PROVIDER REPORT
FOR

COMMUNITY RESOURCES/JUSTICE
355 Boylston Street
Boston, MA 02116

November 04, 2022

Version

Public Provider Report

Prepared by the Department of Developmental Services
OFFICE OF QUALITY ENHANCEMENT

SUMMARY OF OVERALL FINDINGS

Provider	COMMUNITY RESOURCES/JUSTICE
Review Dates	10/4/2022 - 10/7/2022
Service Enhancement Meeting Date	10/21/2022
Survey Team	Elsa Adorno (TL) Carole Black Susan Dudley-Oxx Melanie Hutchison Melanie McNamara Janina Millet
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) 21 audit (s)	Targeted Review	DDS 21/22 Provider 63 / 69 84 / 91 2 Year License 10/21/2022-10/21/2024		DDS 1 / 1 Provider 45 / 45 46 / 46 Certified 10/21/2022 - 10/21/2024
Residential Services	10 location(s) 10 audit (s)			DDS Targeted Review	20 / 20
Placement Services	11 location(s) 11 audit (s)			DDS Targeted Review	20 / 20
Planning and Quality Management				DDS Targeted Review	6 / 6

EXECUTIVE SUMMARY :

Community Resources for Justice (CRJ) is a large organization, headquartered in Boston, whose broader mission focuses on the provision of supports to at-risk populations. The agency's Community Strategies of Massachusetts division, located in Shirley, provides 24-hour residential supports and placement services to individuals with intellectual disabilities, combined with significant behavioral support needs. Currently Community Strategies, CRJ's developmental disabilities service division, provides residential services in forty locations and supports fifty shared living arrangements. The survey sample included audits of ten 24-hour residential support locations and audits of nine individuals in shared-living placement services.

The agency was eligible and received approval from the DDS Regional Office to conduct a self-assessment of its quality management processes for the current licensing and certification cycle. This occurred in conjunction with a targeted licensing review completed by the Office of Quality Enhancement (OQE). The targeted review focused on eight critical licensing indicators applied to residential supports, six licensing indicators and one certification indicator that were not met during the previous cycle, along with nine licensing indicators that were added or revised since CRJ's last survey. The final survey results reflect a combination of ratings from the self-assessment process conducted by CRJ and the targeted review conducted by DDS, with ratings from DDS prevailing where indicators were rated by both entities.

Findings of the targeted review verified that standards for licensing were maintained for the indicators reviewed for residential services. The survey found that CRJ's systems for oversight of medication administration, healthcare protocols, and environmental safeguards were effective. All standards relating to the critical indicators were met as well as requirements for indicators that were previous unmet or recently added or revised. Findings from the targeted review of one previously unmet certification indicator showed that CRJ had successfully supported individuals to engage in their preferred community-based activities on an individualized basis. One area identified from the DDS targeted review as needing improvement related to meeting timelines for entering and reviewing incident reports in the Department's HCSIS data system.

As a result of the agency's self-assessment findings and the targeted review conducted by OQE, CRJ will receive a Two-Year License for its Residential services, with a service group score of 92%. This service group is Certified with an overall score of 100%.

CRJ presented the following self-assessment report, describing the organization's ongoing quality assurance systems and the agency's current evaluation of compliance with DDS licensing.

Description of Self Assessment Process:

CRJ has implemented several processes to monitor and ensure continuous quality assurance and adherence to DDS licensing and certification standards. All residential programs and shared living placements are audited on a regular basis by multiple levels and departments within the organization. Follow up reports are generated electronically and sent to Program Managers and Supervisors, and results are made available for review by all levels of the organization at regular intervals. A data system is updated in real time for all applicable licensing and certification indicators. Program visits occur by a variety of staff at regular intervals and include physical plant check, PBS evaluation/assessments, and unannounced financial and medication audits.

For the self-assessment process in 2022, an 8-person team at CRJ performed a sample audit between September 7th and September 16th using licensing and certification tools that mirror the tools used by DDS (examples available). Scoring also reflects the DDS process with each indicator being met, not met or not applicable. We intentionally stayed true to the DDS process during all facets of this self-assessment process.

Our self-assessment utilized 3 distinct processes as outlined below and are available for review. Virtual audit. These audits were performed by experienced staff in our Quality and Compliance Department. Each of the agency's programs and shared living individuals were assigned a number. A sample of 10 residential programs and 11 shared living placements were then chosen by a random number generator. The virtual audit includes indicators that can be viewed and scored in either HCSIS, Icentrix or SharePoint.

Outside of the self-assessment process these audits occur quarterly at minimum. Scores are sent out by email to all applicable parties with a due date for follow up. Follow ups are recorded and a final score is generated which is available for review at any time. CRJ reviews these scores in monthly performance metric review meetings. Scores are graphed and compared to previous results so that improvement can be noted over time.

