to another service coordinator or vendor if necessary. The records should be organized and clear to ensure that oversight entities can obtain a complete picture of the person and the MSC activities that are being provided on behalf of the person.
2a-15	The service coordinator/case manager meets with the individual in his/her home at least quarterly with a Willowbrook Class Member, annually with a non-class member, and when needed.	Met/Not Met	**"2011 Vendor Manual Pg. 35** For non-Willowbrook Class members, a face-to-face service meeting (i.e., home visit) in the person's home is required at least once annually, based on the calendar year. This is the minimum requirement. A service coordinator may have more in-home meetings if the service coordinator feels that it is needed to monitor the individual's health and safety or if the individual and the service coordinator agree to additional meetings in the individual's home. ... **2011 Vendor Manual Pg. 36** For Willowbrook Class members, a face-to-face service meeting in the person's home is required at least once during each three-month quarter of a calendar year.

2a-16	A Service Coordination Observation Report (SCOR) was completed at least twice yearly for Willowbrook Class Members and as needed.	Met/Not Met	**2011 Vendor Manual Pg. 36** ... The Service Coordination Observation Report (SCOR) must be completed for all Willowbrook Class members living in certified settings, except those living in Developmental Centers. A SCOR must be filed at least two times in a calendar year, (but not in consecutive quarters), even if there is no issue to report. 41-55,45-45,99-82 **2011 Vendor Manual Pg. 87** Thus, for Willowbrook Class members, the SCOR must be completed for each person living in an IRA CR, Family Care Home or ICF (although ICF residents are not MSC eligible). The SCOR does not need to be completed for Willowbrook Class members who live in developmental centers. 41-55,45-45,99-82
2a-17	If the SCOR identifies issues, the case notes in the individual's record evidence advocacy and resolution of the issue(s).	Met/Not Met/NA	**2011 Vendor Manual Pgs. 87-88** … On the SCOR, the service coordinator must indicate whether he or she has observed or become aware of any conditions that place any individual in the home in imminent danger or of any event or situation which may be considered abuse according to the definition in Part 624. If the service coordinator does find any evidence of imminent danger or abuse, he or she must take appropriate action to protect the individual(s) at risk.... If the service coordinator determines that these are real problems for the individual receiving MSC and should be resolved, the service coordinator should record them in the service coordination notes and should follow-up as necessary. ...
2a-18	SC/CC/CC has taken action to affirm that all allegations of abuse and/or neglect were reported to appropriate parties and investigated as appropriate.	Met/Not Met/NA	**2011 Vendor Manual Pg. 15** While the extent of involvement by a service coordinator and the exact tasks he or she undertakes in providing MSC services to each individual will vary, the objectives and focus of every service coordinator in every instance should be the same. Service coordinators must always: ... Take all reasonable steps to ensure the health and safety of the person with developmental disabilities, ...

			2011 Vendor Manual Pg. 29 A critical role of the service coordinator is monitoring the health and safety needs of the person and working to improve the quality and safety of the person's living environment if necessary (e.g., through advocacy). … **2011 Vendor Manual Pg. 29-30** The health and safety reporting requirements and standards are different for individuals who live in OPWDD certified residences and for individuals who live independently or with family members. Regardless of where the individual lives, MSCs must inform the appropriate regional office of any dangerous situations and of any reports made to outside state or law enforcement agencies. This includes reporting any suspected child abuse to the State Central Register of Child Abuse and Maltreatment at 1-800-342-3720. To fulfill responsibilities related to health and safety monitoring for individuals living in OPWDD certified settings, an MSC must: • Report any suspected unmet health or safety needs to the applicable regional office, • Report suspected unmet health or safety needs for any Willowbrook Class member living in any OPWDD certified residential setting using the Service Coordination Observation Report (MSC7-SCOR) (See Appendix Three), • Ensure that IRA residents have Individual Plans of Protective Oversight (IPOP), • For people living in CRs, IRAs, or Family Care, document in the safeguard section of the ISP the supports needed to keep the person safe from harm and actions to be taken when the health or welfare of the person is at risk, including any fire safety actions or provisions necessary, • Comply with Part 624 (Reportable Incidents, Serious Reportable Incidents and Abuse in Facilities Operated or Certified by OPWDD) and take reasonable steps to prevent violation of Part 633 (Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD), and subpart 635-9 (Provision of Required Services). For individuals who live independently, with others, or at home with family, the service coordinator must: ... Report suspected child abuse to the State Register of Child Abuse and Maltreatment at 1-800-342-3720.; Address other suspected abuse, neglect, and financial exploitation of children or adults, including situations where an individual cannot care for him or herself. This

			may require a call to the local adult protective service system. In New York City, suspected abuse or neglect of adults is reported to Protective Services for Adults. Outside New York City, the local county department of social services should be contacted to determine which office has responsibility for this function in the county where the individual lives, ...
2a-19	If abuse was substantiated, SC/CM/CC advocates for the safety and protection of the individual.	Met/Not Met/NA	**2011 Vendor Manual Pg. 15** While the extent of involvement by a service coordinator and the exact tasks he or she undertakes in providing MSC services to each individual will vary, the objectives and focus of every service coordinator in every instance should be the same. Service coordinators must always: ... Take all reasonable steps to ensure the health and safety of the person with developmental disabilities, ... **2011 Vendor Manual Pg. 29** A critical role of the service coordinator is monitoring the health and safety needs of the person and working to improve the quality and safety of the person's living environment if necessary (e.g., through advocacy). …
2a-20	The SC/CM/CC monitors that the individual is linked to and receiving the services he/she wants and that the services are helping the individual to attain his/her valued outcomes and life goals.	Met/Not Met	**2011 Vendor Manual Pg.27-28** The service coordinator: Uses knowledge of the community and available resources to support the person with developmental disabilities to make informed choices regarding how to achieve his or her valued outcomes, Coordinates access to and the delivery of supports and services identified in the ISP, ... The service coordinator: Uses a person centered planning process to review the ISP at least twice annually (at least once annually through a face-to-face meeting with the individual and major service providers) and makes any necessary revisions to ensure the ISP is up-to-date and supports and service are consistent with the needs and goals of the person,; Works with the person and others as appropriate to assess the person's satisfaction with his or her ISP and the services, supports, valued outcomes/goals therein and related service coordination activities and makes adjustments as necessary; Continuously supports the person with developmental disabilities to make

			informed choices and achieve his/her valued outcomes, Establishes and maintains an effective communication network with service providers and others involved with the person with developmental disabilities, Keeps up to date with changes, choices, temporary setbacks and accomplishments related to the ISP and incorporates changes to the ISP as needed, and Advocates for the person with developmental disabilities when his or her rights, protections, or health and safety needs and safeguards are not being met. .
2a-22	The SC/CM/CC monitors that the fire safety safeguard identified in the Person Centered Plan are in place/provided.	Met/Not Met	**2011 Vendor Manual Pg.30** "To fulfill responsibilities related to health and safety monitoring for individuals living in OPWDD certified settings, an MSC must: Report any suspected unmet health or safety needs to the applicable regional office, Report suspected unmet health or safety needs for any Willowbrook Class member living in any OPWDD certified residential setting using the Service Coordination Observation Report (MSC7-SCOR) (See Appendix Three), Ensure that IRA residents have Individual Plans of Protective Oversight (IPOP), For people living in CRs, IRAs, or Family Care, document in the safeguard section of the ISP the supports needed to keep the person safe from harm and actions to be taken when the health or welfare of the person is at risk, including any fire safety actions or provisions necessary,..." **2011 Vendor Manual Pg.30** For individuals who live independently, with others, or at home with family, the service coordinator must: Document in the safeguards section of the ISP that there are safeguards in place to protect the person's health and safety, including a summary of fire safety needs, ... **2011 Vendor Manual Pg. 42** The role of the MSC supervisor is to ensure that service coordinators provide high quality, person centered MSC services and meet all requirements of the service. At a minimum, MSC supervisors must: … Support Service

			Coordinators in their Advocacy Role ... Taking all reasonable steps to ensure that all health, welfare and fire safety needs are met.
2a-23	The SC/CM/CC monitors that individuals receive the health care services identified in their service plan.	Met/Not Met	**2011 Vendor Manual Pg. 27-28** The service coordinator: Uses knowledge of the community and available resources to support the person with developmental disabilities to make informed choices regarding how to achieve his or her valued outcomes, Coordinates access to and the delivery of supports and services identified in the ISP, ... The service coordinator: Advocates for the person with developmental disabilities when his or her rights, protections, or health and safety needs and safeguards are not being met. ...
2a-24	Care/Case/Service Coordinator/Manager advocates for the rights and entitlements of the individual in the home, day and work environments and in all spheres of his/her life.	Met/Not Met	**WPI Appendix I, Section II, 1.a.** Advocacy: a. The case manager shall protect and uphold the rights and entitlements of the class member in the residential program, in the day or work program, and in all spheres of the class member's life. ...
2a-25	The Care/Case/Service Coordinator/Manager ensures that procedural and substantive due process requirements are met.	Met/Not Met/NA	**633.12(a)(5)** The person receiving services, and his or her parent, guardian, correspondent and advocate, as applicable, shall be advised of the mechanism to resolve an objection: upon admission to a facility or enrollment in HCBS waiver services, as changes occur, and upon any substantive amendment to this section. In addition, when an agency proposes to reduce, suspend, or discontinue a person's HCBS waiver service(s), the agency shall, in a form and format approved by the commissioner, advise the person, and his or her advocate and service coordinator (see section 633.99 of this Part) as applicable, of the proposed changes and of the mechanism for resolving an objection to the proposed changes.
2a-26	The WCS Coordinator or WSC ensures active	Met/Not Met	**WPI Appendix I Section II.1.b**

	representation, either by the class member, the correspondent or Consumer Advisory Board (CAB)		The case manager shall ensure active representation either by the class member or by a correspondent or Consumer Advisory Board ("CAB") representative.
2a-27	The person is satisfied with the coordination/case management services he/she receives.	Met/Not Met	**636-1.2(a)(3)(iii)** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services. **Quality Indicator:** This is an indicator of quality outcomes.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities; **2011 Vendor Manual Pg. 46** The first section of a Service Coordination Record contains the eligibility and enrollment documentation for the individual with developmental disabilities and should include: ... Notice of individual rights and responsibilities per Part 633.4. (For Willowbrook Class members, there must be the Notice of Rights for Willowbrook Class members only).
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities;

			633.4(b)(3)(iii) Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-4	The individual is informed of their HCBS rights.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5)** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3)** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

	anonymous complaints if desired.		
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-21	The individual controls their personal resources and decides how to spend their personal discretionary funds.	Met/Not Met	**2011 MSC Vendor Manual pg. 29** ... Another example of advocacy is when a service coordinator who serves individuals residing in certified residences actively seeks to ensure that the individual's right to a monthly personal allowance is maintained. Any individual with income, including Social Security Disability and SSI benefits, is entitled to a personal allowance. An individual's personal funds should be used to support the person's preferences, choices and interests and the service coordinator's advocacy in this area helps ensure the person's rights are upheld....
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii)** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(b)(4)** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a - QQ	The individual is subjected to restrictions or limitations to their rights not associated with a Behavior Support Plan	Met/Not Met	

	(e.g. HCBS Rights Limitations)		
3a-25	When interventions that restrict or modify the individual's rights are used (not part of a behavior support plan), the individual's service plan includes a description of the positive and less intrusive approaches that have been tried but have not been successful.	Met/Not Met	**636-1.4(c)(2)-(3)** "Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (2) the positive interventions and supports used prior to any modifications; (3) less intrusive methods of meeting the need that were tried but did not work. Pathway to employment if activities occur at in agency setting."
3a-26	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights modification (clinical justification).	Met/Not Met	**633.4(b)(6)** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.) **636-1.4 (c)(1)** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan; (1) a specific and individualized assessed need underlying the reason for the modification.
3a-27	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**636-1.4 (c)(6)** Documentation of rights modifications; (c) The service coordinator must ensure documentation of the following in the individual's person-centered service plan; (6)established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

3a-28	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm .	Met/Not Met	**636-1.4(c)(4),(5),(7)** The service coordinator must ensure documentation of the following in the individual's person-centered service plan:... (4) a clear description of the condition that is directly proportionate to the specific assessed need; (5) a regular collection and review of data to measure the ongoing effectiveness of the modification; ...(7) an assurance that interventions and supports will cause no harm to the individual; **Quality Indicator:** This is an indicator of quality outcomes.
3a-29	The individual has given informed consent to the rights limitations/restrictions in place.	Met/Not Met	**636-1.4(c)(8)** The service coordinator must ensure documentation of the following in the individual's person-centered service plan: (8) the informed consent of the individual.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**636-1.3(b)(3), (4), and (8)** "The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (3) the individual's clinical and support needs as identified through an assessment of functional and health-related needs; (4) the necessary and appropriate services and supports (paid and unpaid) that are based on the individual's preferences and needs (as identified through an assessment of functional and health-related needs) and that will assist the individual to achieve his or her identified goals; …(8)the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed" **ADM 2010-04** Program Standards: Individualized Service Plan (ISP) Program Standards: Individualized Service Plan (ISP)… Attachment: ISP Instructions (9/2015 update). Applicable to MSC and PCSS: Safeguards: State the safeguards that must be in place to keep the person safe from harm.

			Safeguards are actions to be taken when the health or welfare of the person is at risk. The habilitation plans, or referenced documents, will provide greater detail about how safeguards are ensured within the context of the respective service environment. The "Individual Plan for Protective Oversight" can be referenced in the safeguards section for people who live in an Individualized Residential Alternative (IRA). However, the service coordinator should also include safeguards that pertain to other environments where the person spends time.
7-8	The individuals is provided necessary supports necessary to facilitate financial stability and freedom from financial exploitation.	Met/Not Met	**ADM 2010-04** Program Standards: Individualized Service Plan (ISP)… Attachment: ISP Instructions (9/2015 update) Safeguards: …state the safeguards that must be in place to keep the person safe from harm. … the following areas should be considered:… ability to manage finances …
8a-2	The individual has someone chosen/delegated to support them in coordinating their health care.	Met/Not Met	**2011 MSC Vendor Manual pg. 26** The service coordinator: Uses a person centered planning approach to develop the ISP. The service coordinator identifies the desired goals and valued outcomes of the person and the supports and services that person wants and needs to achieve those outcomes, Helps a person with developmental disabilities plan by promoting and supporting informed choices and developing a personal network of activities, supports, services, and community resources based on the person's needs and desires, Documents in the ISP the supports, services, community resources needed and chosen by the person with developmental disabilities and the entities that will supply them, ...
8a-3	The individual's service plan identifies the services and supports necessary to access and receive routine professional medical care and evaluation.	Met/Not Met	**2011 MSC Vendor Manual pg. 26** The service coordinator: Uses a person centered planning approach to develop the ISP. The service coordinator identifies the desired goals and valued outcomes of the person and the supports and services that person wants and needs to achieve those outcomes, Helps a person with developmental disabilities plan by promoting and supporting informed choices and developing a personal network of activities, supports, services,

			and community resources based on the person's needs and desires, Documents in the ISP the supports, services, community resources needed and chosen by the person with developmental disabilities and the entities that will supply them, ...
8a-4	The individual's routine health care providers are identified and known to the person and/or their supports.	Met/Not Met	**ADM 2010-04 ISP Instructions** "Medicaid State Plan Services are those services that a person can access with his or her Medicaid card. These services include Medicaid Service Coordination, physician, pharmacy, laboratory, hospital, dental, physical therapy, audiology, durable medical equipment, day treatment, and psychology. Services provided in Article 16, 28, or 31 Clinics should also be described in this section. These services may include Physical, Occupational, Speech, Rehabilitation Counseling, Nutrition, Psychology, Social Work, Psychiatry, nursing, or dental. Indicate what type of Clinic (16, 28, or 31) and the specific service being provided."
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-11	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**2011 MSC Vendor Manual pgs. 27-28** The service coordinator: Uses a person centered planning process to review the ISP at least twice annually (at least once annually through a face-to-face meeting with the individual and major service providers) and makes any necessary revisions to ensure the ISP is up-to-date and supports and service are consistent with the needs and goals of the person, ... Advocates for the person with developmental disabilities when his or her rights, protections, or health and safety needs and safeguards are not being met..
8a-20	The individual exhibits a healthy lifestyle and/or receives support(s) to replace	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.

	the unhealthy behaviors with healthier actions.		
8a-21	The individual is provided choice in health care providers.	Met/Not Met	**633.4(a)(4)(x)** (4) No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-22	The individual is supported to advocate and is included in informed decision-making related to medical care and treatment.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-23	Individuals have been given the opportunity to have advanced directives in place (DNR order, healthcare proxy, or living will).	Met/Not Met	**633.4(a)(4)(xxv)-(xxvi)** "(4) No person shall be denied: (xxv) the opportunity to make, or have made on his or her behalf, an informed decision regarding cardiopulmonary resuscitation (see glossary), in accordance with the provisions of article 29-B of the Public Health Law, and any other applicable law or regulation. Each developmental center (see glossary) shall adopt policies/procedures to actualize this right. (xxvi) the opportunity, if the person is residing in an OPWDD operated or certified facility, to create a health care proxy (see glossary) in accordance with 14 NYCRR 633.20."
8a-25	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**2011 MSC Vendor Manual** The service coordinator: ... Uses a person centered planning process to review the ISP at least twice annually (at least once annually through a face-to-face meeting with the individual and major service providers) and makes any necessary revisions to ensure the ISP is up-to-date and supports and service are consistent with the needs and goals of the person, ... Keeps up to

			date with changes, choices, temporary setbacks and accomplishments related to the ISP and incorporates changes to the ISP as needed,
8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA	**633.4(a)(4)(x)** This is an indicator of quality outcomes.
8a-27	The individual is given access to family planning resources and sexuality education and/or counseling if desired.	Met/Not Met/NA	**633.4(a)(4)(xi)** (4) No person shall be denied:...(xi) access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated.
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall with the medical care that the individual receives.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.

10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)

10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate

			624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)

10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).

10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)

10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives

	needed was provided to the individual.		any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and	Met/Not Met	**624.5(h)(1)**

	Notable Occurrences involving the individual are thorough and documented.		624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3**) 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation.

	incident or notable occurrence is reported.		When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3):** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to

			provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
11-1	The person has the resources to obtain possessions and	Met/Not Met	**Quality Indicator**

	supplies necessary for comfortable daily living.		This is an indicator of quality outcomes.
11-2	The individual is living as independently as able in the home/living environment they choose.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-3	The person is maintaining/improving and/or developing meaningful relationship(s).	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-4	The person is employed, doing volunteer work or participating in other integrated meaningful activities, per their desires/life goals.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-5	The person is maintaining their desired role in their community.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-6	The individual is living safely/receiving supports to live safely in their home/living environment, according to informed choices and responsible consideration.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-7	The person lives safely in their community per their informed choices.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
11-8	The person is satisfied with the supports they receive	Met/Not Met	**Quality Indicator**

	intended to achieve their outcomes.		This is an indicator of quality outcomes.
11-9	The person's service(s) in total, contribute to advancing toward or achieving their specified goals and personal outcomes.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**680.6(d) :** The individual program plan shall be developed and implemented by an interdisciplinary team (see section 680.13 of this Part) including the providers of medical treatment and active programming and direct care staff. One member of this team who is a qualified intellectual disability professional (see section 680.13) shall serve as individual coordinator (see section 680.13) with primary responsibility for implementation of the individual program plan, coordination of its components and for arranging movement of the client to a less restrictive environment as soon as the individual's needs permit.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
1-10	Assessments needed by the individual or required by program regulation were completed to inform the individual's plan development.	Met/Not Met	**680.5(d) :** (d) Individuals admitted to a specialty hospital shall require simultaneous assessment or treatment for their health care needs and structured programming for their developmental disabilities. A specialty hospital covered under this regulation shall admit only individuals who have had a comprehensive assessment (see section 680.13) within the 90 days prior to admission. This assessment shall have identified both the individual's developmental disability(ies) and health care needs which will require more than three hours of daily individualized attention from health care staff. In addition, there shall be an identification of the specific service(s) required by the individual in terms of type and frequency and a declaration of the service

			outcomes to be achieved which are congruent with the conditions necessitating admission. A current individual program plan developed by a State developmental center for the individual within the 90 days prior to admission is considered as complying with this requirement. However, prior admission to a developmental center shall not be a requirement for eligibility for a specialty hospital. (1) This requirement may be waived in an emergency situation which poses a danger of death or irreversible disability to the individual. However, in such instances, the condition necessitating the emergency admission must be identified and assessed prior to admission. (2) In an emergency admission situation, the comprehensive assessment shall be completed within 15 calendar days of admission.
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**680.6(c)**: Each individual program shall state the conditions requiring admission to a specialty hospital, the course of treatment and programs prescribed for these conditions and the anticipated outcomes of treatment and programs.
1-12	The individual's strengths and preferences are documented in the service plan.	Met/Not Met	**680.6(c):** Each individual program shall state the conditions requiring admission to a specialty hospital, the course of treatment and programs prescribed for these conditions and the anticipated outcomes of treatment and programs.
1-13	The individual's identified needs for clinical and/or functional support are documented in the service plan.	Met/Not Met	**680.5(d) :** Individuals admitted to a specialty hospital shall require simultaneous assessment or treatment for their health care needs and structured programming for their developmental disabilities. A specialty hospital covered under this regulation shall admit only individuals who have had a comprehensive assessment (see section 680.13) within the 90 days prior to admission. This assessment shall have identified both the individual's developmental disability(ies) and health care needs which will require more than three hours of daily individualized attention from health care staff. In addition, there shall be an identification of the specific service(s) required by the individual in terms of type and frequency and a declaration of the service outcomes to be achieved which are congruent with the conditions

			necessitating admission. A current individual program plan developed by a State developmental center for the individual within the 90 days prior to admission is considered as complying with this requirement. However, prior admission to a developmental center shall not be a requirement for eligibility for a specialty hospital. (1) This requirement may be waived in an emergency situation which poses a danger of death or irreversible disability to the individual. However, in such instances, the condition necessitating the emergency admission must be identified and assessed prior to admission. (2) In an emergency admission situation, the comprehensive assessment shall be completed within 15 calendar days of admission.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-18	The individual's goals and priorities related to health concerns and medical needs are identified in the person centered plan.	Met/Not Met	**680.6(a) :** Each individual of a specialty hospital shall have an individual program plan which describes for the individual his or her medical treatment for health-related problems and active programming for developmental disability(ies). **680.6(c) :** Each individual program shall state the conditions requiring admission to a specialty hospital, the course of treatment and programs prescribed for these conditions and the anticipated outcomes of treatment and programs.
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**680.6(j)(1)(i)-(vii) :** (j) The specialty hospital shall maintain the following system of records: (1) Individual record. The specialty hospital shall maintain a comprehensive record for each person. Each record shall be organized in the manner and contain the information prescribed by OPWDD. Each individual's record shall contain the following types of information: (i) identification information; (ii) admission information, including the individual's medical and developmental history, and documentation of the commissioner's prior approval of admission; (iii) a current individual program plan (as specified in subdivisions [a] through [i] of this section); (iv) copies of assessments, reassessments, progress notes and previous individual program plans; (v) service plans, description of treatments provided and medications administered; (vi) reports of illness or injury including the date and time of occurrence and action taken regarding each occurrence; (vii) summary of findings, progress and plans when the individual is discharged.

