Applicability Definitions/Key

Flagged critical indicator

All Services = All Residential, Remote Supports and Monitoring, Employment and Community Based Day Services
Residential Services includes: 24-hr residential, ABI/MFP 24-hr residential, Individual Homes Supports (only if > 15/hrs per week), Placement, ABI/MFP Placement, Respite
Remote Supports and Monitoring Services (RSMS)
Employment Services: Individual Supported Employment, Grouped Supported Employment /Enclaves
Community Based Day Services (CBDS)

If a check box is marked (☒), then that indicator is applicable to that service.

If one of the following symbols follows a service type, then the indicator only applies in the indicated circumstances:

● Applies when Provider is responsible for oversight (e.g., ISP/Remote Support Plan)
★ Applies when location is owned, rented or leased by the provider
⧫ Applies when individual is not living in family home

PERSONAL SAFETY

INDICATOR	Regulations 9.04 (2):	All providers shall provide to all individuals served an initial and subsequent, annual training on when and how to file a complaint or obtain assistance under 115 CMR 9.00. Such training shall include use of alternative means of communication where the individual is hearing or speech impaired or unable to communicate without assistance or an interpreter.		
L1. Individuals and guardians are trained in how to report alleged abuse/neglect.	**GUIDELINES:** Individuals must be informed of how to file a complaint, including DPPC Hotline information, what constitutes a reportable condition and their right to file a Complaint if they have reason to believe that there is mistreatment, abuse or neglect occurring. Individuals should be trained in accordance with their communication and other needs. Guardians of individuals need to be provided with information and training on how to file a complaint. This serves as an additional safeguard for individuals who, even with individualized training, may not comprehend how to file a complaint.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
All Services	Abuse and mistreatment training documentation	Individuals' training records are reviewed to determine whether there is documented abuse and mistreatment training to individuals that has occurred in the past	• Individuals have received annual training in the past year in accordance with their method of communication • **and** guardians received information on the procedures	• Individuals have not received annual training at all • **or** did not receive training in accordance with their method of communication

	Staff interview	year. This is further validated by checking those with communication needs and any special accommodations needed against methods used to train. A sample of guardian documentation is reviewed to determine whether guardians have been apprised of how to report alleged abuse/neglect.	for reporting alleged abuse/neglect.	• **and/or** guardians did not receive information on the procedures for reporting alleged abuse/neglect.

INDICATOR ⚐ **L2.** Allegations of abuse/neglect are reported as mandated by regulation	**Regulations 9.06 (2):**	A Department or provider employee is mandated to and shall immediately file a complaint under 115 CMR 9.00 with the DPPC when he or she has reason to believe that there is a non-frivolous allegation of mistreatment, an illegal, dangerous or inhumane condition or incident, or a medicolegal death of an individual. …		
	GUIDELINES: Policies and procedures need to outline staff's role as mandated reporters and specify those conditions and situations requiring the filing of a complaint. All staff need to be knowledgeable concerning what constitutes a reportable condition, their role as mandated reporter, and practices for filing with the DPPC, and reporting to supervisory personnel.			
APPLICABILITY All Services	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Policies and procedures for reporting abuse, neglect, and mistreatment DPPC Complaint Allegations	Review of Policy. A review of complaints filed to identify those complaints that have been filed. A review of a sample of documentation (individual and location) is conducted to	• Policy is in place, and does not require someone to ask permission of their supervisor prior to filing; **and** review of complaints indicates that staff are filing, • **and** information shared through either interview or documentation	• Policy is either not in place or requires someone to ask permission of their supervisor prior to filing, • **and/or** information shared either through interview or documentation shows that potential case of abuse/neglect/mistreatment went unreported.

	Communication Log Individual Record Staff interview	assess whether reportable items noted within communication log or incident reports were also filed as complaints. Staff interviewed to determine knowledge of what constitutes reportable allegations. As mandated reporters, when a reportable incident is revealed, OQE will report it.	showed no evidence of unreported allegations.	

INDICATOR	Regulations 9. 07 (1) and (2)	(1): The Regional Director or designee shall notify the provider, who shall be responsible for taking immediate action; (2): A provider notified of a complaint alleging intentional physical injury of an individual, including any sexual activity between an individual and an employee or volunteer of a provider shall immediately remove the employee or volunteer from all direct contact responsibilities pending resolution or investigation of the complaint.		
L3. Immediate action is taken to protect the health and safety of individuals when potential abuse/neglect is reported	**GUIDELINES:** Immediate actions must be taken by the provider once the provider becomes aware of an allegation. These activities, such as removing the employee from all contact with individuals, must remain in place pending resolution and the results of the investigation. The agency needs to have a system for ensuring that immediate actions are issued when necessary, and for monitoring these actions to ensure that they remain in place pending resolution/decision.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**

All Services	DPPC Complaint allegations Staff Interviews Agency policy	A sample of complaint allegations is reviewed to determine if immediate action occurred as required. Interview of provider staff to determine what immediate action was taken to protect individuals, if necessary.	• Immediate actions were determined to have occurred. and were implemented to protect the individual(s) • **and** these were maintained and adequate until a Resolution/Decision is made.	Immediate actions referenced did not occur • Immediate actions to protect the individual (s) were not implemented • **or** these were not maintained and adequate until a Resolution/ Decision is made.

INDICATOR	Regulations 9.14(6):	Any person or provider required to implement corrective action(s) set forth in the action plan or resolution letter shall provide documentation to the Complaint Resolution Team coordinator as soon as the corrective action(s) have been implemented which the CRT coordinator shall report in writing to the regional director, the senior investigator, and the CRT.		
L4. Action is taken when an individual is subject to abuse or neglect. **APPLICABILITY** All Services	**GUIDELINES:** There are a variety of specific actions that are typically set forth in the Action Plan including but not limited to (re)training, suspension, increased supervision and monitoring and disciplinary actions. The agency needs to have a system for ensuring that all specific actions are taken, and for monitoring these actions to ensure that they remain in place as indicated.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	HCSIS – Review Action Plans Interview with designated staff person responsible for enforcing and monitoring the implementation of action plans – Administrative review	A sample of action plans is reviewed to determine whether recommended actions have been implemented. When the action plan/ resolution report does not indicate that action was completed, follow-up with staff to determine what actions have been implemented.	Actions outlined in the plan/resolution report occurred within specified time frame.	Actions outlined in the plan/resolution report were not fully implemented within specified time frame.

	Provider documentation relative to action plan.			

INDICATOR	Regulations 7.06 (3): (a)	...shall prepare and file with the area office a written safety plan assuring the safety of individuals in the event of a disaster, such as fire, explosion, loss of heat or electricity, interior flooding, or any other circumstances requiring emergency evacuation. Safety plans must be specific to and must be on hand at each site where supports and services are provided and must be easily accessible to all staff and others who provide supports and services to the individual.		
L5. There is an approved safety plan in home and work locations **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ♦ ☒Placement ☒ABI/MFP Placement ☒Respite ☐RSMS ☐Employment Services ☒CBDS	**GUIDELINES:** The safety plan must be approved every two years. It cannot require staff to return to the building to evacuate others. Existing practices must be consistent with the safety plan. (e.g. individuals names; staffing patterns; protocol as written is what is being performed) All required components need to be contained in the safety plan. Plans must include any environmental / other exceptions noted to be present. (e.g. large porch in lieu of second means of egress in house; nighttime fire drills)			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Provider Assurance form Site review Location-specific Safety Plans Staff interviews	A sample of the location-specific Safety Plans is reviewed to determine whether plans are updated as required, contain all the required components and reflect actual conditions in the home or workplace.	• Safety plan must be approved by AD or designee, • **and** be less than two years old, • **and** include all elements, • **and** reflect current practices.	• Safety plan is outdated or not approved by AD or designee • **and/or** reflects staffing pattern not in place • **and/or** does not include all individuals • **and/or** needs to be revised to reflect current practices.

INDICATOR	Regulations 7.06 (3) (b) 6:	For sites where residential supports and 24-hour site based respite supports are provided, safe evacuation is defined as assuring that all individuals can get out of the home in 2 minutes and 30 seconds, with or without assistance, without reliance on staff who have evacuated to return to provide assistance, and in

⚐ **L6.** All individuals are able to evacuate homes in 2 1/2 minutes with or without assistance and workplaces within a reasonable amount of time		accordance with professionally accepted fire safety evacuation procedures. For sites where employment supports or day supports are provided, safe evacuation is defined as assuring that individuals can evacuate in a safe, orderly and timely manner, with staff assigned to individuals needing assistance.		
	GUIDELINES: • This regulation applies to all residential services, as well as all site-based day services. • Where an individual who has consistently evacuated historically, but experiences current difficulties and has not evacuated in 2 minutes and 30 seconds, there is a (training) plan to resolve this situation. • When participant simulation is part of the plan, the rationale for this is clearly outlined, and nighttime evacuation is adequately assured (e.g. staff training; at least one nighttime drill per year). • When living in a high-rise apartment, ambulatory individuals must evacuate promptly via the stairs. • If the building has a place of refuge for individuals who cannot ambulate using the stairs, where they would await pending fire department rescue, the building evacuation plan needs to be outlined in the safety plan. • In site-based respite, staff need to be familiar with evacuate strategies, and fire drills must occur to ensure that staff can implement evacuation procedures consistent with safety plan.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ♦ ☒Placement ☒ABI/MFP Placement ☒Respite ☐RSMS ☐Employment Services ☒CBDS	Fire drill logs for 24-hour homes and site-based day services Staff interview Less than 24-hour residential supports and Placement Services – individual interview	A review of the fire drill records for the location for the past year to determine whether individuals were able to evacuate their homes in 2 minutes and 30 seconds. Day Services – fire drills demonstrate the location is evacuated in a reasonable amount of time. Where the location has a current approved FSES waiver in place, fire drills are assessed to determine whether the evacuation time is consistent with the approved FSES waiver time limit.	Individuals in homes are able to evacuate in two minutes and 30 seconds or less or in site-based day services in a reasonable time. The provider is implementing strategies, which are supported by documentation, to resolve a temporary new situation that has caused evacuation to exceed 2 minutes and 30 seconds from their homes or for day services, when the evacuation exceeds the time allocated within the safety plan.	Individuals are not able to evacuate homes in 2 minutes and 30 seconds or less or in site-based day services in a reasonable time. The provider is not implementing strategies, which are supported by documentation, to resolve a situation that has caused evacuation to exceed two minutes and 30 seconds or for day Services, when evacuation exceeds the time allocated within the safety plan. .

		Determine if individuals have been trained and know how to evacuate safely. In homes where regulation does not specify a minimum requirement for drills, the provider has a means for initial and periodic assessment of the individual's ability to evacuate. (Placement/IHS).		

INDICATOR	Regulations 7.06 (3) (b) 7a.	Providers of residential supports except placement services shall conduct quarterly fire drills and maintain records of evacuation times, types of assistance, if needed, and assessments of individual and staff performance. At least two drills per year shall be conducted in the nighttime when individuals are in bed and asleep. b. Providers of employment supports, or day supports shall conduct two fire drills annually, with records of evacuation times and type of assistance needed, if any, and assessments of individual and staff performance. c. A provider shall not deviate in any respect from the foregoing minimum requirements for fire drills unless it has provided alternative assurances in the provider safety plan submitted to and approved by the area director. d. Records documenting the results of the required fire drills shall be submitted to the area office at the time safety plans are re-filed pursuant to 115 CMR 7.06(3)(e).
L7. Fire drills are conducted as required. **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☐IHS ☐Placement ☐ABI/MFP Placement ☒Respite ☐RSMS ☐Employment Services ☒CBDS	**GUIDELINES:** • The purpose of the fire drills is to ensure that both staff and individuals are trained and familiar with strategies for evacuation and can demonstrate evacuation within 2 minutes and 30 seconds (unless an approved FSES waiver is in place for extended time). • Fire drills need to be conducted with the minimum number of staff noted in the safety plan, and the Provider needs to demonstrate success in meeting evacuation time with the requisite number of staff. • Fire drills must be documented correctly (e.g. type of assistance needed; time to exit, etc.). • Blocked egress fire drills so that both staff and individuals become knowledgeable and trained in the utilization of both ways out, is strongly recommended. • Where the location has a fire drill strategy that differs from regulation, fire drills must meet that particular standard. (e.g. more frequent drills).	

	• If approved through the safety plan, participant simulated fire drills can be conducted. *See participant simulated fire drill guidance for when permissible and how to conduct.*			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Fire drill logs	Fire drill records for the location for the past year are reviewed to determine whether fire drills were conducted as indicated in regulation and documented appropriately.	• Fire drill logs for the location indicate that fire drills were conducted at the frequency (but not less than 4 per year with 2 at night in 24-hour homes and 2 per year in site based day services); • **and** with the minimum ratio of staff outlined in the safety plan • **and** documentation of fire drills is complete.	• Fire drill logs for the location indicate that fire drills were not conducted as frequently as required • **and/or** are not conducted with the minimum ratio of staff; • **or** when there are documentation omissions/ errors.

INDICATOR **L8.** Emergency fact sheets are current and accurate and available on site	**Regulations 4.03 (4):**	Emergency Information. Each individual's area office and provider record shall contain, in readily accessible and duplicate form, descriptive and other information of use in finding an individual if missing, or otherwise in an emergency, as more fully set forth in 4.03 (4) (a) through (n).		
	GUIDELINES: The Emergency Fact Sheet must be accurate and current. It needs to include identifying information such as age, general physical characteristics, emergency contacts, guardian information, general nature of abilities and physical disabilities, special medical needs and current medications. However, confidential information (e.g. HIV status) must be maintained separately.			
APPLICABILITY All Services	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Emergency Fact Sheets - on site Other individual documentation	Emergency Fact Sheets are reviewed and compared with other information (e.g. medical records) regarding an individual(s) to determine whether information is complete and current.	• The Emergency Fact Sheet is current • **and** complete.	• The Emergency Fact Sheet is not current • **and/or** is incomplete.

INDICATOR	Regulations 7.06 (2) (a) (c)	(2) Individual Safety Assessment. (a) All providers shall assure that individual safety assessments are conducted and that strategies are developed for meeting the specific and unique safety needs of each individual. Individual safety assessments shall be conducted as part of the individual's ISP. (c) Safety strategies may include modification to the location where services are provided, other environmental modifications and use of assistive technology, staff supports, staff training focused on the individuals' needs, and education of individuals to assure optimal understanding and independence regarding safety precautions and procedures.

L9. Individuals are able to utilize equipment and machinery safely.

