**PROVIDER REPORT
FOR**

**AMEGO
33 Perry Avenue
Attleboro, MA 02703**

**January 06, 2025**

**Version**

**<span style="color:red">Public Provider Report</span>**

**Prepared by the Department of Developmental Services
OFFICE OF QUALITY ENHANCEMENT**

# SUMMARY OF OVERALL FINDINGS

| | |
|---|---|
| **Provider** | AMEGO |
| **Review Dates** | 12/3/2024 - 12/9/2024 |
| **Service Enhancement Meeting Date** | 12/23/2024 |
| **Survey Team** | Katherine Gregory (TL) |
| | Linda Griffith |
| | William Muguro |
| | Gina Ford |
| **Citizen Volunteers** | |

| Survey scope and findings for Residential and Individual Home Supports | | | | | |
|---|---|---|---|---|---|
| **Service Group Type** | **Sample Size** | **Licensure Scope** | **Licensure Level** | **Certification Scope** | **Certification Level** |
| **Residential and Individual Home Supports** | 21 location(s)<br><br>21 audit (s) | Targeted Review | DDS 15/16 Provider 72 / 76<br><br>87 / 92 2 Year License 12/23/2024-12/23/2026 | | DDS 3 / 5 Provider 42 / 42<br><br>45 / 47 Certified 12/23/2024 - 12/23/2026 |
| Residential Services | 18 location(s)<br><br>18 audit (s) | | | DDS Targeted Review | 19 / 20 |
| Individual Home Supports | 3 location(s)<br>3 audit (s) | | | DDS Targeted Review | 20 / 21 |
| Planning and Quality Management (For all service groupings) | | | | DDS Targeted Review | 6 / 6 |
| Survey scope and findings for Employment and Day Supports | | | | | |
| **Service Group Type** | **Sample Size** | **Licensure Scope** | **Licensure Level** | **Certification Scope** | **Certification Level** |
| **Employment and Day Supports** | 1 location(s)<br>7 audit (s) | Targeted Review | DDS 10/11 Provider 56 / 58<br><br>66 / 69 2 Year License 12/23/2024-12/23/2026 | | DDS 0 / 0 Provider 21 / 21<br><br>21 / 21 Certified 12/23/2024 - 12/23/2026 |
| Community Based Day Services | 1 location(s)<br>7 audit (s) | | | DDS Targeted Review | 15 / 15 |
| Planning and Quality Management (For all service groupings) | | | | DDS Targeted Review | 6 / 6 |

# EXECUTIVE SUMMARY :

AMEGO, Inc., founded in 1971, provides supports to individuals with disabilities in the Southeast, Metro Boston, and Central West regions of Massachusetts. The agency offers residential, clinical, educational, Day Habilitation, and Community Based Day Services (CBDS) to adults and children diagnosed with Autism Spectrum Disorder (ASD) and other intellectual and developmental disabilities. Services include over 70 residential homes and apartments serving over 300 individuals and 2 CBDS programs with over 70 participants. The agency specializes in supporting people with behavioral challenges and provides individualized clinical approaches throughout individuals' lives through applied behavioral analysis and evidence-based practices.

This Department of Developmental Services (DDS) Office of Quality Enhancement (OQE) Review included a sample of 18 residences providing 24-hour support, 3 individuals participating in Individual Home Supports, and 7 individuals in one CBDS program. Based on the outcomes of the last Licensure and Certification Survey conducted in 2022, AMEGO earned the option to conduct a self-assessment for both Residential and Day Services. During this cycle's survey, the DDS Office of Quality Enhancement (OQE) conducted a Targeted Review of all critical indicators for Licensing, and also reviewed all indicators for Licensing and Certification which did not receive a met outcome at the last review. AMEGO conducted a self-assessment for the remainer of the indicators.

Throughout the OQE survey, strengths were noted in various areas. Organizationally, all allegations of suspected abuse and neglect were reported to DPPC. The review confirmed effective processes were in place to promote safeguard systems. The Licensing review confirmed all individuals in both residential and day services were supported to evacuate for emergencies in a timely fashion. The environmental review found both day services and homes to be clean and well-maintained, with all required inspections up to date and all smoke and carbon monoxide detectors in working order. The Medication and Healthcare review for Residential and Day Services revealed that medications administration was completed by certified or licensed staff. All medication administration was carried out accurately, and all related documentation was maintained with timely documentation and accuracy, including the outcome of medications administered only for occasional use. Medication Treatment Plans were submitted and received the required review by ISP teams for both residential and day programs.

Within Certification for the indicators that were reviewed by DDS, areas of success were identified. In residential services for Community Access and Integration the agency demonstrated consistent efforts in assisting individuals to access their communities frequently throughout each week with a focus on individuals' interests and connecting them with others who shared those interests. Individuals were engaging in weekly dances at a local restaurant, walks in multiple local parks, exercising at the YMCA, visits to Patriot Place, attending an arcade, visiting LaSallette Shrine, and a wildlife sanctuary to explore and participate in activities of their interest, and to integrate and find common ground with those who shared their favorite activities. Support was given to help individuals to find additional creative ways to share their interests with others. As an example, one home hosted themed parties, allowing individuals to share their favorite hobbies, pass-times and activities with others such as Toy Story, the 3 Stooges, or wresting in which themed decorations, costumes food and entertainment was shared by others who had similar interests. Individuals were encouraged to interact with others around their interests and were assisted in finding new connections or enhancing those that already existed in the community as well.