2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**680.6(a) :** Each individual of a specialty hospital shall have an individual program plan which describes for the individual his or her medical treatment for health-related problems and active programming for developmental disability(ies).
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**680.1(d)(1)-(2) :** Individuals admitted to a specialty hospital shall have a previously established diagnosis of developmental disability (see section 680.13) and shall require: (1) active programming (see section 680.13) for their developmental disabilities; and (2) individualized attention for more than three hours per day for health care problems. **680.6(a) :** Each individual of a specialty hospital shall have an individual program plan which describes for the individual his or her medical treatment for health-related problems and active programming for developmental disability(ies). **680.6(c) :** Each individual program shall state the conditions requiring admission to a specialty hospital, the course of treatment and programs prescribed for these conditions and the anticipated outcomes of treatment and programs. **680.6(g)(1)-(2) :** (g) Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: (1) the goals and long- and short-term objectives established to attain or maintain the optimal level of health, self-care, communication, learning, mobility,

			recreation and capacity for independent living of which the individual is presently or potentially capable; (2) service plans for each mandatory and selective service which combine into an integrated program of individually designed activities, experiences and programs necessary to achieve each individual's objectives. These plans shall contain, as appropriate, specific individual medical prescriptions or written direction from the interdisciplinary team for all necessary services; **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**680.6(f) :** The combination of goal-oriented health care, medical treatment and active programming, excluding recreation, shall be at least six hours per day, five days per week in the manner recommended by each individual's interdisciplinary team. The medical treatment and active programming for these conditions necessitating admission to the specialty hospital shall be provided with the frequency and duration prescribed by the individual's I.T. Thus, a person may receive more than six hours of medical treatment and structured programming per day, but can only receive less than six hours per day if a physician has certified in writing that such activities would be medically harmful to the individual. For Willowbrook class members, approval of the programming exemption must be obtained from the professional advisory board.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**680.6(g)(3) :** Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: ...(3) progress notes describing the individual's response to programs and services;

			680.6(i)(1)(iv)-(v) : The specialty hospital shall maintain the following system of records: (1) Individual record. The specialty hospital shall maintain a comprehensive record for each person. Each record shall be organized in the manner and contain the information prescribed by OPWDD. Each individual's record shall contain the following types of information: ... (iv) copies of assessments, reassessments, progress notes and previous individual program plans; (v) service plans, description of treatments provided and medications administered;
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix)** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**680.6(h)(1)-(5) :** (h) Review of each individual program plan shall be performed as follows: (1) At least monthly a member or members of the interdisciplinary team shall review the individual's response to the individual program plan to determine any necessary modifications. Written documentation of such reviews shall be maintained in the individual's record. (2) At least quarterly, the interdisciplinary team shall collectively review and evaluate each person's individual program plan. This review shall describe the improvement or lack of improvement in those conditions for which the individual was admitted and additionally include: (i) such reassessments of the individual's condition, assets or disabilities as may be indicated prior to the interdisciplinary team's review conference; (ii) participation by the individual and his or her correspondent, unless the individual is an adult competent to object and objects to such participation; (iii) input and relevant participation from professional and nonprofessional staff providing services to the individual; (i) a review of the individual's response to the active programming provided during the previous quarter; and (v) establishment of modified or new long- and short-range objectives, as appropriate. (3) At least quarterly, the individual coordinator shall send written notification of the individual's medical condition and progress in programs and services to the individual's correspondent. (4) Prior to discharge or for an extended stay beyond six

			months and performed in accordance with individual need, an interdisciplinary team, consisting of individuals who are representative of the professions or services included in this Part (that are relevant in each particular case), including direct care staff, shall conduct a comprehensive reassessment (based upon individual assessments) of each individual, covering self-care, health, communication, learning, mobility and capacity for independent living. (5) At least quarterly, the interdisciplinary team shall collectively review the status of each individual, including consideration of the following: (i) the advisability of continued residence at the specialty hospital and alternative programs; and (ii) review of the need for guardianship and how the individual may exercise his or her civil and legal rights when the person legally becomes an adult.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**680.6(h)(1)-(2) :** (1) At least monthly a member or members of the interdisciplinary team shall review the individual's response to the individual program plan to determine any necessary modifications. Written documentation of such reviews shall be maintained in the individual's record. (2) At least quarterly, the interdisciplinary team shall collectively review and evaluate each person's individual program plan. This review shall describe the improvement or lack of improvement in those conditions for which the individual was admitted and additionally include: (i) such reassessments of the individual's condition, assets or disabilities as may be indicated prior to the interdisciplinary team's review conference;
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**680.6(h)(2)(v) :** (h) Review of each individual program plan shall be performed as follows: (2) At least quarterly, the interdisciplinary team shall collectively review and evaluate each person's individual program plan. This review shall describe the improvement or lack of improvement in those conditions for which the individual was admitted and additionally include: (v) establishment of modified or new long- and short-range objectives, as appropriate.
2-15	The person is satisfied with the specific service.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

2s-1	The service plan (IPP) identifies whether the individual has a health care problem that requires more than three (3) hours of daily individualized care by health care staff.	Met/Not Met	**680.5(c) :** A specialty hospital shall admit only developmentally disabled individuals who have a diagnosis of mental retardation, autism, cerebral palsy, epilepsy or neurological impairment; and who manifest at least one severe deficit in adaptive behavior (see section 680.13 of this Part). Such individual's developmental disability must have originated before the individual's 22nd birthday. In addition, such individuals shall manifest a health care problem which requires more than three hours of daily individualized attention from health care staff (see section 680.13). **680.5(d) :** Individuals admitted to a specialty hospital shall require simultaneous assessment or treatment for their health care needs and structured programming for their developmental disabilities. A specialty hospital covered under this regulation shall admit only individuals who have had a comprehensive assessment (see section 680.13) within the 90 days prior to admission. This assessment shall have identified both the individual's developmental disability(ies) and health care needs which will require more than three hours of daily individualized attention from health care staff. In addition, there shall be an identification of the specific service(s) required by the individual in terms of type and frequency and a declaration of the service outcomes to be achieved which are congruent with the conditions necessitating admission. A current individual program plan developed by a State developmental center for the individual within the 90 days prior to admission is considered as complying with this requirement. However, prior admission to a developmental center shall not be a requirement for eligibility for a specialty hospital. (1) This requirement may be waived in an emergency situation which poses a danger of death or irreversible disability to the client [individual]. However, in such instances, the condition necessitating the emergency admission must be identified and assessed prior to admission. (2) In an emergency admission situation, the comprehensive assessment shall be completed within 15 calendar days of admission. **680.6(c) :** Each individual program shall state the conditions requiring admission to a specialty hospital, the course of treatment and programs prescribed for these conditions and the anticipated outcomes of treatment and programs. **680.6(h)(4) :**

			Prior to discharge or for an extended stay beyond six months and performed in accordance with individual need, an interdisciplinary team, consisting of individuals who are representative of the professions or services included in this Part (that are relevant in each particular case), including direct care staff, shall conduct a comprehensive reassessment (based upon individual assessments) of each client [individual], covering self-care, health, communication, learning, mobility and capacity for independent living.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii)** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.

3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5)** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3)** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-8	The individual is supported to participate in cultural/religious/associational practices, educuation, celebrations and experiences per their interests and preferences.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support**.**	Met/Not Met	**633.4(a)(xx) :** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.

3-20	The individual may view their service record upon request.	Met/Not Met	**680.6(j)(3)(j) :** The individual and his or her correspondent shall have access to the total record upon request unless proscribed by order of the court, or unless the person is an adult and objects to the correspondent's having access to the record.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights modification (clinical justification).	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-4	The individual's service plan identifies specific actions/supports,	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.		
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**680.6(a) :** Each client of a specialty hospital shall have an individual program plan which describes for the client his or her medical treatment for health-related problems and active programming for developmental disability(ies). … (c) Each individual program shall state the conditions requiring admission to a specialty hospital, the course of treatment and programs prescribed for these conditions and the anticipated outcomes of treatment and programs. **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (i) An assessment of functional capacity. (ii) Review and evaluation of the person's written plan of services and his or her progress in relation to that plan;
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**680.6(f) :** The combination of goal-oriented health care, medical treatment and active programming, excluding recreation, shall be at least six hours per day, five days per week in the manner recommended by each client's interdisciplinary team. The medical treatment and active programming for these conditions necessitating admission to the specialty hospital shall be provided with the frequency and duration prescribed by the client's I.T. Thus, a client may receive more than six hours of medical treatment and structured programming per day, but can only receive less than six hours per day if a physician has certified in writing that such activities would be medically

			harmful to the client. For Willowbrook class members, approval of the programming exemption must be obtained from the professional advisory board. **633.4(a)(4)(viii)-(x): :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity …
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met/NA	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
7-5	The individual is provided dining supports for consistency, assistance, and	Met/Not Met/NA	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his

	monitoring per his/her written plan and as needed.		or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff.
8a-1	A health assessment which identifies the individual's health care needs has been completed by a physician, PA, NP or RN.	Met/Not Met	**680.5(d)(1)-(2) :** (d) Individuals admitted to a specialty hospital shall require simultaneous assessment or treatment for their health care needs and structured programming for their developmental disabilities. A specialty hospital covered under this regulation shall admit only individuals who have had a comprehensive assessment (see section 680.13) within the 90 days prior to admission. This assessment shall have identified both the individual's developmental disability (ies) and health care needs which will require more than three hours of daily individualized attention from health care staff. In addition, there shall be an identification of the specific service(s) required by the individual in terms of type and frequency and a declaration of the service outcomes to be achieved which are congruent with the conditions necessitating admission. A current individual program plan developed by a

			State developmental center for the individual within the 90 days prior to admission is considered as complying with this requirement. However, prior admission to a developmental center shall not be a requirement for eligibility for a specialty hospital. (1) This requirement may be waived in an emergency situation which poses a danger of death or irreversible disability to the individual. However, in such instances, the condition necessitating the emergency admission must be identified and assessed prior to admission. (2) In an emergency admission situation, the comprehensive assessment shall be completed within 15 calendar days of admission. **680.6(c) :** Each individual program shall state the conditions requiring admission to a specialty hospital, the course of treatment and programs prescribed for these conditions and the anticipated outcomes of treatment and programs. **680.7(b)(1)(i)(a)(6) :** The medical director shall ensure that the medical staff carries out the following responsibilities relating to services, as appropriate: ...(6) detection and treatment of health problems, through adequate medical surveillance, periodic inspection and regular medical examination.
8a-2	The individual has someone chosen/delegated to support them in coordinating their health care.	Met/Not Met	**680.7(b)(1)(a)(1)-(2) :** The medical director shall ensure that the medical staff carries out the following responsibilities relating to services, as appropriate: (1) providing and supervising medical treatment through the delivery of preventive, habilitative and rehabilitative programs; (2) providing health care consultation and referral of individuals to appropriate health care specialists;
8a-3	The individual's service plan identifies the services and supports necessary to access and receive routine professional medical care and evaluation.	Met/Not Met	**680.6(b)-(c) :** Programming and treatment shall be directed at those aspects of the health-related conditions and developmental disability necessitating the restrictiveness of the specialty hospital placement. The type and duration of programming and treatment shall be structured to enable the individual's movement to a less restrictive environment as quickly as possible with regard for each individual's disabilities. **680.6(c) :** Each individual program shall state the conditions requiring admission to a specialty hospital, the course of treatment and programs prescribed for these conditions and the anticipated outcomes of treatment and programs.

			680.6(g)(2) : Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: ... (2) service plans for each mandatory and selective service which combine into an integrated program of individually designed activities, experiences and programs necessary to achieve each individual's objectives. These plans shall contain, as appropriate, specific individual medical prescriptions or written direction from the interdisciplinary team for all necessary services;
8a-4	The individual's routine health care providers are identified and known to the person and/or their supports.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	Met/Not Met	**633.10(b)(3) :** OPWDD shall verify that staff have been made aware of their responsibilities in accordance with the agency/facility plan. [Context: 633.10(2) States:" There is a written plan specifying how the agency/facility will deal with life threatening emergencies. Such a plan shall address: (i) First aid. (ii) CPR. (iii) Access to emergency medical services."] **680.7(b)(1)(i)(b)(1)-(2)** : There shall be a formal arrangement for qualified medical care for the individual, including care for medical emergencies at all times. (1) Procedures shall be established that provide steps to be followed when the primary care physician is not available. (2) The names and telephone numbers of physicians and/or personnel to be called in the event of an emergency shall be posted.

8a-6	The individual receives routine medical exams/medical appointments per his/her health care professionals' recommendations.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **680.7(b)(1)(i)(a)(2) :** (a) The medical director shall ensure that the medical staff carries out the following responsibilities relating to services, as appropriate: ...(2) providing health care consultation and referral of individuals to appropriate health care specialists; **680.7(b)(1)(i)(e) :** The medical director shall maintain effective arrangements through which medical services required by the individuals but not regularly provided within the specialty hospital can be obtained promptly when needed.
8a-7	The individual receives diagnostic evaluation/testing per his/her health care professionals' recommendations and standard safe practice (e.g. Lab work, x-rays, scans, MRIs, etc.)	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully,

			safely and humanely administered with full respect to his or her dignity and personal integrity. **680.7(b)(1)(i)(7)(ii) :** The medical director shall ensure that the medical staff carries out the following responsibilities relating to services, as appropriate: ...7) semi-annual physical examinations that include: … (ii) routine laboratory examinations, as deemed necessary by the physician; and special studies when the index of suspicion is high; . **680.7(c) :** (c) Selective services (see section 680.13 under specific disciplines) include: (1) communication services; (2) dental services; (3) education services; (4) occupational therapy services; (5) optometric services; (6) orthotic services; (7) pharmacy services; (8) physical therapy services; (9) psychology services; (10) respiratory therapy; (11) social services; (12) special medical services; (13) special diagnostic services; and (14) transportation services.Selective services shall be available at all times to individuals who require them. Because a specialty hospital is designed to provide specialized treatment to individuals whose disability prevents movement to a less restrictive treatment alternative, selective services shall be delivered in such a manner as to effect that movement as soon as possible. Therefore, it may be necessary to concentrate on particular types of services throughout an individual's stay at the specialty hospital while the provision of other kinds of habilitative services which a person needs are postponed until the person has reached the treatment goal of movement to a less restrictive placement.
8a-8	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender and age.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully,

			safely and humanely administered with full respect to his or her dignity and personal integrity. **680.7(c)(2)(ii)(a)(1)-(6) :** Comprehensive dental services shall be provided by the specialty hospital, or through contract, which include the following: (1) a complete extra and intraoral examination utilizing all diagnostic aids necessary to properly evaluate the individual's oral condition. Such examination shall occur within one month following admission, unless such an examination was done within the six months immediately prior to admission and the results are received and reviewed by the specialty hospital's medical director and are entered in the individual's record; (2) dental treatment as needed by individuals, including oral surgery, orthodontics, periodontics and prostheses; (3) provision for emergency treatment on a 24-hour-a-day, 7-day-a-week basis by a qualified dentist (see section 680.13 under “Professional Staff”); (4) a recall system that will ensure that each individual is reexamined at specific intervals in accordance with his or her needs, but at least annually; (5) a dental hygiene program that includes: (i) instruction of individuals and staff in proper oral hygiene methods; and (ii) instruction of parents or other care givers in the maintenance of proper oral hygiene, where appropriate. (6) maintaining a permanent dental record for each individual. A summary dental progress report shall be entered in the individual's record at stated intervals;
8a-9	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender, and age.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :**

			Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-10	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met/NA	**680.6(g)(2) :** Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: ... (2) service plans for each mandatory and selective service which combine into an integrated program of individually designed activities, experiences and programs necessary to achieve each individual's objectives. These plans shall contain, as appropriate, specific individual medical prescriptions or written direction from the interdisciplinary team for all necessary services;
8a-11	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **680.6(d) :** The individual program plan shall be developed and implemented by an interdisciplinary team (see section 680.13 of this Part) including the providers of medical treatment and active programming and direct care staff. One member of this team who is a qualified intellectual disability professional (see section 680.13) shall serve as individual coordinator (see section 680.13) with primary responsibility for implementation of the individual program plan, coordination of its components and for arranging movement of the client to a less restrictive environment as soon as the individual's needs permit.

			680.6(g)(3) : Each individual program plan shall specify the conditions to be treated, and the anticipated preventive and/or restorative outcomes resulting from the various therapeutic interventions to be used. The individual program plan shall be written and maintained in the manner, frequency and format prescribed by OPWDD and shall contain the following components: ... (3) progress notes describing the individual's response to programs and services;
8a-13	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed**.**	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-14	The individual's emerging signs/symptoms are reported to a health care professional, and monitored and addressed appropriately.	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-15	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met/NA	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person,
8a-16	The individual is assessed regarding ability to self-	Met/Not Met/NA	**633.17(b)(2) :**

	administer medications, when medication administration is associated with the service or service environment.		There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8a-17	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA	**633.17(b)(3) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication.
8a-18	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ... **633.17(a)(7) :** All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling.
8a-19	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**633.17(b)(8) :** OPWDD shall verify that the medication regimen of each person in a residential facility has been reviewed at least semi-annually by a registered nurse, physician, physician's assistant, or pharmacist.
8a-23	Individuals have been given the opportunity to have advanced directives in place	Met/Not Met	**633.4(a)(4)(xxv)-(xxvi) :** (4) No person shall be denied: .(xxv) the opportunity to make, or have made on his or her behalf, an informed decision regarding cardiopulmonary resuscitation (see glossary), in accordance with the provisions of article 29-B

	(DNR order, healthcare proxy, or living will).		of the Public Health Law, and any other applicable law or regulation. Each developmental center (see glossary) shall adopt policies/procedures to actualize this right. (xxvi) the opportunity, if the person is residing in an OPWDD operated or certified facility, to create a health care proxy (see glossary) in accordance with 14 NYCRR 633.20.
8a-24	For those that have advanced directives, they are completed properly in accordance with the Healthcare Decisions Act.		**633.10(a)(7)(ii) :** Upon receipt of notification of a decision to withdraw or withhold life-sustaining treatment in accordance with section 1750-b(4)(e)(ii) of the Surrogate's Court Procedure Act (SCPA), the chief executive officer (see glossary, section 633.99 of this Part) of the agency (see glossary, section 633.99 of this Part) shall confirm that the person's condition meets all of the criteria set forth in SCPA section 1750-b(4)(a) and (b). In the event that the chief executive officer is not convinced that all of the necessary criteria are met, he or she may object to the decision and/or initiate a special proceeding to resolve such dispute in accordance with SCPA section 1750-b(5) and (6).
8a-25	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). **680.6(j)(1)(iii)-(vi) :** (j) The specialty hospital shall maintain the following system of records: (1) Individual record. The specialty hospital shall maintain a comprehensive record for each person. Each record shall be organized in the manner and contain the information prescribed by OPWDD. Each individual's record shall contain the following types of information: ...(iii) a current individual program plan (as specified in subdivisions [a] through [i] of this section); (iv) copies of assessments, reassessments, progress notes and previous individual program plans; (v) service plans, description of treatments provided and medications administered; (vi) reports of illness or injury including the date and time of occurrence and action taken regarding each occurrence;

8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA	**633.4(a)(4)(x) :** (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-27	The individual is given access to family planning resources and sexuality education and/or counseling if desired.	Met/Not Met/NA	**633.4(a)(4)(xi) :** (4) No person shall be denied:...(xi) access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated.
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall with the medical care that the individual receives.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive

	intervention(s) and/or limitation on rights.		intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention

			and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(i):** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.

9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the

			person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :**

	device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.		The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order

			and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician’s order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified

	use of the Mechanical Restraining device.		in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(j)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the

			person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(j)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(j)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(j)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.

9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.

9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.

9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)**: Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9e-1	Medication to address the individual's challenging behavior or a symptom of a diagnosed co-occurring psychiatric disorder is administered only as a part of a BSP or Monitoring Plan which includes additional interventions.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9e-2	Written Informed Consent for use of medication by the individuals has been obtained and is current.	Met/Not Met	**633.16(j)(5)(ii)(b) :** Written informed consent shall be obtained prior to the use of the medication. If it is necessary for the medication to be administered before written informed consent can reasonably be obtained, verbal consent may be accepted for only the period of time before written informed consent can be obtained. Verbal consent must be witnessed by two members of the staff and documented in the person's record. This verbal consent may be considered valid for a period of up to 45 days.
9e-3	When the plan includes the medication the Individual's service record includes a semi-annual medication regimen review that is used to evaluate the benefits/risk of continuation.	Met/Not Met	**633.16(j)(5)(i)(d) :** A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of

			continuing the medication(s) outweigh the risk inherent in potential side effects.
9e-4	The Individual's service record includes evidence that the prescriber was consulted regarding administration and continued effectiveness of the medication.	Met/Not Met	**633.16(j)(5)(i)(e)**: At least semi-annually, and more frequently as needed, staff shall consult with the prescriber regarding the administration and continued effectiveness of the medication.
9e-5	The Individual's service record includes evidence that the use of medication is having a positive effect on his/her behavior or target symptoms.	Met/Not Met	**633.16(j)(5)(ii)(c) :** The use of medication shall have a documented positive effect on the person's behavior or target symptoms to justify its ongoing use.
9e-6	The Individual's service record includes evidence that the effectiveness of the medication has been re-evaluated at least semi-annually at the program plan review with required service attendees.	Met/Not Met	**633.16(j)(5)(ii)(d)**: The effectiveness of the medication shall be re-evaluated at least semi-annually at the program plan reviews by the program planning team in consultation with a licensed psychologist, licensed clinical social worker, or behavior intervention specialist, and a health care professional. The goal(s) of this aspect of the plan review include: ensuring that medication is at the minimum and most effective dose; identifying a potential need for a medication with fewer or less intrusive side effects; evaluating the evidence presented to support continuation of the medication at a maintenance level, or recommending reduction or discontinuation of medication use if clinically indicated and authorized by the prescriber.
9e-7	Medications were administered in accordance with requirements.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging

			behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9f-1	When prn medication is prescribed to address behavior or symptoms of a psychiatric disorder, this strategy is included in the Individual's Behavioral Support or Monitoring Plan.	Met/Not Met/NA	**633.16(j)(5)(iii)(a) :** As-needed (also known as PRN) orders for medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, are considered planned use and must be incorporated in and documented as part of a behavior support plan or a monitoring plan.
9f-2	The Individual's service record includes evidence of the display of the behavior(s) or symptom(s) for which the PRN medication is being prescribed in the past 12 months.	Met/Not Met/NA	**633.16(j)(5)(iii)(b) :** Planned use of as-needed orders for medication: The person shall have a recent documented history of displaying the behavior(s) or symptoms (occurring in the last 12 months) for which the as-needed medication is being prescribed.
9f-3	The Individual's Behavioral Support or Monitoring Plan provides instruction and guidance for administration of the PRN medication, consistent with the prescriber's order.	Met/Not Met/NA	**633.16(j)(5)(iii)(c)(1-3) :** The behavior support plan or monitoring plan, consistent with the prescriber's order, shall clearly state: (1) the conditions under which the as-needed medication is to be administered, including the nature and degree of the individual's behavior(s) or symptoms, and the prescriber's recommendations regarding proximity to any scheduled medication administration; (2) the expected therapeutic effects; and (3) if applicable, the conditions under which the medication can be re-administered, and the allowable frequency of re-administration.
9f-4	The Individual's service record must include a summary, in behavioral terms, of the results of the PRN medication administration.	Met/Not Met/NA	**633.16(j)(5)(iii)(d) :** Planned use of as-needed orders for medication: The staff person or family care provider who is responsible for support and supervision of a person who has a behavior support plan or monitoring plan must document in the

			person's clinical record a summary of the results of the medication use in behavioral terms.
9f-5	The Individual's service record includes evidence that any adverse or unexpected side effects were reported to the PRN prescriber immediately and the planning team by the next business day.	Met/Not Met/NA	**633.16(j)(5)(iii)(e) :** Planned use of as-needed orders for medication: Results that are substantively different from the intended effect, and any adverse side effects, shall be reported to the prescriber immediately and the person's program planning team no later than the next business day.
9f-6	Use of PRN Medications on more than four (4) separate days in a 14-day period resulted in consideration of a recommendation for incorporation into a regular drug regimen.	Met/Not Met/NA	**633.16(j)(5)(iii)(f) :** If any as-needed medication is administered on more than four separate days (one day equals 24 hours) in a 14-day period, the individual's program planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist and healthcare professional, must reassess the appropriateness of continuing the as-needed medication, or consider recommending that it be incorporated into the individual's regular drug regimen.
9f-7	Lack of use of a PRN medication during a six-month period resulted in a review of the BSP and a recommendation to the prescriber.	Met/Not Met/NA	**633.16(j)(5)(iii)(h) :** If the as-needed medication is not administered during a six-month period, the program planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist, must review the behavior support plan and develop a recommendation to the prescriber regarding the appropriateness of continuing the as-needed medication as part of the plan. If the order is continued, a clear justification is to be documented in the record.
9f-8	Effectiveness of the medication ordered in an emergency is documented in the Individual's record.	Met/Not Met/NA	**633.16(J)(5)(iv)(c) :**

			Emergency use of medication: The use of the medication, along with the prescription/order and a note on its effectiveness, shall be documented in the person's record.
9f-9	Emergency use of medication in more than 4 instances in a 14-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(J)(5)(iv)(d) :** Emergency use of medication. The emergency use of medication to control challenging behavior or acute symptoms of a co-occurring diagnosed psychiatric disorder in more than four instances in a 14-day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, a licensed clinical social worker or behavioral intervention specialist within three business days of the fifth medication administration.
9f-10	Use of PRN medications in conjunction with a restrictive physical intervention technique were reported electronically to OPWDD.	Met/Not Met/NA	**633.16(j)(5)(iii)(g) :** Each use of an as-needed medication when used in conjunction with a restrictive physical intervention technique to prevent, modify, or control challenging behavior shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9g-1	The Individual's record identifies the symptoms he/she exhibits and each co-occurring psychiatric disorder diagnosis.	Met/Not Met	**633.16(j)(5)(vi)(e) :** Medication use to treat a co-occurring diagnosed psychiatric disorder. Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirement must be met. (e) The symptoms and diagnosis of the co-occurring psychiatric disorder must be documented.
9g-2	The Individual's Monitoring Plan clearly identifies target symptoms associated with each medication prescribed for a psychiatric disorder.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a

			written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented.
9g-3	The Individual's Monitoring Plan includes the method to measure and document symptom reduction and functional improvement.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-4	The Individual's Monitoring Plan includes alternative interventions (other than medication).	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other

			behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-5	The individual's Monitoring Plan is developed by a qualified clinician.	Met/Not Met	**633.16(b)(29) :** Plan, monitoring. A plan developed by a licensed psychologist, licensed psychiatric nurse practitioner, licensed clinical social worker, or a behavioral intervention specialist that identifies the target symptoms of a co-occurring diagnosed psychiatric disorder that are to be prevented, reduced, or eliminated.
9g-6	The effectiveness of the individual's Monitoring Plan in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(j)(5)(i)(d)** : A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving	Met/Not Met/NA	**625.4(a)**

	the individual that are required to be reported have been reported to OPWDD.		The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and	Met/Not Met	**624.5(g)(1)**

	abuse, were implemented immediately.		A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3**) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that

			are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events	Met/Not Met/NA	**624.7(b)(2):**

	involving the individual were planned and implemented.		An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6)

			educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16:

	harm and abuse, were implemented immediately.		624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3**) 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the

			VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary

			investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3):** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(j)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be

			undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**27.3(b) :** Integrated Residential Community: Formulation of the plan. Directors of facilities and their staff shall assure each patient the opportunity to participate to the fullest extent possible in the establishment and revision of his or her individual service plan, except in the case of those programs which comply with the requirements of section 27.2(g) of this Part. Integrated residential communities are required to comply with subdivision (f) of this section. An appropriate staff member of the facility shall note the nature of the participation in the patient's clinical record. **633.4(a)(4)(viii)(a) :** (Other Private Schools): No person shall be denied:.(viii) a written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible. Such right also includes: (a) the opportunity to participate in the development and modification of an individualized plan of services, unless constrained by the person's ability to do so;
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met	**27.3(b) :** Integrated Residential Community: Formulation of the plan. Directors of facilities and their staff shall assure each patient the opportunity to participate to the fullest extent possible in the establishment and revision of his or her individual service plan, except in the case of those programs which comply with the requirements of section 27.2(g) of this Part. Integrated residential communities are required to comply with subdivision (f) of this section. An appropriate staff member of the facility shall note the nature of the participation in the patient's clinical record.