APPLICABILITY

☒24/hr Residential
☒ABI/MFP 24/hr Residential
☒IHS
☒Respite

☒Employment Services
☒CBDS
☒RSM

GUIDELINES:

- Training and education are essential prerequisites to using equipment and machinery as independently as possible. Guidance, supervision, review of safety precautions, and generalized training must be provided for any equipment, such as a microwave or a lawn mower or a piece of machinery, before individuals begin to use them independently.
- Evaluation of the individual's skills and his/her independence in operating devices needs to occur as the first step in the formulation of individualized training that matches an individual's learning style.
- Formalized documented training to individuals to use appliances or daily equipment at home such as the stove, microwave, or blender is not necessary; however, it is important that individuals receive some basic instruction and information prior to use.
- This will assist individuals to become more independent as well as informed and knowledgeable concerning basic safety precautions of appliances and equipment.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Individual Interview/ Observation Staff interview Individual Record Training information – Employment/ CBDS Use of assistive Technology	Individual information is reviewed to determine whether individuals received the necessary training to utilize equipment and machinery safely.	• Individuals are using equipment and machinery safely.	• Individuals are not using equipment and machinery safely • **and/or** teaching is inadequate for an individual to utilize equipment and machinery safely.

INDICATOR	Regulations 5.03(3)(e)	Services and supports are to be provided in such a manner that promotes; ….The opportunity to undergo typical developmental experiences, even though such experiences may entail an element of risk; provided, however, that the individual's safety and well-being shall not be unreasonably jeopardized;

L10. The provider implements interventions to reduce risk for individuals whose behavior may pose a risk to themselves or others.	**GUIDELINES:** • Some individuals may exhibit behaviors, actions, or have conditions that may pose a risk to themselves or others. • Once identified, an assessment of the degree of risk, as well as strategies, must be outlined to address this risk. Strategies may include but are not necessarily limited to risk plans. • Staff must be knowledgeable about the individual's particular behaviors and/or conditions as well as strategies in place to address them. Training in how to implement strategies as designed must occur. • Reviews of the risks and effectiveness of the strategies to manage the risk must also occur.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
APPLICABILITY All Services	Staff Interview Staff Log Individual Record Risk Plans/ ISP Meditech and HCSIS information	Review staff's knowledge of potential individual risky behavior and their plans and activities to mitigate that risk. Assess staff's knowledge of an individual behavior/condition that puts them at risk and the strategies in place to mitigate that risk. Review individual record and staff log to identify need(s) in this area, which should then be reviewed with staff during staff interview. Review whether staff are aware of the individual risks and whether they are being addressed.	• Clear strategies are in place as needed outlining interventions to reduce risk for individuals • **and** are implemented.	• Clear strategies are not in place when needed • **and/or** do not outline needed interventions to reduce risk • **and/or** plans are not fully implemented.

ENVIRONMENTAL SAFETY		
INDICATOR	**Regulations 7.07 (1):**	All homes and work/day supports must meet all applicable building, sanitary, health, safety, and zoning requirements.
⚐ **L11.** All required annual	**Regulations 7.07 (5) (f)**	Heating and plumbing systems shall be installed and maintained for safe, healthy, and comfortable use by the individuals supported by the provider.
	GUIDELINES:	

inspections have been conducted. Revised 3/1/19

APPLICABILITY

☒24/hr Residential
☒ABI/MFP 24/hr Residential
☒IHS ★
☒Placement
☒ABI/MFP Placement
☒Respite
☐RSMS
☐Employment Services
☒CBDS

Required inspections include the following:

- Section 8 Housing Inspection
- Certificate of Occupancy (CO) for day/work program
- Signed building permits for any renovations; CO if needed for major renovations performed prior to occupancy
- Certificate of inspection from Board of Health for any work/day service location that prepares food for retail sale
- If sprinklers are present, annual inspection for sprinklers is needed
- Annual elevator inspection (MGL c 143, sec 64)
- Annual*** maintenance inspections and service (for oil/gas furnaces) *
- Annual maintenance inspections and cleaning for fireplaces, wood-burning and pellet stoves*
- The Placement agency needs to assure either through monthly visits or through some other process (e.g. an annual site inspection)

Where Section 8 Inspections are in place, only a partial site review would be conducted for several of the following indicators.** Although several indicators are not designated for review, if a deficiency is noted while completing other sections of licensure, the deficiency must be noted and the indicator rated.

Each furnace varies, and each manufacturer may assign different level(s) and type(s) of ongoing routine service requirements and maintenance schedules for safe operation. In order to ensure that heating systems are well-maintained and safe, at least annually the furnace needs to be inspected by a qualified service technician to confirm that it is functioning effectively and determine whether any service or maintenance is needed. Demonstration through a tag, invoice, receipt or notation from a qualified person that the unit has been inspected and either requires “no service” or “needs (something) in some (time parameter)” is sufficient to meet this requirement.

(*furnaces must be serviced in accordance with Manufacturer’s specifications)

(**this item is reviewed as part of Section 8)

(***As of 9/1/17, Providers have up to 15 months between heating inspections to be considered acceptable as annual inspections.)

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET

	Inspection and service documentation. Inquiry as to service provider's process. Current Section 8 inspection / letter	A sample of home and work locations is visited, and inspections are viewed.	Presence of all inspections, including annual service inspections from qualified technicians. Or Section 8 letter	One or more inspections (including annual service inspections from qualified technicians) is missing.

INDICATOR	Regulations 7.07 (7)(c)and(d)	(c) All sites shall have smoke detectors as required by 780 CMR: Board of Building Regulations and Standards. If more than one detector is required per site, each detector shall be interconnected so as to activate all other detectors. (d) All sites shall have carbon monoxide detectors as required by 780 CMR: Board of Building Regulations and Standards.		
⚐ **L12.** Smoke detectors and carbon monoxide detectors, and other elements of the fire alarm system required for evacuation are located where required and are operational. **APPLICABILITY** ☒24/hr Residential	**GUIDELINES:** Carbon Monoxide detectors are now required by the Massachusetts State Building Code and must be within 10 feet of bedrooms. In homes, there must be at least one approved smoke detector on each level of the home, including basements. On any floor, level or story exceeding 1200 square feet or part thereof, smoke detectors are located outside sleeping areas on every floor of the home (or inside bedrooms if the fire system has been installed or upgraded after 8/27/97). In residential homes not owned or leased by the individual(s), if more than one smoke detector is required in the home, each detector must be interconnected so that when one activates, all will sound. Where present, such as in sites supporting individuals who are deaf or blind, additional adaptations should be in place and operational including bed shakers, audible horns and strobe lights.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**

☒ABI/MFP 24/hr Residential ☒IHS ★ ☒Placement ☒ABI/MFP Placement ☒Respite ☐RSMS ☐Employment Services ☒CBDS	Location review Current Section 8 inspection / letter re inspection.	The location is reviewed to determine whether smoke and CO detectors are located as required and are tested to determine if they are operational. If sounding the alarm would disrupt others in the building, documentation indicating that alarms are operational will suffice. Not reviewed if reviewed by Section 8	• Smoke detectors and Carbon Monoxide detectors are present in the proper locations. • **and** are operational. If home is owned or leased by the provider, if one smoke detector sounds, all detectors sound. When needed for evacuation additional adaptations are operational. Or Section 8 inspection	• Smoke detectors and/or Carbon Monoxide detectors are not present in the correct locations • **and /or** are not fully operational • **and/or** other needed adaptations are not operational.

INDICATOR	Regulations 7.07 (3)	(3) All providers must assure that the sites where supports and services are provided are clean, environmentally safe, and free of vermin. Any objects or conditions that represent a fire hazard greater than that which could be expected of ordinary household furnishings shall not be permitted.		
⚐ **L13.** Location is clean, environmentally safe, and free of rodent and/or insect infestation	**GUIDELINES:** The site must be free of infestation and in clean, sanitary condition. Cleanliness and sanitation of all areas of the location is critical to prevent the likelihood of infestation. If the agency has experienced problems with rodent or insect infestation in the past, there must be an initial, and possibly a routine pest/insect control service consultation(s)/ schedule established. **Interior:** Home must be clean and free of unnecessary garbage and rubbish that would invite pests. Cleaning of high-touch surfaces in common areas including door handles, faucets, railings, knobs, counters, handrails, and grab bars. Use alcohol wipes to clean tablets, phones, touchscreens, and keyboards. Cleaning of all rooms with a focus on hard surfaces (including desks, tables, countertops, sinks, appliances, and vehicle interiors) with a disinfectant on the EPA list. Proper use and disposal of personal protective equipment (PPE). **Exterior:** Garbage and rubbish are stored in rodent-proof, watertight receptacles with tight fitting covers. There is no rubbish accumulating against or near the home.			
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS★ ☒Placement	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**

☒ABI/MFP Placement ☒Respite ☐RSMS ☐Employment Services ☒CBDS	Location review Documentation of consultation with Pest control services, if pests are present Section 8 inspection/letter Staff interview Schedule of regular cleaning and disinfecting using EPA Registered Disinfectants. Documentation of staff training on the use of disinfectants in a safe and effective manner and to clean up potentially infectious materials and bodily fluid spills	The location is reviewed and inspected. *****also reviewed For Section 8 homes**	• Location is observed to be free of evidence of rodents or insect infestation • **and** the site is clean and sanitary • **and** environmentally safe. • **and** Evidence of frequent cleaning and disinfection practices • **and** Evidence of proper PPE use and disposal Or Section 8 inspection/ letter	• Location is not free from rodent/ insect infestation, • **and/or** the location is not engaged in actions moving toward resolution • **and/or** site is not in clean, sanitary condition • **and/or** is not environmentally safe. • Evidence of infrequent cleaning and disinfection practices. • Evidence of improper PPE use and disposal

INDICATOR	**Regulation 7.07 (1):**	All homes and work/day supports must meet all applicable building, sanitary, health, safety, and zoning requirements.
	GUIDELINES:	

L14. Handrails, balusters, stairs and stairways are in good repair.	Handrails both inside and outside need to be present when required. (shall be provided on at least one side of each continuous run of treads or flight with three or more risers). The handrails need to be between 34-38 inches in height. They need to be sturdy and able to support use of stairs for all individuals.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ★ ☒Placement ☒ABI/MFP Placement ☒Respite ☐RSMS ☐Employment Services ☒CBDS	Site review Current Section 8 inspection/letter	The location is reviewed to determine if handrails and balusters are located as required and in good repair. Not reviewed if reviewed by Section 8	• All handrails and balusters are located as required • **<u>and</u>** in good repair. Or Section 8 inspection/ letter	• Handrails and balusters are not located as required • **<u>and/or</u>** are not in good repair.

INDICATOR	**Regulations 7.07 (1):**	All homes and work/day supports must meet all applicable building, sanitary, health, safety, and zoning requirements.
L15. Hot water temperature tests between 110 and 120 degrees.	**Regulations 7.07 (5)(f):**	Heating and plumbing systems shall be installed and maintained for safe, healthy and comfortable use by individuals.

GUIDELINES:

As of January 2014, the more stringent standard which is based on the plumbing code and the Consumer Product Safety Commission's recommendations is being applied: *Deliverable water temperatures should be no more than 112 degrees for shower temperatures, and no more than 120 degrees for residential faucets and 110 degrees for faucets in public buildings (employment / day sites).*

While water heaters can be set slightly higher to ensure that bacteria is killed and dishwashers are accommodated, the delivered water temperature (temperature when it comes out of the faucet) should be at these lower levels. This can be accomplished by equipping faucets and shower heads with thermostatic mixing valves and/ or anti-scald devices. To ensure that the temperatures remain within acceptable limits, it is important that the providers develop a system to regularly check deliverable water temperatures.

APPLICABILITY

☒24/hr Residential

☒ABI/MFP 24/hr Residential ☒IHS★ ☒Placement ☒ABI/MFP Placement ☒Respite ☐RSMS ☐Employment Services ☒CBDS	In work/day locations, standard for water temperature at sinks must be no higher than 110 degrees; plumbing fixtures requiring higher temperatures for their proper use e.g. if showering facilities present must be between 110 and 120 degrees. In all locations, where individuals are utilizing water with staff assistance, all necessary precautions must be taken to regulate the water temperature, and to keep the temperatures at safe optimal levels. For example, in locations where individuals are less mobile, water may pool/ collect on the individual and is more likely to scald at lower temperatures. In these locations, use of scald protectors, adjustment of the water temperature to lower levels, and ongoing checks of the water temperature is advised. Anti-scalding devices installed that shut water off when temperature exceeds 120 degrees are typically found in apartment dwellings where water temperature is not under the control of the provider.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site review current Section 8 inspection/letter	Water is tested with a thermometer to determine if it is within acceptable range. Not reviewed if reviewed by Section 8 and explicitly written in inspection/letter (sometimes performed and referenced; sometimes not)	Water temperature is within acceptable limits. If reviewed by Section 8, the inspection/letter confirms the standard was met.	Water temperature is not within limits.

INDICATOR **L16.** The location is adapted and accessible to the needs of the individuals. **APPLICABILITY** ☒24/hr Residential	**Regulation 7.07 (4):**	All providers must assure that the sites used by persons with substantial mobility impairment are barrier-free to the extent necessary to permit access to the supports, services, personal, and common areas. A location shall be deemed to be barrier-free, in whole or part, if it meets the applicable standards of 521 CMR: Architectural Access Board as adopted by 780 CMR: Board of Building Regulations and Standards.
	Regulations 7.07 5(e):	Major environmental controls, including those for lighting, appliances, plumbing, windows, and shades shall be operable by and accessible to individuals.
	GUIDELINES: A barrier free environment is essential for individuals with mobility impairments to fully access their home as independently as possible; such as roll under sinks and stove tops. Additionally, adaptations to meet individual needs, such as rails on walls/enhanced lighting for individuals with vision impairments, and visual alerts for doorbells for those with hearing impairments.	

☒ABI/MFP 24/hr Residential ☒IHS ★ ☒Placement ☒ABI/MFP Placement ☒Respite ☐RSMS ☐Employment Services ☒CBDS	INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
	Location Review Observation Staff Interview Individual record review	The location is reviewed to determine whether it is adapted and accessible to meet the needs of the individuals supported.	• The location has the necessary accessibility • **and** adaptations to meet the needs of the individuals supported.	• The site does not have the necessary accessibility • **and/or** adaptations to meet the needs of the individuals supported.