In addition to the positive findings, areas were identified that need further attention from the agency to meet DDS standards. In residential services additional oversight is needed to ensure that all incident reports are submitted and finalized within the required timelines in HCSIS. Another area requiring increased oversight is acquisition of water safety training for CBDS staff who are accompanying individuals on swimming activities.

For both day and residential programs, a strengthened system is needed for involving the individuals in the pre-hiring process to gather their feedback on potential employees, as well as soliciting their feedback on current employees working with them. A consistent system is needed for ensuring

individuals' feedback for their staff's ongoing performance is shared with current employees.

As a result of this review, AMEGO's residential service has earned a two year license with a score of 95%, and has achieved Certification with a score of 96%. AMEGO's day service has also earned a two-year license with a score of 96% and has achieved Certification with a score of 100%. AMEGO will submit their follow-up review for any Licensing indicators not met to the DDS OQE within 60 days.

# Description of Self Assessment Process:

Date(s) of assessment:11/14/24-11/25/24

Self-Assessment Scope and results:
Service Grouping # Licensure Indicators std. met/ reviewed # Certification Indicators std. met/ reviewed

Residential and Individual Home Supports 86 / 93 (92.5%) 26 / 27 (96.3%)
Employment and Day Supports 67 / 70 (95.7%) 21 / 21 (100.0%)

Description of Self-Assessment Process

 Amego's self-assessment process utilized a hybrid approach of on-site inspection and auditing, along with a review of existing quality management systems, to determine scoring for each licensure and certification indicator. The processes involved in each are further described below.

On-Site Audit Process
A team of senior leaders was assembled to comprise the audit team. DDS' licensure & certification worksheets were used to conduct audits of all applicable standards. Prior to conducting on-site audits, training was provided to audit team members on applicable DDS standards, the audit methodology, and guidance tools to use for aiding in determining ratings for each standard. The scoring methodology used to rate overall compliance for the agency mirrored the one used by DDS in that standards were rated as 'met' when compliance across all locations/individuals reviewed were 80% or higher.

A random sample of program locations and individuals served by those programs was selected as follows:
 24-hour Residential Supports: 18 locations, a primary and secondary individual was randomly selected at each.
 Individual Home Supports: Three individuals at three locations.
 CBDS: Seven individuals total across both program locations.

On-site audits were conducted between November 14, 2024 and November 25, 2024. The results of each audit were reviewed by the Quality Assurance (QA) Department to ensure they were correctly rated before being aggregated.

Quality Management System Review
Where possible, existing quality management systems which allowed for compliance measurement of specific standards were reviewed in lieu of or as an adjunct to the on-site audits to determine the agency's compliance with specific standards. The following section summarizes the review of these systems.
 [L3 & L4] - The QA Department maintains a detailed tracking system for all DPPC investigations. The system documents immediate actions taken in response to each allegation and helps ensure that action plans are completed and submitted according to assigned timelines. Review of data collected through this system identified consistent and appropriate immediate action taken in response to DPPC cases and that action plan submission timelines were met for 97.7% of cases since 1/1/2023.
 [L6 & L7] - Programs complete fire drills through a mobile application on a tablet. Data from completed fire drills is visualized on the QA Department's business intelligence dashboard to ensure drills are conducted at the required frequency and drills meet all requirements for staffing ratios and duration. Alerts are sent to program managers when a program's fire drill is not compliant to ensure the issue is immediately rectified. Automated reminder emails are sent to program managers who are not on track to complete required drills. Review of the fire drill dashboard demonstrates 100% of programs have completed drills at the required frequency in the last 12 months.
 [L11 - L26] - The Facilities Department introduced a new work order system in 2023. The system allows for anyone to submit a work order by scanning a QR code and then entering basic information about the request. Work orders are triaged by the Facilities Department to respond immediately to emergency requests. Work orders can be automatically routed to external vendors to complete when needed. The system allows for information about each program's appliances to be tracked, allowing for

easy repair and replacement of parts when needed. Each program's gas/oil burning furnaces, water heaters, and generators were added to the system and now have automatic work orders routed to external vendors to complete annual inspections. Review of the work order system identified all gas/oil burning equipment has been inspected within the last year and automatically renewing work orders are scheduled to be assigned to external inspectors for 2025.

[L13] - All Amego owned and leased program locations receive monthly preventative and as-needed visits by a pest control vendor to ensure programs remain free of rodent and/or insect infestation.

[L15] - Hot water temperatures are tested by each program monthly. QA and Facilities staff additionally test water temperatures during their routine visits. Review of water temperatures reviewed by each program identified temperatures to be in range 93% of the time (82% of those out of range were below 110 degrees). Water temperatures were also confirmed to be routinely in range during on-site audits conducted for this self-assessment.

[L48] - Amego maintains three regional Human Rights Committees to provide oversight and advisement on ensuring the rights of individuals served are continually upheld. Review of minutes for the last year of each of the three Committees identifies they each consistently maintained required composition, meeting frequency, reviewed mandated areas, and conducted site visits.

[L76] - Amego uses an online Learning Management System (LMS) to record completion of in-person training events and to host online training modules for staff to complete. The LMS records data on staff's compliance with required trainings. Review of training compliance data for all eligible staff identified that 86.9% of staff were compliant with all required trainings. Amego is in the process of rolling out a new LMS and expects to further increase overall staff compliance with required trainings as part of the optimization period of the LMS rollout.