1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
1-10	Assessments needed by the individual or required by program regulation were completed to inform the individual's plan development.	Met/Not Met	**27.3(c)(1) :** Integrated Residential Community: Contents of plan. Appropriate members of each facility's staff shall establish for each patient a written individual service plan. For outpatients, this plan shall include those elements below which are appropriate to the goals of service. For inpatients, the plan shall include:(1) a comprehensive statement of the physical, psychological, social, economic, educational and vocational assets and disabilities stated in terms of performance and functional capabilities of the patient; **81.6(a)(2) :** other Private Schools: Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title.
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**27.3(c)(2): :** Integrated Residential Community: 27.3(c)(2) Appropriate members of each facility's staff shall establish for each patient a written individual service plan. For outpatients, this plan shall include those elements below which are appropriate to the goals of service. For inpatients, the plan shall include: (2) a statement of the goals of the services to be provided, derived from and based on the statement of assets and disabilities and related to plans for return to the larger community; **27.3(f)(2) :** Integrated residential communities are required to develop a narrative description for each client served in the program setting. The narrative shall

			include: (2) an annual summary encompassing the client's activities and interests in all aspects of life, including work, home social/leisure, community involvement and family involvement wherein the resident's contribution to the program setting is described. The client's activities and role in the community will depend on his or her interests, skill development and community needs; **81.6(a)(2) :** Other Private Schools: 81.6(a)(2) Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title.
1-12	The individual's strengths and preferences are documented in the service plan.	Met/Not Met	**27.3(c)(2) :** Integrated Residential Community: 27.3(c)(2) Appropriate members of each facility's staff shall establish for each patient a written individual service plan. For outpatients, this plan shall include those elements below which are appropriate to the goals of service. For inpatients, the plan shall include: (2) a statement of the goals of the services to be provided, derived from and based on the statement of assets and disabilities and related to plans for return to the larger community; **27.3(f)(1)** Integrated residential communities are required to develop a narrative description for each client served in the program setting. The narrative shall include:(1) a description of the individual's strengths and needs. **81.6(a)(2) :** Other Private Schools: 81.6(a)(2) Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title,

			shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title.
1-13	The individual's identified needs for clinical and/or functional support are documented in the service plan.	Met/Not Met	**27.3(f)(3) :** Integrated Residential Community: 27.3(f)(3) Integrated residential communities are required to develop a narrative description for each client served in the program setting. The narrative shall include: (3) a description of the approaches that will be used to address each identified need within the integrated 24-hour setting. Staff responsible for implementing components specified in the program narrative shall be identified; **81.6(a)(2) :** Other Private Schools: 81.6(a)(2) Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**27.3(f)(2) :** Integrated Residential Community: 27.3(f)(2) Integrated residential communities are required to develop a narrative description for each client served in the program setting. The narrative shall include: (2) an annual summary encompassing the client's activities and interests in all aspects of life, including work, home social/leisure, community involvement and family involvement wherein the resident's contribution to the program setting is described. The client's activities and role in the community will depend on his or her interests, skill development and community needs;

			Quality Indicator : Other Private Schools: This is an indicator of quality service planning.
1-16	The individual's goals and priorities regarding meaningful relationships are identified in the person centered plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**27.3(f)(2) :** Integrated Residential Community: Integrated residential communities are required to develop a narrative description for each client served in the program setting. The narrative shall include: (2) an annual summary encompassing the client's activities and interests in all aspects of life, including work, home social/leisure, community involvement and family involvement wherein the resident's contribution to the program setting is described. The client's activities and role in the community will depend on his or her interests, skill development and community needs; **Quality Indicator :** This is an indicator of quality outcomes.
1-18	The individual's goals and priorities related to health concerns and medical needs are identified in the person centered plan.	Met/Not Met	**27.3(c)(1)-(2):** : Integrated Residential Community 27.3(c)(1)-(2): Appropriate members of each facility's staff shall establish for each patient a written individual service plan. For outpatients, this plan shall include those elements below which are appropriate to the goals of service. For inpatients, the plan shall include: (1) a comprehensive statement of the physical, psychological, social, economic, educational and vocational assets and disabilities stated in terms of performance and functional capabilities of the patient; (2) a statement of the goals of the services to be provided, derived from and based on the statement of assets and disabilities and related to plans for return to the larger community; **81.6(a)(2) :** Other Private Schools 81.6(a)(2): Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of

			care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title.
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for	Met/Not Met	**81.8(a)(1)-(2) :** From Operation of Schools for … [People with Developmental Disabilities] regulations applicable to Private Schools, including Residential Schools and Integrated Residential Communities. "(a) Case records. (1) There shall be an individual record for each person admitted to the school. (2) Each case record shall include: (i) legal admission documents; (ii) identifying information

	HCBS Waiver Service providers.		on the individual and his family; (iii) source of referral, date of commencing service and name of staff member carrying overall responsibility for treatment and care; (iv) initial, intercurrent and final diagnoses, including psychiatric or mental retardation diagnoses in official terminology; (v) reports of all diagnostic examinations and evaluations, including findings and conclusions; (vi) reports of all periodic medical, dental, eye and hearing examinations; (vii) reports of all special studies performed, including X-rays, clinical laboratory tests, clinical psychological testing, electro-encephalograms, psychometric tests; (viii) the individual written plan of care, treatment and training (section 81.6[a][2] of this Part) or the program narrative as discussed in section 27.3(f) of this Title for integrated residential communities as defined in section 27.2(g). Integrated residential communities pursuant to section 27.2(g) shall comply with section 27.3(f) and are exempt from the requirements of subparagraphs (a)(2)(ix), (x) and (xii) of this section; (ix) progress notes written and signed by all staff members having significant participation in the program of treatment and care; (x) summaries of case conferences and special consultations; (xi) dated and signed prescriptions or orders for all medications with notation of termination dates; (xii) a closing summary of the course of treatment and care; and (xiii) documentation of any referrals to another agency." **27.3(e) :** From Quality of Care and Treatment regulations applicable to Integrated Residential Communities ONLY. Filing in patient's record. The designated staff members of facilities shall include a copy of the service plan and a written report on the content and results of each review in the patient's clinical record. The written report should include the dates of resolution (or nonresolution) of specific problems. **27.3(f)(1)-(5)** : From Quality of Care and Treatment regulations applicable to Integrated Residential Communities ONLY. (f) Program narrative. Integrated residential communities are required to develop a narrative description for each client served in the program setting. The narrative shall include: (1) a description of the individual's strengths and needs; (2) an annual summary encompassing the client's activities and interests in all aspects of life, including work, home social/leisure, community involvement and family involvement wherein the resident's contribution to the program setting is described. The client's activities and role in the community will depend on his or her interests, skill

			development and community needs; 3) a description of the approaches that will be used to address each identified need within the integrated 24-hour setting. Staff responsible for implementing components specified in the program narrative shall be identified; (4) a means of identifying how the client's overall degree of independence, capacity for responsibility and involvement in the community has been facilitated or enhanced; and (5) for clients who are receiving psychotropic medications, a full description of the reasons justifying the use of such medications and a specific program plan designed to eliminate the need for the use of said psychotropic medications.
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**81.8(a)(2)(viii) :** From Operation of Schools for … [People with Developmental Disabilities] regulations applicable to Private "Residential' Schools, but not Integrated Residential Communities. Records and statistics. (a) Case records. … (2) Each case record shall include: …(viii) the individual written plan of care, treatment and training (section 81.6[a][2] of this Part) or the program narrative as discussed in section 27.3(f) of this Title for integrated residential communities as defined in section 27.2(g). **81.6(a)(2) :** From Operation of Schools for … [People with Developmental Disabilities] regulations applicable to Private "Residential' Schools, but not Integrated Residential Communities. Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title. **27.3(f)(3) and (4) :** From Quality of Care and Treatment regulations applicable to Integrated Residential Communities ONLY. Program narrative. Integrated residential communities are required to develop a narrative description for each client served in the program setting. The narrative shall include: … (3) a description of the approaches that will be used to address each identified need within the integrated 24-hour setting. Staff responsible for implementing components specified in the program narrative shall be identified; (4) a

			means of identifying how the client's overall degree of independence, capacity for responsibility and involvement in the community has been facilitated or enhanced; and (5) for clients who are receiving psychotropic medications, a full description of the reasons justifying the use of such medications and a specific program plan designed to eliminate the need for the use of said psychotropic medications.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**81.6(a)(2) :** From Private School regulations applicable to Private "Residential" Schools, but not Integrated Residential Communities. "Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title. **27.3(f) :** From Quality of Care and Treatment regulation applicable to Private Schools identified as Integrated Residential Communities ONLY. Program narrative. Integrated residential communities are required to develop a narrative description for each client served in the program setting. The narrative shall include: (1) a description of the individual's strengths and needs; …; (3) a description of the approaches that will be used to address each identified need within the integrated 24-hour setting. Staff responsible for implementing components specified in the program narrative shall be identified; (4) a means of identifying how the client's overall degree of independence,

			capacity for responsibility and involvement in the community has been facilitated or enhanced;" **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**81.6(a)(2) :** From Private School regulations applicable to Private "Residential" Schools, but not Integrated Residential Communities. "Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title." **27.3(g) :** From Quality of Care and Treatment regulations applicable to Private Schools identified as Integrated Residential Communities ONLY. "Program narrative review and update. An integrated residential community creates a setting in which consistent, continuous and routine interaction occurs between program staff, who live and work with clients and the clients themselves. Review of the progress of individuals is therefore an ongoing, integral part of the program structure. A specific review or update of each individual's program narrative shall be required on an annual basis. All staff who are responsible for implementation of components of the program narrative shall participate in the annual review. More frequent reassessments of the individual's strengths and needs as part of the program narrative will formally occur only when necessary, as indicated by dramatic changes in

			client behavior or interest, or by staff concerns that warrant such reassessment." **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.		**633.4(a)(4)(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**81.8(a)(2)(ix) :** From Private School regulations applicable to Private "Residential" Schools, but not Integrated Residential Communities. Each case record shall include:…(ix) progress notes written and signed by all staff members having significant participation in the program of treatment and care **81.6(a)(2) :** From Private School regulations applicable to Private "Residential" Schools, but not Integrated Residential Communities. Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title. **27.3(f) :**

			From Quality of Care and Treatment regulations applicable to Private Schools identified as Integrated Residential Communities ONLY. "Program narrative review and update. An integrated residential community creates a setting in which consistent, continuous and routine interaction occurs between program staff, who live and work with clients and the clients themselves. Review of the progress of individuals is therefore an ongoing, integral part of the program structure. A specific review or update of each individual's program narrative shall be required on an annual basis. All staff who are responsible for implementation of components of the program narrative shall participate in the annual review. More frequent reassessments of the individual's strengths and needs as part of the program narrative will formally occur only when necessary, as indicated by dramatic changes in client behavior or interest, or by staff concerns that warrant such reassessment."
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service	Met/Not Met	**633.4(a)(4)(ix)** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely

	plan and the person's needs, preferences and goals related to the service.		and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**81.6(a)(2) :** From Operation of Schools for … [People with Developmental Disabilities] regulations applicable to Private "Residential' Schools, but not Integrated Residential Communities. Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title. **27.3(g) :** From Quality of Care and Treatment regulations applicable to Private Schools identified as Integrated Residential Communities ONLY. "Program narrative review and update. An integrated residential community creates a setting in which consistent, continuous and routine interaction occurs between program staff, who live and work with clients and the clients themselves. Review of the progress of individuals is therefore an ongoing, integral part of the program structure. A specific review or update of each individual's program narrative shall be required on an annual basis. All staff who are responsible for implementation of components of the program narrative shall participate in the annual review. More frequent reassessments of the individual's strengths and needs as part of the program narrative will formally occur only when necessary, as indicated by dramatic changes in client behavior or interest, or by staff concerns that warrant such reassessment."
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**81.8(a)(2)(ix)-(x) :** From Private School regulations applicable to Private "Residential" Schools, but not Integrated Residential Communities. Each case record shall include:…(ix) progress notes written and signed by all staff members having significant participation in the program of treatment and care; (x) summaries of case conferences and special consultations"

			27.3(g) : From Quality of Care and Treatment regulations applicable to Private Schools identified as Integrated Residential Communities ONLY. “Program narrative review and update. An integrated residential community creates a setting in which consistent, continuous and routine interaction occurs between program staff, who live and work with clients and the clients themselves. Review of the progress of individuals is therefore an ongoing, integral part of the program structure. A specific review or update of each individual's program narrative shall be required on an annual basis”
2-14	The individual’s services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**81.6(a)(2) :** From Operation of Schools for … [People with Developmental Disabilities] regulations applicable to Private “Residential’ Schools, but not Integrated Residential Communities. Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title. **27.3(g) :** From Quality of Care and Treatment regulations applicable to Private Schools identified as Integrated Residential Communities ONLY. Program narrative review and update. An integrated residential community creates a setting in which consistent, continuous and routine interaction occurs between program staff, who live and work with clients and the clients themselves. Review of the progress of individuals is therefore an ongoing, integral part of the program structure. A specific review or update of each individual's program narrative shall be required on an annual basis. All staff who are responsible for implementation of components of the program narrative shall participate in the annual review. More frequent reassessments of the individual's strengths and needs as part of the program narrative will formally occur only when necessary, as indicated by dramatic changes in client behavior or interest, or by staff concerns that warrant such reassessment.

2-15	The person is satisfied with the specific service.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
2r-1	If the individual is engaged in pre-vocational training, it is in accordance with applicable federal and state labor and wage laws, including periodic review of pre-vocational task to deem if they require compensation.	Met/Not Met/NA	**25.3(b) :** Prevocational training and evaluation may include performance of work tasks without compensation which would otherwise require compensation provided that: (1) patient [the individual's] participation in such activities is voluntary; (2) the work tasks are part of an overall plan designed and implemented to increase work readiness and training potential; and (3) work tasks are directed and supervised in accordance with the patient's [individual's] overall service plan. **25.3(c) :** While compensation for work tasks performed as part of prevocational training and evaluation is not required, it is encouraged especially for its incentive effect. **25.3(d) :** At the conclusion of three months of performance of prevocational work tasks, these tasks shall be considered to be work requiring compensation in accordance with section 25.5 of this Part, unless: (1) there is a comprehensive review of the prevocational training or evaluation plan and the patient's [individual's] progress in performance of assigned tasks by a multi-disciplinary group which, on the basis of the review, finds and certifies that: (i) the prevocational plan is adequate to indicate the probability that it will result in the patient [individual] being able to undertake vocational training in the future; and (ii) the patient's [individual's] work performance is such that the production of the patient [individual] is insignificant; (2) such review is repeated each 60 days if performance of work tasks without compensation is continued; (3) a written report of each such review is made part of the patient's [individual's] record; and (4) the patient [individual] is informed of the results of the review and of his or her right to object and appeal as provided in section 27.8 of this Part. **25.7(c) :** Note: 25.7(c) This Part [Part 25] shall not apply to clients [individuals] who reside and work within an integrated residential community pursuant to

			sections 27.2(g) [correction: actually 27.2(e)] and 27.3(f) of this Title. However: (1) an integrated residential community shall design and implement a means to ensure that clients [individuals] are protected from exploitation; and (2) under no conditions shall a client [resident] of an integrated residential community be permitted to perform work tasks or activities without appropriate supervision or perform on equipment and under conditions which do not adequately provide for the client's [his or her] health, safety and welfare.
2r-2	When the individual's services include vocational services, compliance with federal and state laws regarding labor wages and safety is evidenced.	Met/Not Met/NA	**25.6(a)-(e) :** Any facility in which patients [individuals] perform work tasks shall establish and maintain for each such patient [individual] a record in addition to the patient's [his or her] service plan and record (as indicated in section 25.1[c] and [d] of this Part) which includes the following in addition to any information required by Federal or State laws: (a) a cumulative record of dates and hours worked; (b) a description of the work performed; (c) the name of the immediate supervisor; (d) the rate of payment; and (e) a summary total of payments made **25.5(g) :** Under no circumstances shall any patient [individual receiving services] be allowed to perform work tasks under conditions, in facilities, or on machines or equipment which are not in full compliance with all applicable Federal and State laws and regulations.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such

			information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii)** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5)** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3)** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

	anonymous complaints if desired.		
3-7	The individual is supported to express themselves through personal choices/decisions on style of dress and grooming preferences.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-8	The individual is supported to participate in cultural/religious/associational practices, educuation, celebrations and experiences per their interests and preferences.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-9	The individual is supported to have visitors of their choosing according their preferences.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-10	The individual has privacy in his/her home, bedroom or other service environments and according to their needs for support**.**	Met/Not Met	**633.4(a)(xx) :** No person shall be denied the right to a reasonable degree of privacy in sleeping, bathing and toileting areas.
3-13	The individual can choose to eat meals when they want to, even if mealtimes occur at routine or scheduled times.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-14	The individual has access/is supported to have access to food at any time and to store their own food and snack	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

	choices for their use at any time as desired, similar to people without disabilities.		
3-15	The individual is supported to have independent access to the site/service setting with freedom to come and go as desired, similar to people without disabilities.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-16	The individual has full/unrestricted access to typical spaces and facilities in the home or day setting and are supported to use them.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-17	The setting reflects the individual's needs and preferences including the presence of any necessary physical modifications, if applicable.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-21	The individual controls their personal resources and decides how to spend their personal discretionary funds.	Met/Not Met	**633.15(c)(5)-(6) :** The expenditure of personal allowance must personally benefit the person and reflect his/her personal spending choices. The person shall be involved in all decisions regarding the use of his/her personal allowance funds. OMRDD assumes that all people with developmental disabilities have some capacity for self-advocacy and decision making related to the expenditure of personal allowance.

3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
3a-2	When interventions are used that restrict or modify the individual's rights (but not part of a behavior support plan), the individual's service plan includes a description of the individualized assessed need and/or behavior that justifies the rights restriction or rights modification (clinical justification).	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)
3a-3	When interventions restrict or modify the individual's rights (not part of a behavior support plan), the service plan includes time limits for imposition and review of continued necessity.	Met/Not Met	**633.4(b)(6) :** For the person who has had limitations placed on any rights, there is documentation in the person's plan of services as the clinical justification and specific period of time the limitation is to remain in effect. (Note: see section 636-1.4 of this Title for documentation requirements specific to the person-centered service plan and section 633.16 of this Part for documentation requirements concerning person-centered behavioral intervention.)

3a-4	The individual's service plan identifies specific actions/supports, collection/review of data related to effectiveness, and actions to ensure the interventions cause no harm.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
3a-5	The individual has given informed consent to the rights limitations/restrictions in place.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	meaningful to them for the period of time desired.		
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
6-1	The individual is satisfied with their living situation and does not express a desire (when questioned) to move to another living setting and/or with another roommate.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
6-2	If the individual is NOT satisfied with living situation, there is evidence that the staff is proactively working to find an alternate arrangement based on the person's needs, choices and preferences in a timely manner.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
6-3	The individual's personal living spaces(s) reflect their individualized interest and tastes.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or	Met/Not Met	**27.3(f) :** From Quality of Care and Treatment regulation applicable to Private Schools identified as Integrated Residential Communities ONLY. Program narrative. Integrated residential communities are required to develop a narrative description for each client served in the program setting. The narrative shall include: (1) a description of the individual's strengths and needs; …; (3) a description of the approaches that will be used to address each identified

	attachment according to service/setting requirements.		need within the integrated 24-hour setting. Staff responsible for implementing components specified in the program narrative shall be identified. **633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (i) An assessment of functional capacity. (ii) Review and evaluation of the person's written plan of services and his or her progress in relation to that plan …; **81.6(a)(2) :** From Private School regulations applicable to Private "Residential" Schools ONLY: Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title."
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**81.6(a)(2) :** Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. **633.4(a)(4)(viii)-(x): :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live

			as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **81.6(a)(2) :** Private "Residential" Schools: Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. **25.7(c) :** Private Schools, Integrated Residential Communities: This Part shall not apply to clients who reside and work within an integrated residential community pursuant to sections 27.2(g) and 27.3(f) of this Title. However: (1) an integrated residential community shall design and implement a means to ensure that clients are protected from exploitation; and (2) under no conditions shall a client of an integrated residential community be permitted to perform work tasks or activities without appropriate supervision or perform on equipment and under conditions which do not adequately provide for the client's health, safety and welfare.
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met/NA	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful

			recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **81.6(a)(2) :** Applicable to Private "Residential" Schools ONLY 81.6(a)(2): Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. **81.6(d)(3) :** Therapies such as physical therapy, occupational therapy, indoor and outdoor recreational and social therapy, speech and hearing therapy, and others shall be provided at the school or by arrangement with outside resources as needed for individual residents.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met/NA	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **81.6(a)(2) :** Applicable to Private "Residential" Schools ONLY 81.6(a)(2): Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating

			these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. **ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff.
8a-1	A health assessment which identifies the individual's health care needs has been completed by a physician, PA, NP or RN.	Met/Not Met	**81.6(a)(6) :** A single case record, which contains current information regarding diagnosis, treatment and training, and evaluation of results of care, treatment and training for each person served, shall be available to all professional staff involved in the care or treatment of that person. In the circumstance of an integrated residential community, as defined in section 27.2(g) of this Title, paragraph (7) of this subdivision shall be controlling. **81.8(a)(2)(iv)-(vi) :** 81.8(a)(2)(iv), (v), (vi) Each case record shall include: (iv) initial, intercurrent and final diagnoses, including psychiatric or mental retardation diagnoses in official terminology; (v) reports of all diagnostic examinations and evaluations, including findings and conclusions; (vi) reports of all periodic medical, dental, eye and hearing examinations;... **633.10(a)(2)(iii)** :

			(2) In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). On no less than an annual basis, the agency/facility or the sponsoring agency shall ensure the following requirements are met to ensure the protection of persons under their care and treatment: (iii) For persons in a residential facility, at least a medical/dental evaluation by a physician or registered physician's assistant addressing the person's need for an examination or specific medical/dental services; or by a dentist for dental services. The determination of the basis for such evaluation (e.g., appraisal of the person through records and previous contacts) shall be that of the qualified professional.
8a-2	The individual has someone chosen/delegated to support them in coordinating their health care.	Met/Not Met	**81.6(d)(4)(i)-(ii) :** (4) (i) The school shall provide full-time nursing services under the direction of a currently registered professional nurse experienced in the care of the mentally retarded if any of the following are served on a regular basis: the severely or profoundly retarded, the mildly or moderately retarded who are also physically handicapped, or the mentally retarded under five years of age. (ii) If the facility is not required to provide full-time nursing services, all usual and necessary activities and procedures for the maintenance of physical well-being of the residents shall be provided under the supervision of a regularly scheduled part-time currently registered professional nurse.
8a-3	The individual's service plan identifies the services and supports necessary to access and receive routine professional medical care and evaluation.	Met/Not Met	**81.6(a)(2) :** (2) Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title. **633.4(a)(4)(x) :**