Onsite audit. Our administrative/program walkthrough encompasses all the indicators that are not otherwise covered by the virtual audit form. The sample was chosen using the same method as the virtual audits. These audits were performed by the CRJ/CS Training Department. A debrief occurred every day during this process so that all indicators could be reviewed, any outstanding questions or concerns could be discussed, and a dedicated staff person tallied the scores on an excel spreadsheet that combined both virtual and onsite.

Agency Indicator Audit. This audit encompasses all the applicable organizational indicators. This audit was done by CRJ's Vice President of Quality and Compliance in conjunction with the Vice President of Community Strategies. This process again mirrored that of DDS and consisted of an interview portion as well as review of records. The Human Rights Committee Chairperson was interviewed, and all paperwork was reviewed. Staff training was reviewed and cross checked on the agency SharePoint website where dates are kept. All DPPC and investigation paperwork was reviewed, and an interview took place to highlight immediate actions taken and review timelines.

All of the above audit tools as well as an audit form that assesses critical and new indicators are used by the Program Managers and Residential Directors to audit their own programs routinely and are also used to cross audit programs on a periodic basis. The CRJ training department utilizes the audit forms as a guide in conjunction with a modified PBS assessment form during regularly scheduled program visits. They assist and train programs as needed, which may include submission of maintenance requests where appropriate and providing training on specific indicators if they see an area is lacking or in need of attention. For instance, they assess the food in the program and can provide assistance with following EO-509, creating menus or working with clinical and nursing if there are questions about specific diet plans in place. Based on their findings they produce a visit form that highlights any staffing, paperwork or programmatic issues that need to be flagged for follow up. That information is sent to all relevant CRJ staff. If follow up training is requested, they schedule with the Program Manager to attend a staff meeting. They can offer PABC or refresher trainings for example or help the staff if they

are struggling with setting/maintaining boundaries. CRJ/CS utilizes the Icentrix database as it's platform for all individual and DDS required paperwork. Icentrix works in conjunction with HCSIS, and data is able to be moved between the two platforms.

MAP audits are completed at each residence by an agency RN. In addition, audits are completed on an as needed basis particularly if a program has been noted as having an increase in frequency of medication occurrences. The results of these audits are shared with the manager and residential director for follow up. Nursing will discuss any areas of particular concern with both parties as well as anybody identified in the program to be involved with overseeing the accuracy of the medications, such as an assistant manager or designated MAP certified employee. At times, additional training by the MAP trainer for the entire program may be required.

Med occurrences are reviewed weekly at PBS Leadership Team meeting and follow up is done by agency nurses as appropriate. Med certified staff are required to attend a yearly in-service with our MAP trainer to review and demonstrate the most important MAP principles including daily audits of their own medication passes. In the event of occurrences by the same staff, discussions will be had between the RN, manager, and RD as how to proceed with the staff. The nursing department holds managers meetings on a quarterly basis where common themes in medication errors or practice are discussed. Rotating medication audit related tasks are assigned to the managers so they may audit their own programs using these guidelines.

Required data such as parameters with notification ordered by the HCP are reported to the RN in real time, interventions are implemented as needed. In some cases, an action plan may need to be implemented by nursing. Certain programs may require additional monitoring and may need to submit medical data to nursing on a more frequent basis such as weekly, or bi-weekly.
Weekly PBS Leadership Teams are conducted with operations, nursing, clinical, CRJ's Human Rights Committee, the training department, and any relevant program staff in attendance. Restraints, med occurrences and investigations are reviewed in detail, discussed and if follow up is necessary a staff or team is assigned to that task. A comprehensive review is then done of all programs or individuals that are a concern. This is a collaborative approach to problem solving where ideas and data are shared across departments and clusters. A tally of restraints going back to the beginning of the year is kept on the agenda so that the number of occurrences can be monitored and flagged if needed. Minutes are generated weekly and include staff assignments so that follow up can occur at the next meeting.

CRJ utilizes an online ticketing system for facilities requests. Requests are labelled as routine or emergency, and emergency requests are immediately sent to that departments phones as an alert so they can provide 24/7 follow up if needed. This system is checked on a routine basis by staff from the training and operations departments. When they visit and notice an issue the system is checked to see if a ticket was submitted and what the timeframe for follow up is.

A master score sheet was utilized to tabulate final results for each indicator. This consisted of an excel document with 21 separate worksheets that included all rated indicators, and a worksheet that rolled up all of the scores to determine if indicators were met or not met. That information was then transcribed into the final DDS scoring sheet for submission.
Overall CRJ missed a total of 6 indicators. Follow up action plans were created and, in many cases, have already been implemented. That detailed information is available on the self-assessment scoring document.