INDICATOR	Regulations 7.07(7) (a):	All sites shall have two means of egress from floors at grade level; all other floors above grade level shall have one means of egress and one escape route serving each floor and leading to grade. This requirement shall not apply to employment supports or day supports when the second floor is used on an intermittent basis only. Any proven usable path to the open air outside at grade shall be deemed acceptable as an escape route, including but not limited to connecting doors, porches, windows within six feet of grade, ramps, fire escapes, and balcony evacuation systems.		
L17. There are two means of egress from floors at grade level **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential	**GUIDELINES:** Egresses must be proven and usable by all individuals; e.g. if stairs are present for front and back egresses, these egresses cannot be utilized for individuals in wheelchairs. The location must have at least one accessible egress for those who have mobility impairments (e.g. ramp without stairs.). Egresses cannot be blocked.			
	INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET

☒Placement ☒IHS ★ ☒ABI/MFP Placement ☒Respite ☐RSMS ☐Employment Services ☒CBDS	Site review Staff interview/ observation Current Section 8 inspection/letter	The location is reviewed to determine whether there are two means of egress from floors at grade level. Individual's ability to utilize the egress is assessed. Since the Section 8 review does not review whether egresses are usable, this aspect will always be reviewed. If there are non-ambulatory individuals, the location is reviewed to determine whether there is at least one ramp.	• The location has two means of egress from floors at grade level that individuals are able to use. • **or** at least one ramp and one other usable exit in locations where individuals with mobility impairments are supported.	• The location does not have two means of egress at grade level that individuals are able to use • **and/or** location does not at least one ramp and one other usable exit in locations where individuals with mobility impairments are supported.

INDICATOR	Regulations 7.07(7) (a):	…all other floor above grade level shall have one means of egress and one escape route serving each floor and leading to grade. Any proven usable path to the open air outside at grade shall be deemed acceptable as an escape route, including but not limited to connecting doors, porches, windows within six feet of grade, ramps, fire escapes, balcony evacuation systems, etc. …
L18. All other floors above grade have one means of egress and one escape route on each floor leading to grade **APPLICABILITY** ☒24/hr Residential	**GUIDELINES:** Escape routes/ egresses must be proven and usable by all individuals; e.g. If requiring an individual to leave from a window, the individual(s) must have the physical capacity to use this route and their ability to use this route has been tested successfully. High rise apartments are subject to different building codes. As such, apartments within the high rise must have one egress and one escape route, and an apartment plan that identifies units within the building that rely on fire department rescue. Residential elevators cannot be utilized in the event of a fire, and therefore do not "count" as an egress/ escape route for individuals in wheelchairs. Basement levels utilized as sleeping space must also have one means of egress and one escape route from that floor.	

☒ABI/MFP 24/hr Residential ☒IHS ★ ☐Placement ☐ABI/MFP Placement ☒Respite ☐RSMS ☐Employment Services ☒CBDS	A provider shall not deviate in any respect from the foregoing environmental requirements of 115 CMR 7.07(7) as they apply to that provider, unless the provider demonstrates that the safety needs of individuals are otherwise adequately addressed and has received approval from the area director within its safety plan as required by 115 CMR 7.06. (Regulations 7.07(8))			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site review Staff interview/ observation current Section 8 inspection / letter	The location is reviewed to determine the individual's ability to utilize the egress is assessed. Since the Section 8 review does not assess that the egresses are "proven usable" this aspect will always be reviewed.	The location has one means of egress and one proven escape route from floors above grade level that individuals are able to use or there is an exception approved through the Safety Plan.	The location does not have one means of egress and one proven escape route from floors above grade level that individuals can use, and there is no exception to this requirement noted and approved through the Safety Plan.

INDICATOR **L19.** Bedrooms for individuals requiring hands on physical assistance to evacuate or who have mobility impairments are on a floor at grade or with a horizontal exit. **APPLICABILITY**	**Regulations 7.07 (h):**	Bedrooms of individuals requiring hands on assistance to evacuate or who have a mobility impairment, including individuals who use a wheelchair, shall be on a floor at grade or on a floor with a horizontal exit: as set forth in current Massachusetts State Building Code requirements for horizontal exits.		
	GUIDELINES: Individuals who need assistance to ambulate or move from one place to another using stairs cannot have bedrooms above grade. This would include individuals who use wheelchairs and most likely individuals who use a walker. Individuals must be capable of walking down the stairs on their own, although they may need physical guidance from staff because they are confused or unsure of what to do in an emergency. High rise apartments are subject to different building codes. As such, apartments within the high rise can serve individuals in wheelchairs on the upper floors provided that the apartment building has a plan that identifies units within the building that rely on fire department rescue, and the fire department is aware of their role in evacuation. Residential elevators cannot be utilized in the event of a fire, and therefore placement of individuals in wheelchairs on upper floors in homes is not permitted.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**

☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ★ ☒Placement ☒ABI/MFP Placement ☒Respite	Site Review Individual / staff interview/ observation	The location is reviewed to determine whether any individuals with mobility impairments are situated in bedrooms not located at grade or with a horizontal exit.	Bedrooms where individuals requiring hands on physical assistance to evacuate or who have mobility impairments are on a floor at grade or with a horizontal exit.	Bedrooms where individuals requiring hands on physical assistance to evacuate or who have mobility impairments are not on a floor at grade or with a horizontal exit.

INDICATOR	Regulations 7.07 (7) (a)	…Double cylinder dead bolt locks that require key operation from within are prohibited on egress doors.		
L20. Exit doors are easily operable by hand from inside without the use of keys.	**GUIDELINES:** If a connecting door between two apartments is utilized as each apartment's second exit (e.g. through the other apartment to the outside), both sides of the door must be easily openable by residents from either apartment without use of keys. For individuals who cannot operate door knobs, door handles can be used in place of the door knobs.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒Respite ☒IHS ★ ☐Employment Services ☒CBDS	Site Review current Section 8 inspection / letter	The location is reviewed to determine whether there are any exit doors that require the use of keys. Not reviewed if reviewed by Section 8	• Exit doors are free of inside locks that require keys, • **and** are easily operable. Or Section 8 inspection / letter	• Exit doors have inside locks that require keys, • **and/or** are not easily operable.

INDICATOR	Regulations: 7 (1)	All homes and work/day supports must meet all applicable building, sanitary, health, safety and zoning requirements.		
L21. Electrical equipment is safely maintained.	**GUIDELINES:** Locations must meet the following: • Wall receptacles and power strips are not overloaded; e.g. there must be no more than one appliance cord plugged into an outlet and limit the number of items plugged into any given power strip. • All visible cords are free from cracks or wear. Multiple plug adapters are not used on any appliance. • There is no electrical wiring passing across frequently traveled floor areas, under floor coverings such as rugs, or extending through doorways or other openings. • When necessary, only heavy-duty cords can be used on major appliances such as air conditioners. • Fuses and circuit breakers are labeled. A supply of fuses is kept next to the fuse box.			
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ★ ☒Placement ☒ABI/MFP Placement ☒Respite ☐Employment Services ☒CBDS	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site Review Section 8 letter	The location is reviewed to determine if electrical equipment is safely maintained. Not reviewed if reviewed by Section 8	Each of the five requirements as outlined in the guidelines has been met. Or Section 8 letter.	The presence of one or more issues as noted in the guidelines is observed.

INDICATOR	No specific regulatory reference
L22. All appliances and equipment are clean, operational and properly maintained.	**GUIDELINES:** All major appliances and equipment, including seasonally and periodically used appliances need to be properly maintained and in good working order. This includes items such as washers, dishwashers, stoves, toasters, toaster ovens, air conditioners, dehumidifiers, and other equipment that requires proper maintenance to assure its safe use. Appliances need to be free of visible leaks. Dryer vents and filters need to be properly maintained, and lint free. Provider must assure that appliances and equipment are maintained in good working order by conducting and documenting on-going safety checks. Provider must also obtain any necessary inspections for equipment as indicated.

APPLICABILITY	Portable free-standing heaters can only be utilized in limited circumstances. Radiator-type heaters that are UL inspected, and electric or oil-filled with automatic shut-off switches are acceptable. They must not be used as the primary source of heat, nor can they be used when people are asleep. They can be used in cases of unusual or rare situations, and not routinely through the winter. A written plan outlining the proposed use and addressing the implementation and monitoring is required. The outdoor grill is located away from the home and is properly maintained according to local town ordinances. Gas grills cannot be located on wooden porches or on balconies. They must be located at least 10 feet from the house.			
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS★ ☒Respite ☐Employment Services ☒CBDS	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site Review current Section 8 inspection/letter	The location is reviewed to determine if appliances are clean and properly maintained as outlined in the guidelines. Not reviewed if reviewed by Section 8	Each appliance within the location is clean and properly maintained. Or Section 8 inspection/ letter	• The location has one or more appliance or equipment that are found to be not clean and/or properly maintained in good working order • **and/or** provider does not have an adequate system to assure the ongoing maintenance and safety of equipment/ appliances. ("Point in time" - new situations in which immediate actions have already been taken by the agency to resolve, do not require a rating of "not met"; e.g. dishwasher broke on date of visit; plumber was immediately called) Lint in the dryer filter, without any other problem in this area is not sufficient to rate "standard not met." Lint build-up in the dryer hose, behind the dryer or in the vent must be rated "standard not met."

INDICATOR	**Regulations 7.07 (7) (g):**	Locks on bedroom doors which provide access to an egress are prohibited.
	GUIDELINES:	

L23. There are no locks on bedroom doors that provide access to an egress. **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒Respite	Privacy may be impacted for any individual whose bedroom provides access to an egress. Therefore, the individual must understand that his/her bedroom will be used during fire drills and fire emergencies, and not to use a lock on his/her bedroom door.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site Review	The location is reviewed to determine whether there are any locks on bedroom doors that provide access to an egress.	There are no locks on bedroom door(s) that provide access to an egress.	There is a lock on bedroom door(s) that provides access to an egress.

INDICATOR **L24.**Locks on doors not providing egress can be opened by the individuals from the inside and staff carry a key to open in an emergency.	**Regulations 7.07 (7) (g)**	Locks on bedroom doors which do not provide access to an egress shall be permitted only in accordance with the following: 1. The head of the provider has documentation that the lock may be easily opened from the inside without a key and that the individual is able to unlock the door from the inside; and 2. At all times staff carry a key or have immediate access to a key to open the door in the event of an emergency.		
	Regulation 7.07 (7) (f)	Bedroom doors are lockable unless clinically contraindicated or unless an individual, or his or her guardian, if applicable, chooses a bedroom with access to egress and consents to the bedroom door not having any lock.		
	GUIDELINES: Doors not providing access to an egress (bedrooms, bathrooms, closets) can only have a lock if they can be opened by the individuals, and staff are able to open in an emergency.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**

☒24/hr Residential ☒ABI/MFP 24/hr Residential ☐IHS ☒Placement ☒ABI/MFP Placement ☒Respite	Site Review Documentation review	A sample of homes is reviewed to determine if locks on bedroom doors can be opened by the individual from the inside and staff carry a key to open in an emergency. Documentation on the clinical contraindication for any applicable bedroom door without a lock.	• Locks on doors are either not present or individuals can open • **and** staff have a key.	• Locks on doors are present and individuals cannot open • **and/or** staff do not have a key.

INDICATOR	Regulations 7.07 (5) (h):	All substances that are potentially dangerous in nature shall be stored separately from food in containers which are accurately labeled.		
L25. Potentially dangerous substances are stored separately from food and are in containers that are accurately labeled.	**GUIDELINES:** Household cleaners and other non-edible, toxic items must be stored away from food items, and clearly labeled. If anyone at the location exhibits pica, the provider must take necessary steps to eliminate access to these items for those who need that level of support / restriction, e.g. supplies are locked up.			
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS★ ☒Respite ☐Employment Services ☒CBDS	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site Review	The location is reviewed to determine that potentially dangerous substances are stored separately from food and are in containers that are accurately labeled.	• No dangerous substances are present near food, • **and/or** unlabeled.	• Potentially dangerous items are present near food • **and/or** unlabeled.

INDICATOR	Regulation 7.07 (1):	All sites where residential supports, 24-hour site-based respite supports, employment supports and day supports must meet all applicable building, sanitary, health, safety and zoning requirements.		
L26. Walkways, driveways and ramps are in good repair and clear of ice and snow.	**GUIDELINES:** Ramps, driveways and handrails must be adequately maintained (accessible, useable, functional, safe, and with adequate lighting on pathways, exits and ramps.) Walkways need to be maintained in safe condition in all seasons (e.g. kept reasonably clear of ice, leaves, snow, and other elements of the weather). This includes both the primary and secondary egress pathways. Following a snowstorm or other weather condition, actions need to be taken promptly.			
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ★ ☒Placement ☒ABI/MFP Placement ☒Respite ☐Employment Services ☒CBDS	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site Review	The location is reviewed to determine whether driveways and ramps are in good repair and clear of ice and snow.	• Walkways, driveways and ramps are in good repair • **and** clear of ice and snow.	• One or more walkways, driveways and ramps are not in good repair • **and/or** are not clear of ice and snow.

INDICATOR	Regulation 7.07 (1):	All sites where residential supports, 24-hour site-based respite supports, employment supports and day supports must meet all applicable building, sanitary, health, safety and zoning requirements.
L27. Swimming pools are safe and secure according to policy.	**GUIDELINES:** Having a pool in the home can be positive when used safely. There needs, however, to be procedures in place that support safety when there is a pool or any body of water. Safety requirements are covered in the “Water Safety - Safeguards at Home and Within the Community” document. When individuals are using a pool or other body of water, there needs to be at least one staff present that has completed a water safety training and is certified in CPR. For all service locations where a pool is present, there needs to be policies and procedures that cover the assessment of individual water safety skills, staff training and supervision requirements and environmental safeguards that meet applicable local ordinances and for when the pool temporarily is not in use.	

APPLICABILITY	Please refer to Water Safety Interpretations.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS★ ☒Placement ☒ABI/MFP Placement ☒Respite ☐Employment Services ☒CBDS	Site review Policies, procedures, and training around the use of the pool Staff interview	Homes with swimming pools are reviewed to determine whether the entrance to the pool is locked and the pool is maintained safely as per DDS policy. Review of training information (water safety), policies and precautions regarding pool use. Determine whether staff are knowledgeable about the agency pool policies and procedures.	Swimming pool is safe and secure according to DDS policy. The following items are necessary per DDS policy: Environmental safeguards (e.g. locked access when not in use) must be in place. An assessment of each individual's water safety skills must be made. The staff/ home care provider supervising individuals must be trained in water safety and CPR, with documentation present in the home. (An on-line Basic Water Safety course which covers basic water safety can suffice). Policies and procedures outlining supervision and use of pool need to be in place, and the home care provider needs to be knowledgeable in these.	Compliance with one or more requirements from the DDS policy is not present.

INDICATOR	Regulations 7.07 (5) (h):	No flammable liquids, such as gasoline, shall be stored in the home or in spaces attached to the home.		
L28. Flammables are stored appropriately.	**GUIDELINES:** Store oxygen per manufacturer's direction, and away from heat sources. Regarding other materials such as small amounts of lighter fluid for grills and the like, placement must be at least 10 feet away from the house and/or stored in a fireproof container away from heat sources.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS★ ☒Respite ☒Placement ☒ABI/MFP Placement ☐Employment Services ☒CBDS	Site Review	The location is reviewed to determine that flammables are stored appropriately.	Flammables are stored appropriately in fire rated containers (UL listing).	Flammables are not stored appropriately in fire rated containers (UL listing).