			No person shall be denied: ...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;... **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-4	The individual's routine health care providers are identified and known to the person and/or their supports.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known).
8a-5	The individual and/or their support(s) knows how to access emergency medical care.	Met/Not Met	**633.10(b)(3) :** OPWDD shall verify that staff have been made aware of their responsibilities in accordance with the agency/facility plan. [Context: 633.10(2) States:" There is a written plan specifying how the agency/facility will deal with life threatening emergencies. Such a plan shall address: (i) First aid. (ii) CPR. (iii) Access to emergency medical services."]
8a-6	The individual receives routine medical exams/medical appointments per his/her health care professionals' recommendations.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :**

			Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-7	The individual receives diagnostic evaluation/testing per his/her health care professionals' recommendations and standard safe practice (e.g. Lab work, x-rays, scans, MRIs, etc.)	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-8	The individual receives preventative testing and/or care based on recommended professional guidelines for medical conditions, gender and age.	Met/Not Met	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-9	The individual receives preventative testing and/or	Met/Not Met	**633.4(a)(4)(x) :**

	care based on recommended professional guidelines for medical conditions, gender, and age.		No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8a-10	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met/NA	**ADM 2003-01 :** The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in theconsumer's condition. **81.6(a)(2) :** (2) Direct services to residents shall be provided in accordance with an individual written plan of care, treatment and training specifying the nature of the conditions and the disabilities found to be present and those which are to be affected, relating these to the methods of care, treatment and training to be provided, identifying the intended benefits of care and treatment and providing for appropriate review and revision. Integrated residential communities, as defined in section 27.2(g) of this Title, shall be exempt from the requirements of this section and shall instead comply with section 27.3(f) of this Title.
8a-11	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES	Met/Not Met/NA	**633.4(a)(4)(x) :** No person shall be denied: (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;

	NOT APPLY TO MEDICATION.		**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity.
8-12	The individiual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**633.10(a)(1) :** Section 33.03 of the Mental Hygiene Law requires that each person shall receive care and treatment that is suited to his or her needs and skillfully, safely and humanely administered with full respect to his or her dignity and personal integrity. **633.17(a)(15)(i)-(ii) :** Supervision and monitoring of staff. (i) Medical or nursing supervision of those staff responsible for administering medication shall be provided. (ii) Supervision and monitoring shall be in accordance with agency/facility policies/procedures. **ADM 2003-01 :** A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities
8a-13	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed**.**	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2003-01 :** The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.
8a-14	The individual's emerging signs/symptoms are reported to a health care professional,	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or

	and monitored and addressed appropriately.		through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-15	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met/NA	**633.17(b)(3)(i)-(ii) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication. The record contains: (i) name of the person; (ii) name of medication, dosage, and route of administration; **633.17(b)(9) :** OMRDD shall verify that in residential facilities and nonresidential facilities that assume the responsibility for the administration of medication, there is information on each medication being used by each person and that the information is specific to that person,
8a-16	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met/NA	**633.17(b)(2) :** There is documentation that at least annually, each person at a residential facility has been evaluated as to his or her ability to self-administer medication. If a nonresidential facility assumes the responsibility for the administration of medication, there is documentation that those persons who do not live in an OMRDD facility have been evaluated by the nonresidential facility, at least annually, as to their ability to administer medication.
8a-17	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA	**633.17(b)(3) :** Except as specified in paragraph (4) of this subdivision, there is a record for each person in any facility where medication is administered which documents the administration of medication.
8a-18	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**633.17(a)(5) :** Each agency/facility shall develop its own policies/procedures relative to prescribed (see glossary) and over-the-counter medication (see glossary) as is relevant to its needs. Family care homes shall adhere to policies/procedures as developed by their sponsoring agency. All such policies/procedures shall be in conformance with this Part. ...

			633.17(a)(7) : All medication shall be prescribed or ordered, obtained, provided, received, administered, safeguarded, documented, refilled and/or disposed of in a manner that ensures the health, safety, and well-being of the people being served and in conformance with all applicable Federal and State statute or regulations. Where requirements are more restrictive in Part 681 (for ICF/DD's), they shall be controlling. **ADM 2003-01 :** The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status.
8a-19	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**633.17(b)(8) :** OPWDD shall verify that the medication regimen of each person in a residential facility has been reviewed at least semi-annually by a registered nurse, physician, physician's assistant, or pharmacist.
8a-20	The individual exhibits a healthy lifestyle and/or receives support(s) to replace the unhealthy behaviors with healthier actions.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
8a-21	The individual is provided choice in health care providers.	Met/Not Met	**633.4(a)(4)(x)** : (4) No person shall be denied:. (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-22	The individual is supported to advocate and is included in informed decision-making	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

	related to medical care and treatment.		
8a-23	Individuals have been given the opportunity to have advanced directives in place (DNR order, healthcare proxy, or living will).	Met/Not Met	**633.4(a)(4)(xxv)-(xxvi) :** (4) No person shall be denied: .(xxv) the opportunity to make, or have made on his or her behalf, an informed decision regarding cardiopulmonary resuscitation (see glossary), in accordance with the provisions of article 29-B of the Public Health Law, and any other applicable law or regulation. Each developmental center (see glossary) shall adopt policies/procedures to actualize this right. (xxvi) the opportunity, if the person is residing in an OPWDD operated or certified facility, to create a health care proxy (see glossary) in accordance with 14 NYCRR 633.20.
8a-24	For those that have advanced directives, they are completed properly in accordance with the Healthcare Decisions Act.		**633.10(a)(7)(ii) :** Upon receipt of notification of a decision to withdraw or withhold life-sustaining treatment in accordance with section 1750-b(4)(e)(ii) of the Surrogate's Court Procedure Act (SCPA), the chief executive officer (see glossary, section 633.99 of this Part) of the agency (see glossary, section 633.99 of this Part) shall confirm that the person's condition meets all of the criteria set forth in SCPA section 1750-b(4)(a) and (b). In the event that the chief executive officer is not convinced that all of the necessary criteria are met, he or she may object to the decision and/or initiate a special proceeding to resolve such dispute in accordance with SCPA section 1750-b(5) and (6).
8a-25	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**633.10(a)(2) :** In accordance with the regulations for the class of facility, there shall be a current record (see glossary, section 633.99 of this Part) that includes all information concerning or relating to the examination or treatment of the person for whom the record is kept, and which includes a plan of services (by whatever name known). **81.6(a)(7) :** Appropriate access to the case records of an integrated residential community which contain current information regarding diagnosis, treatment, training, and assessment of the results of care for each person served, shall

			be guaranteed by the provider agency. Information will be made available to staff interacting with the client, consulting professionals, parents and OMRDD staff in accordance with the facility's policies, subject to the review and approval of OMRDD.
8a-26	The individual is supported to obtain a second opinion or submit a grievance when the medical service is considered unsatisfactory.	Met/Not Met/NA	**633.4(a)(4)(x) :** (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8a-27	The individual is given access to family planning resources and sexuality education and/or counseling if desired.	Met/Not Met/NA	**633.4(a)(4)(xi) :** (4) No person shall be denied:...(xi) access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated.
8a-28	The individual has all necessary medical services and supports in place that allow him/her to live as independently as possible in the least restrictive setting.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
8a-29	The individual and his/her guardian, family member, or advocate is satisfied overall with the medical care that the individual receives.	Met/Not Met	**Quality Indicator** This is an indicator of quality outcomes.
9-1	A Functional Behavioral Assessment is completed for	Met/Not Met	**633.16(d)(1)-(2) :**

	the individual prior to the development of the Behavior Support Plan.		Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging	Met/Not Met	**633.16(d)(1)(i - v)** :

	behaviors and all contextual factors as required.		Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline	Met/Not Met	**633.16(d)(1)(x) :**

	description of their challenging behaviors.		Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).

9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii):** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.

9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical	Met/Not Met	**633.16(i)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical

	intervention techniques (if applicable).		intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a

	inclusion of the current interventions.		restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how	Met/Not Met	**633.16(e)(3)(ii)(f) :**

	the use of each intervention or limitation is to be documented.		A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(i):** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention:

	Support Plan that includes restrictive/intrusive interventions.		written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the

	in a 30-day period resulted in a comprehensive review.		program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.

9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :**

	any Mechanical Restraining device that was not commercially available or designed for human use.		Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician’s order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person’s clinical record with a full record of the use of the device.

9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(i)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.

9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(i)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(i)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(i)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person’s behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed for possible injuries as soon	Met/Not Met	**633.16(j)(1)(vi) :**

	as possible following the use of physical interventions.		After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.

9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the

			licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)** : Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9e-1	Medication to address the individual's challenging behavior or a symptom of a diagnosed co-occurring psychiatric disorder is administered only as a part of a BSP or Monitoring Plan which includes additional interventions.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9e-2	Written Informed Consent for use of medication by the individuals has been obtained and is current.	Met/Not Met	**633.16(j)(5)(ii)(b) :** Written informed consent shall be obtained prior to the use of the medication. If it is necessary for the medication to be administered before written informed consent can reasonably be obtained, verbal consent may be accepted for only the period of time before written informed consent can be obtained. Verbal consent must be witnessed by two members of the staff and documented in the person's record. This verbal consent may be considered valid for a period of up to 45 days.
9e-3	When the plan includes the medication the Individual's service record includes a semi-annual medication regimen review that is used to	Met/Not Met	**633.16(j)(5)(i)(d) :** A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team

	evaluate the benefits/risk of continuation.		and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
9e-4	The Individual's service record includes evidence that the prescriber was consulted regarding administration and continued effectiveness of the medication.	Met/Not Met	**633.16(j)(5)(i)(e)** : At least semi-annually, and more frequently as needed, staff shall consult with the prescriber regarding the administration and continued effectiveness of the medication.
9e-5	The Individual's service record includes evidence that the use of medication is having a positive effect on his/her behavior or target symptoms.	Met/Not Met	**633.16(j)(5)(ii)(c) :** The use of medication shall have a documented positive effect on the person's behavior or target symptoms to justify its ongoing use.
9e-6	The Individual's service record includes evidence that the effectiveness of the medication has been re-evaluated at least semi-annually at the program plan review with required service attendees.	Met/Not Met	**633.16(j)(5)(ii)(d)** : The effectiveness of the medication shall be re-evaluated at least semi-annually at the program plan reviews by the program planning team in consultation with a licensed psychologist, licensed clinical social worker, or behavior intervention specialist, and a health care professional. The goal(s) of this aspect of the plan review include: ensuring that medication is at the minimum and most effective dose; identifying a potential need for a medication with fewer or less intrusive side effects; evaluating the evidence presented to support continuation of the medication at a maintenance level, or recommending reduction or discontinuation of medication use if clinically indicated and authorized by the prescriber.
9e-7	Medications were administered in accordance with requirements.	Met/Not Met	**633.16(j)(5)(ii)(a) :** Medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, must be

			administered only as an integral part of a behavior support plan or monitoring plan, in conjunction with other interventions which are specifically directed toward the potential reduction and eventual elimination of the challenging behavior(s) or target symptoms of the co-occurring diagnosed psychiatric disorder.
9f-1	When prn medication is prescribed to address behavior or symptoms of a psychiatric disorder, this strategy is included in the Individual's Behavioral Support or Monitoring Plan.	Met/Not Met/NA	**633.16(j)(5)(iii)(a) :** As-needed (also known as PRN) orders for medication to prevent, modify, or control challenging behavior, or to treat symptoms of a co-occurring diagnosed psychiatric disorder, are considered planned use and must be incorporated in and documented as part of a behavior support plan or a monitoring plan.
9f-2	The Individual's service record includes evidence of the display of the behavior(s) or symptom(s) for which the PRN medication is being prescribed in the past 12 months.	Met/Not Met/NA	**633.16(j)(5)(iii)(b) :** Planned use of as-needed orders for medication: The person shall have a recent documented history of displaying the behavior(s) or symptoms (occurring in the last 12 months) for which the as-needed medication is being prescribed.
9f-3	The Individual's Behavioral Support or Monitoring Plan provides instruction and guidance for administration of the PRN medication, consistent with the prescriber's order.	Met/Not Met/NA	**633.16(j)(5)(iii)(c)(1-3) :** The behavior support plan or monitoring plan, consistent with the prescriber's order, shall clearly state: (1) the conditions under which the as-needed medication is to be administered, including the nature and degree of the individual's behavior(s) or symptoms, and the prescriber's recommendations regarding proximity to any scheduled medication administration; (2) the expected therapeutic effects; and (3) if applicable, the conditions under which the medication can be re-administered, and the allowable frequency of re-administration.
9f-4	The Individual's service record must include a summary, in behavioral terms,	Met/Not Met/NA	**633.16(j)(5)(iii)(d) :**

	of the results of the PRN medication administration.		Planned use of as-needed orders for medication: The staff person or family care provider who is responsible for support and supervision of a person who has a behavior support plan or monitoring plan must document in the person's clinical record a summary of the results of the medication use in behavioral terms.
9f-5	The Individual's service record includes evidence that any adverse or unexpected side effects were reported to the PRN prescriber immediately and the planning team by the next business day.	Met/Not Met/NA	**633.16(j)(5)(iii)(e) :** Planned use of as-needed orders for medication: Results that are substantively different from the intended effect, and any adverse side effects, shall be reported to the prescriber immediately and the person's program planning team no later than the next business day.
9f-6	Use of PRN Medications on more than four (4) separate days in a 14-day period resulted in consideration of a recommendation for incorporation into a regular drug regimen.	Met/Not Met/NA	**633.16(j)(5)(iii)(f) :** If any as-needed medication is administered on more than four separate days (one day equals 24 hours) in a 14-day period, the individual's program planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist and healthcare professional, must reassess the appropriateness of continuing the as-needed medication, or consider recommending that it be incorporated into the individual's regular drug regimen.
9f-7	Lack of use of a PRN medication during a six-month period resulted in a review of the BSP and a recommendation to the prescriber.	Met/Not Met/NA	**633.16(j)(5)(iii)(h) :** If the as-needed medication is not administered during a six-month period, the program planning team, in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist, must review the behavior support plan and develop a recommendation to the prescriber regarding the appropriateness of continuing the as-needed medication as part of the plan. If the order is continued, a clear justification is to be documented in the record.

9f-8	Effectiveness of the medication ordered in an emergency is documented in the Individual's record.	Met/Not Met/NA	**633.16(J)(5)(iv)(c) :** Emergency use of medication: The use of the medication, along with the prescription/order and a note on its effectiveness, shall be documented in the person's record.
9f-9	Emergency use of medication in more than 4 instances in a 14-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(J)(5)(iv)(d) :** Emergency use of medication. The emergency use of medication to control challenging behavior or acute symptoms of a co-occurring diagnosed psychiatric disorder in more than four instances in a 14-day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, a licensed clinical social worker or behavioral intervention specialist within three business days of the fifth medication administration.
9f-10	Use of PRN medications in conjunction with a restrictive physical intervention technique were reported electronically to OPWDD.	Met/Not Met/NA	**633.16(j)(5)(iii)(g) :** Each use of an as-needed medication when used in conjunction with a restrictive physical intervention technique to prevent, modify, or control challenging behavior shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9g-1	The Individual's record identifies the symptoms he/she exhibits and each co-occurring psychiatric disorder diagnosis.	Met/Not Met	**633.16(j)(5)(vi)(e) :** Medication use to treat a co-occurring diagnosed psychiatric disorder. Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirement must be met. (e) The symptoms and diagnosis of the co-occurring psychiatric disorder must be documented.
9g-2	The Individual's Monitoring Plan clearly identifies target symptoms associated with	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such

	each medication prescribed for a psychiatric disorder.		circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented.
9g-3	The Individual's Monitoring Plan includes the method to measure and document symptom reduction and functional improvement.	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-4	The Individual's Monitoring Plan includes alternative interventions (other than medication).	Met/Not Met	**633.16(j)(5)(vi)(g) :** Medication may be used as part of the treatment for the symptoms of a co-occurring diagnosed psychiatric disorder, including challenging behavior that occurs exclusively or almost exclusively as a result of that disorder. In such circumstances, the following requirements must be met. (g) The use of medication and the target symptoms shall be specified and documented in a written monitoring plan. The plan must specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress,

			will be measured and documented. If all of the requirements of this clause are met, the agency is not required to conduct and document a functional behavioral assessment or develop a behavior support plan, as long as other behavioral interventions are not needed for the individual to address challenging behaviors which do not reflect the psychiatric symptomatology. The monitoring plan shall describe how challenging behavior(s) -- including those that reflect psychiatric symptomatology, should they occur -- will be addressed through the use of other appropriate interventions. If it is expected that the person might need restrictive/intrusive interventions, a functional behavioral assessment and behavior support plan must be developed.
9g-5	The individual's Monitoring Plan is developed by a qualified clinician.	Met/Not Met	**633.16(b)(29) :** Plan, monitoring. A plan developed by a licensed psychologist, licensed psychiatric nurse practitioner, licensed clinical social worker, or a behavioral intervention specialist that identifies the target symptoms of a co-occurring diagnosed psychiatric disorder that are to be prevented, reduced, or eliminated.
9g-6	The effectiveness of the individual's Monitoring Plan in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(j)(5)(j)(d)** : A semi-annual medication regimen review that includes any medications prescribed to treat a co-occurring diagnosed psychiatric disorder, or to prevent, modify, or control challenging behavior(s), must be conducted in accordance with section 633.17 of this Part. The results of these medication regimen reviews shall be shared with the person's program planning team and the prescriber, and documented in the person's record, in order to assist healthcare providers and the team to evaluate whether the benefits of continuing the medication(s) outweigh the risk inherent in potential side effects.
10a-1	Events involving the individual that meet the definition of reportable incident or notable	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or

	occurrence have been reported.		situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be

			recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3**)

			When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not

			limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the

			recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or

	in reported 625 event/situations.		financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable

			and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and	Met/Not Met	**624.5(h)(1)**

	Notable Occurrences involving the individual are thorough and documented.		624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3**) 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation.

	incident or notable occurrence is reported.		When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3):** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the

			continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(j)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(j-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**ADM 2005-02:** For consumers enrolled in the HCBS waiver, the ISP, which is developed by the consumer's Medicaid Service Coordination (MSC) service coordinator or Plan of Care Support Services (PCSS) service coordinator, serves as the "authorization" for the Respite service. The ISP must include the following elements related to the Respite service: 1. Respite must be included as a waiver service the consumer receives and (your) agency must be identified as the provider of the Respite service. **633.4(a)(4)(viii)-(ix)**: No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix):** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **635-10(g)(4)**: Respite care services in the person's home shall be delivered by parties who are qualified to provide the level of care specified in the person's individualized service plan.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**ADM 2005-02:** Service documentation must be contemporaneous with Respite service provision. Required service documentation elements are: 1. Consumer's name, TABS ID and if applicable, the Medicaid ID (CIN) 2. Identification of the category of waiver service provided, which, in this case, is "Respite" 3. Name of the agency providing the Respite service (that is, your agency) 4.

			The date the service was provided 5. The start time and stop time for each continuous period of Respite service 6. Verification of service provision by the Respite staff person who delivered the service (this is accomplished with a staff signature and title) 7. The date the service was documented (that is, the date must be "contemporaneous" with service provision
2-15	The person is satisfied with the specific service.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix)** : No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4) :** OMRDD shall verify that staff are aware of the rights of persons in the facility.
8b-1	A medical assessment which identifies the individual's health care needs has been completed by a physician, PA, NP, or RN.	Met/Not Met	**ADM 2015-03: Page 4:** With respect to each new individual served by an approved provider, the approved provider, in collaboration with an RN employed by or under contract with the approved provider, shall review the individual's nursing needs, if any. If the RN determines that the individual requires nursing services, the RN shall complete a comprehensive assessment of the individual to determine whether nursing tasks, in whole or in part, can be delegated to DSPs with adequate training and nursing supervision. The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences; (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional; and (4) a review of all medications that the individual is

			currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.
8b-2	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met	**ADM 2015-03: Pages 5-6:** The RN shall develop an individualized plan of nursing services based on the comprehensive nursing assessment of the individual, which identifies the nursing services to be provided to the individual, including delegated nursing tasks. An RN who delegates the performance of nursing tasks shall note in the individualized plan of nursing services a description of the nursing task, the name of the DSP(s) to whom the task is delegated, the date of delegation, the RN who will initially be assigned to supervise the DSP(s), and the RN's signature. The RN may include specific recommendations relating to the RN supervision of the delegated tasks. The RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. A delegating RN shall provide written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications to the qualified DSPs to whom the nursing task is delegated. An RN shall document in the plan of nursing services the delegation of nursing tasks to qualified DSPs as well as any changes in or termination of nursing tasks. The RN shall provide the DSP with written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 8 The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the individual's condition. The PONS shall identify the RN(s) who delegated each nursing task and the nursing tasks that were delegated.

8b-3	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**ADM 2015-03 Page 6:** An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 9: The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.
8b-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**ADM 2015-03 Page 5:** . It shall be the responsibility of the RN to determine, using professional nursing judgment, whether any and which nursing tasks can be delegated to DSPs and which DSPs will be authorized and trained to perform the delegated tasks. The RN shall exercise professional judgment as to when delegation is unsafe and/or not in the individual's best interest...Page 6: ...An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities... Page 6-7: ...The amount and type of nursing supervision required will be determined by the RN responsible for supervising the task or activity, and will depend upon:the complexity of the task; the skill, experience and training of the DSP; and the health conditions and health status of the individual being served.... Page 7: ...The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications... Page 8:... The frequency of visits to sites where DSPs provide nursing tasks shall be at the discretion of the RN responsible for supervision but in no case shall visits occur less frequently than once during the month in which such nursing tasks are delivered.... Page 9: ...The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.
8b-5	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the

	or directed.		choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8b-6	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**ADM 2015-03: Page 4:** An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants. Page 5: The RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. Page 8: The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the individual's condition.
8c-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met	**ADM 2015-03 : Page 4**: The comprehensive nursing assessment must include the following information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8:The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii). **ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8: ...The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii).

8c-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences;
8c-3	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA	**ADM 2015-03 : Page 7:** .. The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications.
8c-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**ADM 2015-03 : Page 8:** The approved provider shall ensure that all supervising RNs (including supervising RNs working during off-hours or on-call), will be immediately notified of changes in medical orders for an individual and/or of changes in an individual's health status. This notification may be provided by the DSP or by other staff working with the individual at the time a change occurs (e.g., by the DSP who accompanied an individual to a medical appointment that resulted in a new medical order; an individual becomes ill or injured while under the care of the assigned DSP or other staff member, etc.)
8c-5	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (4) a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application

			(IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2) The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4) :** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1) :** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern or volunteer, consultant, or contractor

			alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or

			contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the

			continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii) :** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l) :** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the

			Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** : Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2) :** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3) :** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)

10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1) :** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3) :** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5) :** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2) :** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or

			notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met	**624.7(b)(2); :** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** : (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii) :**

			When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met	**625.4(b)(2)(i-ii) :** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2m-1	The person's need for the adaptive device is documented in his/her ISP.	Met/Not Met	**635-10.5(g)(1)(i) :** The requested adaptive technologies must be included in and consistent with the person's individualized service plan (ISP).
2m-2	The specific device is identified in the ISP.	Met/Not Met	**635-10.4(f) :** Adaptive technologies are those devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community-based setting with independence and safety. The equipment, whether of a communication or adaptive type, must be documented in the person's individualized service plan as being essential to the person's habilitation, ability to function, or safety (including fire safety evacuation needs); and have an essential relationship to support/maintain (or obtain) the person's current or desired residence.
2m-3	The adaptive device increases/maintains the individual's safety, independence and/or community integration.	Met/Not Met	**635-10.4(f) :** Adaptive technologies are those devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community-based setting with independence and safety. The equipment, whether of a communication or adaptive type, must be documented in the person's individualized service plan as being essential to the person's habilitation, ability to function, or safety (including fire safety evacuation needs); and have an essential relationship to support/maintain (or obtain) the person's current or desired residence.
2m-4	The individual receives on-going support needed to use the device, as identified in his/her ISP.	Met/Not Met/NA	**The Key to Individualized Services, 11-1 :** Although the regulations in 635-10 regulate allowable services and billing related activity, The Key notes that services may also be provided to assist an individual in the use of an AT device. The service coordinator and/or other providers need to ensure that an individual is provided with on-going supports, when needed, to use the device as intended.
2m-5	The effectiveness of the device is periodically reviewed/assessed.	Met/Not Met/NA	**The Key to Individualized Services, 11-1** : Although regulations in 635-10 regulate allowable services and billing related activity, The Key notes that services may also be provided to help an individual to make the best possible use of an AT device, and to periodically assess the continued effectiveness of the device in accordance with an

			individual's changing needs and capabilities - and to explore use of new technology, when indicated.
2n-1	The person's need for the E-mod is documented in his/her ISP.	Met/Not Met	**635-10.5(f)(1)(i) :** Environmental modifications. (1) Reimbursement for environmental modifications shall be made pursuant to a contract between OPWDD and a contractor (see paragraph [4] of this subdivision) and subject to Subpart 635-6 of this Part. … (i) The requested environmental modifications must be included in and consistent with the person's individualized service plan (ISP).
2n-2	The E-Mod enables the person to live safely in the home and/or improve/maintain independence.	Met/Not Met	**635-10.4(e) :** Environmental modifications are selected internal and external changes to a person's physical home environment, required by the person's individualized service plan, which provide appropriate site accommodations to meet the person's fire safety evacuation needs …[eliminated outdated regulatory reference], and which are necessary to ensure the health, welfare and safety of the person or which enable him or her to function with greater independence in the home and without which the person's continued residence could be jeopardized.
2n-3	As appropriate, the E-Mod involved the professional consultation necessary for the E-Mod construction or use.	Met/Not Met/NA	**The Key to Individualized Services, 10-5:** The Key advises that professional staff are available to the individual, advocate, and service coordinator to provide guidance in evaluating the need for E-Mods and guidance on the actual construction. Making good use of professional expertise can assure good quality work and assure that safety and accessibility of the modification for the individual receiving services. These professional staff include DDSOO Community Development housing office staff, plant superintendents, and safety officers in State operated services; architects; clinicians, such as physical and occupational therapists; independent living centers; and colleges and universities.
2n-4	The E-Mod was provided with attention to requirements for building and fire safety codes as necessary.	Met/Not Met/NA	**635-10.5(f)(2) :** The contract shall specify whether the environmental modification(s) must meet the requirements of the Uniform Code, the Building Code of the City of New York, or any other local codes and OPWDD regulations. The contract shall specify which of these requirements the environmental modification(s) must meet, if any, and state who is responsible for ensuring compliance with the applicable requirements.