The following indicators were not met: L69 Managing of funds, L67 FMTP's, L33 Physical exam within 15 months, L36 Tests and appointments with specialists are made and kept, L43 Health Care Record, L35 Preventative Screenings.

LICENSURE FINDINGS

	Met / Rated	Not Met / Rated	% Met
Organizational	**10/10**	**0/10**	
Residential and Individual Home Supports	**74/81**	**7/81**	
Residential Services Placement Services			
Critical Indicators	**8/8**	**0/8**	
Total	**84/91**	**7/91**	**92%**
2 Year License			
# indicators for 60 Day Follow-up		**7**	

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.	Incident Reports were not submitted or finalized within required timelines for five of the twenty-four locations and one placement location in the survey sample. The agency needs to ensure incident reports are submitted and finalized within the required timeframes.

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

Indicator #	Indicator	Issue identified	Action planned to address
L33	Individuals receive an annual physical exam.	One individual out of 21 individuals did not have a physical completed within the 15-month time frame requirement. An appointment has been scheduled for him. The indicator was not met overall due to documentation issues with the required paperwork including the preventative screening and Health Review Checklist that were either missing or incomplete when filled out.	Further training will take place for all Managers, Assistant Managers and Meaningful Day Coordinators (the staff with access to preparing and entering all appointments onto ICentrix). Nurses will be required to review all annual physical appointments and follow up with the Managers when required documentation is missing.

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

Indicator #	Indicator	Issue identified	Action planned to address
L35	Individuals receive routine preventive screenings.	Required preventative screenings outlined on the Preventative Checklist were not completed or have not been properly documented.	Further training will occur for all Managers, Assistant Managers and Meaningful Day Coordinators (the staff with access to preparing and entering all appointments onto ICentrix). Nurses will be required to review all preventative screenings for each individual each year to ensure their required screenings have occurred or proper documentation is in place why they did not occur.
L36	Recommended tests and appointments with specialists are made and kept.	Recommended or requested follow ups for medical appointments were not properly documented with proof of them occurring.	Training will occur for all Managers, Assistant Managers and Meaningful Day Coordinators (the staff with access to preparing and entering all appointments onto ICentrix) as well as direct care staff who attends the medical appointments. Nurses will be required to review all medical appointments as needed to ensure required tests, lab work, etc. have been completed as well as entered onto ICentrix.
L43	The health care record is maintained and updated as required.	The Health Care Records (HCR) were not current which included not being up to date with screenings, immunizations, medications, weights and/or diagnoses. The other issue identified was events were not updated to the HCR within the 30-day requirement.	All Managers will be retrained of the HCR requirements and how to properly update the form and address the current missing items on the HCR. A position was created within Community Strategies in July 2022 which directly oversee HCSIS. This role oversees reviewing incidents and ensuring they are entered onto the individual's HCR. We have seen an increase in compliance since the role took effect.

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

Indicator #	Indicator	Issue identified	Action planned to address
L67	There is a written plan in place accompanied by a training plan when the agency has shared or delegated money management responsibility.	The current Funds Training Plans do not match the procedures in place; primarily in the Shared Living Department. The individuals are more financially independent and require a more personalized template to address how each individual handles their funds which includes maximizing their independence.	Community Strategies is in the process of adjusting how individual financials are handled which requires a new Funds Training Plan. These plans are being rolled out as the programs become a part of the new process. Each Manager is personally trained on the new Funds Training Plan and reviewed for accuracy.
L69	Individual expenditures are documented and tracked.	The prior months of financials (January, February, and May 2022) were missing various transactions that were not documented into the monthly ledgers as required.	Community Strategies is in the process of adjusting how individual financials are handled. We are centralizing the process within our fiscal department and all information is kept and audited in an electronic database. This also involves a training to all Managers as they become a part of the new process. In addition to the new process, the new role created for Community Strategies in July 2022 has an additional function to review financials and ensure they are accurate and corrective actions have been completed before moving forward. Since this staff person has started their role, we have found the ledgers from July and August to be compliant with the regulations and standards during a recent audit.