INDICATOR	Regulation 7.07 (1):	All sites where residential supports, 24-hour site-based respite supports, employment supports and day supports must meet all applicable building, sanitary, health, safety and zoning requirements.		
L29. No rubbish or other combustibles are accumulated within the location including near heating equipment and exits.	**GUIDELINES:** This gets evaluated when the provider has either direct (e.g. provider as homeowner) or indirect responsibility (e.g. provider as renter). For example, when the provider is leasing the home from a community landlord who has stored items inappropriately by the furnace, the provider needs to ensure that rubbish and/or combustibles are removed from the heating equipment and exits.			
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ★ ☒Placement ☒ABI/MFP Placement ☒Respite ☐Employment Services ☒CBDS	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site visit Current Section 8 inspection / letter	The location is reviewed to determine that no rubbish or other combustibles are accumulated near heating equipment and exits. Not reviewed if inspected by Section 8	No excessive rubbish or other combustibles are accumulated within the location near heating equipment and exits. Or Section 8 inspection / letter	Excessive rubbish or other combustibles are present near heating equipment and /or exits.

INDICATOR	Regulation 7.07 (1):	All sites where residential supports, 24-hour site-based respite supports, employment supports and day supports must meet all applicable building, sanitary, health, safety and zoning requirements.		
L30. The exterior of the home, including every porch, balcony, deck or roof used as a porch or deck has a wall or protective railing, is in good repair.	**GUIDELINES:** Each porch, deck, balcony or roof intended for use by staff and individuals which 30 inches or more above the ground has a wall or guardrail at least 36 inches high. The exterior of the home / work location including porches roof, decks, and other elements are in good repair. Structural safety concerns relative to porches and balconies need to be ensured.			
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ★ ☒Placement ☒ABI/MFP Placement ☒Respite ☐Employment Services ☒CBDS	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site visit Current Section 8 inspection / letter	The location is reviewed to determine whether the exterior of the location is in good repair and porches, balconies, decks or roofs used as a porch or deck has a wall or protective railing in good repair. Not reviewed if inspected by Section 8	At each location visited, the decks, porches, walls and exterior of the location are in good repair. Or Section 8 inspection / letter	At each location visited one or more item is in need of repair.

COMMUNICATION

INDICATOR	Regulation 7.04 (1) (b)	Individual Choice and Control. Opportunities for exercising choice and control in all aspects of an individual's life by providing the education and supports to enable the individual to make informed decisions, and by promoting an environment and culture where the individual's opinions are listened to and treated seriously.
L31. Staff understand and can communicate with individuals in their primary language and method of communication	**GUIDELINES:** The ability of staff to understand what an individual is communicating is essential in assisting an individual to meet his/her needs. Staff need to have a familiarity and be well versed in the individual's mode of communication, whether it is English, ASL, or other language or method of communication or make ongoing efforts to understand communication modes for the individuals served. If augmentative devices and communication tools are recommended, these must be present, well-maintained, and used.	

APPLICABILITY	INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
All Services	Staff Interview Individual Record	Review if staff have an understanding of and competence in the individual's communication style including the use of any augmentative devices, if needed, and can communicate and respond to the individual. Review documentation to determine if there are any additional communication needs and whether they are being addressed.	• Staff have an understanding of the individual's communication needs • **and** can communicate or are making concerted efforts to communicate with the individual.	• Staff either do not have an understanding of the individual's communication needs • **and/or** cannot communicate or are not making concerted efforts to communicate with the individual.

INDICATOR	Regulations 5.04(1) (a), (b):	The right to communicate, including (a) the right to have reasonable access to a telephone, internet, email, social media and other web-based communication applications and opportunities to make and receive confidential communications, and to have assistance when desired and necessary to implement this right, and (b) the right to unrestricted mailing privileges, to have access to stationery and postage, and to assistance when desired and necessary to implement this right
L32. Individuals receive support to understand verbal and written communication.	**GUIDELINES:** This includes support to use the telephone and other electronic modes of communication, write and receive letters and emails, as well as understand written reports sent to the individual. Staff need to serve as a bridge so that communication from others to the individual is facilitated and understood. For example, staff can assist the individual to understand a third party, assisting as needed to facilitate a positive exchange. Staff also need to support individuals to understand written communication including information about him/herself. For example, when the individual receives an email or letter from family, staff can support the individual by offering to read it to him/her. This also includes supporting the individual to understand written information about him/her.	
APPLICABILITY All Services		

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Staff Interview Individual interview Observation	Review and observe if staff support individuals to understand verbal, electronic and written communication involving them. Review if individuals feel they receive needed support.	Staff support individuals to understand verbal, electronic and written communication.	Staff do not support individuals to understand verbal, electronic and/or written communication.

HEALTH

INDICATOR	Regulation 6.22(3)(b):	In the case of individuals residing in facilities or in homes operated, licensed or funded by the Department, the residential provider shall provide or arrange for annual health and dental assessments.
L33. Individuals receive an annual physical exam.	**4.03 (10)**	Medical Information. Each individual's area office and provider record shall contain the following information: (a) Summary reports of the individual's most recent physical and dental examinations, as required in 115 CMR 6.51, except that only the area office and the individual's residential provider shall be required to maintain the medical and dental examination summary report; (b) A record of special diets prescribed for the individual, if any, upon recommendation of a physician; (c) Upon recommendation of a physician, a record of frequency and type of all seizures, in order to assess the effects of anti-convulsant medication, other therapies, and environmental factors; (d) A list of any conditions requiring ongoing management by health care professionals, including a summary of necessary treatment(s) for each condition; (e) Any information concerning the individual's HIV status shall be maintained confidentially and strictly in accordance with the written policy of the Department.

APPLICABILITY

☒24/hr Residential
☒ABI/MFP 24/hr Residential
☒IHS ●
☒Placement
☒ABI/MFP Placement

GUIDELINES:
Agencies providing residential supports need to support individuals to receive annual physical exams.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Provider Health Care Record Physical exam documentation in the individual's record and on site	A sample of Health Care Records is reviewed to check the date of the most current physical exam. Current annual physical examinations should be within 15 months of the previous physical examination.	The physical exam has occurred within 15 months of previous physical exam (to allow reasonable time for any potential scheduling difficulties/ reporting)	The physical exam did not occur within 15 months of last physical exam.

INDICATOR	Regulation 6.22(3)(b):	In the case of individuals residing in facilities or in homes operated, licensed, or funded by the Department, the residential provider shall provide or arrange for annual health and dental assessments.
L34. Individuals receive an	**GUIDELINES:** Individuals who are edentulous require an oral examination annually by a Health Care Practitioner or dentist to assess for oral disease or cancer. This can be performed by the individual's physician during the annual physical examination.	

annual dental exam. **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Placement ☒ABI/MFP Placement	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Provider Health Care Record Dental exam documentation in the individual's record and on site	A sample of Health Care Records is reviewed to check the date of the most recent dental exam.	Dental examination or oral examination if applicable occurred within 15 months of last examination (to allow reasonable time for any potential scheduling difficulties/ reporting).	Dental examination or oral examination if applicable did not occur within 15 months of last examination or is not present.)

INDICATOR	Regulation 7.04 (f) 1:	… promote optimal health of the individual by arranging for coordinated routine, preventive, specialty, and emergency health care, professional clinical services …

L35. Individuals receive routine preventive screenings.

APPLICABILITY

☒24/hr Residential
☒ABI/MFP 24/hr Residential
☒IHS ●
☒Placement
☒ABI/MFP Placement

GUIDELINES:

Individuals need to be supported to receive routine screenings in accordance with the " DDS Adult Screen Recommendations" developed by DDS as part of the Department's Health Promotion and Coordination Initiative. Several screenings are recommended to be performed annually.

To better assure that individuals receive consistent and appropriate standardized preventive and routine health care screenings, provider staff must complete the DDS Adult Screening Recommendations Checklist prior to the annual physical. The checklist serves as a guide for the individual and support providers regarding what to request or expect during the annual physical examination.

Screenings are typical of those recommended for the general population (e.g. mammography, pap smear, prostate cancer screen, Colonoscopy for individuals over 50, eye exam/hearing exam done by the primary care physician satisfactory without need for referral to specialist, gyn exam). Immunizations such as flu vaccines and shingles vaccines should also be performed per Health Care guidance.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Health Care Record Staff interview/ active health care information	A sample of Health Care Records is reviewed to check the routine screenings and immunizations (dates and type) conducted in the past two years. When screenings are not present, discussion with staff and review of documentation of communication and coordination of routine screenings to Health Care Practitioners is completed to determine whether routine screenings have been	• Screenings and immunizations have occurred for individuals in 24-hour residential supports or in less than 24 hour supports if it is part of the contract, • **or** if screenings did not occur, staff can demonstrate that recommendations outlined in the DDS Adult Screening Recommendations Checklist were communicated to the physician. Staff can explain why the physician did not conduct (e.g. ability of the individual to cooperate).	• Key screenings and immunizations (e.g. colonoscopy, mammogram; PSA, flu vaccine) were not conducted • **and** staff cannot demonstrate that recommendations outlined in the DDS Adult Screening Checklist were brought to the attention of the Health Care Practitioner.

		discussed with the Health Care Practitioner.		

INDICATOR	Regulation 7.04 (f) 1	… promote optimal health of the individual through arrangements for coordinated routine, preventive, specialty, and emergency health care, professional clinical services …		
L36. Recommended tests and appointments with specialists are made and kept.	**GUIDELINES:** Optimal health care includes assuring that recommended specialty referrals are made, and appointments kept. This includes both initial and ongoing follow-up with specialists including but not limited to neurology, psychiatry, gastroenterology, nutritionist, and podiatry.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Placement ☒ABI/MFP Placement ☒Respite	Health Care Record and other medical information	A sample of individuals' Health Care Records and medical appointment logs is reviewed to determine whether recommendations for tests and appointments are scheduled and kept.	Regular visits to specialists occur when recommended. Additional tests and appointments recommended are made and kept within the time frames recommended by the Health Care Practitioner.	• Regular visits to specialists are not occurring when recommended. • **and/or** notation of appointments/ tests needed have not been scheduled within the timeframes recommended by the Health Care Practitioner.

INDICATOR		
L37. Individuals receive prompt treatment for acute and episodic health care conditions.	**Regulation 7.04 (f) 1:**	… promote optimal health of the individual through arrangements for coordinated routine, preventive, specialty, and emergency health care, professional clinical services …
	Regulation 4.03 (10) (d):	Each individual's area office and provider's record shall contain the following information: d. A list of any conditions requiring ongoing management by health care professionals including a summary of necessary treatment(s) for each condition;
APPLICABILITY	**GUIDELINES:**	
	The health status of individuals does not neatly lend itself to an annual review and physical exam. Accurately recognizing signs and symptoms of illness will facilitate individuals receiving timely medical care. It is critical that direct support professionals, as the first line of defense, be knowledgeable about what issues to report on and to whom they need to report them. Fact sheets included in the "Health Promotion and Coordination Initiative" are useful tools as quick reference guides to better define a condition, identify observable symptoms, and recommend action for direct support professionals.	
All Services		

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Policies and procedures for reporting and obtaining treatment for acute and episodic conditions. Staff interview Current health care record and other medical information Communication logs	Policies and procedures for reporting and obtaining treatment for acute and episodic conditions. Staff interview Current health care record and other medical information Communication logs	Staff are knowledgeable concerning signs and symptoms of illness and information indicates that individuals are receiving prompt treatment for episodic conditions.	Staff are not knowledgeable concerning signs and symptoms of illness and /or information indicates that individuals are not always receiving prompt treatment for episodic conditions.

INDICATOR		
⚐ **L38.** Physicians' orders and	**Regulation 4.03 (10) (c)and (d):**	Each individual's area office and provider's record shall contain the following information… c. Upon recommendation of a physician, a record of frequency and type of all seizures, in order to assess the effects of anti-convulsant medications, other therapies, and environmental factors; d. A list of any conditions requiring ongoing management by health care professionals including a summary of necessary treatment(s) for each condition;
	GUIDELINES:	

treatment protocols are followed (when agreement for treatment has been reached by the individual/ guardian/ team). **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Placement ☒ABI/MFP Placement ☒Respite ☒Employment Services ☒CBDS ☒ RSM ●	Effective implementation of treatment protocols recommended by an individual's health care practitioner is central to maintaining optimal health. Examples of protocols can include but are not limited to seizure protocols, bowel regimens, and protocols to prevent aspiration.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Current Health Care Record and other medical information Staff interview Review of staff training	Individuals' medical records and other treatment orders is reviewed to determine who is on a treatment protocol. A comparison is made with other site information (e.g. communication log; training information; staff interview) to determine whether treatment protocols are being followed. If the protocol or treatment recommendation is not being followed, determine whether a second opinion or guardian approval being sought. Staff is interviewed to evaluate their training, knowledge and implementation of treatment protocols. Validate that staff have received training in necessary treatment protocols; e.g. seizure, use of O2, PAP, vital signs, etc.	• Staff are knowledgeable concerning physician's orders and treatment protocols • **and** information indicates that these are being consistently followed. If not being followed, this is due to seeking a second opinion or obtaining guardian approval.	• Staff are not knowledgeable concerning physician's orders and treatment protocols • **and /or** information indicates that these are not being consistently followed • **and/or** a second opinion or guardian approval has not been pursued.

INDICATOR	**Regulation 7.04 (f) 3:**	… assure that … all individuals have nourishing and well-balanced meals, provided at typical times and frequencies, of typical variety, and chosen by the individual, unless there exist medical contraindications related to the health of an individual and these have been documented by a physician.

L39. Special dietary requirements are followed.	**Regulations 4.03 (10)(b)**	Each individual's area office and provider record shall contain… (b) A record of special diets prescribed for the individual, if any, upon recommendation of a physician;		
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Placement ☒ABI/MFP Placement ☒Respite ☒Employment Services ☒CBDS ☒ RSM ●	**GUIDELINES:** This includes but is not limited to specialized diets such as diets to manage diabetes, weight loss diets, and diet textures for individuals with swallowing disorders. Dietary guidelines and practices at the location should recognize and be responsive to all individuals' particular food allergies and conditions. This includes addressing such items as lactose intolerance, Celiac's disease, need for a glutton-free diet, or food allergies such as to peanuts or shell-fish.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Current Health Care Record and medical information including diets, protocols, menus. Staff interview	Individuals' Health care Records and other treatment orders are reviewed to determine who is on a specialized diet, and /or a dietary treatment protocol. A comparison is made with other site information to determine whether treatment protocols are being followed. Staff are interviewed to evaluate their training, knowledge and implementation of specialized diets, dining protocols, G tube, J tube, etc.	• Staff are knowledgeable concerning specialized diets. • **and** information indicates that specialized diets are being consistently followed.	• Staff are not knowledgeable concerning specialized diets. • **and/or** information indicates that specialized diets are not being consistently followed.