Standard No.	Standard Text	Decision	Regulatory References
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2b-1	The individual is supported to exercise budget authority over how his or her resources are budgeted and managed within the Personal Resources Account (PRA).	Met/Not Met	**ADM 2015-06 Service Documentation for Support Broker:** "A Start-up Broker assists the individual to develop a complete and approvable self-direction budget within the individual's Personal Resource Account (PRA) amount. This assistance may also include helping the individual to develop a planning team. Additional activities such as hiring staff, assisting with service documentation, and other tasks are allowed and need to be outlined in the support brokerage agreement." A Support Broker also "provides support and training to individuals and their families regarding the ongoing decisions and tasks associated with self-direction. …The Support Broker provides assistance and practical skills training to the individual in the areas of: understanding and managing the responsibilities involved with self-direction, community inclusion and independent living; developing daily implementation of and managing the self-directed budget; monitoring expenditures; negotiating terms and service arrangements with providers; employer responsibilities such as recruiting, supervising, and training of individual hired staff; service documentation requirements to ensure agreement with program and Medicaid standards; planning and ensuring safeguards are identified and met. The extent of the assistance provided is determined by the individual and is specified in a written agreement signed by the individual and Support Broker. **ADM #2015-04 Service Documentation for Fiscal Intermediary:** "Fiscal Intermediary services (FI Services) are HCBS Waiver services that include tasks performed by a Fiscal Intermediary (FI) which support a participant who self directs an individualized budget. Such tasks include billing and payment of approved goods and services, fiscal accounting and reporting, Medicaid and corporate compliance, and general administrative supports. The FI is the employer of record for staff hired by the participant [where applicable]. … A participant must choose an FI to handle billing if any of the following services is included in his or her budget: Individual Directed Goods and Services; Live-in Caregiver; Brokerage Services; Community Transition Services; Any type of 100% state-funded service(s) that is listed in the participant's individualized budget; or Any self-hired staff for Community Habilitation, Supported Employment (SEMP), and/or Respite."

2c-1	The individual is supported by the Fiscal Intermediary (FI) to complete billing and payment for goods and services identified in his/her Self Direction budget when the individual exercises Budget Authority.	Met/Not Met	**ADM #2015-04 Service Documentation for Fiscal Intermediary:** "Fiscal Intermediary services (FI Services) are HCBS Waiver services that include tasks performed by a Fiscal Intermediary (FI) which support a participant who self directs an individualized budget. Such tasks include billing and payment of approved goods and services, fiscal accounting and reporting, Medicaid and corporate compliance, and general administrative supports. The FI is the employer of record for staff hired by the participant [where applicable]. … A participant must choose an FI to handle billing if any of the following services is included in his or her budget: Individual Directed Goods and Services; Live-in Caregiver; Brokerage Services; Community Transition Services; Any type of 100% state-funded service(s) that is listed in the participant's individualized budget; or Any self-hired staff for Community Habilitation, Supported Employment (SEMP), and/or Respite."
2c-2	The individual is supported by the Fiscal Intermediary (FI) to complete billing and payment for goods and services identified in his/her Self Direction budget and to provide additional staffing-related services when the individual exercises Budget and Employment Authority.	Met/Not Met	**ADM #2015-04 Service Documentation for Fiscal Intermediary:** "Fiscal Intermediary services (FI Services) are HCBS Waiver services that include tasks performed by a Fiscal Intermediary (FI) which support a participant who self directs an individualized budget. Such tasks include billing and payment of approved goods and services, fiscal accounting and reporting, Medicaid and corporate compliance, and general administrative supports. The FI is the employer of record for staff hired by the participant. These staff are referred to as "self-hired staff." A participant must choose an FI to handle billing if any of the following services is included in his or her budget: Individual Directed Goods and Services; Live-in Caregiver; Brokerage Services; Community Transition Services; Any type of 100% state-funded service(s) that is listed in the participant's individualized budget; or Any self-hired staff for Community Habilitation, Supported Employment (SEMP), and/or Respite."
2c-3	The individual is provided a monthly expenditure report.	Met/Not Met	**ADM #2015-04 Service Documentation for Fiscal Intermediary:** "[FI] Fiscal accounting and reporting [responsibilities include:] a. Establish and maintain a separate account for each participant; b. Track disbursements and balances of participant funds for those services that are included in the self-directed budget; c. Send monthly expenditure reports to the participant by the end of the following month…"
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.

10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency.

			624.5(g)(3) When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3**) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate

			justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes

			recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i)

			implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless

	thorough and documented.		OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3)** 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining

			necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take

			specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2f-1	The Individual Directed Goods and Services (IDGS) a person receives address an identified need in a person's ISP, to promote his/her inclusion in the community, and/or increase the person's safety and independence in the home environment, and/or decrease the need for other Medicaid services.	Met/Not Met	**ADM 2015-05 Service Documentation for Individual Directed Goods and Services :** IDGS "are services, equipment or supplies not otherwise provided through OPWDD's HCBS Waiver or through the Medicaid State Plan that address an identified need in a participant's service plan, which include improving and maintaining the participant's opportunities for full membership in the community. IDGS, as part of a person-centered plan, allow an individual to receive services in the most integrated setting possible. IDGS items and services decrease the need for other Medicaid services, promote inclusion in the community, and/or increase the individual's safety and independence in the home environment." Also from ADM 2015-05: "For IDGS, the following elements must be included in the ISP: Identification of the IDGS category of waiver service (i.e., Individual Directed Goods and Services)[,] Identification of the FI agency billing IDGS[,] Specification of an effective date for IDGS that is on or before the date of service for which the FI agency bills IDGS for the participant[,] Specification of the frequency for IDGS is "day[,]" [and] Specification of the duration for IDGS is "ongoing." And finally, from ADM 2015-05: "A summary of expenses paid on behalf of the participant along with supporting receipts/documents must also be made maintained. This expense summary must include: 1. Individual's name and Medicaid number (CIN) 2. Name of the FI agency paying for IDGS supports and services 3. Identification of the category of waiver service provided (e.g., Individual Directed Goods and Services or IDGS) A list of expenses paid on behalf of the participant 5. The date(s) the expenses were paid 6.The amount paid."
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as	Met/Not Met/NA	**625.4(a)**

	defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.		The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)

			624.5(g)(2) When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3)** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is

			complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee.

			624.5(i)(2)(i)-(ii) When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)

10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)

			624.5(g)(4) If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3**) 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional

			information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide

			a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take

			specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2b-1	The individual is supported to exercise budget authority over how his or her resources are budgeted and managed within the Personal Resources Account (PRA).	Met/Not Met	**ADM 2015-06 Service Documentation for Support Broker:** "A Start-up Broker assists the individual to develop a complete and approvable self-direction budget within the individual's Personal Resource Account (PRA) amount. This assistance may also include helping the individual to develop a planning team. Additional activities such as hiring staff, assisting with service documentation, and other tasks are allowed and need to be outlined in the support brokerage agreement." A Support Broker also "provides support and training to individuals and their families regarding the ongoing decisions and tasks associated with self-direction. …The Support Broker provides assistance and practical skills training to the individual in the areas of: understanding and managing the responsibilities involved with self-direction, community inclusion and independent living; developing daily implementation of and managing the self-directed budget; monitoring expenditures; negotiating terms and service arrangements with providers; employer responsibilities such as recruiting, supervising, and training of individual hired staff; service documentation requirements to ensure agreement with program and Medicaid standards; planning and ensuring safeguards are identified and met. The extent of the assistance provided is determined by the individual and is specified in a written agreement signed by the individual and Support Broker. **ADM #2015-04 Service Documentation for Fiscal Intermediary:** "Fiscal Intermediary services (FI Services) are HCBS Waiver services that include tasks performed by a Fiscal Intermediary (FI) which support a participant who self directs an individualized budget. Such tasks include billing and payment of approved goods and services, fiscal accounting and reporting, Medicaid and corporate compliance, and general administrative supports. The FI is the employer of record for staff hired by the participant [where applicable]. … A participant must choose an FI to handle billing if any of the following services is included in his or her budget: Individual Directed Goods and Services; Live-in Caregiver; Brokerage Services; Community Transition Services; Any type of 100% state-funded service(s) that is listed in the participant's individualized budget; or Any self-hired staff for Community Habilitation, Supported Employment (SEMP), and/or Respite."

2e-1	The Support Broker assists the individual with developing a comprehensive self-direction budget within the person's Personal Resource Account (PRA) amount.	Met/Not Met	**ADM 2015-06 Service Documentation for Support Broker:** "A Start-up Broker assists the individual to develop a complete and approvable self-direction budget within the individual's Personal Resource Account (PRA) amount. This assistance may also include helping the individual to develop a planning team. Additional activities such as hiring staff, assisting with service documentation, and other tasks are allowed and need to be outlined in the support brokerage agreement."
2e-2	There is a written support brokerage agreement describing the broker's responsibilities to assist the individual.	Met/Not Met	**ADM 2015-06 Service Documentation for Support Broker:** " The Support Broker provides assistance and practical skills training to the individual in the areas of: understanding and managing the responsibilities involved with self-direction, community inclusion and independent living; developing daily implementation of and managing the self-directed budget; monitoring expenditures; negotiating terms and service arrangements with providers; employer responsibilities such as recruiting, supervising, and training of individual hired staff; service documentation requirements to ensure agreement with program and Medicaid standards; planning and ensuring safeguards are identified and met. The extent of the assistance provided is determined by the individual and is specified in a written agreement signed by the individual and Support Broker."
2e-3	Face-to-face planning meetings (Circle of Support meetings) occur 4 times per year. They may occur concurrently with the ISP review meetings.	Met/Not Met	**ADM 2015-06 Service Documentation for Support Broker:** "Planning team meetings, also known as Circle of Support meetings, need to occur 4 times per year (every 3 months is recommended) and must be face-to-face with the individual. These planning team meetings (also known as circle of support meetings) can occur concurrently with the ISP review meetings."
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial

			information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an

	individual are thorough and documented.		investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3)** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or

			provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence	Met/Not Met	**624.5(g)(1)**

	(MNO): Immediate care and treatment identified and needed was provided to the individual.		A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3**) 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional

			information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar

			reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2g-1	The individual receiving Live-in Caregiver services resides in his/her own home or a leased residence where he/she is responsible for the residence.	Met/Not Met	**ADM 2016-03 Live-in Caregiver Service Documentation :** “The individual must reside in his/her own home or leased residence. Payment will not be made when the individual lives in the caregiver's home, in a residence that is owned or leased by the provider of Medicaid services, in a Family Care home, or any other residential arrangement where the individual is not directly responsible for the residence.”
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable

			and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3**) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must

			report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to

			provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or

	event/situations.		financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the

	implemented immediately.		chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3**) 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves

			employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)**

			When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**636-1.2(a)(1)-(2) :** (1) The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-4	The individual's planning meetings are scheduled at the times and locations	Met/Not Met	**636-1.2(b)(2)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the

	convenient to the individual.		HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: scheduling with the individual at times and locations of convenience to the individual.
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met	**636-1.2(b)(1)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**636-1.2(b)(5)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (5) developing strategies that address conflicts or disagreements in the process, including clear conflict of interest guidelines for individuals, and communicating such strategies to the individual who is receiving services as appropriate.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(a)(2**) A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences. **636-1.2(b)(1) :** A person-centered planning process is required for developing the person-

			centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **ADM 2015-01 :** The Community Habilitation Plan developed by the agency providing CH services that conforms to the Habilitation Plan requirements found in Administrative Memorandum #2012-01. **ADM 2012-01** : ADM 2012-01 The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into

	planning/plan.		account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-16	The individual's goals and priorities regarding meaningful relationships are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes

1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**ADM 2012-01 :** The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ...For all other habilitation services...safeguards must be included in the Habilitation Plan or the plan must reference other documentation that specifies the safeguards. Information on the safeguards must be readily available to the habilitation service provider staff. **636-1.3(b)(8)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed; and
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**ADM 2012-01 :** Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or his/her advocate.
1-34	The individual has been	Met/Not Met	**636-1.2(b)(4) -**

	informed that they can request a change to the plan and understands how to do so.		A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**ADM 2015-01 :** In addition to the service note(s) ...the agency providing CH services must maintain the following documentation: A copy of the individual's Individualized Service Plan (ISP), developed by the individual's Medicaid Service Coordinator (MSC) or Plan of Care Support Services (PCSS) Service Coordinator if the individual is HCBS Waiver enrolled or receives service coordination.
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :**.. If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. **ADM 2015-01:** The Community Habilitation Plan developed by the agency providing CH services that conforms to the Habilitation Plan requirements found in Administrative Memorandum #2012-01. For Community Habilitation, the habilitation plan should clearly identify that the habilitation plan is for

			Community Habilitation (e.g., titled "Community Habilitation Plan"). **635-99.1(bl) :.** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2012-01 :** Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: an ISP review date, or the date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**ADM 2012-10 Habilitation Plan Requirements : pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes

			as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. ... c. Exploration of new experiences is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ...

			633.4(a)(4) : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(b)(3)(i)-(ii) :** Hourly community habilitation services (CH) are similar in scope to residential habilitation services and day habilitation services, however, the focus of these services is directed towards service delivery occurring largely in community (non-certified) settings to facilitate and promote independence and community integration. ...(i) Community habilitation services include all of the types of services specified in paragraphs (1) and (2) of this subdivision. (ii) Allowable activities include all of the allowable activities specified in subparagraphs (1)(i)-(xiv) and (2)(i)-(xiv) of this subdivision. **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**636-1.2(a)(3)(ii) :** The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii) :**

			A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**635-10.4(ab)(9)(i)(ii) :** For each continuous service delivery period or session, the CH provider must document: (i) the service start time and the service stop time; (ii) the provision of at least one service/staff action delivered in accordance with the individual's CH plan; **ADM 2015-01** : Medicaid rules require that service documentation be contemporaneous with the service provision. Acceptable formats for the service documentation ...include a narrative note or a checklist/chart with an entry made contemporaneously during CH service delivery.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-11	The person's services are delivered by competent staff/supports that understand	Met/Not Met	**633.4(a)(4)(ix)** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely

	their role, the service/service plan and the person's needs, preferences and goals related to the service.		and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers. **635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this

	and recommendations.		review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives.....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such

			information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii)** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-4	The individual is informed of their HCBS rights.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5)** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3)** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-8	The individual is supported to participate in cultural/religious/associational practices, educuation,	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

	celebrations and experiences per their interests and preferences.		
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs..	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii)** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4)** OMRDD shall verify that staff are aware of the rights of persons in the facility.
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community**.**	Met/Not Met	**441.301 (C)(4)(i)** : The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree	Met/Not Met	**441.301(C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal

	as individuals not receiving HCBS.		resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**636-1.2(3)(ii) :** supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect;
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**ADM 2012-01 – Habilitation Plan Requirements : Safeguards**. The safeguards delineated in the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation; Day Habilitation (in certified day habilitation sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY.
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x);** : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and

			personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All

			habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with

			14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified

			applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
8b-1	A medical assessment which identifies the individual's health care needs has been completed by a physician, PA, NP, or RN.	Met/Not Met	**ADM 2015-03: Page 4:** With respect to each new individual served by an approved provider, the approved provider, in collaboration with an RN employed by or under contract with the approved provider, shall review the individual's nursing needs, if any. If the RN determines that the individual requires nursing services, the RN shall complete a comprehensive assessment of the individual to determine whether nursing tasks, in whole or in part, can be delegated to DSPs with adequate training and nursing supervision. The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences; (3) current medical or nursing treatments ordered or prescribed by the

			individual's physician, nurse practitioner, or other qualified health professional; and (4) a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.
8b-2	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met	**ADM 2015-03: Pages 5-6:** The RN shall develop an individualized plan of nursing services based on the comprehensive nursing assessment of the individual, which identifies the nursing services to be provided to the individual, including delegated nursing tasks. An RN who delegates the performance of nursing tasks shall note in the individualized plan of nursing services a description of the nursing task, the name of the DSP(s) to whom the task is delegated, the date of delegation, the RN who will initially be assigned to supervise the DSP(s), and the RN's signature. The RN may include specific recommendations relating to the RN supervision of the delegated tasks. The RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. A delegating RN shall provide written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications to the qualified DSPs to whom the nursing task is delegated. An RN shall document in the plan of nursing services the delegation of nursing tasks to qualified DSPs as well as any changes in or termination of nursing tasks. The RN shall provide the DSP with written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 8 The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant

			change in the individual's condition. The PONS shall identify the RN(s) who delegated each nursing task and the nursing tasks that were delegated.
8b-3	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**ADM 2015-03 Page 6:** An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 9: The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.
8b-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**ADM 2015-03 Page 5:** . It shall be the responsibility of the RN to determine, using professional nursing judgment, whether any and which nursing tasks can be delegated to DSPs and which DSPs will be authorized and trained to perform the delegated tasks. The RN shall exercise professional judgment as to when delegation is unsafe and/or not in the individual's best interest...Page 6: ...An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities... Page 6-7: ...The amount and type of nursing supervision required will be determined by the RN responsible for supervising the task or activity, and will depend upon:the complexity of the task; the skill, experience and training of the DSP; and the health conditions and health status of the individual being served.... Page 7: ...The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications... Page 8:... The frequency of visits to sites where DSPs provide nursing tasks shall be at the discretion of the RN responsible for supervision but in no case shall visits occur less frequently than once during the month in which such nursing tasks are delivered.... Page 9: ...The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.
8b-5	The individual and/or their support(s) report the	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and

	individual's health concerns/symptoms to appropriate parties as needed or directed.		the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8b-6	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**ADM 2015-03: Page 4:** An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants. Page 5: The RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. Page 8: The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the individual's condition.
8c-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met	**ADM 2015-03 : Page 4**: The comprehensive nursing assessment must include the following information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8:The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii). **ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8: ...The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered.

			This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii).
8c-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences;
8c-3	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA	**ADM 2015-03 : Page 7:** .. The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications.
8c-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**ADM 2015-03 : Page 8:** The approved provider shall ensure that all supervising RNs (including supervising RNs working during off-hours or on-call), will be immediately notified of changes in medical orders for an individual and/or of changes in an individual's health status. This notification may be provided by the DSP or by other staff working with the individual at the time a change occurs (e.g., by the DSP who accompanied an individual to a medical appointment that resulted in a new medical order; an individual becomes ill or injured while under the care of the assigned DSP or other staff member, etc.)
8c-5	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (4) a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.
9-1	A Functional Behavioral Assessment is completed for the individual prior to the	Met/Not Met	**633.16(d)(1)-(2) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric

	development of the Behavior Support Plan.		disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	Met/Not Met	**633.16(d)(1)(i - v)** : Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional

			behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed

	by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.		psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive

	and reinforcing alternative skills and adaptive behaviors.		(replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii);** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as

	behavior support plan.		the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(i)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must

	restrictive/intrusive intervention(s) and/or limitation on rights.		include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication

			to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(i);** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-

	Support Plan that includes restrictive/intrusive interventions.		giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :**

	Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.		The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The

	device.		order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or designed for human use.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such

			a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(i)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or

	supervision of a senior member of the staff.		totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(i)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(i)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(i)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed	Met/Not Met	**633.16(j)(1)(vi) :**

	for possible injuries as soon as possible following the use of physical interventions.		After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and

	Plan.		continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)** : Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part

	required to be reported have been reported to OPWDD.		as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor

			alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3**) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed	Met/Not Met	**624.5(n)(1-2)**

	no later than 30 calendar days after the incident or notable occurrence is reported.		Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and

			OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition

	in reported 625 event/situations.		of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the

			injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3)** 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the

			VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."

10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes

			recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**636-1.2(a)(1)-(2) :** (1) The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-4	The individual's planning meetings are scheduled at the times and locations convenient to the individual.	Met/Not Met	**636-1.2(b)(2)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: scheduling with the individual at times and locations of convenience to the individual.
1-5	The individual is supported to direct the planning process to	Met/Not Met	**636-1.2(b)(1)** A person-centered planning process is required for developing the person-

	the maximum extent possible and desired.		centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**636-1.2(b)(5)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (5) developing strategies that address conflicts or disagreements in the process, including clear conflict of interest guidelines for individuals, and communicating such strategies to the individual who is receiving services as appropriate.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(a)(2**) A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences. **636-1.2(b)(1) :** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she

			receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **ADM 2012-01** : ADM 2012-01 The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning	Met/Not Met	**Quality Indicator –**

	and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.		This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**ADM 2012-01 :** The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ...For all other habilitation services...safeguards must be included in the Habilitation Plan or the plan must reference other documentation that specifies the safeguards. Information on the safeguards must be readily available to the habilitation service provider staff. **636-1.3(b)(8)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed; and
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**ADM 2012-01 :** Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or

			his/her advocate.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**636-1.2(b)(4) -** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**635-10.5(ah)(2)(i)** : Reimbursement of community prevocational services shall be contingent on prior OPWDD approval for individuals who enroll in such service on and after July 1, 2015. OPWDD approval will be based on the following criteria: (i) the individual must have a goal to develop pre-employment skills, which must be identified in the individual's individualized service plan (ISP);
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :**.. If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. **635-10.4(ah)(8)(iii) :** The service provider must develop a service delivery plan in the form and format specified by OPWDD that guides the delivery of the service for each individual receiving services. The plan must be documented, reviewed, and updated in accordance with section 635-99.1 of this Part.
2-3	The individual's written service plan is developed within time frames required	Met/Not Met	**ADM 2012-01 :** Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the

	for the specific service.		habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: an ISP review date, or the date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**ADM 2012-10 Habilitation Plan Requirements : pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or

			welfare, or to reach a valued outcome. ... c. Exploration of new experiences is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ... **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(l)(1) :** Community prevocational services are habilitation services that assist the individual to develop employment readiness skills and that are provided in the most integrated setting appropriate to the needs of the individual receiving such services. The services consist of learning and work experiences, including volunteer work, that are not job-task specific but contribute to an individual's ability to attain paid employment in the community. **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-6	The service plan/provided	Met/Not Met	**636-1.2(a)(3)(ii) :**

	services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.		The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**635-10.5(ah)(8)(iv) :** The service provider shall maintain documentation that the individual receiving community prevocational services has received the services in accordance with the individual's ISP and service delivery plan. **635-10.5(ah)(8)(v) :** For each continuous community prevocational service period/session, the service provider shall document the service start time and the service stop time, the ratio of individuals to staff at the time of service provision and the provision of at least one allowable activity that was delivered in accordance with the service delivery plan.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**635-10.4(l)(3)(i)-(iii) :** Community prevocational services shall be provided in the most integrated setting appropriate to the needs of the individual receiving such services, provided that: (i) individuals may use a site (see subdivision [k] of this section) as a meeting space for job readiness training on a time limited basis not to exceed two hours; (ii) individuals may gather at a site to identify prevocational activities for the day on a time limited basis not to exceed two hours; or (iii) activities need to be held at a site due to inclement weather, a public safety emergency or any other significant circumstance in which service delivery in the community may jeopardize the health and safety of individuals.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative,	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

	autonomy, independence, and dignity.		
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix)** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers. **635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this

	and recommendations.		review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives.....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2j-1	Services delivered to the individual other than in the community do not exceed 2 hours per day.	Met/Not Met	**635-10.4(l)(3) :** Community prevocational services shall be provided in the most integrated setting appropriate to the needs of the individual receiving such services, provided that:(i) individuals may use a site (see subdivision [k] of this section) as a meeting space for job readiness training on a time limited basis not to exceed two hours; (ii) individuals may gather at a site to identify prevocational activities for the day on a time limited basis not to exceed two hours; or (iii) activities need to be held at a site due to inclement weather, a public safety emergency or any other significant circumstance in which service delivery in the community may jeopardize the health and safety of individuals.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such

			information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii)** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-4	The individual is informed of their HCBS rights.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5)** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3)** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-8	The individual is supported to participate in cultural/religious/associational	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

	practices, educuation, celebrations and experiences per their interests and preferences.		
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs..	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii)** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4)** OMRDD shall verify that staff are aware of the rights of persons in the facility.
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community**.**	Met/Not Met	**441.301 (C)(4)(i)** : The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are meaningful to them for the period of time desired.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
7-1	The individual's specific	Met/Not Met	**ADM 2012-01 – Habilitation Plan Requirements : Safeguards**.

	safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.		The safeguards delineated in the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation; Day Habilitation (in certified day habilitation sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY.
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x);** : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with

			14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately,

			skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **ADM #2012-04 OPWDD Choking Prevention Initiative :** This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (henceforth known as applicable parties) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services. All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide.

			Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative. The OPWDD CPI training consists of two parts. CPI Part I, Prevention of Choking and Aspiration, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration…. Part II, Preparation Guidelines for Food and Liquid Consistency, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff. **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
8b-1	A medical assessment which identifies the individual's health care needs has been completed by a physician, PA, NP, or RN.	Met/Not Met	**ADM 2015-03: Page 4:** With respect to each new individual served by an approved provider, the approved provider, in collaboration with an RN employed by or under contract with the approved provider, shall review the individual's nursing needs, if any. If the RN determines that the individual requires nursing services, the RN shall complete a comprehensive assessment of the individual to determine whether nursing tasks, in whole or in part, can be delegated to DSPs with adequate training and nursing supervision. The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to

			the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences; (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional; and (4) a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.
8b-2	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met	**ADM 2015-03: Pages 5-6:** The RN shall develop an individualized plan of nursing services based on the comprehensive nursing assessment of the individual, which identifies the nursing services to be provided to the individual, including delegated nursing tasks. An RN who delegates the performance of nursing tasks shall note in the individualized plan of nursing services a description of the nursing task, the name of the DSP(s) to whom the task is delegated, the date of delegation, the RN who will initially be assigned to supervise the DSP(s), and the RN's signature. The RN may include specific recommendations relating to the RN supervision of the delegated tasks. The RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. A delegating RN shall provide written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications to the qualified DSPs to whom the nursing task is delegated. An RN shall document in the plan of nursing services the delegation of nursing tasks to qualified DSPs as well as any changes in or termination of nursing tasks. The RN shall provide the DSP with written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 8 The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the individual's condition. The PONS shall identify the RN(s) who delegated each nursing task and the nursing tasks that were delegated.

8b-3	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**ADM 2015-03 Page 6:** An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 9: The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.
8b-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**ADM 2015-03 Page 5:** . It shall be the responsibility of the RN to determine, using professional nursing judgment, whether any and which nursing tasks can be delegated to DSPs and which DSPs will be authorized and trained to perform the delegated tasks. The RN shall exercise professional judgment as to when delegation is unsafe and/or not in the individual's best interest...Page 6: ...An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities... Page 6-7: ...The amount and type of nursing supervision required will be determined by the RN responsible for supervising the task or activity, and will depend upon:the complexity of the task; the skill, experience and training of the DSP; and the health conditions and health status of the individual being served.... Page 7: ...The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications... Page 8:... The frequency of visits to sites where DSPs provide nursing tasks shall be at the discretion of the RN responsible for supervision but in no case shall visits occur less frequently than once during the month in which such nursing tasks are delivered.... Page 9: ...The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.
8b-5	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8b-6	The individual's service record/service plan is maintained to reflect current	Met/Not Met	**ADM 2015-03: Page 4:** An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants. Page 5: The RN shall promptly document

	status of the individual's health.		in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. Page 8: The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the individual's condition.
8c-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met	**ADM 2015-03 : Page 4**: The comprehensive nursing assessment must include the following information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8:The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii). **ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8: ...The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii).
8c-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences;
8c-3	The individual receives or self-administers medications	Met/Not Met/NA	**ADM 2015-03 : Page 7:** .. The supervising RN must periodically review the performance of DSPs to

	and treatments safely as prescribed.		verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications.
8c-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**ADM 2015-03 : Page 8:** The approved provider shall ensure that all supervising RNs (including supervising RNs working during off-hours or on-call), will be immediately notified of changes in medical orders for an individual and/or of changes in an individual's health status. This notification may be provided by the DSP or by other staff working with the individual at the time a change occurs (e.g., by the DSP who accompanied an individual to a medical appointment that resulted in a new medical order; an individual becomes ill or injured while under the care of the assigned DSP or other staff member, etc.)
8c-5	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (4) a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.
9-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	Met/Not Met	**633.16(d)(1)-(2) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service

			providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	Met/Not Met	**633.16(d)(1)(i - v)** : Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.	Met/Not Met	**633.16(d)(1)(vi-ix) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely

			on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target

	behavioral approaches, strategies and supports to address the target behavior(s).		behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii);** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no

	effectiveness of the interventions included in the behavior support plan.		less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(i)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure

			health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.
9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use

			of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(i);** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or

			portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :**

	Support Plan that includes a Mechanical Restraining device specifies the maximum intervals of time for monitoring his/her needs, comfort, and safety.		The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a

	designed for human use.		commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(i)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a	Met/Not Met	**633.16(j)(4)(ii)(k) :**

	mechanical device did not occur unless necessitating behavior reoccurred**.**		If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(i)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(i)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(i)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20

			minutes.
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's

			behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(3)(iv)(d)** : Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)**

			The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and

			specifically relieves the agency of the obligation to investigate **624.5(h)(3)** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to:

	involving the individual were planned and implemented.		ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports

	Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.		of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives

	individual.		any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3)** 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the

			additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16)

			624.5(k)(1)-(3); (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**636-1.2(a)(1)-(2) :** (1) The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-4	The individual's planning meetings are scheduled at the times and locations	Met/Not Met	**636-1.2(b)(2)** A person-centered planning process is required for developing the person-

	convenient to the individual.		centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: scheduling with the individual at times and locations of convenience to the individual.
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met	**636-1.2(b)(1)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**636-1.2(b)(5)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (5) developing strategies that address conflicts or disagreements in the process, including clear conflict of interest guidelines for individuals, and communicating such strategies to the individual who is receiving services as appropriate.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(a)(2**) A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences. **636-1.2(b)(1) :**

			A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **ADM 2016-01, pg. 11** The SEMP Service Delivery Plan (Habilitation Plan) developed by the agency providing SEMP services must conform to the Habilitation Plan requirements found in Administrative Memorandum #2012-01. **ADM 2012-01** : ADM 2012-01 The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into

			account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**ADM 2012-01 :** The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ...For all other habilitation services...safeguards must be included in the Habilitation Plan or the plan must reference other documentation that specifies the safeguards. Information on the safeguards must be readily available to the habilitation service provider staff. **636-1.3(b)(8)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed; and
1-28	The plan is written in plain	Met/Not Met	**636-1.2(b)(3)**

	language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.		A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**ADM 2012-01 :** Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or his/her advocate.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	636-1.2(b)(4) - A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**ADM 2016-01 Supported Employment (SEMP) :** In addition to the checklist and monthly summary ... the agency providing SEMP services must maintain the following documentation: ....A copy of the individual's ISP, developed by the individual's Medicaid Service Coordinator (MSC) or Plan of Care Support Services (PCSS) Coordinator....The SEMP Service Delivery Plan (Habilitation Plan) developed by the agency providing SEMP services must conform to the Habilitation Plan requirements found in Administrative Memorandum #2012-01.

2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :**.. If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. **635-10.4(j)(5)(i) :** The service provider must develop a supported employment service delivery plan that guides the delivery of the service for each individual receiving SEMP services. (ii) The plan must identify the responsibilities of the individual and the service provider necessary for delivery of the service and the achievement of the individual's employment goals. (iii) The plan must be documented, reviewed, and updated in accordance with section 635-99.1 of this Part.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2016-01 :** The SEMP Service Delivery Plan (Habilitation Plan) developed by the agency providing SEMP services must conform to the Habilitation Plan requirements found in Administrative Memorandum #2012-01. **ADM 2012-01 :** Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service

			coordinator no more than 30 days after either: an ISP review date, or the date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**635-10.4(j)(5)(i-iii) :** (i)The service provider must develop a supported employment service delivery plan that guides the delivery of the service for each individual receiving SEMP services. (ii) The plan must identify the responsibilities of the individual and the service provider necessary for delivery of the service and the achievement of the individual's employment goals. (iii) The plan must be documented, reviewed, and updated in accordance with section 635-99.1 of this Part. **ADM 2012-10 Habilitation Plan Requirements : pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the

			person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. ... c. Exploration of new experiences is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ... **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;

2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(j) :** SEMP is a person-centered employment planning and support service that provides assistance for an individual to obtain, maintain, or advance in self-employment or in competitive integrated employment in the general workforce, for which the individual is compensated at or above the State or Federal minimum wage (whichever is greater). The goal of this service is sustained self-employment or competitive integrated employment at or above the State or Federal minimum wage (whichever is greater) in the general workforce, in a job that meets the individual's personal and career goals. **ADM 2016-01 :** SEMP may be delivered in an Intensive Phase or Extended Phase and may be provided to a single individual or a group of two to eight (2-8) individuals. **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**636-1.2(a)(3)(ii) :** The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery	Met/Not Met	**ADM 2016-01 :**

	of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.		The acceptable format for the service documentation ... for SEMP services includes a Checklist and Monthly Summary. ....A narrative monthly summary note must include a summary of the following: 1. The implementation of the individual's SEMP Habilitation Plan for the month; 2. A description of the individual's vocational progress; 3. A description of some of the actions of staff to address vocational challenges; 4. A description of the individual's response; and 5. Any issues or concerns. The narrative monthly summary note must be completed, signed, and dated no later than the 30th day after the month of service. **635-10.5(af)(8)(ii)-(iii) :** (ii) The service provider must maintain documentation to show that an individual received SEMP services in accordance with his or her ISP and supported employment service delivery plan. (iii) For each continuous SEMP service session, the service provider must document date of service, the service start and stop times, the ratio of individuals to staff at the time of the SEMP service provision; and the allowable activities delivered during the SEMP services session.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service	Met/Not Met	**635-10.4(j)(4)(i)-(ii) :** All staff providing SEMP services must: (i) have at least a high school equivalency diploma or one year of work experience providing vocational or

	plan and the person's needs, preferences and goals related to the service.		pre-vocational services to individuals with disabilities; and (ii) complete an OPWDD approved vocational rehabilitation or supported employment training program. **633.4(a)(4)(ix)** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers. **635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.

			635-10.4(j)(5)(iii) : The plan must be documented, reviewed, and updated in accordance with section 635-99.1 of this Part.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives.....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
2h-1	SEMP services are directed toward achieving sustained	Met/Not Met	**635-10.4(j) :** Supported employment (SEMP) services on and after July 1, 2015. SEMP is

	self-employment or competitive integrated employment in the general workforce, in a job that meets the individual's personal and career goals.		a person-centered employment planning and support service that provides assistance for an individual to obtain, maintain, or advance in self-employment or in competitive integrated employment in the general workforce, for which the individual is compensated at or above the State or Federal minimum wage (whichever is greater). The goal of this service is sustained self-employment or competitive integrated employment at or above the State or Federal minimum wage (whichever is greater) in the general workforce, in a job that meets the individual's personal and career goals.
2h-2	Individuals receiving SEMP who are earning a wage must be compensated at or above the minimum wage.	Met/Not Met/NA	**635-10.4(j) :** Supported employment (SEMP) services on and after July 1, 2015. SEMP is a person-centered employment planning and support service that provides assistance for an individual to obtain, maintain, or advance in self-employment or in competitive integrated employment in the general workforce, for which the individual is compensated at or above the State or Federal minimum wage (whichever is greater). The goal of this service is sustained self-employment or competitive integrated employment at or above the State or Federal minimum wage (whichever is greater) in the general workforce, in a job that meets the individual's personal and career goals.
2h-3	Services provided without the individual present are documented and serve to benefit the individual in attaining his/her employment goals.	Met/Not Met	**635-10.5(af)(8)(ii) and (iii) Documentation.** (ii) The service provider must maintain documentation to show that an individual received SEMP services in accordance with his or her ISP and supported employment service delivery plan. (iii) For each continuous SEMP service session, the service provider must document date of service, the service start and stop times, the ratio of individuals to staff at the time of the SEMP service provision; and the allowable activities delivered during the SEMP services session. **ADM 2016-01 Supported Employment (SEMP) :** “Billing for SEMP Services Delivered Without the Individual Present. Some SEMP services may be delivered on behalf of an individual who is not actually present at the time of service delivery. Such services include: discussions with families about transportation to a job or benefits planning, meetings with businesses about hiring an individual, development of the SEMP Service Delivery Plan (also known as the Habilitation Plan), documentation of the delivery of SEMP services, travel to a job site to

			provide coaching services, etc. These services may be delivered and billed for during times when an individual may also be receiving another OPWDD service. This is not considered double billing because the individual is receiving two separate services. **635-10(j)(1) :** SEMP consists of the following allowable activities provided to and/or on behalf of an individual: (i) vocational assessment; (ii) person-centered employment planning; (iii) job-related discovery; (iv) job development, analysis, customization, and carving; (v) training and systematic instruction prior to employment;(vi) job placement; (vii) job coaching, training, and planning within the work environment; (viii) development and review of a business plan (for individuals who are pursuing self-employment or are self-employed); (ix) transportation between activities; (x) travel training; (xi) development of soft skills and job retention strategies (e.g., social interaction, maintaining relationships with co-workers and supervisory personnel); (xii) benefits support and asset development; (xiii) career advancement services; (xiv) other workplace support services including services that enable the individual to be successfully integrated into the job setting (e.g., development of natural supports in the work environment); (xv) negotiating potential jobs with prospective employers on behalf of an individual; (xvi) communication with an existing employer to review the individual's progress in meeting workforce expectations and to discuss and address any challenges the individual may have in the work environment; (xvii) communication with family or other members of the individual's circle of support to discuss and address employment-related issues, such as management of benefits or challenges the individual may have in the work environment; and/or (xviii) meetings and communications with staff providing other OPWDD approved services that impact an individual's ability to successfully achieve employment goals; (xix) documentation of the delivery of SEMP services; and (xx) other activities previously approved by OPWDD.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or

			correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii)** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-4	The individual is informed of their HCBS rights.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5)** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3)** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

	complaint including anonymous complaints if desired.		
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs..	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii)** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4)** OMRDD shall verify that staff are aware of the rights of persons in the facility.
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the same degree as others in the community**.**	Met/Not Met	**441.301 (C)(4)(i)** : The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**ADM 2012-01 – Habilitation Plan Requirements : Safeguards**. The safeguards delineated in the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except

			that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation; Day Habilitation (in certified day habilitation sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY.
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x);** : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with

			14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-4	The individual is provided	Met/Not Met	**633.4(a)(4)(viii)-(x) :**

	mobility supports per his/her written plan and as needed.		No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and

			guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
8b-1	A medical assessment which identifies the individual's health care needs has been completed by a physician, PA, NP, or RN.	Met/Not Met	**ADM 2015-03: Page 4:** With respect to each new individual served by an approved provider, the approved provider, in collaboration with an RN employed by or under contract with the approved provider, shall review the individual's nursing needs, if any. If the RN determines that the individual requires nursing services, the RN shall complete a comprehensive assessment of the individual to determine whether nursing tasks, in whole or in part, can be delegated to DSPs with adequate training and nursing supervision. The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences; (3) current medical or nursing treatments ordered or prescribed by the

			individual's physician, nurse practitioner, or other qualified health professional; and (4) a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.
8b-2	There is a written plan/instruction to address routine care/monitoring to be provided related to the individual's specific medical condition(s).	Met/Not Met	**ADM 2015-03: Pages 5-6:** The RN shall develop an individualized plan of nursing services based on the comprehensive nursing assessment of the individual, which identifies the nursing services to be provided to the individual, including delegated nursing tasks. An RN who delegates the performance of nursing tasks shall note in the individualized plan of nursing services a description of the nursing task, the name of the DSP(s) to whom the task is delegated, the date of delegation, the RN who will initially be assigned to supervise the DSP(s), and the RN's signature. The RN may include specific recommendations relating to the RN supervision of the delegated tasks. The RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. A delegating RN shall provide written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications to the qualified DSPs to whom the nursing task is delegated. An RN shall document in the plan of nursing services the delegation of nursing tasks to qualified DSPs as well as any changes in or termination of nursing tasks. The RN shall provide the DSP with written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 8 The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant

			change in the individual's condition. The PONS shall identify the RN(s) who delegated each nursing task and the nursing tasks that were delegated.
8b-3	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**ADM 2015-03 Page 6:** An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 9: The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.
8b-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**ADM 2015-03 Page 5:** . It shall be the responsibility of the RN to determine, using professional nursing judgment, whether any and which nursing tasks can be delegated to DSPs and which DSPs will be authorized and trained to perform the delegated tasks. The RN shall exercise professional judgment as to when delegation is unsafe and/or not in the individual's best interest...Page 6: ...An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities... Page 6-7: ...The amount and type of nursing supervision required will be determined by the RN responsible for supervising the task or activity, and will depend upon:the complexity of the task; the skill, experience and training of the DSP; and the health conditions and health status of the individual being served.... Page 7: ...The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications... Page 8:... The frequency of visits to sites where DSPs provide nursing tasks shall be at the discretion of the RN responsible for supervision but in no case shall visits occur less frequently than once during the month in which such nursing tasks are delivered.... Page 9: ...The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.
8b-5	The individual and/or their support(s) report the	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and

	individual's health concerns/symptoms to appropriate parties as needed or directed.		the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8b-6	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**ADM 2015-03: Page 4:** An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants. Page 5: The RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. Page 8: The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the individual's condition.
8c-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met	**ADM 2015-03 : Page 4**: The comprehensive nursing assessment must include the following information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8:The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii). **ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8: ...The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered.

			This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii).
8c-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences;
8c-3	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA	**ADM 2015-03 : Page 7:** .. The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications.
8c-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**ADM 2015-03 : Page 8:** The approved provider shall ensure that all supervising RNs (including supervising RNs working during off-hours or on-call), will be immediately notified of changes in medical orders for an individual and/or of changes in an individual's health status. This notification may be provided by the DSP or by other staff working with the individual at the time a change occurs (e.g., by the DSP who accompanied an individual to a medical appointment that resulted in a new medical order; an individual becomes ill or injured while under the care of the assigned DSP or other staff member, etc.)
8c-5	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (4) a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.
10a-1	Events involving the individual that meet the definition of reportable incident or notable	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or

	occurrence have been reported.		situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2) The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives

			any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3)** When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)**

			The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals

			receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the

			manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives

			any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3**)

			624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification. (i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary

			investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD

	from the investigation findings and incident review.		may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-2	The individual's planning process/planning meetings include people chosen by and important to the individual.	Met/Not Met	**636-1.2(a)(1) :** The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. **636-1.2(a)(2) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**636-1.2(a)(1)-(2) :** (1) The person-centered planning process involves parties chosen by the individual, often known as the individual's circle of support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law. (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences.
1-4	The individual's planning meetings are scheduled at the times and locations	Met/Not Met	**636-1.2(b)(2)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the

	convenient to the individual.		HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: scheduling with the individual at times and locations of convenience to the individual.
1-5	The individual is supported to direct the planning process to the maximum extent possible and desired.	Met/Not Met	**636-1.2(b)(1)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**636-1.2(b)(5)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (5) developing strategies that address conflicts or disagreements in the process, including clear conflict of interest guidelines for individuals, and communicating such strategies to the individual who is receiving services as appropriate.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**636-1.2(a)(2**) A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). (2) The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, where necessary, assisting the individual to communicate his or her preferences. **636-1.2(b)(1) :** A person-centered planning process is required for developing the person-

			centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person-centered planning process involves: (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions
1-11	The individual's goals and desired outcomes are documented in the person-centered service plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **ADM 2012-01** : ADM 2012-01 The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.
1-14	The individual's cultural/religious and other personalized associational interests/preferences are included in person centered planning/plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-15	The individual's priorities/interests regarding meaningful community based activities, including the	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and

	desired frequency and the supports needed are identified in the person centered plan.		makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-16	The individual's goals and priorities regarding meaningful relationships are identified in the person centered plan.	Met/Not Met	**636-1.2(a) :** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-17	The individual's goals, priorities, and interests regarding meaningful work, volunteer and recreational activities are identified in the person centered plan.	Met/Not Met	**636-1.2(a)** A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home).
1-21	The person centered planning and plan allow for acceptance of risk in support of the individual's desired outcomes when balanced with the conscientious discussion, and proportionate safeguards and risk mitigation strategies.	Met/Not Met	**Quality Indicator –** This is an indicator of quality outcomes
1-22	Risks to the individual and the strategies, supports, and safeguards to minimize risk, including specific back-up plans, are identified in the person centered plan.	Met/Not Met	**ADM 2012-01 :** The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is

			acceptable. ...For all other habilitation services...safeguards must be included in the Habilitation Plan or the plan must reference other documentation that specifies the safeguards. Information on the safeguards must be readily available to the habilitation service provider staff. **636-1.3(b)(8)** (b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: ... (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed; and
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**636-1.2(b)(3)** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual.
1-32	The person-centered plan is distributed to the individual and service providers.	Met/Not Met	**ADM 2012-01 :** Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b) the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or his/her advocate.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**636-1.2(b)(4) -** A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: providing a method for the individual to request updates to the person-centered service plan as needed.
2-1	The service provider	Met/Not Met	**2006-01 Group Day Habilitation :**

	maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.		Group Day Habilitation: In addition to the service note(s) supporting Group Day Habilitation or Supplemental Group Day Habilitation... agency must maintain the following documentation: A copy of the consumer's Individualized Service Plan ISP), developed by the consumer's Medicaid Service Coordinator (MSC) or Plan of Care Support Services (PCSS) service coordinator. **635-10.4(b) :** Habilitation services are designed to provide general assistance to persons, in accordance with their individualized service plan, to acquire and maintain those life skills that enable them to cope more effectively with their environments.
2-2	The service record contains the current service plan(s) required for the service/service setting.	Met/Not Met	**635-99.1(bl) :**.. If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider... **ADM 2012-01 :** The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator….The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-3	The individual's written service plan is developed within time frames required for the specific service.	Met/Not Met	**ADM 2012-01 :** Habilitation Plan Requirements: The initial Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.... Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service

			coordinator no more than 30 days after either: an ISP review date, or the date on which the habilitation service provider makes a significant change in the Habilitation Plan.
2-4	The person's service specific written plan meets the content requirements for the specific service, and describes action expected by service provider and the individual.	Met/Not Met	**ADM 2012-10 Habilitation Plan Requirements: pgs. 4-5:** Every Habilitation Plan must include the following sections: 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful. 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes. 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan. a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection. Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery

			team, activities specified in the Habilitation Plan can be directed to skill retention. b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. ... c. Exploration of new experiences is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. ... 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. ... **633.4(a)(4) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. … (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-5	The individual is provided the service(s) and activities identified/described in the written plan and/or required by the service type.	Met/Not Met	**635-10.4(b)(2) :** Day habilitation services are delivered primarily in a nonresidential setting separate from the person's home/residence with exceptions allowed to promote transition or adaptation. Such services shall provide assistance with acquisition, retention or improvement of self-help, socialization, adaptive skills and development of manual and perceptual motor skills. **633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services …

			which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. …(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-6	The service plan/provided services clearly evidence the intent to facilitate advancement of the individual towards achievement of outcomes.	Met/Not Met	**636-1.2(a)(3)(ii) :** The person-centered planning process requires that: supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect. **633.4(a)(4)(viii) :** A written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who are nonhandicapped), and which enables him or her to live as independently as possible.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**ADM 2006-02 :** The acceptable format for the service documentation ... is either a narrative note or a checklist/chart with an entry made at the same time each Individual Day Habilitation service is delivered and billed. **ADM 2006-01:** The acceptable format for the service documentation ... is either a narrative note or a checklist/chart with an entry made at the same time each Group Day Habilitation service is delivered and billed.
2-8	The person is participating in activities in the most natural context.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-9	Services and supports are delivered in the most integrated setting appropriate to the individual's needs, preferences, and desired outcomes.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