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 1/1 Provider 39/39**	**40/40**	**0/40**	
Placement Services	DDS 0/0 Provider 20/20	20/20	0/20	
Residential Services	DDS 1/1 Provider 19/19	20/20	0/20	
Total		**46/46**	**0/46**	**100%**
Certified				

MASTER SCORE SHEET LICENSURE

Organizational: COMMUNITY RESOURCES/JUSTICE

Indicator #	Indicator	Reviewed by	Met/Rated	Rating(Met,Not Met,NotRated)
L2	Abuse/neglect reporting	**DDS**	**9/9**	**Met**
L3	Immediate Action	**Provider**	**-**	**Met**
L4	Action taken	**Provider**	**-**	**Met**
L48	HRC	**Provider**	**-**	**Met**
L65	Restraint report submit	**Provider**	**-**	**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**	10/10		11/11				**21/21**	**Met**
L7	Fire Drills	L	**Provider**	-		-				**-**	**Met**
L8	Emergency Fact Sheets	I	**Provider**	-		-				**-**	**Met**
L9 (07/21)	Safe use of equipment	I	**DDS**	10/10						**10/10**	**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**	10/10		10/10				**20/20**	**Met**
L12	Smoke detectors	L	**DDS**	9/10		10/11				**19/21**	**Met (90.48 %)**
L13	Clean location	L	**DDS**	10/10		11/11				**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	**DDS**			10/10				**10/10**	**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	**DDS**			10/11				**10/11**	**Met (90.91 %)**
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**	-		-				**-**	**Not Met**
L34	Dental exam	I	**Provider**	-		-				**-**	**Met**
L35	Preventive screenings	I	**Provider**	-		-				**-**	**Not Met**
L36	Recommended tests	I	**Provider**	-		-				**-**	**Not Met**
L37	Prompt treatment	I	**Provider**	-		-				**-**	**Met**
L38	Physician's orders	I	**DDS**	10/10		4/4				**14/14**	**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	**Provider**	-		-				**-**	**Not Met**
L44	MAP registration	L	**Provider**	-		-				**-**	**Met**
L45	Medication storage	L	**Provider**	-		-				**-**	**Met**
L46	Med. Administration	I	**DDS**	10/10		8/9				**18/19**	**Met (94.74 %)**
L47	Self medication	I	**Provider**	-		-				**-**	**Met**
L49	Informed of human rights	I	**Provider**	-		-				**-**	**Met**
L50 (07/21)	Respectful Comm.	I	**DDS**	10/10		11/11				**21/21**	**Met**
L51	Possessions	I	**Provider**	-		-				**-**	**Met**
L52	Phone calls	I	**Provider**	-		-				**-**	**Met**
L53	Visitation	I	**Provider**	-		-				**-**	**Met**
L54 (07/21)	Privacy	I	**DDS**	10/10		11/11				**21/21**	**Met**
L56	Restrictive practices	I	**DDS**	8/9						**8/9**	**Met (88.89 %)**
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**

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
L61	Health protection in ISP	I	**Provider**	-		-				**-**	**Met**
L62	Health protection review	I	**Provider**	-		-				**-**	**Met**
L63	Med. treatment plan form	I	**Provider**	-		-				**-**	**Met**
L64	Med. treatment plan rev.	I	**DDS**	9/9		9/9				**18/18**	**Met**
L67	Money mgmt. plan	I	**Provider**	-		-				**-**	**Not Met**
L68	Funds expenditure	I	**Provider**	-		-				**-**	**Met**
L69	Expenditure tracking	I	**Provider**	-		-				**-**	**Not 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**
L81	Medical emergency	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
L82	Medication admin.	L	**DDS**	10/10						**10/10**	**Met**
L84	Health protect. Training	I	**Provider**	-		-				**-**	**Met**
L85	Supervision	L	**Provider**	-		-				**-**	**Met**
L86	Required assessments	I	**DDS**	8/9		10/10				**18/19**	**Met (94.74 %)**
L87	Support strategies	I	**DDS**	8/9		11/11				**19/20**	**Met (95.00 %)**
L88	Strategies implemented	I	**Provider**	-		-				**-**	**Met**
L90	Personal space/ bedroom privacy	I	**Provider**	-		-				**-**	**Met**
L91	Incident management	L	**DDS**	5/10		10/11				**15/21**	**Not Met (71.43 %)**
L93 (05/22)	Emergency back-up plans	I	**DDS**	10/10		11/11				**21/21**	**Met**
L94 (05/22)	Assistive technology	I	**DDS**	10/10		11/11				**21/21**	**Met**
L96 (05/22)	Staff training in devices and applications	I	**DDS**	7/7		10/10				**17/17**	**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**	2/2						**2/2**	**Met**
#Std. Met/# 81 Indicator										**74/81**	
Total Score										**84/91**	
										92.31%	

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	Provider	-	**Met**
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**

Residential Services

Indicator #	Indicator	Reviewed By	Met/Rated	Rating
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	DDS	10/10	**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**

Placement Services

Indicator #	Indicator	Reviewed By	Met/Rated	Rating
C7	Feedback on staff / care provider performance	Provider	-	**Met**
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**

Placement Services

Indicator #	Indicator	Reviewed By	Met/Rated	Rating
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**