INDICATOR	**Regulation 5.04(4): …**	Basic goods and services include at least the following: (a) A nutritionally sound diet of wholesome and appetizing food served at appropriate times and in as normative a manner as possible;
L40. There is an adequate supply of nutritional foods available at all times.	**GUIDELINES:** Providers must be aware of the array of foods that are nutritional, and homes must have a sufficient supply available. The provider can certainly acknowledge and take into full consideration an individual(s) tastes or preferences (e.g. does not like fresh fruit), while also making available an adequate supply of various fresh foods such as vegetables, fruits, and other perishables such as milk, juice and eggs.	

APPLICABILITY	There needs to be at least a two days supply of nutritious food in the home, stocked with healthy items consistent with the tastes and preferences of the individuals (e.g. juice for the person who does not like fresh fruit). This expectation to ensure an adequate supply of healthy foods does not limit providers from fully promoting individual's choices in other ways. For example, other favorite (e.g. non-nutritious) food items might be also made available consistent with individual's tastes. Care Providers must also ensure the adequate supply, variety and array of nutritional foods.			
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ●	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site visit Staff interview	Home is reviewed and the kitchen and pantries checked to determine the adequacy of nutritional food available, including the presence of at least a 2 day supply of fresh or combination of fresh and frozen items such as fruits, vegetables, bread, as well as dairy items. Staff are interviewed to determine grocery shopping routines, and the types and amounts of nutritional foods typically available on site for individuals at all times.	The home has at least a two-day supply of nutritional foods in the home.	The home does not have at least a two-day supply of nutritional foods in the home.

INDICATOR	**Regulation 7.04 (f) 3:**	… store, prepare and serve food in a clean, safe, nutritious, tasteful, and appetizing manner and for each individual to have regularly nourishing and well-balanced meals. The meals must be provided at least three times a day including one in the morning, one in the afternoon and one in the evening and be chosen by the individual unless there is documentation from a physician that the frequency, amount, texture or type of meal is medically contraindicated for the individual;
L41. Individuals are supported to follow a healthy diet. **APPLICABILITY**	**GUIDELINES:** Staff can play an important role in supporting individuals to make healthy choices regarding diet and food intake. While individuals may not always make healthy choices, staff must prepare nutritional meals and assist individuals to learn about healthy diets. Nutritional information released by the United States Department of Agriculture (USDA) on April 19, 2005, The 2005 Dietary Guidelines describe a healthy diet as one that: • Emphasizes fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products.	

☒24/hr Residential
☒ABI/MFP 24/hr Residential
☒IHS ●
☒Placement
☒ABI/MFP Placement
☒Respite
☒ RSM ●

- Includes lean meats, poultry, fish, beans, eggs, and nuts; and
- Is low in saturated fats, *trans* fats, cholesterol, salt (sodium), and added sugars.

Staff need to be knowledgeable and trained in Executive Order 509 regarding healthy diets.

Staff need to assist individuals to make smart choices from every food group, get the most nutrition out of calories, and find a balance in the quantity consumed.

This expectation to support individuals to follow a healthy diet does not restrict providers from fully promoting individual's choices. The provider must first promote a variety of healthy choices, encouraging the individuals to make personal choices from a variety of healthy alternatives. Providers may also make non-nutritious preferred food items available for snacks and desserts consistent with individual's tastes.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Review of menus and snack items – on site Staff/care provider interview – on site	Menus and snack items are reviewed to determine whether an adequate, nutritional diet is provided. Staff are interviewed to assess their knowledge about what constitutes a nutritionally sound diet, including familiarity with USDA dietary guidelines and Executive Order 509 and other nutritional models; e.g. American Heart Association. Staff/care providers are interviewed to determine what the typical meals are offered/ provided within the home, and how individuals are being supported to make healthy choices.	• Menus, meals and snack items indicate that over the course of one week, a balanced diet has been offered, • **and** staff are knowledgeable about what constitutes a nutritionally sound diet.	• Menus, meals and snack items indicate that over the course of one week, a balanced diet has not been consistently offered, • **and/or** staff are unfamiliar with what constitutes a nutritionally sound diet.

INDICATOR	Regulations 5.04 (4) (b):	… Basic goods and services include at least the following… (b) Opportunities for daily recreational activity and physical exercise, as appropriate to the age and interests of the individual...		
L42. Individuals are supported to engage in physical activity.	**GUIDELINES:** While there is no exact standard established, it is generally recommended that adults try to get at least some exercise daily. According to www.MyPramid.gov, it is recommended that adults get at least 30 minutes of moderate level activity most days. While individuals may choose not to engage in some form of daily activity, there is an expectation that staff at the home will support and offer opportunities for regular physical activity. Unless contraindicated, (e.g. for medically involved individual where exercise is not advised within the ISP) the provider needs to encourage physical exercise and movement routinely. Movement for any length of time is good. For individuals who have a specific weight loss/ exercise goal noted within their ISP, the provider needs to develop and implement specific support strategies to address these. For example, implementation of more structured exercise plans such as supporting the individual to attend an aerobics class three times per week, may be appropriate.			
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Placement ☒ABI/MFP Placement ☒Respite ☒ RSM ●	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site visit including review of schedules, routines and activities listed Staff interview	Home is visited and the schedules, routines and activities of the individuals are checked to determine the frequency and duration of physical activity for each individual, and for the group of individuals on average. Staff are interviewed to assess their knowledge about the importance of physical activity in daily life, and on their provision of options and encouragement to individuals.	Individuals have engaged in (or have been offered) physical activity routinely.	Individuals have not been offered or have had limited opportunities to engaged in physical activity routinely.

INDICATOR	Regulations 4.03 (10)(a- e)	Medical information. Each individual's area office and provider record shall contain…see regulations for details		
L43. The health care record is maintained and updated as required.	**GUIDELINES:** The DDS electronic Health Care Record submitted in HCSIS is required to be updated annually (in preparation for the ISP). The HCR also needs to be updated when significant changes occur throughout the year. Significant changes requiring HCR update: New diagnosis (including COVID positive dx), hospitalization, immunizations (including flu shots; pneumovax); preventative screenings. The medical information in the individual record located within the residential home needs to be current and updated in an ongoing manner, so that it can serve to facilitate routine, specialty and emergency medical contacts and encounters. For example, doctor or hospital visits should be documented in the record.			
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Placement ☒ABI/MFP Placement	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	DDS Electronic Health Care Record Current Provider health care and medical information Staff interview	DDS Health Care Records reviewed to determine whether the electronic ISP has been updated annually. ` If needed, a sample of Health Care Records is reviewed on site to determine whether it has been completed as required. Discussion occurs with staff and medical information in the individual record is reviewed to determine if information is current.	The DDS electronic Health Care Record is updated annually and is updated when significant changes occur. Medical information in the individual record is located at the home, is current.	• The DDS electronic or paper Health Care Record has not been updated within the past year or when significant changes occurred. • **and/or** medical information in the individual record located at the home is not current.

INDICATOR	Regulation 5.15 (7);	Certified program staff of community programs may administer prescription medications to non-self-medicating individuals, provided that the community program is registered with the Department of Public Health in accordance with 105 CMR 700.004 …
L44. The location where MAP certified		

staff is administering medication is registered by DPH. **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ♦ ● ☒Respite ☒Employment Services ☒CBDS	**GUIDELINES:** Licensed, funded or operated community residential programs that are individuals' primary residences and/or are locations where individuals are participating in day programs and short-term respite programs must apply for a Massachusetts Controlled Substance Registration (MCSR) from DPH for the purpose of authorizing non-licensed employees to administer or assist in the administration of medications and for storage of medications on site. The MCSR is issued to the geographic site where the medication is stored. The original MCSR must be kept at the site with a copy of the MCSR kept at the service provider's administrative office, or vice versa.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	DPH Registration	The location is reviewed to determine whether the site is registered with DPH when medications are administered by MAP certified staff.	Site has a DPH MAP registration number (MCSR) where medications are administered by MAP certified staff.	Site has does not have a DPH MAP registration number (MCSR) where medications are administered by MAP certified staff.

INDICATOR **L45.** Medications are stored in a locked container or area in which nothing except such	**Regulation 5.15 (8) (a):**	Prescription medications for all individuals who are non-self-medicating shall be labeled and stored in a locked container or area in which nothing except such medications are stored.
	GUIDELINES: Each program site must have a specific area dedicated to the storage of all Schedule II-VI prescription medications and OTC medications. Procedures must limit access to this area to the individual authorized to administer medications during each shift and limit possession of the key to the medication area to the authorized staff on that shift. The key must be stored in a locked area within the site accessible to designated staff only.	
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**

medications are stored. **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒ IHS ♦ ● ☒Respite ☒Employment Services ☒CBDS	Medication storage area	The location is reviewed to determine whether medications are stored properly.	• Medications are stored in a locked container or area in which nothing but medications is stored, • **and** external medications • **and** medications that require refrigeration are stored correctly.	• Medications are not stored in a locked container or area in which nothing but medications is stored • **and/or** external medications • **and/or** medications that require refrigeration are not stored correctly.

INDICATOR	**Regulation 5.15 (10) (a):**	All prescription medications shall be administered in accordance with the written prescription of a practitioner.
⚐ **L46.** All prescription medications are administered according to the written order of a practitioner and are properly documented on a Medication Treatment Chart.	**Regulation 5.15 (11):**	All prescriptions for, and administration of, medication shall be documented in accordance with 105 CMR 700.003(F)(6), 115 CMR 5.19(9) …
	GUIDELINES: Prescription medications must be administered exactly as ordered by the practitioner, which could include a physician, dentist, nurse practitioner or physician's assistant. Medications and dosage information as listed on the doctor's orders needs to match the container obtained from the pharmacy. Failure to accurately record and/or transcribe an order is the second leading contributing factor in medication occurrences in MAP. An improperly transcribed order is at risk of remaining incorrect for some time and poses a significant risk for serious outcomes. Review PRN guidelines for medications prescribed PRN as well as over-the-counter products. Both require Doctor's order including specific, observable criteria for determining when the medication is needed. All prescription medications are documented on the Medication Treatment Chart and specify: Name of medication and dosage; When and how the medication is to be given; if the medication is ordered for a set number of days, the start and stop dates, and	
APPLICABILITY ☒24/hr Residential		

☒ABI/MFP 24/hr Residential ☒IHS ♦ ● ☒Placement ☒ABI/MFP Placement ☒Respite ☒Employment Services ☒CBDS	special instructions for administration. Documentation on the Medication Treatment Chart is in ink with no white out, erasures. While MAP does not apply to placement service locations, all prescriptions need to be administered in accordance with a written order, and there needs to be some system of documentation indicating that medications are being administered correctly.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Individual Medication Administration information documentation	The location is reviewed, medication documentation is reviewed for a sample of individuals and containers of prescription medications are compared against written orders and documentation on Medication Treatment Charts. Three months medication and treatment charts and medication information is reviewed.	There is no evidence of any unidentified medication errors. and Past MORs have been appropriately identified and addressed. and Any recent discrepancy is in the process of being resolved and the doctor has been contacted. and No significant errors are revealed that either have caused harm or have the potential to cause harm and/or frequent and recurring medication issues. and There are no significant discrepancies in written documentation and information.	There is evidence of previously unidentified or uncorrected MORs. And/or Past MORs have not been appropriately identified and/or addressed. And/or Any recent discrepancy was not noted and/or is not in the process of being resolved. And/or Significant errors are revealed that either have caused harm or have the potential to cause harm and/or frequent and recurring medication issues. And/or There are significant discrepancies in written documentation and information.

INDICATOR	**Regulation 5.15 (12):**	Programs shall permit and encourage self-medication by individuals capable of self-medicating, provided that (a) the risks of misuse or abuse to the individual and other persons within the program are minimal, and (b) the program provides the individual with adequate training and assistance.
L47. Individuals are supported to become self-medicating when appropriate.	**GUIDELINES:** Individuals must be supported to self-medicate whenever possible. In order to self-medicate, an individual must be able to store his/her medication so that it is inaccessible to others, understand the type of medication, its purpose and for what symptoms or condition it is being prescribed, know the frequency of doses and have a familiarity with the most common side effects.	

APPLICABILITY	MAP policy manual requires that a periodic review of the individual is in place to ensure that individuals who are found to be self-medicating continue to take their medications independently. If the individual requires assistance to administer medications, the agency must apply as a DPH MAP registered location. MAP does not apply to Placement Services; however, the home provider needs to have some system to ensure that individuals who are self-medicating understand the type of medication, its purpose and for what symptoms or condition it is being prescribed, know the frequency of doses and have a familiarity with the most common side effects.			
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Placement ☒ABI/MFP Placement ☒ RSM ●	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	ISP including self-medicating assessment Medication systems review Staff interview	Review the self-medication assessments for individuals identified in the ISP as being independent in medications. Medication documentation and storage is reviewed for a sample of individuals noted to be self-medicating to determine whether appropriate safeguards are in place. A comparison of the individual's current status and capabilities with the self-medication assessment referenced within the ISP is conducted to determine whether there is a process of re-evaluating individuals who are found to be unable to continue to take their medications independently so that they can obtain additional support.	• Individuals who are self-medicating have a clear assessment documenting their skills in this area; medications • **and** are stored appropriately; • **and** the location takes appropriate actions when individuals are found unable to remain independent. • **and** the individual is assessed regularly to determine whether any changes are needed to the medication support plan	• Individuals who are self-medicating do not have a clear assessment documenting their skills in this area, • **and/or** medications are not stored appropriately; • **and/or** the location has not taken appropriate actions when the individual is found unable to remain independent.

HUMAN RIGHTS

INDICATOR

L48. The agency has an effective Human Rights Committee.

APPLICABILITY

All Services

Regulation 3.09 (1):

The head of every provider of residential, day, or site-based respite services … and every specialized home care placement agency subject to 115 CMR 5.00 shall establish and empower a human rights committee in accordance with the requirements of 115 CMR 3.09 …
3.09 (1)
(a) location requirements
(b) responsibilities and duties
(c) membership requirements
(d) meeting and minutes requirements

GUIDELINES:

An effective human rights committee (HRC) provides an essential safeguard for individuals served by the provider. As an independent, neutral voice, members of the human rights committee both assure that basic reviews and approvals have occurred for behavior plans as well as whether rights are affirmed on an on-going basis.

The HRC must perform reviews of behavior plans, restraints, and other items within their purview.