2-10	Services and supports are delivered in a manner that optimizes and fosters the individual's initiative, autonomy, independence, and dignity.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**633.4(a)(4)(ix)** No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;
2-12	The individuals' service and/or plan is reviewed to determine whether the services/supports delivered are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers. **635-99.1(bl) :** If habilitation services are provided (i.e., residential habilitation, day habilitation, community habilitation, supported employment, pre-vocational

			services, pathway to employment), the relevant habilitation plan(s) must be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation service provider.
2-13	There is a review summary note reporting on the service delivery, actions taken, evaluation of effectiveness and recommendations.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.
2-14	The individual's services/supports and/or delivery modalities are modified as needed/desired in conjunction with the person to foster the advancement/achievement of his/her goals/outcomes.	Met/Not Met	**ADM 2012-01 :** Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression. The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives.....Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service.
2-15	The person is satisfied with the specific service.	Met/Not Met	**636-1.2(a)(3)(iii) :** The person-centered planning process requires that: (iii) the individual is satisfied with activities, supports, and services.
3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or

			correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities;
3-3	The individual is informed of their right to objections of services/service plan and process to do so.	Met/Not Met	**633.4(b)(2)(ii)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent):(ii) the availability of a process for resolving objections, problems or grievances relative to the person's rights and responsibilities; **633.4(b)(3)(iii)** Such information as required in paragraph (2) of this subdivision has been provided to all appropriate parties as follows: (iii) When changes have been made, OMRDD shall verify that the information was provided to all appropriate parties. **633.12(b)(1)** OMRDD shall verify that the agency/facility or the sponsoring agency has advised a person and his or her parent, guardian, correspondent and advocate, as applicable, of relevant objection processes.
3-4	The individual is informed of their HCBS rights.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-5	The individual is provided with information about their rights in plain language and in a way that is accessible to them.	Met/Not Met	**633.4(b)(5)** OMRDD shall verify that affirmative steps have been taken to make persons at the facility aware of their rights to the extent that the person is capable of understanding them. **636-1.2(b)(3)** (b) A person-centered planning process is required for developing the person-centered service plan (see section 636-1.3 of this Subpart), including the HCBS waiver service habilitation plan, with the individual and parties chosen by the individual. The person centered planning process involves: (3) taking into account the cultural considerations of the individual and providing information in plain language and in a manner that is accessible to and understood by the individual and parties chosen by the individual;
3-6	The individual knows who to contact/how to make a	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

	complaint including anonymous complaints if desired.		
3-8	The individual is supported to participate in cultural/religious/associational practices, educuation, celebrations and experiences per their interests and preferences.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-9	The individual is supported to have visitors of their choosing according their preferences.	Met/Not Met	**636-1.4(b)(4) :** Each individual is able to have visitors of his or her choosing at any time.
3-12	The individual is encouraged and supported to make their own scheduling choices and changes according to their preferences and needs..	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-20	The individual may view their service record upon request.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-22	The individual is encouraged and supported to advocate for themselves and to increase their self-advocacy skills.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
3-23	The individual is not subjected to coercion (includes subtle coercion).	Met/Not Met	**441.301 (C)(4)(iii)** The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
3-24	The individual's rights are respected and staff support/advocate for the individual's rights as needed.	Met/Not Met	**633.4(a)(4)(ix) :** No person shall be denied services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. **633.4(b)(4)** OMRDD shall verify that staff are aware of the rights of persons in the facility.
4-1	The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities to the	Met/Not Met	**441.301 (C)(4)(i)** : The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of

	same degree as others in the community**.**		access as individuals not receiving Medicaid HCBS.
4-2	The individual regularly participates in unscheduled and scheduled community activities to the same degree as individuals not receiving HCBS.	Met/Not Met	**441.301(C)(4)(i) :** The setting is integrated in, and facilitates the individual's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
4-3	The individual is satisfied with their level of access to the broader community as well as the support provided to pursue activities that are meaningful to them for the period of time desired.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
5-1	The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to them.	Met/Not Met	**636-1.2(3)(ii) :** supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect;
7-1	The individual's specific safeguarding needs and related interventions (including supervision) are identified and documented in their service specific plan or attachment according to service/setting requirements.	Met/Not Met	**ADM 2012-01 – Habilitation Plan Requirements: Safeguards**. The safeguards delineated in the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.] Applicable to IRA, CR, and Family Care Residential Habilitation; Day Habilitation (in certified day habilitation

			sites and non-certified settings); Community Habilitation; Site-Based and Community Prevocational Services; Supported Employment; and Pathway to Employment ONLY.
7-2	The individual is provided necessary safeguards/supports per his/her written plan and as needed (excludes supervision, mobility and dining supports).	Met/Not Met	**633.4(a)(4)(viii)-(x);** : No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion. **ADM 2012-01 Habilitation Plan Requirements: Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-3	The individual is provided supervision per his/her written plan and as needed.	Met/Not Met	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services …

			which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity … **ADM 2012-01 Habilitation Plan Requirements: Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
7-4	The individual is provided mobility supports per his/her written plan and as needed.	Met/Not Met/NA	**633.4(a)(4)(viii)-(x) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of

			physician and dentist; or the opportunity to obtain a second medical opinion; **ADM 2012-01 Habilitation Plan Requirements: Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.
7-5	The individual is provided dining supports for consistency, assistance, and monitoring per his/her written plan and as needed.	Met/Not Met/NA	**633.4(a)(4)(viii)-(ix) :** No person shall be denied: …(viii) a written individualized plan of services … which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs …), and which enables him or her to live as independently as possible. ...(ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; **ADM 2012-01 Habilitation Plan Requirements : Safeguards.** The safeguards delineated in …the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or

			referencing the safeguards in an attached document is acceptable. [Except that] safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be attached to the IRA Residential Habilitation Plan. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, … and Supported Employment. [Pathway to Employment services must also met requirements of ADM 2012-01, as cross-referenced in ADM 2015-07 that is specific to PE services.]
8b-1	A medical assessment which identifies the individual's health care needs has been completed by a physician, PA, NP, or RN.	Met/Not Met	**ADM 2015-03: Page 4:** With respect to each new individual served by an approved provider, the approved provider, in collaboration with an RN employed by or under contract with the approved provider, shall review the individual's nursing needs, if any. If the RN determines that the individual requires nursing services, the RN shall complete a comprehensive assessment of the individual to determine whether nursing tasks, in whole or in part, can be delegated to DSPs with adequate training and nursing supervision. The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences; (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional; and (4) a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.
8b-2	There is a written plan/instruction to address routine care/monitoring to be provided related to the	Met/Not Met	**ADM 2015-03: Pages 5-6:** The RN shall develop an individualized plan of nursing services based on the comprehensive nursing assessment of the individual, which identifies the

	individual's specific medical condition(s).		nursing services to be provided to the individual, including delegated nursing tasks. An RN who delegates the performance of nursing tasks shall note in the individualized plan of nursing services a description of the nursing task, the name of the DSP(s) to whom the task is delegated, the date of delegation, the RN who will initially be assigned to supervise the DSP(s), and the RN's signature. The RN may include specific recommendations relating to the RN supervision of the delegated tasks. The RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. A delegating RN shall provide written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications to the qualified DSPs to whom the nursing task is delegated. An RN shall document in the plan of nursing services the delegation of nursing tasks to qualified DSPs as well as any changes in or termination of nursing tasks. The RN shall provide the DSP with written individual-specific instructions for performing each delegated nursing task and criteria for identifying, reporting, or responding to problems or complications. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 8 The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the individual's condition. The PONS shall identify the RN(s) who delegated each nursing task and the nursing tasks that were delegated.
8b-3	The individual receives needed care/support/interventions, through arranged supports or independent delivery. DOES NOT APPLY TO MEDICATION.	Met/Not Met/NA	**ADM 2015-03 Page 6:** An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities. Page 7: The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications. Page 9: The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of

			individuals.
8b-4	The individual's health care services are competently overseen by an RN, to ensure receipt of needed health care services and the competent delivery of delegated nursing services.	Met/Not Met	**ADM 2015-03 Page 5:** . It shall be the responsibility of the RN to determine, using professional nursing judgment, whether any and which nursing tasks can be delegated to DSPs and which DSPs will be authorized and trained to perform the delegated tasks. The RN shall exercise professional judgment as to when delegation is unsafe and/or not in the individual's best interest...Page 6: ...An RN shall be responsible for the supervision of DSPs in the performance of nursing tasks and activities... Page 6-7: ...The amount and type of nursing supervision required will be determined by the RN responsible for supervising the task or activity, and will depend upon:the complexity of the task; the skill, experience and training of the DSP; and the health conditions and health status of the individual being served.... Page 7: ...The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications... Page 8:... The frequency of visits to sites where DSPs provide nursing tasks shall be at the discretion of the RN responsible for supervision but in no case shall visits occur less frequently than once during the month in which such nursing tasks are delivered.... Page 9: ...The approved provider is responsible for ensuring that adequate, qualified staffing is available at all times to meet the specific nursing care needs of individuals.
8b-5	The individual and/or their support(s) report the individual's health concerns/symptoms to appropriate parties as needed or directed.	Met/Not Met/NA	**633.4(a)(4)(x) :** (4) No person shall be denied:...(x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion;
8b-6	The individual's service record/service plan is maintained to reflect current status of the individual's health.	Met/Not Met	**ADM 2015-03: Page 4:** An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants. Page 5: The RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature. Page 8: The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any

			individual who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the individual's condition.
8c-1	The individual's current medications are correctly documented as prescribed when support for administration is needed/provided.	Met/Not Met	**ADM 2015-03 : Page 4**: The comprehensive nursing assessment must include the following information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8:The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii). **ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (3) current medical or nursing treatments ordered or prescribed by the individual's physician, nurse practitioner, or other qualified health professional;... Page 8: ...The RN is responsible for developing an individualized Plan of Nursing Services (PONS) for any individual who requires nursing care, including those who require medication administration for diagnosed medical conditions.... The RN shall ensure that there is an individual specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR §633.l7(a)(l7)(iii).
8c-2	The individual is assessed regarding ability to self-administer medications, when medication administration is associated with the service or service environment.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: (1) the individual's current health status and a review of the individual's psychosocial, functional, behavioral, and cognitive status as they relate to the provision of nursing services to the individual at home or in community settings; (2) the individual's strengths, goals, and care preferences;

8c-3	The individual receives or self-administers medications and treatments safely as prescribed.	Met/Not Met/NA	**ADM 2015-03 : Page 7:** .. The supervising RN must periodically review the performance of DSPs to verify that the DSP's care is consistent with written individual-specific instructions for performing each delegated nursing task and for responding to problems or complications.
8c-4	Problems or errors with administration of the individual's medication are reported and remediated per agency processes.	Met/Not Met/NA	**ADM 2015-03 : Page 8:** The approved provider shall ensure that all supervising RNs (including supervising RNs working during off-hours or on-call), will be immediately notified of changes in medical orders for an individual and/or of changes in an individual's health status. This notification may be provided by the DSP or by other staff working with the individual at the time a change occurs (e.g., by the DSP who accompanied an individual to a medical appointment that resulted in a new medical order; an individual becomes ill or injured while under the care of the assigned DSP or other staff member, etc.)
8c-5	The individual's medication regimen is reviewed on a regular basis by a designated professional.	Met/Not Met	**ADM 2015-03 : Page 4:** The comprehensive nursing assessment must include the following information: ... (4) a review of all medications that the individual is currently taking to identify any potential issues (e.g., significant adverse effects, duplicate drug therapy, ineffective drug therapy, significant drug interactions, or non-compliance with drug therapy). An RN shall update the comprehensive nursing assessment as frequently as the individual's condition warrants.
9-1	A Functional Behavioral Assessment is completed for the individual prior to the development of the Behavior Support Plan.	Met/Not Met	**633.16(d)(1)-(2) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging

			behavior; (v) identify the general conditions or probable consequences that may maintain the behavior; (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors; and (x) provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day. (2) In exceptional circumstances (e.g., unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavioral assessment shall be completed within 60 days of admission or the commencement of services.
9-2	The Individual's Functional Behavioral Assessment identifies the challenging behaviors and all contextual factors as required.	Met/Not Met	**633.16(d)(1)(i - v)** : Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (i) identify/describe the challenging behavior in observable and measureable terms; (ii) include identification and consideration of the antecedents for the behavior(s); (iii) identify the contextual factors, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior; (iv) identify the likely reason or purpose for the challenging behavior; (v) identify the general conditions or probable consequences that may maintain the behavior;
9-3	The Individual's Functional	Met/Not Met	**633.16(d)(1)(vi-ix) :**

	Behavioral Assessment includes an evaluation of possible social and environmental alterations, any additional factors and reinforcers that may serve to reduce or eliminate behaviors.		Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: (vi) include an evaluation of whether environmental or social alterations, or further assessments to rule out a contextual factor, would serve to reduce or eliminate the behavior(s); (vii) include an evaluation of preferred reinforcers; (viii) consider multiple sources of data including, but not limited to: (a) information gathered through direct observations of the individual; (b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and (c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources; (ix) not be based solely on an individual's documented history of challenging behaviors
9-4	The Individual's Functional Behavioral Assessment provides a baseline description of their challenging behaviors.	Met/Not Met	**633.16(d)(1)(x) :** Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavioral assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavioral assessment must: provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.
9-5	The Individual's Behavior Support Plan was developed by a BIS, a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques; and supervised by appropriate clinician as determined by the interventions in the plan.	Met/Not Met	**633.16(e)(2)(i) :** All behavior support plans must be developed by a BIS, or a licensed psychologist or a licensed clinical social worker with training in behavioral intervention techniques.
9-6	The Individual's Behavior Support Plan was developed in consultation, as clinically	Met/Not Met	**633.16(e)(2)(ii) :** All behavior support plans must be developed in consultation, as clinically

	appropriate, with the individual receiving services and/or other parties involved with implementation of the plan.		appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan.
9-7	The Individual's Behavior Support Plan was developed from their Functional Behavioral Assessment.	Met/Not Met	**633.16(e)(2)(iii) :** All behavior support plans must be developed on the basis of a functional behavioral assessment of the target behavior(s).
9-8	The Individual's Behavior Support Plan includes a concrete, specific description of the challenging behavior(s) targeted for intervention.	Met/Not Met	**633.16(e)(2)(iv) :** All behavior support plans must include a concrete, specific description of the challenging behavior(s) targeted for intervention.
9-9	The Individual's Behavior Support Plan includes a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s).	Met/Not Met	**633.16(e)(2)(v) :** All behavior support plans must include a hierarchy of evidence-based behavioral approaches, strategies and supports to address the target behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports.
9-10	The Individual's Behavior Support Plan includes a personalized plan for teaching and reinforcing alternative skills and adaptive behaviors.	Met/Not Met	**633.16(e)(2)(vi) :** All behavior support plans must include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's personal satisfaction, degree of independence, or sense of success.
9-11	The Individual's Behavior Support Plan includes the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address the challenging behavior.	Met/Not Met	**633.16(e)(2)(vii);** All behavior support plans must include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others. **633.16(e)(3)(ii)(c) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights shall be designed in accordance with the following: (ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:(c) designation of the interventions in a hierarchy of

			implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed.
9-12	People responsible for the support and supervision of the individual who has a behavior support plan know how to implement the person's plan and the specific interventions included.	Met/Not Met	**633.16(i)(1) :** Staff, family care providers and respite substitute providers responsible for the support and supervision of a person who has a behavior support plan must be trained in the implementation of that person's plan.
9-13	The Individual's Behavior Support Plan provides a method for collection of behavioral data to evaluate treatment progress.	Met/Not Met	**633.16(e)(2)(viii) :** All behavior support plans must provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated.
9-14	The Individual's Behavior Support Plan includes a schedule to review the effectiveness of the interventions included in the behavior support plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-15	The effectiveness of the individual's Behavior Support in improving the quality of his/her life is reviewed as identified in the plan.	Met/Not Met	**633.16(e)(2)(ix) :** All behavior support plans must include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.
9-16	The individual's support staff has completed and is annually recertified in an OPWDD-approved training course in positive behavioral strategies and physical intervention techniques (if applicable).	Met/Not Met	**633.16(i)(3)-(7) :** (3) Staff who are responsible for implementing behavior support plans that incorporate the use of any physical intervention technique(s) must have: (i) successfully completed an OPWDD-approved training course on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques; and (ii) been certified or recertified in the use of positive behavioral approaches, strategies and/or supports and the use of physical intervention techniques by an instructor, instructor-trainer or master trainer within the year. However, in the event that OPWDD approves a new

			curriculum, OPWDD may specify a period of time greater than one year before recertification is required. (4) Supervisors of such staff shall receive comparable training. (5) If permitted by their graduate programs, graduate level interns may implement restrictive/intrusive interventions with appropriate supervision. The graduate level intern must also meet the requirements for training and certification specified in paragraphs (1)-(3) of this subdivision. Volunteers and undergraduate interns are not permitted to implement restrictive/intrusive interventions. (6) Retraining of staff, family care providers and respite/substitute providers as described in paragraphs (1) and (2) of this subdivision shall occur as necessary when the behavior support plan is modified, or at least annually, whichever comes first. (7) The agency must maintain documentation that staff, family care providers, respite/substitute providers, and supervisors have been trained and certified as required by this subdivision.
9a-1	The Individual's Behavior Support Plan includes a description of the person's behavior that justifies the inclusion of the restrictive/intrusive intervention(s) and/or limitation on rights.	Met/Not Met	**633.16(e)(3)(ii)(a) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior.
9a-2	The Individual's Behavior Support Plan includes a description of all approaches that have been tried but have been unsuccessful, leading to inclusion of the current interventions.	Met/Not Met	**633.16(e)(3)(ii)(b) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, and a justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others.

9a-3	The Individual's Behavior Support Plan includes the criteria to be followed regarding postponement of other activities or services, if applicable.	Met/Not Met/NA	**633.16(e)(3)(ii)(d) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (e.g., to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities.
9a-4	The Individual's Behavior Support Plan includes a specific plan to minimize, fade, eliminate or transition restrictions and limitations to more positive interventions.	Met/Not Met	**633.16(e)(3)(ii)(e) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use.
9a-5	The Individual's Behavior Support Plan describes how the use of each intervention or limitation is to be documented.	Met/Not Met	**633.16(e)(3)(ii)(f) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting.
9a-6	The Individual's Behavior Support Plan includes a schedule to review and analyze the frequency, duration and/or intensity of use of the intervention(s) and/or limitation(s).	Met/Not Met	**633.16(e)(3)(ii)(g) :** A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph [c][9] of this section) shall be designed in accordance with the following: A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components: a schedule to review and

			analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.
9a-7	The Behavior Support Plan was approved by the Behavior Plan/Human Rights Committee prior to implementation and approval is current.	Met/Not Met	**633.16(e)(4)(i);** : Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention; the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section. **633.16(f)(5)(i) :** The committee chairperson must verify that: the proposed behavior support plans presented to the committee are approved for a time period not to exceed one year and are based on the needs of the person.
9a-8	Written informed consent was obtained from an appropriate consent giver prior to implementation of a Behavior Support Plan that includes restrictive/intrusive interventions.	Met/Not Met	**633.16(e)(4)(ii) :** Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention: written informed consent shall be obtained from the appropriate consent-giver.
9a-9	Written informed consent is obtained annually for a plan that includes a limitation on the individual's rights and/or a restrictive/intrusive intervention.	Met/Not Met	**633.16(g)(3) :** Written informed consent obtained in accordance with this subdivision shall have a maximum duration of one year.
9a-10	Rights Limitations were implemented in accordance with Behavior Support Plans.	Met/Not Met	**633.16(J)(2)(i)(a-b) :** The limitation of a person's rights as specified in section 633.4 of this Part (including but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior) shall be in conformance with the following: (a) limitations must be on an individual basis, for a specific period of time, and

			for clinical purposes only; and (b) rights shall not be limited for the convenience of staff, as a threat, as a means of retribution, for disciplinary purposes or as a substitute for treatment or supervision.
9a-11	Clinical justification for use of rights limitations in an emergency is documented in the individual's record.	Met/Not Met/NA	**633.16(j)(2)(ii) :** In an emergency, a person's rights may be limited on a temporary basis for health or safety reasons. A clinical justification must be clearly noted in the person's record with the anticipated duration of the limitation or criteria for removal specified.
9a-12	Repeated use of emergency or unplanned rights limitations in a 30-day period resulted in a comprehensive review.	Met/Not Met/NA	**633.16(j)(2)(iii) :** The emergency or unplanned limitation of a person's rights more than four times in a 30 day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9b-1	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the facts justifying the use of the device.	Met/Not Met	**633.16(j)(4)(ii)(e)(1) :** The behavior support plan, consistent with the physician's order specify the following conditions for the use of a mechanical restraining device: the facts justifying the use of the device.
9b-2	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies staff actions required when the device is used.	Met/Not Met	**633.16(j)(4)(ii)(e)(2) :** The behavior support plan, consistent with the physician's order shall specify the following conditions for the use of a mechanical restraining device: staff or family care provider action required when the device is used.
9b-3	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies criteria for the application, removal and duration of device use.	Met/Not Met	**633.16(j)(4)(ii)(e)(3) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: criteria for application and removal and the maximum time period for which it may be continuously employed.
9b-4	The Individual's Behavior Support Plan that includes a Mechanical Restraining device specifies the maximum	Met/ Not Met	**633.16(j)(4)(ii)(e)(4) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a

	intervals of time for monitoring his/her needs, comfort, and safety.		mechanical restraining device: the maximum period of time for monitoring the person's needs, comfort, and safety.
9b-5	The Individual's Behavior Support Plan that includes a Mechanical Restraining device includes a description of how the use of the device is expected to be reduced and eventually eliminated.	Met/Not Met	**633.16(j)(4)(ii)(e)(5) :** The behavior support plan, consistent with the physician's order (see clause [g] of this subparagraph) shall specify the following conditions for the use of a mechanical restraining device: a description of how the use of the device is expected to be reduced and eventually eliminated.
9b-6	The Individual's service record contains a current physician's order for the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(1-3) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall: (1) specify the type of device to be used; (2) set forth date of expiration of the order; (3) specify any special considerations related to the use of the device based on the person's medical condition, including whether the monitoring which is required during and after use of the device must incorporate specific components such as checking of vital signs and circulation.
9b-7	The Individual's service record includes a written physicians order for the use of immobilization of the extremities or total immobilization.	Met/Not Met/NA	**633.16(j)(4)(ii)(l) :** The planned use of a device which will prevent the free movement of both arms or both legs, or totally immobilize the person, may only be initiated by a written order from a physician after the physician's personal examination of the person. The physician must review the order and determine if it is still appropriate each time he or she examines the person, but at least every 90 days. The review must be documented. The planned use of stabilizing or immobilizing holds or devices during medical or dental examinations, procedures, or care routines must be documented in a separate plan/order and must be reviewed by the program planning team on at least an annual basis.
9b-8	The Behavior Plan/Human Rights Committee and OPWDD approved the use of any Mechanical Restraining device that was not commercially available or	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(2) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially

	designed for human use.		available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD.
9b-9	Each individual's service record includes documentation of a consultation (i.e. OT or PT) if the Mechanical Restraining device has modified.	Met/Not Met/NA	**633.16(j)(4)(ii)(a)(3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: an occupational or physical therapist has been consulted if modification of the device is needed.
9b-10	Mechanical restraining devices were used in accordance with the Behavior Support Plan.	Met/Not Met	**633.16(j)(4)(ii)(a)(1-3) :** Mechanical restraining devices to prevent or modify challenging behavior may only be used in accordance with a behavior support plan if the devices meet the following criteria: (1) the device shall be designed and used in such a way as to minimize physical discomfort and to avoid physical injury; (2) the device shall be commercially available and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (e.g., modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and (3) an occupational or physical therapist has been consulted if modification of the device is needed.
9b-11	The indivdual's service record contains a full record of the use of the Mechanical Restraining device.	Met/Not Met	**633.16(j)(4)(ii)(g)(4) :** A physician's order is required for the use of a mechanical restraining device as part of a behavior support plan. The order shall be renewed as specified in the plan, but in all cases no less frequently than every six months. The order shall be retained in a person's clinical record with a full record of the use of the device.
9b-12	Release from mechanical restraining devices was provided in 1 hour and 50 minutes intervals or according to physician's orders.	Met/Not Met	**633.16(j)(4)(ii)(i)(1-4) :** Planned use of mechanical restraining devices: (i) Release from the device: (1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. (2) If the person requests release for movement or access to a toilet before the specified time period has elapsed, this should be afforded to him/her as soon as possible. (3) If the person has fallen asleep while wearing a mechanical device, opportunity for movement, exercise, necessary eating, drinking and toileting shall always be