[L65 & L66; L86 & L87; L91] - Reports from HCSIS were reviewed to determine compliance with multiple standards, including Restraint Report submission/review timelines, ISP assessment & support strategy submission timelines, and Incident Report submission/review timelines. A complete data set from a 12-month period was used in each case to avoid sampling bias. With the exception of Human Rights committee review of restraint reports (L66), review of these HCSIS reports largely identified compliance to be below 80%.

Lastly, Amego has several quality assurance systems which ensure the agency regularly meets or exceeds DDS and industry standards. These systems include:

The Quality Assurance Department conducts in-depth audits of every program once every 6 months. The QA team utilizes a customized electronic checklist which reviews 418 data points on average, assessing a wide variety of areas such as:
o environmental cleanliness, safety, and cosmetic appearance;
o adherence to agency systems for conducting drills, holding staff meetings, house meetings with individuals served, staff training compliance, proper management of funds of individuals served, proper data collection for ISP/BSP/MTP data, and proper management and administration of medications;
o documentation for individuals served required to be in their record is present, timely, accurate, and complete;
o quality of life indicators.
Any deficiencies identified during QA audits are documented on an action plan which is sent to program management for correction. Every action plan is tracked to completion to ensure deficiencies are resolved. Data is used from analysis of QA audits to guide future QA improvement activities such as identifying systems to target for performance improvement or specific programs requiring additional support.

The Nursing Department also regularly audits all programs utilizing a customized electronic checklist that covers medication and other healthcare-related areas. Deficiencies are tracked and responded to in a similar fashion as the QA Department's audit process.

[L68 & L69] - In July 2023, the Finance Department introduced a new funds management process that uses debit cards instead of cash for individuals whose funds are managed by the agency. This system allows for automatic electronic recording and reconciliation of all transactions. Receipts are uploaded through a mobile app, and all transactions are monitored for appropriateness. An additional benefit of this system has been the ability to measure community engagement for the individuals served by analyzing transaction data, which provides insight into the variety and frequency of their community purchases.

[C3] - Amego solicits feedback from stakeholders in a variety of ways. Satisfaction surveys are conducted annually. Results are analyzed and shared with Amego leadership to inform service

improvement efforts. Stakeholder meetings are also held routinely via video conferencing. Families, guardians, individuals, and other stakeholders are invited to join to hear updates on changes within Amego and provided opportunities to provide their feedback as well.

Amego-owned vehicles have GPS telemetry devices installed. These devices relay data about the driver's behavior such as speeding, acceleration, cornering, braking, and seat belt use. The devices also emit an audible alert to the driver when they exceed speed thresholds or when they are operating the vehicle without their seat belt buckled, prompting the driver to self-correct their behavior. Data is aggregated on the QA Department's business intelligence dashboard to identify trends and opportunities for improvement.

[C12] - After an opportunity for improvement was identified following the last DDS licensing survey, Amego collaborated with a DDS OQE representative and other providers to enhance systems for supporting individuals in the areas of intimacy and companionship. Amego has delivered a series of sexuality education programs, each lasting 6 to 9 weeks, focused on positive self-awareness, respect, communication, consent, decision-making, healthy relationships, and anatomy. These programs were facilitated by a licensed social worker and certified sexuality educator, utilizing the curriculum "Sexuality Education for Adults with Developmental Disabilities" by Katherine McLaughlin, along with Amego-developed and community-shared materials. Amego emphasizes sexuality as a vital part of personal growth, providing tailored education while prioritizing safety, privacy, and access to trusted support.

The Amego Health, Safety, & Restraint Committee meets monthly to review several domains such as healthcare, workplace injuries, facilities management, Quality Assurance metrics, Critical Incidents, and restraint reduction. The Risk Management Committee provides also meets monthly with the aim of reducing risk across the agency. Topics for discussion include review and response to trends in allegations of abuse, root cause analysis of Critical Incidents, case reviews, and agency-wide safety metrics.

The agency created a Forms Standardization Committee to strengthen procedures for updating, standardizing, and disseminating programmatic forms. The Committee has updated several forms to reduce complexity and more clearly prompt users for information and has also created a new SharePoint site to house form templates ensuring forms are easily accessible to programs and can be appropriately version controlled.

In the Summer of 2024, the agency's Positive Behavior Supports (PBS) Leadership Team rolled out a PBS observation and feedback process. Managers conduct at least one observation of each of their staff per months using a standardized tool that gauges the meaningfulness of activities individuals are engaged in, the positivity of staff interactions with individuals, whether individuals are offered appropriate choices, proper implementation of the individual's Positive Behavior Support Plan, and appropriate response to challenging behavior.