An approved waiver for HRC location (e.g. to serve locations in more than one region) or composition can be granted.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Administrative review- HRC membership, HRC by-laws, HRC minutes HRC Coordinator interview	Review of HRC membership, by-laws, and minutes for the past two years to determine whether the agency is in compliance with regulations. Review of training to HRC members to determine whether they have been trained in their responsibilities and duties. Review of mechanisms to familiarize the HRC members with the locations they serve.	The HRC meets the following: • mandated composition, • quarterly meetings; • maintaining a quorum at meetings; requisite expertise present at the meetings during reviews; • reviews and makes recommendations in mandated areas; • trained and knowledgeable in their role; familiarity with the locations they serve.	The HRC fails to fully meet any of the following: • mandated composition, • quarterly meetings; • maintaining a quorum at meetings; requisite expertise present at the meetings during reviews; reviews and makes recommendations in mandated areas; trained and knowledgeable in their role; • familiar with the locations they serve. A pattern of no meetings, or not meeting mandated composition

		Assess whether specific behavior plans have been reviewed by the HRC.		would result in a standard "not met" rating. ("Point in time" - situations in which immediate actions have already been taken by the agency to resolve do not require a "not met;" e.g. the committee didn't have a quorum for one meeting during the year and got feedback by phone for this meeting would not in and of itself cause the standard to be "not met")

INDICATOR	Regulations 3.09 (3) (b) (1) through and (4)	….shall designate and empower a person employed or affiliated with the provider or agency… 3. to provide individuals served with opportunities to exercise their rights to the fullest extent of their capabilities and interests, including informing them of the grievance procedures and the right to go to the human rights committee on any issue involving human rights;……		
L49. Individuals and guardians have been informed of their human rights and know how to file a grievance or to whom they should talk if they have a concern.	**GUIDELINES:** Both individuals and guardians need to be apprised of their rights to file a grievance. This is distinct from being trained in reporting an allegation of abuse or mistreatment and is more focused on ensuring that individuals know that there is at least one person that they can turn to if questions or concerns arise. Therefore, while individuals may not understand the exact process or be familiar with the human rights committee, individuals should be able to identify one person, be it the Human Rights Officer, or someone else referenced by name with whom they feel comfortable sharing concerns and raising issues. In addition, guardians also need to be aware that there is someone that they can speak to in the event that they have a concern. The Office of Human Rights suggests identifying for guardians and family members the Human Rights Officer for the program, the Human Rights Coordinator for the agency and the DDS Human Rights Specialist. Lastly, individuals residing in provider owned or operated homes are expected to have the same protections from arbitrary and capricious eviction that are afforded to others renting in the community.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**

All Services	Individual training and guardian documentation Individual interview and observation Guardian information Guardian Interview	Review training to individuals and guardians and whether human rights training has occurred at least annually. Determine whether individuals/ guardians have been informed of the right to be free from arbitrary eviction, through the presence of a residential agreement. Assess whether individuals are aware of whom they can talk to in the event of a concern. Observe individual's capabilities and how they share concerns within the setting. Determine whether guardians have been informed of how to file a grievance and report concerns to human rights and/or can identify someone to whom they feel comfortable talking to if they have a concern.	• Individuals and/or guardians have been trained in how to file a grievance • **and/or** individuals and guardians can identify someone to whom they feel comfortable talking to if they have a concern. • **and** individuals and guardians have received annual training in human rights and residential agreements are in place as appropriate.	• Individuals and/or guardians have not been trained in how to file a grievance • **and/or** Individuals and /or guardians cannot identify someone to whom they feel comfortable talking to if they have a concern • **and/or** individuals and guardians have not received annual training in human rights and/or residential agreement is not in place when appropriate.

INDICATOR	**Regulations 7.04 (1) (a):**	All providers shall assure that the supports and services they provide to individuals promote the following … (a) Rights and dignity: Protection and affirmation of the rights and dignity of individuals, including but not limited to a focus of respect of the individual… CMS § 441.530 Home and Community-Based Setting (a) (1) (iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
L50. Written and oral communication		

with and about individuals is respectful.

APPLICABILITY

All Services

GUIDELINES:

Promoting people's self-esteem is a fundamental ingredient in all services and supports. It is demonstrated when interactions with and attitudes about individuals are respectful and acknowledge the inherent value of each person. Service practices and supports, such as using a respectful tone of voice, and adult language when speaking with and assisting people, encourage people to see themselves and have others view them as unique, valuable individuals and adults. Staff call people by their preferred names instead of overly familiar terms like "honey" or "sweetie". Staff do not talk about people in the third person or use labels ("the runner", "the autistic"). Staff need to listen to what individuals have to say and support individuals to have a voice. Staff should always have conversations with individuals, rather than talking at or over individuals. If staff cannot immediately address a need, staff ensure that the individual understands that the need has been heard and will be addressed soon. In addition, it is essential that respectful communication when discussing or reporting information about individuals occurs.

Staff are sensitive to the ways to approach and relate to an individual with a disability when interacting with individuals specific to their needs. This includes proper wheelchair use which recognizes that wheelchairs are an extension of personal space, speaking at the appropriate tone/level of voice for people who are hearing impaired (no shouting), and having a person who is blind hold the arm instead of leading or propelling the person, etc. Staff describe people in positive and affirming ways with a focus on their abilities, not their disabilities. This includes the use of people –first language.

Any electronic or written communications that have the potential to convey individuals' personal protected information needs to be on a secure, encrypted, and HIPPA compliant platform.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Individual Record Staff Log Staff Interview Observation Individual Interview	Individual supports are reviewed to determine whether written and oral communication with and about individuals is respectful.	• Oral and written communication with and about individuals is respectful • **and** supports individuals as adults.	• Oral and/or written communication with and about individuals is not always respectful • **and/or** does not always support individuals as adults.

INDICATOR		
	Regulations 5.10 (1);	No provider subject to 115 CMR 5.00 shall interfere with the right of an individual to acquire, retain, and dispose of personal possessions unless authorized by a guardian, conservator, or representative payee; the interference or restriction is part of a duly developed and reviewed ISP; ordered by the court; or possession poses an immediate threat of serious physical harm to the individual or other persons. In the

L51. Individuals can access and keep their own possessions.

event of restriction of possession by the provider on the grounds of imminent and serious physical harm, the provider shall be authorized to place the object in custodial safekeeping for the individual..
(a) Any restriction on personal possessions … shall be documented in the individual's record, and a copy sent promptly to the provider's human rights committee.
(b) Such restriction shall be accompanied where appropriate by a training plan, documented in the individual's record, to eliminate the need for the restriction.

GUIDELINES:

Any restrictions on possessions need to be included in the individual's record, reviewed by the ISP team and the Human Rights Committee.

When a restriction is in place at a location shared by others that are impacted by this restriction, provision must be made for others to maintain access The provider should not lock an individuals' personal possessions from him/her for safe keeping to avoid having a roommate take the device.

Locking personal devices such as laptops and smart phones to prevent access of the individual to their own possessions should not occur unless this restriction is needed to prevent risk of harm.

Restriction needs to be accompanied where appropriate by a training plan, documented in the individual's record, to eliminate the need for this restriction.

At an employment / work setting, storage of personal possessions and reasonable practices for the use of and access to possessions, may be established. For example, all employees, including staff, may be required to store personal possessions within lockers prior to initiating work, and have access to these items only during lunch and free time.

APPLICABILITY

☒24/hr Residential
☒ABI/MFP 24/hr Residential
☒IHS
☒Placement
☒ABI/MFP Placement
☒Respite

☒Employment Services
☒CBDS

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Site Review ISP	Review a sample of sites to determine whether individuals can access and keep their own possessions. Compare site restrictions (e.g. locked possessions) with a corresponding plan.	There is free access to individuals to keep and own their personal possessions; or restrictions on possessions are in place with a plan that has been reviewed and approved per regulation.	There is a restriction(s) on possessions without evidence of a plan that has been reviewed and approved per regulation.

INDICATOR		
L52. Individuals can make and receive phone calls and use other communication technology.	**Regulation 5.04 (1) (a-d):**	… The right to have reasonable access to a telephone, the internet, email, social media and other web-based communication applications and the opportunity to make and receive confidential communications, and to have assistance when desired and necessary to implement this right; (c) Any restriction of telephone or internet use must be based upon a demonstrable risk, documented in the individual's record, and promptly provided to the provider's human rights committee. (d) Such restriction shall be accompanied by a training plan to eliminate the need for the restriction, documented in the individual's Individual Support Plan (ISP), and should be included in a PBSP, if clinically required.
	CMS § 441.530 Home and Community-Based Setting (a) (1) (iii)	Ensures an individual's rights of privacy...

APPLICABILITY

All Services

GUIDELINES:

Individuals must have the opportunity to privately use communication technology (telephone, mail, email, instant messaging, Facebook, video calls, twitter, and other applications) in most circumstances. Opportunities to make and receive calls or use communication devices can be restricted for clinical / safety reasons provided however, it is part of an approved written plan, with approval from the necessary review groups including but not limited to the individual/guardian and the human rights committee.

At an employment / day setting, reasonable practices concerning use and access to the telephone and other communication technologies may be established. For example, the service may establish guidelines in which all employees, including staff, have access to the telephone and other communication devices for personal calls only during lunch and free time. Opportunities to make and receive calls in emergency situations should not be restricted.

Communication technology must be accessible to all individuals including individuals who are deaf or hard of hearing.

Staff need to provide assistance to those who need help utilizing communication devices and the telephone such as by facilitating dialing, adjusting the volume, holding the phone, assisting individuals to send/ receive emails etc. This assistance should still allow for privacy to the greatest extent possible. Staff provide support in other ways as well including, but not limited to, training on computer use and internet safety. Training may also be provided by an outside agency/source as necessary.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET

	Individual interview and observation Site review and staff interview	Review a sample of individuals to determine whether individuals can access communication devices such as but not limited to telephone, cell phone, computer, mail in private if wanted. Compare observations and staff reports of communication practices and restrictions if any with a corresponding written rationale, plan and approval to determine whether there is consistency between what is being reported and any written plan.	There is free access to individuals to use communication devices in private or restrictions to such use are in place with plan that has been reviewed and approved per regulation.	There is not free access to individuals to use communication devices in private or restrictions to such use are in place without a plan that has been reviewed and approved per regulation.

INDICATOR	Regulation 5.04 (3) (a-c):	The right to be visited and to visit with others under circumstances that are conducive to friendships and relationships, in accordance with the following requirements: (a) An individual shall be permitted to receive visitors, unless ill or incapacitated to the degree that a visit would cause serious physical or emotional harm; provided that the individual's attorney, guardian, legal or designated representative, personal physician, clergy, or family members shall be permitted to visit at all times, unless the individual objects, and shall be provided with a suitable place to confer on a confidential basis; (b) Reasonable restrictions may be placed on the time and place of the visit in order to protect the welfare of the individual or the privacy of other individuals and to avoid serious disruptions in the normal functioning of the provider. Arrangements shall be made for private visitation to the maximum extent possible; (c) Denial of visitation or restrictions for any reason other than those stated in 115 CMR 5.04 (3) (b), shall be treated as a modification of the ISP, and requires compliance with the regulations governing ISP modifications. The human rights committee shall be notified of the intention to deny or restrict visitation no later the next meeting following the ISP modification meeting or, in the case of the waiver of an ISP modification meeting, at the next meeting following the implementation of the ISP modification.
L53. Individuals can visit with family and friends. **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ☒Placement	**GUIDELINES:**	

☒ABI/MFP Placement ☒Respite	Providers need to assist individuals to visit with family and friends in accordance with their clinical needs and to the extent of their interests and desires.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Site review and staff interview Individual interview Guardian/ family interview	A sample of sites is reviewed, and staff is interviewed regarding visitation patterns and routines. A sample of individuals is interviewed to determine whether individuals understand and are given opportunities to visit with family and friends unless otherwise indicated. A sample of guardians is interviewed to determine whether family and friends understand and are given opportunities visit with individuals unless otherwise indicated.	• Individuals have free access to visit with family and friends • **or** any restriction on visitation in place is in writing and has been reviewed and approved by the ISP team.	• Individuals do not have free access to visit with family and friends • **and/or** there is a restriction(s) on visitation in place without being documented and/or has not been reviewed and approved by the ISP team.

INDICATOR	**Regulation 5.03 (3)(7):**	Privacy, including the opportunity wherever possible, to be provided clearly defined private living, sleeping and personal care spaces …
L54. Individuals have privacy when taking care of personal needs and discussing personal matters.	**CMS § 441.530 Home and Community-Based Setting.(a)(1) (iii)**	Ensures an individual's rights of privacy...
	GUIDELINES: Individuals have the right to privacy. Personal care, provided for or by the individual, must occur in a private space. This means that e.g., among other situations, the bathroom door is shut when in use and that staff assist individuals with	

APPLICABILITY	dressing/undressing in the individuals' bedroom/bathroom. Opportunities are provided for individuals to have private conversations with family, friends, other housemates and staff. Personal information and personal conversations must be kept private and not be posted or discussed.			
All Services	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Staff interview Staff log Individual interview/ observation	A sample of staff is interviewed, and individuals are interviewed/ observed to determine whether individuals understand that they must be afforded privacy when engaging in personal needs or discussing personal matters. Sites are observed to determine whether privacy is supported in practice.	• There is observational evidence that individuals have privacy when taking care of personal needs and discussing personal matters • **and** there is no publicly displayed information about individuals.	• There is minimal observational evidence that individuals have privacy when taking care of personal needs and discussing personal matters • **and/or** there is publicly displayed information about individuals.

INDICATOR		
L55. Informed consent is obtained from individuals or their guardians when required; Individuals or their guardians know that they have the right to withdraw consent.	**Regulation 5.08 (1):**	The informed and voluntary consent of the individual or of a guardian if the individual is incompetent or is not capable of providing informed consent, shall be required in the following circumstances (see regulations for details).
	Regulation 5.04 (2):	(2) The right to be protected from private and commercial exploitation including: the right not to be exposed to public view by photograph, film, video, interview, or other means unless prior written consent of the individual or guardian is obtained for such release; and the right not to be identified publicly by name or address without the prior written consent of the individual or guardian.
	GUIDELINES: This indicator does not cover consents for behavior modifying medications or behavior plans, there are covered in other indicators. Individuals or their guardians need to knowingly and voluntarily give consent and have the opportunity to refuse approval in the following circumstances: • Release of personal information • Involvement in research activities	

APPLICABILITY

All Services

Items covered in this indicator include release of information, and specific photo/media and news release consents whether they are printed, web-based or by other means; these consents need to be issued for situations in which the individuals' picture/ information is being shared. The individual / guardian may give consent to use:

- only one single photo for a specific event, such as an awards ceremony or a conference.
- only one photo for several purposes, such as in a brochure, poster or public display or on the provider's website or on Facebook, Instagram, or Twitter.
- to use many images for one specific purpose, such as any photo of a previous event to get people excited about this year's event.
- to use any photo taken for any purpose, such as for any conference or meeting that comes up, or another event.