			provided immediately upon wakening if more than one hour and fifty minutes has elapsed since the device was employed or the end of the last release period. (4) If a physician specifies a shorter period of time for release, the person shall be released in accordance with the physician's order.
9b-13	Re-employment of a mechanical device did not occur unless necessitating behavior reoccurred**.**	Met/Not Met	**633.16(j)(4)(ii)(k) :** If, upon being released from a mechanical restraining device before the time limit specified in the order, a person makes no overt gesture(s) that would threaten serious harm or injury to self or others, the mechanical restraining device shall not be reemployed by staff unless the behavior which necessitated the use of the device reoccurs.
9b-14	Immobilizing devices were only applied under the supervision of a senior member of the staff.	Met/Not Met/NA	**633.16(j)(4)(ii)(m) :** A device which will prevent the free movement of both arms or both legs or totally immobilize the person may only be applied under the supervision of a senior member of the staff or, in the context of a medical or dental examination or procedure, under the supervision of the healthcare provider or staff designated by the healthcare provider. Staff assigned to monitor a person while in a mechanical restraining device that totally immobilizes the person shall stay in continuous visual and auditory range for the duration of the use of the device.
9b-15	Mechanical restraining devices are clean, sanitary and in good repair.	Met/Not Met	**633.16(j)(4)(i)(e) :** Mechanical restraining devices shall be maintained in a clean and sanitary condition, and in good repair.
9b-16	Helmets with chin straps are used only when Individuals are awake and in a safe position.	Met/Not Met/NA	**633.16(j)(4)(i)(g) :** Helmets with any type of chin strap shall not be used while a person is in the prone position, reclining, or while sleeping, unless specifically approved by OPWDD.
9c-1	Physical Interventions were used in accordance with the individual's Behavior Support Plans.	Met/Not Met	**633.16(j)(1)(i)(a-d) :** (1) Physical intervention techniques (includes protective, intermediate and restrictive physical intervention techniques). (i) The use of any physical intervention technique shall be in conformance with the following standards: (a) the technique must be designed in accordance with principles of good body alignment, with concern for circulation and respiration, to avoid pressure on joints, and so that it is not likely to inflict pain or cause injury; (b) the technique must be applied in a safe manner; (c) the technique shall be applied with the minimal amount of force necessary to safely interrupt the

			challenging behavior; (d) the technique used to address a particular situation shall be the least intrusive or restrictive intervention that is necessary to safely interrupt the challenging behavior in that situation.
9c-2	Physical Interventions used were terminated as soon as the individual's behavior had diminished significantly, within timeframes or if he/she appeared physically at risk.	Met/Not Met	**633.16(j)(1)(iv) :** The use of any intermediate or restrictive physical intervention technique shall be terminated when it is judged that the person's behavior which necessitated application of the intervention has diminished sufficiently or has ceased, or immediately if the person appears physically at risk. In any event, the continuous duration for applying an intermediate or restrictive physical intervention technique for a single behavioral episode shall not exceed 20 minutes.
9c-3	The individual was assessed for possible injuries as soon as possible following the use of physical interventions.	Met/Not Met	**633.16(j)(1)(vi) :** After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable incident or serious reportable incident must also be reported in accordance with Part 624.
9c-4	Use of intermediate or restrictive physical intervention techniques in an emergency resulted in notification to appropriate parties within two business days.	Met/Not Met/NA	**633.16(j)(1)(viii-ix) :** (viii) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, and the appropriate clinician, if applicable, must be notified within two business days after the intervention technique has been used. (ix) Whenever any intermediate or restrictive physical intervention technique has been used in an emergency, the person's guardian, parent, actively involved family member, representative of the Consumer Advisory Board (for Willowbrook class members it fully represents), correspondent, or advocate must be notified within two business days after the intervention has been used, unless the person is a capable adult who objects to such notification.
9c-5	Repeated emergency use of physical interventions in a 30-day period or six month period resulted in a	Met/Not Met/NA	**633.16(j)(1)(x) :** The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six

	comprehensive review.		month period shall require a comprehensive review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.
9c-6	The use of restrictive physical interventions was reported electronically to OPWDD.	Met/Not Met	**633.16(j)(1)(vii) :** Each use of a restrictive physical intervention technique shall be reported electronically to OPWDD in the form and format specified by OPWDD.
9d-1	Time-out was used in accordance with the Individual's Behavior Support Plan.	Met/Not Met	**633.16(j)(3)(iv)(a)(1) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: such action shall be taken only in accordance with a person's behavior support plan.
9d-2	Constant auditory and visual contact was maintained during time-outs to monitor the Individual's safety.	Met/Not Met	**633.16(j)(3)(iv)(a)(2) :** The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered a form of time-out (see glossary). The use of a time-out room shall be in conformance with the following: constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
9d-3	The maximum duration of the individual's placement in a time out room did not exceed one continuous hour.	Met/Not Met	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour.
9d-4	Use of a time-out room on five or more occasions within a 24-hour period resulted in a review of the Behavior Support Plan within three business days.	Met/Not Met/NA	**633.16(j)(3)(iv)(c) :** The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, or behavioral intervention specialist within three business days.
9d-5	The use of a time out room	Met/Not Met	**633.16(j)(3)(iv)(d)** :

	was reported electronically to OPWDD.		Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be

			recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)** When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate **624.5(h)(3**) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD),

			the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or

			eliminate inconsistencies; **624.5(k)(1)-(3);** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with

			developmental disabilities. Such actions, as appropriate, may include but are not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or

			after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3**) 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified

			programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and	Met/Not Met/NA	**624.7(b)(2);** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial,

	implemented.		and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3);** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the

			agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.

Standard No.	Standard Text	Decision	Regulatory References
1-3	The individual's planning process/planning meetings include participation and input from required parties.	Met/Not Met	**WPI Appendix I Section II.3.a :** The case manager shall make every effort to ensure that all appropriate parties, including the class member, the correspondent, the Mental Hygiene Legal Services ("MHLS") and the CAB representative to the extent it represents a class member, are invited and in attendance at interdisciplinary treatment team meetings.
1-6	Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual's planning process.	Met/Not Met	**WPI Appendix I Section I :** A case manager is a qualified mental retardation professional (QMRP) [sic] who is either a state employee, or an employee of a voluntary agency that does not provide residential or day services to the class member. A class member or the class member's correspondent may choose a functionally independent case manager employed by the same agency that provides residential or day services if such a person is available.
1-7	The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-10	Assessments needed by the individual or required by program regulation were completed to inform the individual's plan development.	Met/Not Met	**WPI Appendix I Section II.2.b :** The case manage shall ensure that all assessments for the class member including, where applicable but not limited to, medical, psycho-social, habilitative, psychological, speech therapy, food and nutrition, physical therapy, and occupational therapy, have been either completed or schedule and the case manager shall request appropriate documentation of such.
1-11	The individual's goals and desired outcomes are	Met/Not Met	**~~636-1.2(a)~~**

	documented in the person-centered service plan.		A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of his or her services and makes informed choices about the services and supports that he or she receives. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her (e.g., health, relationships, work, and home). **636-1.3(b)(1)** b) The individual's service coordinator must develop a person-centered service plan with the individual. The plan must include and document the following: (1) the individual's goals and desired outcomes;
1-15	The individual's priorities/interests regarding meaningful community based activities, including the desired frequency and the supports needed are identified in the person centered plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-28	The plan is written in plain language, in a manner that is accessible to the individual and parties responsible for the implementation of the plan.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.
1-34	The individual has been informed that they can request a change to the plan and understands how to do so.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

1-35	The Individual's written person centered service plan is reviewed with regular required frequency .	Met/Not Met	**WPI Appendix I Section II.3.c :** The case manager shall ensure that each class member's developmental plan is reviewed by the class member's interdisciplinary treatment team at least annually or more frequently when required by the class member's individual needs. A class member's development plan shall be reviewed by the interdisciplinary treatment team on a semiannual or quarterly basis if the class member, the correspondent, Consumer Advisory Board, or MHLS, to the extent it represents a class member, so requests.
1-36	Review of the plan includes the individual's status/progress towards the achievement of his/her goals, priorities and outcomes.	Met/Not Met	**WPI Appendix I Section II.8.a-b : Monitoring/Follow-Up**: a. The case manager shall assure that the class member is receiving appropriate services in accordance with their plans of needs and goals, and periodic reassessment of the class member's progress. b. The case manager shall ensure that the class member's correspondent or CAB and MHLS representatives are kept informed of the class member's educational, vocational and living skills, progress, medical conditional and other matters relevant to his or her care, treatment and development.
1-37	The individual's person centered service plan is revised whenever changes are necessary and warranted and/or as directed/preferred by the individual.	Met/Not Met/NA	**WPI Appendix I Section II.3.c :** The case manager shall ensure that each class member's developmental plan is reviewed by the class member's interdisciplinary treatment team at least annually or more frequently when required by the class member's individual needs. A class member's development plan shall be reviewed by the interdisciplinary treatment team on a semiannual or quarterly basis if the class member, the correspondent, Consumer Advisory Board, or MHLS, to the extent it represents a class member, so requests.
1-40	The SC/CM/CC competently assures person centered planning as evidenced by the individual's written plan for services and supports and interview.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

2-1	The service provider maintains the service record in compliance with content requirements, including a copy of the current ISP for HCBS Waiver Service providers.	Met/Not Met	**WPI Appendix I Section II.4.a : 4. Recordkeeping:** a. The case manager shall ensure that the individual's record is maintained including the individual's plan for needs and services, persons responsible, and plans for date maintenance and monitoring. b. The case manager shall prepare monthly case notes reflecting visits and progress. c. The case manager shall ensure written notifications to the class member and correspondent as required by OMRDD's [sic] Client Placement Procedures.
2-7	Documentation of the delivery of services, supports, interventions, and therapies to the individual meets quality expectations specific to the service type.	Met/Not Met	**WPI Appendix I. Section II 4.b : 4. Recordkeeping:** … b. the case manager shall prepare monthly notes reflecting visits and progress. **WPI Appendix I. Section II 10.a** : 10. Case Manager Reporting: a. Case managers shall keep a list of dates of monthly contact with the class members and dates of attendance at team meetings, which shall be available to the plaintiffs and CAB upon request.
2-11	The person's services are delivered by competent staff/supports that understand their role, the service/service plan and the person's needs, preferences and goals related to the service.	Met/Not Met	**WPI Appendix I. Section I : I. Definition of Case Management:** … The case manager: 1. Promotes self-advocacy, self-direction and choice; 2. Advocates and arranges for service that are accessible, community based, comprehensive and culturally appropriate.
2a-1	The individual was provided a choice of service/care manager/coordinator.	Met/Not Met	**Quality Indicator :** This is an indicator of quality outcomes.

2a-5	The Willowbrook class member's Notice of Rights is placed in the SC /CM/CC service record.	Met/Not Met	**WPI Item. 17 : 17. Notice of Rights.** The OMRDD [sic] defendants shall place the following information describing the rights and entitlements under the permanent injunction in the permanent record of each class member, shall retain such information on record for so long as the class member is alive, and shall enter such information in the class member's file maintained by all providers of residential and habilitative services to class members: (a). designation of membership in the Willowbrook class; (b). notation that class membership results in rights and services guaranteed by this permanent injunction issued by the United States District Court, Eastern District, and a summary of those rights; and (c). the name, address and telephone number of plaintiffs' counsel, MHLS and the Consumer Advisory Board.
2a-6	The SC/CM/CC advocates/ensures that rights limitations occur only with required protections, justifications and approvals in place.	Met/Not Met/NA	**WPI Appendix I. Section II. 1.a : 1. Advocacy:** a. The case manager shall protect and uphold the rights and entitlements of the class member in the residential program, in the day or work program, and in all spheres of the class member's life.
2a-11	The SC/CM/CC solicits input from/among members of the person's "circle"/team as part of the review of the person's services and status as needed.	Met/Not Met	**WPI Appendix I Section II.8.b :** The case manager shall ensure that the class member's correspondent or CAB and MHLS representatives are kept informed of the class member's educational, vocational and living skills, progress, medical condition and other matters relevant to his or her care, treatment and development.
2a-12	Meetings for the review of the person centered service plan must be face to face as required by the service type.	Met/Not Met	**WPI Appendix I Section II.3.a.** : The case manager shall make every effort to ensure that all appropriate parties, including the class member, the correspondent, the Mental Hygiene Legal Services ("MHLS") and the CAB representatives to the extent it

			represents a class member, are invited and in attendance at the interdisciplinary treatment team meetings.
2a-14	The SC/CM/CC notes indicate that the service coordinator/case manager has contact with the individual in the frequency and manner required by service and when needed.	Met/Not Met	**WPI Appendix I. Section II.4.b :** The case manager shall prepare monthly case notes reflecting visits and progress.
2a-15	The service coordinator/case manager meets with the individual in his/her home at least quarterly with a Willowbrook Class Member, annually with a non-class member, and when needed.	Met/Not Met	**2011 Vendor Manual Pg. 36** For Willowbrook Class members, a face-to-face service meeting in the person's home is required at least once during each three-month quarter of a calendar year.
2a-16	A Service Coordination Observation Report (SCOR) was completed at least twice yearly for Willowbrook Class Members and as needed.	Met/Not Met	**2011 Vendor Manual Pg. 36** ... The Service Coordination Observation Report (SCOR) must be completed for all Willowbrook Class members living in certified settings, except those living in Developmental Centers. A SCOR must be filed at least two times in a calendar year, (but not in consecutive quarters), even if there is no issue to report. 41-55,45-45,99-82 **2011 Vendor Manual Pg. 87** Thus, for Willowbrook Class members, the SCOR must be completed for each person living in an IRA CR, Family Care Home or ICF (although ICF residents are not MSC eligible). The SCOR does not need to be completed for Willowbrook Class members who live in developmental centers. 41-55,45-45,99-82
2a-17	If the SCOR identifies issues, the case notes in the	Met/Not Met/NA	**2011 Vendor Manual Pgs. 87-88**

	individual's record evidence advocacy and resolution of the issue(s).		… On the SCOR, the service coordinator must indicate whether he or she has observed or become aware of any conditions that place any individual in the home in imminent danger or of any event or situation which may be considered abuse according to the definition in Part 624. If the service coordinator does find any evidence of imminent danger or abuse, he or she must take appropriate action to protect the individual(s) at risk.... If the service coordinator determines that these are real problems for the individual receiving MSC and should be resolved, the service coordinator should record them in the service coordination notes and should follow-up as necessary. ...
2a-18	SC/CC/CC has taken action to affirm that all allegations of abuse and/or neglect were reported to appropriate parties and investigated as appropriate.	Met/Not Met/NA	**WPI Appendix I. Section II.8.c :** The case manager shall ensure reporting, investigation, implementation of preventive actions, and other needed follow-up on incidents which pose a risk to the health and safety of the class member or to others in the class member's immediate environment.
2a-19	If abuse was substantiated, SC/CM/CC advocates for the safety and protection of the individual.	Met/Not Met/NA	**WPI Appendix I. Section II.8.c :** The case manager shall ensure reporting, investigation, implementation of preventive actions, and other needed follow-up on incidents which pose a risk to the health and safety of the class member or to others in the class member's immediate environment.
2a-20	The SC/CM/CC monitors that the individual is linked to and receiving the services he/she wants and that the services are helping the individual to attain his/her valued outcomes and life goals.	Met/Not Met	**WPI Appendix I. Section II.5.b : 5. Coordination:** b. The case manager shall coordinate among the diverse providers of service required by the class member, including their day and residential programs. **WPI Appendix I. Section II.8.a :** 8. Monitoring/Follow-Up: a. The case manager shall assure that the class member is receiving appropriate services in accordance with their plans of needs and goals, and periodic reassessment of the class member's progress.
2a-21	The WCS Coordinator or WSC assists the QIDP,	Met/Not Met	**WPI Appendix I. Section II.6.a : Linking:**

	treatment coordinator and/or IDT members in linking to services and/or in support during crisis intervention, as needed.		a. The case manager shall ensure that the class member is linked to new services, as needed. In doing so, the case manager shall, as needed, make referrals for the new services, arrange services at generic agencies, accompany the class member to agencies providing services or arrange for a person familiar with the class member and his or her needs to do so, assist in completing forms and applications, and perform other related duties. **WPI Appendix I. Section II.7.a : Support:** a. The case manager shall assist the class member and/or their family with unanticipated crisis intervention.
2a-24	Care/Case/Service Coordinator/Manager advocates for the rights and entitlements of the individual in the home, day and work environments and in all spheres of his/her life.	Met/Not Met	**WPI Appendix I. Section II. 1.a.** Advocacy: a. The case manager shall protect and uphold the rights and entitlements of the class member in the residential program, in the day or work program, and in all spheres of the class member's life. ...
2a-25	The Care/Case/Service Coordinator/Manager ensures that procedural and substantive due process requirements are met.	Met/Not Met/NA	**WPI Appendix I. Section II. 1.a. : Advocacy:** a. The case manager shall ensure that procedural and substantive due process requirements are met with regard to the class members and the class member's representatives.
2a-26	The WCS Coordinator or WSC ensures active representation, either by the class member, the correspondent or Consumer Advisory Board (CAB)	Met/Not Met	**WPI Appendix I Section II.1.b** The case manager shall ensure active representation either by the class member or by a correspondent or Consumer Advisory Board ("CAB") representative.
2a-27	The person is satisfied with the coordination/case management services he/she receives.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.

3-1	The individual is informed of their rights according to Part 633.4.	Met/Not Met	**633.4(b)(2)(i)** OMRDD shall verify (see glossary) that the following information was provided to each individual and/or his or her parents, guardians or correspondents (unless the person is a capable adult and objects to such information being provided to a parent or correspondent): (i) rights and responsibilities; **2011 Vendor Manual Pg. 46** The first section of a Service Coordination Record contains the eligibility and enrollment documentation for the individual with developmental disabilities and should include: ... Notice of individual rights and responsibilities per Part 633.4. (For Willowbrook Class members, there must be the Notice of Rights for Willowbrook Class members only).
3-6	The individual knows who to contact/how to make a complaint including anonymous complaints if desired.	Met/Not Met	**Quality Indicator:** This is an indicator of quality outcomes.
10a-1	Events involving the individual that meet the definition of reportable incident or notable occurrence have been reported.	Met/Not Met/NA	**624.5(b)(1)** 624.5(b)(1) All agency employees, interns, volunteers, consultants, contractors, and family care providers are required to report any event or situation that meets the criteria of a reportable incident or notable occurrence as defined in this Part.
10a-2	Events and situations as defined in Part 625 involving the individual that are required to be reported have been reported to OPWDD.	Met/Not Met/NA	**625.4(a)** The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows: (1) The agency must submit an initial report about the event or situation in the OPWDD Incident Report and Management Application (IRMA). (2) The agency or sponsoring agency must enter initial information about the event or situation within twenty-four hours of occurrence or discovery or by close of the next working day, whichever is later. Such initial

			information must identify all actions taken by the agency, including any initial actions taken to protect the involved individual. **625.5(c)(2)** The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of any agency, must be reported to OPWDD as follows: (2)The agency must submit an initial report about the death in IRMA within twenty-four hours of discovery of the death, or by close of the next working day, whichever is later, in the form and format specified by OPWDD.
10b-1	Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)** If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10b-2	Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(2)**

			When appropriate, an employee, intern or volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10b-3	Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center and specifically relieves the agency of the obligation to investigate. **624.5(h)(3**) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16)

			624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10b-4	Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).
			recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16)

10b-5	Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; **624.5(k)(1)-(3):** Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD. (1) Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)

10b-6	Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10b-7	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect involving the individual were implemented.	Met/Not Met/NA	**624.5(l)** Corrections in response to findings and recommendations made by the Justice Center. When the Justice Center makes findings concerning reports of abuse and neglect under its jurisdiction and issues a report and/or recommendations to the agency regarding such matters, the agency must: (1) make a written response that identifies action taken in response to each correction requested in the report and/or each recommendation made by the Justice Center; and (2) Submit the written response to OPWDD in the manner specified by OPWDD, within 60 days after the agency receives a report of findings and/or recommendations from the Justice Center. (Incidents on or after 01/01/16)
10b-8	The Agency has intervened to protect the individual involved in reported 625 event/situations.	Met/Not Met	**625.3(b)(1-6)** The agency must intervene in an event or situation that meets the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation by taking actions to protect the involved individual with developmental disabilities. Such actions, as appropriate, may include but are

			not limited to the following:(1) notifying an appropriate party that may be in a position to address the event or situation (e.g., Statewide Central Register of Child Abuse and Maltreatment, Adult Protective Services, law enforcement officials, family members, school, hospital, or the Office of Professional Discipline); (2) offering to make referrals to appropriate service providers, clinicians, State agencies, or any other appropriate parties; (3) interviewing the involved individual and/or witnesses; (4) assessing and monitoring the individual; (5) reviewing records and other relevant documentation; and (6) educating the individual about his or her choices and options regarding the matter.
10b-9	For Part 625 events involving the individual, actions reported in IRMA in response to recommendations were implemented as reported.	Met/Not Met	**625.4 (b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.
10c-1	Minor Notable Occurrence (MNO): Immediate care and treatment identified and needed was provided to the individual.	Met/Not Met	**624.5(g)(1)** A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16) **624.5(g)(4)**

			If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained. (Incidents on or after 01/01/16)
10c-2	MNO: Initial measures to protect the individual from harm and abuse, were implemented immediately.	Met/Not Met	**624.5(g)(1)** "Incidents on and after 01/01/16: 624.5(g)(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (Incidents on or after 01/01/16)" **624.5(g)(2)** When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (Incidents on or after 01/01/16) **624.5(g)(3)** When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility. (Incidents on or after 01/01/16)
10c-3	MNO: Investigations of Reportable Incidents and Notable Occurrences involving the individual are thorough and documented.	Met/Not Met	**624.5(h)(1)** 624.5(h)(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated by the chief executive officer, unless OPWDD or the Justice Center advises the chief executive officer that the incident or occurrence will be investigated by OPWDD or the Justice Center

			and specifically relieves the agency of the obligation to investigate (see subdivision [j] of this section). (Incidents on or after 01/01/16) **624.5(h)(3)** 624.5(h)(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.(i) If the incident was classified as a reportable incident by the VPCR, or the additional information may warrant its classification as a reportable incident, a program certified or operated by OPWDD must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on the additional information (ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under section 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification in IRMA. (This reclassification is subject to review by OPWDD.)(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification. (Incidents on or after 01/01/16) **624.5(h)(5)** 624.5(h)(5) The investigation must continue through completion regardless of whether an employee or other custodian who is directly involved leaves employment (or contact with individuals receiving services) before the investigation is complete. (Incidents on or after 01/01/16)
10c-4	MNO: Investigation was completed no later than 30 calendar days after the incident or notable occurrence is reported.	Met/Not Met	**624.5(n)(1-2)** "Timeframe for completion of the investigation. When the agency is responsible for the investigation of an incident or notable occurrence: (1) The investigation must be completed no later than 30 days after the incident or notable occurrence is reported to the Justice Center and/or OPWDD, or, in the case of a minor notable occurrence, no later than 30 days

			after completion of the written initial occurrence report or entry of initial information in IRMA. An investigation is considered complete upon completion of the investigative report. (2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to): (i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and (ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement)."
10c-5	MNO: Measures/actions identified to prevent future similar events involving the individual were planned and implemented.	Met/Not Met/NA	**624.7(b)(2):** An IRC must review reportable incidents and notable occurrences to: (2) ascertain that necessary and appropriate corrective, preventive, remedial, and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences, and to make written recommendations to the chief executive officer to correct, improve, or eliminate inconsistencies; (Incidents on or after 01/01/16) **624.5(k)(1)-(3):** (1)Within 10 days of the IRC review of a completed investigation, the agency must develop a plan of prevention and remediation to be taken to assure the continued health, safety, and welfare of individuals receiving services and to provide for the prevention of future acts of abuse and neglect. (2) The plan must include written endorsement by the CEO or designee. (3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial

			action identified and for assessing the efficacy of the remedial action. (Incidents on or after 01/01/16) **624.5(i)(2)(i)-(ii)** When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:(i) implement each recommendation in a timely manner and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD, within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed. (Incidents on or after 01/01/16)
10c-6	MNO: Actions were taken to implement and/or address recommendations resulting from the investigation findings and incident review.	Met/Not Met/NA	**625.4(b)(2)(i-ii)** When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to the agency or sponsoring agency concerning any matter related to the event or situation. This may include a recommendation that the agency conduct an investigation and/or take specific actions to intervene. In the event that OPWDD makes recommendations, the agency or sponsoring agency must either:(i) implement each recommendation in a timely fashion and submit documentation of the implementation to OPWDD; or (ii) in the event that the agency does not implement a particular recommendation, submit written justification to OPWDD within a month after the recommendation is made, and identify the alternative means that will be undertaken to address the issue, or explain why no action is needed.