## LICENSURE FINDINGS

| | Met / Rated | Not Met / Rated | % Met |
|---|---|---|---|
| **Organizational** | 9/10 | 1/10 | |
| **Residential and Individual Home Supports** | 78/82 | 4/82 | |
| Residential Services Individual Home Supports | | | |
| **Critical Indicators** | 8/8 | 0/8 | |
| **Total** | 87/92 | 5/92 | 95% |
| **2 Year License** | | | |
| **# indicators for 60 Day Follow-up** | | 5 | |

| | Met / Rated | Not Met / Rated | % Met |
|---|---|---|---|
| **Organizational** | 9/10 | 1/10 | |
| **Employment and Day Supports** | 57/59 | 2/59 | |
| Community Based Day Services | | | |
| **Critical Indicators** | 8/8 | 0/8 | |
| **Total** | 66/69 | 3/69 | 96% |
| **2 Year License** | | | |
| **# indicators for 60 Day Follow-up** | | 3 | |

**Organizational Areas Needing Improvement on Standards not met/Follow-up to occur:**
**From Provider review:**

| Indicator # | Indicator | Issue identified | Action planned to address |
|---|---|---|---|
| L65 | Restraint reports are submitted within required timelines. | Review of Restraint Reports in HCSIS found that only 54% were submitted and reviewed within required timeframes. | The agency will review existing responsibilities for Restraint Report submission and review to ensure they roles are clear and designed to meet required timelines. Training will be conducted to all responsible for submission and review to ensure awareness of required timelines. The QA Department will monitor compliance by verifying that 90% or more of Restraint Reports have been submitted and reviewed within required timeframes. Results will be reviewed with program leadership each month until compliance is maintained for four consecutive months. |

**Residential Areas Needing Improvement on Standards not met/Follow-up to occur:**
**From DDS review:**

| Indicator # | Indicator | Area Needing Improvement |
|---|---|---|
| L91 | Incidents are reported and reviewed as mandated by regulation. | At 7 homes, incident reports were submitted and / or finalized in HCSIS outside the required timelines. The agency needs to ensure that all incidents are submitted and finalized within required timelines. |

**Residential Areas Needing Improvement on Standards not met/Follow-up to occur:**
**From Provider review:**

| Indicator # | Indicator | Issue identified | Action planned to address |
|---|---|---|---|

**Residential Areas Needing Improvement on Standards not met/Follow-up to occur:**
**From Provider review:**

| Indicator # | Indicator | Issue identified | Action planned to address |
|---|---|---|---|
| L56 | Restrictive practices intended for one individual that affect all individuals served at a location need to have a written rationale that is reviewed as required and have provisions so as not to unduly restrict the rights of others. | Residential service program audits revealed that only 67% of programs had all required components in place for restrictive practices implemented. Most often, a plan to fade the restrictive practice was incomplete or not present. | The agency will review existing templates for documenting restrictive practices to identify opportunities to streamline and simplify the process, ensuring that all required components can be easily captured. Once the new template has been created, the QA Department will monitor compliance by verifying through its ongoing program audits. Results will be reviewed with program leadership each month until 90% or more of programs demonstrate compliance for four consecutive months. |
| L86 | Required assessments concerning individual needs and abilities are completed in preparation for the ISP. | Review of ISP assessment submission timelines found that only 64.2% of assessments were submitted on time in Residential Services. | Staff responsible for ISP assessment submissions will receive additional training on how to use HCSIS to identify ISP assessment due dates. The QA Department will also develop a notification system to alert staff of upcoming due dates, ensuring they are informed in advance of upcoming due dates. The QA Department will monitor compliance by verifying that 90% or more of individuals with an ISP in a given month have their assessments submitted on time. Results will be reviewed with program leadership each month until compliance is maintained for four consecutive months. |

**Residential Areas Needing Improvement on Standards not met/Follow-up to occur:**
**From Provider review:**

| Indicator # | Indicator | Issue identified | Action planned to address |
|---|---|---|---|
| L87 | Support strategies necessary to assist an individual to meet their goals and objectives are completed and submitted as part of the ISP. | Review of ISP support strategy submission timelines found that only 78% of individuals receiving Residential services and 63% of individuals receiving CBDS services had their ISP support strategies submitted on time. | Staff responsible for ISP support strategy submissions will receive additional training on how to use HCSIS to identify ISP support strategy due dates. The QA Department will also develop a notification system to alert staff of upcoming due dates, ensuring they are informed in advance of upcoming due dates. The QA Department will monitor compliance by verifying that 90% or more of individuals with an ISP in a given month have their support strategies submitted on time. Results will be reviewed with program leadership each month until compliance is maintained for four consecutive months. |

**Employment/Day Areas Needing Improvement on Standards not met/Follow-up to occur:**
**From DDS review:**

| Indicator # | Indicator | Area Needing Improvement |
|---|---|---|
| L27 | If applicable, swimming pools and other bodies of water are safe and secure according to policy. | At the agency's CBDS location individuals were accompanied by staff to the YMCA regularly. Staff had not been trained in Water Safety. The agency needs to ensure that all staff accompanying individuals on activities that involve proximity to water are trained in Water Safety. |

**Employment/Day Areas Needing Improvement on Standards not met/Follow-up to occur: From Provider review:**

| Indicator # | Indicator | Issue identified | Action planned to address |
|---|---|---|---|
| L87 | Support strategies necessary to assist an individual to meet their goals and objectives are completed and submitted as part of the ISP. | Review of ISP support strategy submission timelines found that only 78% of individuals receiving Residential services and 63% of individuals receiving CBDS services had their ISP support strategies submitted on time. | Staff responsible for ISP support strategy submissions will receive additional training on how to use HCSIS to identify ISP support strategy due dates. The QA Department will also develop a notification system to alert staff of upcoming due dates, ensuring they are informed in advance of upcoming due dates. The QA Department will monitor compliance by verifying that 90% or more of individuals with an ISP in a given month have their support strategies submitted on time. Results will be reviewed with program leadership each month until compliance is maintained for four consecutive months. |