Image(s) and/or video(s) posted on the internet can be viewed and downloaded by others and social media posts may be shared or re-tweeted by other accounts once posted by the Provider. Therefore, the individual/ guardian needs to be informed of this possibility, acknowledge this possibility and consent to the same. The consent form itself should clearly outline the parameters for which consent is being requested.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Any consent documentation	Review of sample of required prior written consent documents to determine whether consent was obtained and that provision to withdraw consent was outlined.	Consent such as for photo/media release are present as required.	Consent such as for photo/media release are not present as required.

INDICATOR		
L56. Environmental Restrictive practices intended for one individual that affect all individuals	**Regulation 7.04 (1) (a):**	All providers shall assure that the supports and services they provide to individuals promote the following …. (a) Rights and dignity: Protection and affirmation of the rights of individuals, including but not limited to…. Support of an individual's… freedom of movement both at home and in the workplace… and provision of safeguards whenever limitations are imposed.
	Regulation 5.03 (3) c and d	Services and supports are provided in a manner that promotes: …. (c) self determination and freedom of choice to the individuals' choice and fullest capability. (d) the opportunity to live and receive supports in the least restrictive most typical setting possible
	Regulation 5.14 (1)	…Therefore PBS focuses on environmental modifications and antecedents. The strategies used to modify the behaviors of individuals should involve PBS which promote the dignity and respect of individuals and should not be unduly restrictive or intrusive.
	GUIDELINES:	

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. **APPLICABILITY** All Services	If there are any interventions in place for one person, provision needs to be made to ensure that others in the same location are not unnecessarily subject to restrictions. Any house or site restriction to safeguard a specific individual(s) but not all individuals served at the site (such as a lock on a refrigerator) needs to have a written rationale for the restriction, review by the Human Rights Committee and have practices in place that ensure access for those not requiring the restriction.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Documentation of site restrictions Staff interview Site review	Sample of sites are reviewed to determine whether required reviews have been conducted when restrictions are imposed. Compare observations and staff reports of restrictions with a corresponding written rationale, plan and approval by the HRC. Determine if there are any additional site restrictions without a plan	• Required components are in place • **and** practices are in place to mitigate the restriction for others.	• One or more of the required components are missing when there are restrictions • **and/or** practices are not in place to mitigate the impact of the restriction on others.

INDICATOR	**Regulation 5.14 (8) (a)** ***(current Regs)***	(a) A written PBSP is required for Targeted or Intensive Supports. The PBSP must be designed and written by a PBS qualified clinician. A PBSP should include the elements consistent with guidance provided by the Department.
	5.14(4) (b) 6: ***(previous Regs)***	No intervention may be administered to any client in the absence of a written behavior modification plan.
	GUIDELINES:	

L57. All behavior plans are in a written plan. **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ☒Placement ☒ABI/MFP Placement ☒Respite ☐RSMS ☒Employment Services ☐CBDS	There needs to be a written behavior plan for all restrictive practices and/or negative components (level I or II). Aversive consequences that are part of house rules, teaching programs, etc. need to be spelled out in writing. This is the first step in ensuring that the proper reviews are conducted. Behavior plans do not need to be revised if they are working but do need to be reviewed at least annually by the ISP team, and the data for plans containing level 2 or 3 interventions need to be reviewed at least weekly by the treating clinician. PBS Intensive and Targeted Plans also need to be in writing and include relevant information on implementation and data collection.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Behavior plan documentation Staff log Staff interview	Through staff logs and interviews, determine if any restrictive interventions are implemented without the presence of a written plan. Compare observations and staff reports of restrictions with a corresponding written rationale, and plan.	All restrictive practices and/or negative components are part of a written plan.	There are any restrictive practices and/or negative components that are not part of a written plan.

INDICATOR **L58. All behavior plans contain the required components.**	**Regulation 5.14 (7)** ***(current regs)***	General Principles of Positive Behavior Supports… (c) Targeted and Intensive Supports require a statement of the areas of concern, a functional behavior assessment (abbreviated or informal for Targeted Supports and formal for Intensive Supports) and a written Positive Behavior Support Plan. (d) PBSPs should focus on alternative strategies that address people's needs and provide meaningful choices. PBSPs should document such strategies (e) PBSPs that incorporate restrictive procedures must focus on alternative strategies the elements contained in 115 CMR 5.14(9)(d).
APPLICABILITY ☒24/hr Residential	**Regulations 5.14 (4)(b) 2:** ***(previous regs)***	… No interventions shall be approved in the absence of a determination, arrived at in accordance with all applicable requirements of 115 CMR 5.14 that the behaviors sought to be addressed may not be effectively treated by any less intrusive, less restrictive procedure, would not pose an unreasonable degree of intrusion, restriction of movement, physical harm, or psychological harm.
	Regulation 5.14 (4) (c) 1-5:	Written Plan. All proposed uses of Level II and Level III Interventions for treatment purposes shall be set forth in a written plan which shall contain at least the following: (see guidelines for detail).

☒ABI/MFP 24/hr Residential ☒IHS ☒Placement ☒ABI/MFP Placement ☒Respite ☒CBDS ☒Employment Services	**GUIDELINES:** The Behavior Plan needs to identify: • Target behavior(s) to decrease • Desired positive replacement behavior(s) • Level(s) of intervention(s) • Rationale based on functional analysis of target behavior(s) & antecedents • Less restrictive alternatives/measures tried & that this is least intrusive intervention • Person providing clinical oversight • Procedures outlined for monitoring, documenting & clinical oversight • Criteria for eliminating or revising plan Most of the above components also apply to Level I Plans which include interventions beyond positive reinforcement.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Behavior plan documentation	Sample of behavior plans are reviewed to determine whether they contain all required components.	Plans contain all required components.	Plans do not contain all required components.

INDICATOR		
L59. Behavior plans have received all the required reviews.	**Regulation 5.08** ***(Current Regs)***	d) Prior to the initiation of a targeted or intensive positive behavior support plan, in accordance with 115 CMR 5.14; (e) Prior to the initiation of level III interventions for behavior modification purposes, in accordance with 115 CMR 5.14A (Level III Interventions);
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ☒Placement	**Regulation 5.14 (12 -13)** ***(Current Regs)***	(12)(c) PBSPs containing Intensive Supports shall be submitted for peer consultation to at least one qualified clinician who did not participate in the development of the submission. (13)(a) Positive behavior support plan review. New PBSPs containing restrictive procedures shall be submitted to the program's human rights committee. (c) PBSP Review. The human rights committee's review of an existing PBSP containing restrictive procedures shall occur: 1. upon the introduction of a new procedure; or 2. at least annually.
	Regulation 5.14 (4) (d) 1-6: ***(Previous Regs)***	Review and Approval. In addition to consent requirements stated in 115 CMR 5.14(4)(e) the following reviews and approvals are required prior to the implementation of any Behavior Modification plan involving the use of level II or Level III Interventions: (see guidelines for details).
	GUIDELINES: Behavior plans with restrictive interventions have been reviewed and approved by:	

☒ABI/MFP Placement ☒Respite ☒CBDS ☒Employment Services	• Individual and/or guardian • ISP team • Human Rights Committee • Peer Review Committee (level II and III) • Physician (level II and III) This also includes ensuring that any additional required reviews are followed. For example, that court review substituted judgment has occurred for Level III plans.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Behavior plan documentation	Behavior plan documentation is reviewed for sample of individuals, including dates and times of required reviews to determine whether all required reviews have occurred.	All required reviews have occurred.	One or more of the required reviews has not occurred.

INDICATOR **L60.** Data are consistently maintained and used to determine the efficacy of behavioral interventions. **APPLICABILITY**	**Regulation 5.14 (8)(d)** ***(Current Regs)***	..implementing a formal skill acquisition plan and data collection procedure in order to assess the effectiveness of skill acquisition activities; increasing monitoring of all aspects of the plan; and, initiating more frequent or external reviews of data to insure treatment integrity.		
	Regulation 5.14 (4) (c) 5: ***(Previous Regs)***	… A procedure for monitoring, evaluating, and documenting the use of each Intervention including a provision that the treating clinician(s) who will oversee implementation of the plan shall review a daily record of the frequency of target behaviors, frequency of interventions, safety checks, reinforcement data, and other such documentation as is required under the plan. Such treating clinician(s) shall review the plan for effectiveness at least weekly and shall record his/her assessment of the plan's effectiveness in achieving the stated goals.		
	GUIDELINES: Data are kept consistently. Data are kept on both the target behaviors and the interventions being utilized. Data are cross walked with review of behavioral interventions and changes made to plan as needed.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**

☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ☒Placement ☒ABI/MFP Placement ☒Respite ☒CBDS ☒Employment Services	Behavior plan data documentation Interview with clinician (if employed by the provider)	Review record to determine if data on target behaviors and interventions are kept and utilized to make changes.	• Data are maintained regularly • **and** reviewed as required to determine the plan's efficacy • **and** plans are revised when indicated by data.	• Data are not maintained regularly **and/or** reviewed as required to determine the plan's efficacy • **and/or** plans are not revised when indicated by data.

INDICATOR **L61.** Supports and health related protections are included in ISP assessments and the continued need is outlined. **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS	**Regulations5.12 (1)(a) and (b) (2)(c):**	Health Related Supports and Protective Equipment … (a) Health-related Supports may be used only to achieve proper body position and balance, to permit the individual to actively participate in ongoing activities… (b) Health-related Protective Equipment. (1) Health-related protective equipment used during a specific medical or dental procedure for the individual's protection during the time the individual is undergoing treatment or to prevent injury for an ongoing medical condition. (2) Health related protective equipment used to prevent risk of harm during challenging self-injurious behavior, for example, a helmet or arm splints, may only be used when authorized by a PBS Qualified Clinician. *(see regulations for further limitations)* (c) Providers must assure all health-related supports and protective equipment are: 1. described with specificity in the order authorizing their use or in an intensive PBSP, and 2. are in good repair and properly applied. (2) (a) In accordance with principles of good body alignment, concern for circulation, and allowance for change of position; (b)In accordance with safety checks and opportunities for exercise as specified by the order authorizing their use or in an Intensive PBSP, if the health-related protective equipment is used to prevent harm during challenging self-injurious behavior qualified professional, and, if applicable, set forth in the individual's ISP; and (c)(d) With documentation as to the frequency and duration of use.
	GUIDELINES: Health-related Supports are devices and equipment used to achieve proper body position, balance, or alignment; to prevent reinjury during healing or prevent infection; to permit active participation in activities without risk of harm; or to enable evacuation	

☒Placement ☒ABI/MFP Placement ☒Respite ☒CBDS ☒Employment Services	of an individual. Health-related Protective Equipment are devices and equipment generally applied to the individual to prevent self-injury. At a minimum, information on the Health-related Protective device needs to include: Reason for use/ rationale Authorization by a Qualified Clinician Least restrictive alternatives previously utilized Details as to how and when (frequency and duration) used Frequency of safety checks Maintenance and cleaning instructions Conditions for modification and discontinuance HEALTH-RELATED SUPPORTS include but are not limited to: Achieve proper body position and balance • Ambulation devices and accessories • Wheelchairs, shower chairs, commodes, walkers, canes, crutches, gait belt, wheelchair accessories, including seatbelts, harness, lap trap, foot strap, head immobilizer. Orthopedically prescribed appliances (Orthotics) • Braces with straps for back, neck, hip, knee, wrist, ankle (AFOs); Elastic supports for knee, wrist, elbow, ankle Prosthetics • Artificial limbs Sensory Aids • Hearing aids and glasses Therapeutic Footwear • Shoes manufactured for foot deformities, or conditions. Shoes with lifts, built-up heels, or cushioned insoles to prevent skin breakdown (diabetic shoes) Prevent injury during healing; prevent infection • Surgical dressings, bandages, casts, walking boot Permit active participation in activities without risk of harm • Protective Gear • Helmet for seizure disorder • Hospital bed and accessories such as bedrails • Transfer lifts (Hoyer) Other • Medically-ordered compression stocking (TEDs, Jobst stockings). Enable evacuation of individual HEALTH-RELATED PROTECTIVE EQUIPMENT Protective equipment to prevent self-injury • Helmet for self-injurious behavior, protective mitts, gloves, protective sleeve, arm splint

to prevent SIB or aggression.

Any health-related protective equipment needs to be authorized for use and if used for behavioral reasons, included within an intensive PBS plan. The health- related protective equipment should be referenced in the ISP. Documentation on the use of a health-related protective equipment needs to include the following elements: purpose; specificity of use (frequency and duration); safety checks; cleanliness.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Health related supports and protective equipment documentation (individual record, ISP) Staff communication log	Review information for sample of individuals that have a health-related support and protective equipment to determine if the continued need is outlined. Review staff log to determine if any health-related supports and protective equipment is utilized without required approval.	• Health related supports and protective equipment are authorized with completion of components for use and • • Are utilized appropriately **and** the continued need is outlined.	• Health related supports and protective equipment are not authorized and do not include one or more components of the criteria for use and • • Are not utilized appropriately **and/or** the continued need is not outlined.

INDICATOR		
L62. Supports and health related protections receive the required reviews.	**Regulation 5.12 (1)(a):**	(a) Health-related Supports may be used only to achieve proper body position and balance, to permit the individual to actively participate in ongoing activities without the risk of physical harm from those activities, to prevent re-injury during the time that an injury is healing or to prevent infection of a condition for which the individual is being treated, or to enable provider staff to evacuate an individual who is not capable of evacuation.
	Regulations 5.12 (1)(b)(2) (2) (b)	Health-related Protective equipment used to prevent risk of harm during self-injurious behavior may only be used as part of an Intensive PBSP and is subject to human rights committee review. (2)(b) if applicable, set forth in the individual's ISP
APPLICABILITY	**Regulations 3.09 (1)(b) 2**	Protection of Human Rights/Human Rights Committee The committee shall have the following duties... 1.To monitor and review the authorization and use of all emergency restraints and other limitations on movement in accordance with 115 CMR 5.04 and 5.05…
☒24/hr Residential	**GUIDELINES:** The support or health related protection as implemented needs to be referenced within the ISP if applicable. Protective equipment which is used to prevent risk of harm during self-injurious behavior needs to be included within an Intensive PBS	

☒ABI/MFP 24/hr Residential ☒IHS ☒Placement ☒ABI/MFP Placement ☒Respite ☒CBDS ☒Employment Services	plan. Although not required when the reason for use is medical, Providers are highly encouraged to seek human right's input for Health related supports and protective equipment that are medical oriented since they are mandated to incorporate behavioral supports in PBSP which are reviewed by HRC.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Health related protection documentation (individual record, ISP) Staff communication log	Review information for sample of individuals that have a health-related protective equipment or support to determine if required reviews have occurred. Review staff log to determine if any health-related protection is utilized without required reviews.	Review by the HRC of any Health-Related Protective equipment used for self-injurious behavior and included in an Intensive PBS Plan has occurred.	Review by the HRC of any Health-Related Protective equipment used for self-injurious behavior and included in an Intensive PBS Plan has not occurred

INDICATOR	**Regulation 5.15 (4) (a and b) (1-4):**	(a) Medication used to manage or treat challenging behavior shall be administered in accordance with the recommendations of the prescribing health care provider and contained in a medication treatment plan referencing the individual's PBSP, if appropriate. (b) The medication treatment plan shall contain at least the following: 1. a description of the behavioral symptoms to be managed or treated; 2. information concerning the common risks and side effects of the medication, procedures to minimize such risks, and description of clinical indications that might require suspension or termination of the drug therapy; 3. monitoring data pertaining to the target behavior, including goals, and target behavior prior to and subsequent to the administration of the medication(s), such that the individual's clinical course may be evaluated;
L63. Medication treatment plans are in written format with required components.		