# CERTIFICATION FINDINGS

| | Reviewed By | Met / Rated | Not Met / Rated | % Met |
|---|---|---|---|---|
| **Certification - Planning and Quality Management** | **DDS 0/0 Provider 6/6** | **6/6** | **0/6** | |
| **Residential and Individual Home Supports** | **DDS 3/5 Provider 36/36** | **39/41** | **2/41** | |
| Individual Home Supports | DDS 0/1 Provider 20/20 | 20/21 | 1/21 | |
| Residential Services | DDS 3/4 Provider 16/16 | 19/20 | 1/20 | |
| **Total** | | **45/47** | **2/47** | **96%** |
| **Certified** | | | | |

| | Reviewed By | Met / Rated | Not Met / Rated | % Met |
|---|---|---|---|---|
| **Certification - Planning and Quality Management** | **DDS 0/0 Provider 6/6** | **6/6** | **0/6** | |
| **Employment and Day Supports** | **DDS 0/0 Provider 15/15** | **15/15** | **0/15** | |
| Community Based Day Services | DDS 0/0 Provider 15/15 | 15/15 | 0/15 | |
| **Total** | | **21/21** | **0/21** | **100%** |
| **Certified** | | | | |

**Individual Home Supports- Areas Needing Improvement on Standards not met From DDS Review:**

| Indicator # | Indicator | Area Needing Improvement |
|---|---|---|
| C7 | Individuals have opportunities to provide feedback at the time of hire / time of the match and on an ongoing basis on the performance/actions of staff / care providers that support them. | One individual receiving Individual Home Supports was not provided the opportunity to offer feedback on their potential staff before they were hired or on their current staff's ongoing performance. The agency needs to solicit individuals' opinions on staff prior to hire and to ensure individuals opinions of their ongoing staff's performance is shared during their performance evaluation process. |

**Residential Services- Areas Needing Improvement on Standards not met From DDS Review:**

| Indicator # | Indicator | Area Needing Improvement |
|---|---|---|
| C7 | Individuals have opportunities to provide feedback at the time of hire / time of the match and on an ongoing basis on the performance/actions of staff / care providers that support them. | 18 individuals in residential services were not provided the opportunity to offer feedback on potential staff before they were hired or on their current staff's ongoing performance. The agency needs to solicit individuals' opinions on staff prior to hire and to ensure individuals opinions of their ongoing staff's performance is shared during their performance evaluation process. |

**MASTER SCORE SHEET LICENSURE**

**Organizational: AMEGO**

| Indicator # | Indicator | Reviewed by | Met/Rated | Rating(Met,Not Met,NotRated) |
|---|---|---|---|---|
| L2 | Abuse/neglect reporting | **DDS** | **22/22** | **Met** |
| L3 | Immediate Action | **Provider** | - | **Met** |
| L4 | Action taken | **Provider** | - | **Met** |
| L48 | HRC | **Provider** | - | **Met** |
| L65 | Restraint report submit | **Provider** | - | **Not Met** |
| L66 | HRC restraint review | **Provider** | - | **Met** |
| L74 | Screen employees | **Provider** | - | **Met** |
| L75 | Qualified staff | **Provider** | - | **Met** |
| L76 | Track trainings | **Provider** | - | **Met** |
| L83 | HR training | **Provider** | - | **Met** |

**Residential and Individual Home Supports:**

| Ind. # | Ind. | Loc. or Indiv. | Reviewed by | Res. Sup. | Ind. Home Sup. | Place. | Resp. | ABI-MFP Res. Sup. | ABI-MFP Place. | Total Met/Rated | Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| L1 | Abuse/neglect training | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L5 | Safety Plan | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L6 | Evacuation | L | **DDS** | 18/18 | 3/3 | | | | | **21/21** | **Met** |
| L7 | Fire Drills | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L8 | Emergency Fact Sheets | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L9 (07/21) | Safe use of equipment | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L10 | Reduce risk interventions | I | **Provider** | - | - | | | - | - | **-** | **Met** |

| Ind. # | Ind. | Loc. or Indiv. | Reviewed by | Res. Sup. | Ind. Home Sup. | Place. | Resp. | ABI-MFP Res. Sup. | ABI-MFP Place. | Total Met/Rated | Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| L11 | Required inspections | L | **DDS** | 18/18 | 3/3 | | | | | **21/21** | **Met** |
| L12 | Smoke detectors | L | **DDS** | 18/18 | 3/3 | | | | | **21/21** | **Met** |
| L13 | Clean location | L | **DDS** | 18/18 | 3/3 | | | | | **21/21** | **Met** |
| L14 | Site in good repair | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L15 | Hot water | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L16 | Accessibility | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L17 | Egress at grade | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L18 | Above grade egress | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L19 | Bedroom location | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L20 | Exit doors | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L21 | Safe electrical equipment | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L22 | Well-maintained appliances | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L23 | Egress door locks | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L24 | Locked door access | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L25 | Dangerous substances | L | **Provider** | - | - | | | - | - | **-** | **Met** |

| Ind. # | Ind. | Loc. or Indiv. | Reviewed by | Res. Sup. | Ind. Home Sup. | Place. | Resp. | ABI-MFP Res. Sup. | ABI-MFP Place. | Total Met/Rated | Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| L26 | Walkway safety | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L27 | Pools, hot tubs, etc. | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L28 | Flammables | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L29 | Rubbish/combustibles | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L30 | Protective railings | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L31 | Communication method | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L32 | Verbal & written | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L33 | Physical exam | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L34 | Dental exam | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L35 | Preventive screenings | I | **DDS** | 14/17 | 3/3 | | | | | **17/20** | **Met (85.00%)** |
| L36 | Recommended tests | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L37 | Prompt treatment | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L38 | Physician's orders | I | **DDS** | 18/18 | 2/2 | | | | | **20/20** | **Met** |
| L39 | Dietary requirements | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L40 | Nutritional food | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L41 | Healthy diet | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L42 | Physical activity | L | **Provider** | - | - | | | - | - | **-** | **Met** |

| Ind. # | Ind. | Loc. or Indiv. | Reviewed by | Res. Sup. | Ind. Home Sup. | Place. | Resp. | ABI-MFP Res. Sup. | ABI-MFP Place. | Total Met/Rated | Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| L43 | Health Care Record | I | **DDS** | 16/18 | 3/3 | | | | | **19/21** | **Met (90.48 %)** |
| L44 | MAP registration | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L45 | Medication storage | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L46 | Med. Administration | I | **DDS** | 18/18 | | | | | | **18/18** | **Met** |
| L47 | Self medication | I | **DDS** | 1/1 | 2/3 | | | | | **3/4** | **Met** |
| L49 | Informed of human rights | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L50 (07/21) | Respectful Comm. | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L51 | Possessions | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L52 | Phone calls | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L53 | Visitation | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L54 (07/21) | Privacy | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L55 | Informed consent | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L56 | Restrictive practices | I | **Provider** | - | - | | | - | - | **-** | **Not Met** |
| L57 | Written behavior plans | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L58 | Behavior plan component | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L59 | Behavior plan review | I | **Provider** | - | - | | | - | - | **-** | **Met** |

| Ind. # | Ind. | Loc. or Indiv. | Reviewed by | Res. Sup. | Ind. Home Sup. | Place. | Resp. | ABI-MFP Res. Sup. | ABI-MFP Place. | Total Met/Rated | Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| L60 | Data maintenance | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L61 | Health protection in ISP | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L62 | Health protection review | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L63 | Med. treatment plan form | I | **DDS** | 16/17 | 1/2 | | | | | **17/19** | **Met (89.47 %)** |
| L64 | Med. treatment plan rev. | I | **DDS** | 16/16 | 2/2 | | | | | **18/18** | **Met** |
| L67 | Money mgmt. plan | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L68 | Funds expenditure | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L69 | Expenditure tracking | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L70 | Charges for care calc. | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L71 | Charges for care appeal | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L77 | Unique needs training | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L78 | Restrictive Int. Training | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L79 | Restraint training | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L80 | Symptoms of illness | L | **Provider** | - | - | | | - | - | **-** | **Met** |

| Ind. # | Ind. | Loc. or Indiv. | Reviewed by | Res. Sup. | Ind. Home Sup. | Place. | Resp. | ABI-MFP Res. Sup. | ABI-MFP Place. | Total Met/Rated | Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| L81 | Medical emergency | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L82 | Medication admin. | L | **DDS** | 18/18 | 1/1 | | | | | **19/19** | **Met** |
| L84 | Health protect. Training | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L85 | Supervision | L | **Provider** | - | - | | | - | - | **-** | **Met** |
| L86 | Required assessments | I | **Provider** | - | - | | | - | - | **-** | **Not Met** |
| L87 | Support strategies | I | **Provider** | - | - | | | - | - | **-** | **Not Met** |
| L88 | Strategies implemented | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L90 | Personal space/ bedroom privacy | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L91 | Incident management | L | **DDS** | 9/15 | 2/3 | | | | | **11/18** | **Not Met (61.11 %)** |
| L93 (05/22) | Emergency back-up plans | I | **Provider** | - | - | | | - | - | **-** | **Met** |
| L94 (05/22) | Assistive technology | I | **DDS** | 15/18 | 3/3 | | | | | **18/21** | **Met (85.71 %)** |
| L96 (05/22) | Staff training in devices and applications | I | **Provider** | - | - | | | - | - | **-** | **Met** |

| Ind. # | Ind. | Loc. or Indiv. | Reviewed by | Res. Sup. | Ind. Home Sup. | Place. | Resp. | ABI-MFP Res. Sup. | ABI-MFP Place. | Total Met/Rated | Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| L99 (05/22) | Medical monitoring devices | I | **DDS** | 4/5 | | | | | | **4/5** | **Met (80.0%)** |
| **#Std. Met/# 82 Indicator** | | | | | | | | | | **78/82** | |
| **Total Score** | | | | | | | | | | **87/92** | |
| | | | | | | | | | | **94.57%** | |

**Employment and Day Supports:**

| Ind. # | Ind. | Loc. or Indiv. | Reviewed by | Emp. Sup. | Cent. Based Work | Com. Based Day | Total Met / Rated | Rating |
|---|---|---|---|---|---|---|---|---|
| L1 | Abuse/neglect training | I | **Provider** | | | - | **-** | **Met** |
| L5 | Safety Plan | L | **Provider** | | | - | **-** | **Met** |
| L6 | Evacuation | L | **DDS** | | | 1/1 | **1/1** | **Met** |
| L7 | Fire Drills | L | **Provider** | | | - | **-** | **Met** |
| L8 | Emergency Fact Sheets | I | **Provider** | | | - | **-** | **Met** |
| L9 (07/21) | Safe use of equipment | I | **Provider** | | | - | **-** | **Met** |
| L10 | Reduce risk interventions | I | **Provider** | | | - | **-** | **Met** |
| L11 | Required inspections | L | **DDS** | | | 1/1 | **1/1** | **Met** |
| L12 | Smoke detectors | L | **DDS** | | | 1/1 | **1/1** | **Met** |
| L13 | Clean location | L | **DDS** | | | 1/1 | **1/1** | **Met** |
| L14 | Site in good repair | L | **Provider** | | | - | **-** | **Met** |
| L15 | Hot water | L | **Provider** | | | - | **-** | **Met** |
| L16 | Accessibility | L | **Provider** | | | - | **-** | **Met** |

| Ind. # | Ind. | Loc. or Indiv. | Reviewed by | Emp. Sup. | Cent. Based Work | Com. Based Day | Total Met / Rated | Rating |
|---|---|---|---|---|---|---|---|---|
| L17 | Egress at grade | L | **Provider** | | | - | **-** | **Met** |
| L18 | Above grade egress | L | **Provider** | | | - | **-** | **Met** |
| L20 | Exit doors | L | **Provider** | | | - | **-** | **Met** |
| L21 | Safe electrical equipment | L | **Provider** | | | - | **-** | **Met** |
| L22 | Well-maintained appliances | L | **Provider** | | | - | **-** | **Met** |
| L25 | Dangerous substances | L | **Provider** | | | - | **-** | **Met** |
| L26 | Walkway safety | L | **Provider** | | | - | **-** | **Met** |
| L27 | Pools, hot tubs, etc. | L | **DDS** | | | 0/1 | **0/1** | **Not Met (0 %)** |
| L28 | Flammables | L | **Provider** | | | - | **-** | **Met** |
| L29 | Rubbish/combustibles | L | **Provider** | | | - | **-** | **Met** |
| L30 | Protective railings | L | **Provider** | | | - | **-** | **Met** |
| L31 | Communication method | I | **Provider** | | | - | **-** | **Met** |
| L32 | Verbal & written | I | **Provider** | | | - | **-** | **Met** |
| L37 | Prompt treatment | I | **Provider** | | | - | **-** | **Met** |
| L38 | Physician's orders | I | **DDS** | | | 7/7 | **7/7** | **Met** |
| L39 | Dietary requirements | I | **Provider** | | | - | **-** | **Met** |
| L44 | MAP registration | L | **Provider** | | | - | **-** | **Met** |
| L45 | Medication storage | L | **Provider** | | | - | **-** | **Met** |
| L46 | Med. Administration | I | **DDS** | | | 7/7 | **7/7** | **Met** |
| L49 | Informed of human rights | I | **Provider** | | | - | **-** | **Met** |
| L50 (07/21) | Respectful Comm. | I | **Provider** | | | - | **-** | **Met** |
| L51 | Possessions | I | **Provider** | | | - | **-** | **Met** |

| Ind. # | Ind. | Loc. or Indiv. | Reviewed by | Emp. Sup. | Cent. Based Work | Com. Based Day | Total Met / Rated | Rating |
|---|---|---|---|---|---|---|---|---|
| L52 | Phone calls | I | **Provider** | | | - | **-** | **Met** |
| L54 (07/21) | Privacy | I | **Provider** | | | - | **-** | **Met** |
| L55 | Informed consent | I | **Provider** | | | - | **-** | **Met** |
| L56 | Restrictive practices | I | **Provider** | | | - | **-** | **Met** |
| L57 | Written behavior plans | I | **Provider** | | | - | **-** | **Met** |
| L58 | Behavior plan component | I | **Provider** | | | - | **-** | **Met** |
| L59 | Behavior plan review | I | **Provider** | | | - | **-** | **Met** |
| L60 | Data maintenance | I | **Provider** | | | - | **-** | **Met** |
| L63 | Med. treatment plan form | I | **Provider** | | | - | **-** | **Met** |
| L64 | Med. treatment plan rev. | I | **DDS** | | | 7/7 | **7/7** | **Met** |
| L77 | Unique needs training | I | **Provider** | | | - | **-** | **Met** |
| L78 | Restrictive Int. Training | L | **Provider** | | | - | **-** | **Met** |
| L79 | Restraint training | L | **Provider** | | | - | **-** | **Met** |
| L80 | Symptoms of illness | L | **Provider** | | | - | **-** | **Met** |
| L81 | Medical emergency | L | **Provider** | | | - | **-** | **Met** |
| L82 | Medication admin. | L | **DDS** | | | 1/1 | **1/1** | **Met** |
| L85 | Supervision | L | **Provider** | | | - | **-** | **Met** |
| L86 | Required assessments | I | **Provider** | | | - | **-** | **Met** |
| L87 | Support strategies | I | **Provider** | | | - | **-** | **Not Met** |
| L88 | Strategies implemented | I | **Provider** | | | - | **-** | **Met** |
| L91 | Incident management | L | **DDS** | | | 1/1 | **1/1** | **Met** |
| L93 (05/22) | Emergency back-up plans | I | **Provider** | | | - | **-** | **Met** |

| Ind. # | Ind. | Loc. or Indiv. | Reviewed by | Emp. Sup. | Cent. Based Work | Com. Based Day | Total Met / Rated | Rating |
|---|---|---|---|---|---|---|---|---|
| L94 (05/22) | Assistive technology | I | **Provider** | | | - | **-** | **Met** |
| L96 (05/22) | Staff training in devices and applications | I | **Provider** | | | - | **-** | **Met** |
| **#Std. Met/# 59 Indicator** | | | | | | | **57/59** | |
| **Total Score** | | | | | | | **66/69** | |
| | | | | | | | **95.65%** | |

## MASTER SCORE SHEET CERTIFICATION

### Certification - Planning and Quality Management

| | Indicator # | Indicator | Reviewed By | Met/Rated | Rating |
|---|---|---|---|---|---|
| | C1 | Provider data collection | Provider | - | **Met** |
| | C2 | Data analysis | Provider | - | **Met** |
| | C3 | Service satisfaction | Provider | - | **Met** |
| | C4 | Utilizes input from stakeholders | Provider | - | **Met** |
| | C5 | Measure progress | Provider | - | **Met** |
| | C6 | Future directions planning | Provider | - | **Met** |

### Residential Services

| Indicator # | Indicator | Reviewed By | Met/Rated | Rating |
|---|---|---|---|---|
| C7 | Feedback on staff / care provider performance | DDS | 0/18 | **Not Met (0 %)** |
| C8 | Family/guardian communication | Provider | - | **Met** |
| C9 | Personal relationships | DDS | 18/18 | **Met** |
| C10 | Social skill development | Provider | - | **Met** |
| C11 | Get together w/family & friends | Provider | - | **Met** |
| C12 | Intimacy | DDS | 18/18 | **Met** |
| C13 | Skills to maximize independence | Provider | - | **Met** |

**Residential Services**

| Indicator # | Indicator | Reviewed By | Met/Rated | Rating |
|---|---|---|---|---|
| C14 | Choices in routines & schedules | Provider | - | **Met** |
| C15 | Personalize living space | Provider | - | **Met** |
| C16 | Explore interests | DDS | 18/18 | **Met** |
| C17 | Community activities | Provider | - | **Met** |
| C18 | Purchase personal belongings | Provider | - | **Met** |
| C19 | Knowledgeable decisions | Provider | - | **Met** |
| C46 | Use of generic resources | Provider | - | **Met** |
| C47 | Transportation to/ from community | Provider | - | **Met** |
| C48 | Neighborhood connections | Provider | - | **Met** |
| C49 | Physical setting is consistent | Provider | - | **Met** |
| C51 | Ongoing satisfaction with services/ supports | Provider | - | **Met** |
| C52 | Leisure activities and free-time choices /control | Provider | - | **Met** |
| C53 | Food/ dining choices | Provider | - | **Met** |

**Individual Home Supports**

| Indicator # | Indicator | Reviewed By | Met/Rated | Rating |
|---|---|---|---|---|
| C7 | Feedback on staff / care provider performance | DDS | 2/3 | **Not Met (66.67 %)** |
| C8 | Family/guardian communication | Provider | - | **Met** |
| C9 | Personal relationships | Provider | - | **Met** |
| C10 | Social skill development | Provider | - | **Met** |
| C11 | Get together w/family & friends | Provider | - | **Met** |
| C12 | Intimacy | Provider | - | **Met** |
| C13 | Skills to maximize independence | Provider | - | **Met** |
| C14 | Choices in routines & schedules | Provider | - | **Met** |
| C15 | Personalize living space | Provider | - | **Met** |
| C16 | Explore interests | Provider | - | **Met** |
| C17 | Community activities | Provider | - | **Met** |
| C18 | Purchase personal belongings | Provider | - | **Met** |
| C19 | Knowledgeable decisions | Provider | - | **Met** |

**Individual Home Supports**

| Indicator # | Indicator | Reviewed By | Met/Rated | Rating |
|---|---|---|---|---|
| C21 | Coordinate outreach | Provider | - | **Met** |
| C46 | Use of generic resources | Provider | - | **Met** |
| C47 | Transportation to/ from community | Provider | - | **Met** |
| C48 | Neighborhood connections | Provider | - | **Met** |
| C49 | Physical setting is consistent | Provider | - | **Met** |
| C51 | Ongoing satisfaction with services/ supports | Provider | - | **Met** |
| C52 | Leisure activities and free-time choices /control | Provider | - | **Met** |
| C53 | Food/ dining choices | Provider | - | **Met** |

**Community Based Day Services**

| Indicator # | Indicator | Reviewed By | Met/Rated | Rating |
|---|---|---|---|---|
| C7 | Feedback on staff / care provider performance | Provider | - | **Met** |
| C8 | Family/guardian communication | Provider | - | **Met** |
| C13 | Skills to maximize independence | Provider | - | **Met** |
| C37 | Interpersonal skills for work | Provider | - | **Met** |
| C38 (07/21) | Habilitative & behavioral goals | Provider | - | **Met** |
| C39 (07/21) | Support needs for employment | Provider | - | **Met** |
| C40 | Community involvement interest | Provider | - | **Met** |
| C41 | Activities participation | Provider | - | **Met** |
| C42 | Connection to others | Provider | - | **Met** |
| C43 | Maintain & enhance relationship | Provider | - | **Met** |
| C44 | Job exploration | Provider | - | **Met** |
| C45 | Revisit decisions | Provider | - | **Met** |
| C46 | Use of generic resources | Provider | - | **Met** |
| C47 | Transportation to/ from community | Provider | - | **Met** |
| C51 | Ongoing satisfaction with services/ supports | Provider | - | **Met** |