APPLICABILITY		
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Placement ☒ABI/MFP Placement ☒Employment Services ☒CBDS		4. data tracking of all relevant effects of the treatment with the medication(s), including secondary effects such as weight gain or loss and changes in sleep patterns; and
	Regulation 5.15 (5) (a-e) :	Medication Incidental to Treatment. (b) ISPs should incorporate objectives to assist individuals that receive medication incidental to treatment to learn to cope with medical treatment in order to reduce or eliminate the need for medication incidental to treatment. (c) (e) Medication may be prescribed PRN for treatment purposes. For non-self-administering individuals who are prescribed medication PRN for treatment, the program shall obtain from the prescribing practitioner: a statement of specific criteria, in the form of observable symptoms, for determining when the medication is to be administered.

GUIDELINES:

If the individual is prescribed any medication to modify behavior, including but not limited to, medications for sleep or medication for depression the ISP contains:

- Description of behavior to be controlled/modified
- Data tracking necessary for ongoing monitoring such that the individual's clinical course may be evaluated
- Information about side effects, procedures to minimize risks and clinical indications for terminating the drug
- If the individual is prescribed any medication to calm or relax him or her during medical treatment, the ISP contains:
- Plan to reduce or eliminate the need for medication

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Medication information ISP/Individual Record	Individual medication information is reviewed to determine if medication to control or modify behavior is utilized. If medication is used to control or modify behavior confirm that there is a written plan in place with the required components through a review of the ISP and individual record.	Written treatment plans with all required components are present.	One or more of the required components is missing from the treatment plan.

INDICATOR		
	Regulations 5.15 (4)(a) and (b)	The presence of a medication treatment plan should be noted at the next annual individual support planning meeting.

L64. Medication treatment plans are reviewed by the required groups.		(4)(b)(5) in the case of antipsychotic medications only where there is a court order specifying the treatment unless the individual is capable of giving informed consent for such treatment and has given consent or a medical emergency exists.		
	Regulation 5.15 (5)(a)	Medication Incidental to Treatment. (a) Administration of medication incidental to the treatment requires the consent of the individual or guardian, except in a medical emergency.		
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Placement ☒ABI/MFP Placement ☐Employment Services ☐CBDS	**GUIDELINES:** Both medication treatment plans and medication to calm or relax during medical procedures need review by the ISP team. Any medications used to control or modify behavior, such as medications prescribed to decrease agitation, need to receive the required reviews.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Medication information Individual Record/ISP	Individual medication information to determine if any medication is used to modify behavior or calm or relax during medical treatment. If medication is used to modify behavior or calm or relax during medical treatment, confirm that the required reviews through the ISP process have been conducted.	Medications used to modify behavior or calm or relax during medical treatment have the required reviews.	Medications used to modify behavior or calm or relax during medical treatment do not have the required reviews.

INDICATOR **L65.** Restraint reports are submitted within the required timelines.	**Regulation 5.11 (1) (c: iii), (d: i, ii, iii):**	Documentation Requirements. … Each provider shall ensure that a restraint form is completed on each occasion when an individual is placed in restraint … (See regulations for details.)
	GUIDELINES:	

APPLICABILITY	It is important that restraint information be reported in a timely and accurate way. The initial report must be completed within 3 calendar days of the restraint. The submission and finalization of the restraint report must be completed within 5 calendar days of the restraint.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
☒24/hr Residential ☒IHS ☒Placement ☒Respite ☒Employment Services ☒CBDS	Restraint Forms Staff Log Incident Reports	HCSIS report of restraint forms is reviewed to determine if timelines were met. Review staff logs and incident reports for locations to determine if any restraints were applied that were not reported.	Restraint forms meet identified timelines **and** there were no identified restraints that were not documented.	Restraint forms did not meet identified timelines **and/or** there were identified restraints that were not documented.

INDICATOR	**Regulation 5.11 1 (d) (c):**	Restraint forms shall be reviewed by the provider's human rights committee.		
L66. All restraints are reviewed by the Human Rights Committee.	**GUIDELINES:** Restraint forms need to be provided to the Human Rights Committee for their review. The Human Rights Committee must review the restraint at the next meeting following the restraint or not later than 120 calendar days of the restraint.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
APPLICABILITY ☒24/hr Residential ☒IHS ☒Placement ☒Respite ☒Employment Services ☒CBDS	Restraint forms Administrative Interview Human Rights Committee minutes	A HCSIS report of restraints is reviewed to determine if the restraint forms are reviewed by the Human Rights Committee within the required timelines (within 120 calendar days. If the HCSIS report indicates that restraint reports were not reviewed by the Human Rights Committee in a timely	Restraints were reviewed by the human rights committee within the required timeframes (either at the next meeting or within 120 days of the restraint).	One or more restraints were not forwarded to the human rights committee **and/or** restraints are not reviewed by the committee within the required timeframes (either at the next meeting or within 120 days of the restraint).

		manner, this is further reviewed during the administrative interview and in a review of the committee minutes.		

INDICATOR	Regulation 5.10 (3) (c) 4:	A plan for shared or delegated management responsibilities shall be accompanied by a training plan,… to eliminate the need for such assistance, unless it is established by clinical evaluation that the individual cannot learn how to manage or spend any portion of his or her funds, even with supports.		
L67 There is a written plan in place accompanied by a training plan when the agency has shared or delegated money management responsibility. **APPLICABILITY** ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ☒Placement ☒ABI/MFP Placement ☒Employment Services ☒CBDS	**GUIDELINES:** When staff hold an individual's money and provide support in the use of their funds, there needs to be a shared and delegated money management plan for the money management responsibilities which includes a training plan to eliminate or reduce the need for assistance unless there is a clinical evaluation that the individual cannot learn how to manage or spend his or her funds. There needs to be agreement to the plan by the individual, guardian or conservator. The plan needs to establish the personal spending money which can be managed by the individual and specify the agency's responsibilities in its role. It is important that the training plan contain the required components and foster increased independence on the part of the individual in the management of his/her money. Providers need to support individuals to actively participate and develop skills in the management of money on both a daily and long-term basis, such as in provision of assistance in long term planning, budgeting and bill-paying activities. Training plans need to be utilized as effective tools to promote individuals to become more involved and independent. It is only in the event that a clinical evaluation determines that the individual cannot learn to manage or spend his/her money (any portion) and would not benefit from a training plan, that this will not be present. The ISP team, in lieu of one specific clinician, can review the individuals' need for training in the area of financial management.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Money management plan review Individual Support Plan	A sample of individuals is reviewed for whom the provider has shared or delegated money management responsibilities to determine whether there	• A shared or delegated money management plan is in place • <u>and</u> Training plan is present (unless clinically contraindicated) • **<u>and</u>** there is a plan to reduce or eliminate assistance or clinical evaluation	• A shared or delegated money management plan is not in place when needed and/or • Training plan is not present • **<u>and/or</u>** no plan to reduce or eliminate without clinical evaluation

	DDS Financial Assessment Staff logs Individual interview	is a training plan with the required components.	• **and** agreement is present as required.	• **and/or** agreement has not been obtained.

INDICATOR	Regulation 5.10 (3) (c) 1-2:	Individuals' funds shall not be applied to goods or services the provider is obligated by law or funded by contract to provide. The provider or provider staff may not…. expend or borrow the funds of any individual for the use of anyone other than that individual.		
L68. Expenditures of individual's funds are made only for purposes that directly benefit the individual.	**GUIDELINES:** When the agency is the Rep Payee and / or staff hold an individual's money and provide support in the use of their funds, expenditures must be made only to directly benefit the individual. Individuals' money cannot be used for such things as paying for staff or buying items for the house that the agency should be providing. The provider needs to have a system of financial protection, monitoring, and reimbursement in place in the event that funds are erroneously expended for something that does not directly benefit the individual.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ☒Placement ☒ABI/MFP Placement ☒Respite ☒Employment Services ☒CBDS	Review of money expenditure documentation (Rep payee and cash on hand) Agency funds management policies and procedures Individual interview and observation	Review identified individual's Financial Transaction Record information and personal cash on hand for three months to determine that individual money is used only to benefit the individual. Documentation for the past year needs to be available from which the surveyor chooses 3 months to audit.	Individuals' funds are used only to directly benefit the individual.	Individuals' funds are utilized to pay for items that do not directly benefit the individual.

INDICATOR	Regulation 5.10 (3) (c) 6:	A record shall be kept of every transaction, including the date, amount received or disbursed, the manner in which funds were managed or expended, identification of involved parties, and receipts for expenditures exceeding $25.00.		
L69 Individual expenditures are documented and tracked.	**GUIDELINES:** When staff hold an individual's money and provide support in the use of funds, they need to document and track all expenditures, maintaining receipts for purchases over $25. Although receipts for purchases less than $25 are not required, staff need to be aware of spending habits so as to limit individuals' exposure to financial exploitation. An individual's money might also include food stamps, pay checks and gift cards.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS● ☒Placement ☒ABI/MFP Placement ☒Respite ☒Employment Services ☒CBDS	Review of funds expenditure documentation Documentation should include bank books and check books in addition to transaction logs Agency funds management policies and procedures	Review identified sample of individuals' funds to determine whether receipts over $25 are kept and funds are tracked accurately. Documentation for the past year needs to be available from which the surveyor chooses 3 months to audit.	• Funds are tracked with receipts • **and** are received and disbursed are documented accurately and timely.	• Funds are not tracked accurately, • **and /or** receipts are not available • **and /or** tracking is not accurate and/or timely.

INDICATOR	Regulations 3.05 (5) (e-g)	Determination of Charges: For an individual receiving recurrent payments other than earned income, the monthly fee-pay or charge shall be an amount equal to 75% of the individual's recurrent payments received in the month for which the charge for residential services and supports accrued … For an individual receiving earned income only, the monthly fee-payor charge shall be an amount equal to 50% of earned income that exceeds $65 in the month the charge for residential services and supports accrued…
L70. Charges for care are calculated appropriately	**GUIDELINES:** Charges for Care are calculated as required. Notification of charges is conducted annually with adjustments as necessary.	
APPLICABILITY	At Placement Service homes, room and board may be charged rather than Charges for Care.	

	INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☐IHS ☒Placement ☒ABI/MFP Placement ☐Respite	Charges for Care documentation such as benefit or entitlement letters, employment paystubs, etc.	Review of the individual's Charges for Care to determine that they have been calculated as required by regulation.	Charges for care are calculated and documented as required by regulation.	Charges for care are not calculated and documented as required by regulation.

INDICATOR		
L71. Individuals are notified of their appeal rights for their charges for care.	**Regulation 5.10 (3) (c) 8:**	… These charges shall be treated as any other significant debt of the individual, to be collected only after an appropriate explanation and written billing, including notice of means available to contest the charges for care…
	GUIDELINES: Individuals and guardians are informed of their right to appeal their charges for care or room and board charges. Individuals and guardians need to be informed of their appeal rights in writing and a copy of this entered into the individual's record.	

APPLICABILITY	INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☐IHS ☒Placement ☒ABI/MFP Placement ☐Respite	Charges for Care documentation	Documentation is reviewed for individuals and guardians to determine if they have been informed of their right to appeal their charges for care.	Individuals and guardians have been informed of their appeal rights.	Individuals and guardians have not been informed of their appeal rights.

INDICATOR	Regulations 7.04 (1) (f) 8:	… comply with state and federal wage-hour requirements when individuals engage in any work which must be compensated;		
L72. Sub-minimum wages earned are paid in accordance with Department of Labor (DOL) requirements for compensation. **APPLICABILITY**	**GUIDELINES:** Wages are in accordance with DOL requirements.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Day service time studies and DOL documentation. Payroll and time records.	DOL documentation is reviewed to determine if DOL rates are being computed and wages are earned in accordance with DOL standards.	• DOL wage and hour requirements are being computed correctly • **and** wages are earned in accordance with DOL standards.	• DOL wage and hour requirements are not computed correctly • **and/or** wages are not earned in accordance with DOL standards.

INDICATOR	Regulations 7.04 (1) (f) 8:	… comply with state and federal wage-hour requirements when individuals engage in any work which must be compensated;		
L73. The provider has a current DOL certificate. **APPLICABILITY**	**GUIDELINES:** Current federal and state DOL Certificates need to be in place.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	DOL documents	Review to determine if there is current DOL certificates for the program.	Current DOL certificates are present.	Current DOL certificates are not present.

COMPETENT AND SKILLED WORKFORCE

INDICATOR		
L74. The agency screens prospective employees per requirements.	**Regulations 7.05 (1) (a)(1)(2):**	(a)(1) Screening of Provider Staff and Care Providers.1. All providers shall comply with applicable federal and state labor laws and not engage in discriminatory employment practices. (2) All providers shall comply with all required Criminal Offender Record Checks.
	Regulation 7.05 (4):	All providers of supports and services unless specifically exempted by law or regulations, shall be subject to the following requirements:(All providers shall have current staff job descriptions that describe the education, skills, and experience required of staff to meet the standards set forth in 115 CMR 7.04.

APPLICABILITY

All Services

GUIDELINES:

The agency has a process for interviewing prospective employees, check references and qualifications for the particular job, as needed, so as to hire qualified staff.

Note: effective as of 7/1/14, DDS began to license ABI/ MFP residential and placement services. MRC required, and DDS will continue to require staff serving individuals in ABI/ MFP residential habilitation or placement services, to abide by certain additional screenings. The agency is required to screen ABI/ MFP employees against the List of Exclusionary Individuals and Entities (LEIE). The agency is also required to ensure that all ABI/ MFP staff are TB screened upon hire and every two years thereafter. Lastly, ABI/MFP staff whose job requires driving must be screened to ensure that he/she has a valid current driver's license.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Review of agency system Job descriptions Resumes	Compare the hiring requirements against new hire information to determine whether employees met applicable provider and DDS requirements. For ABI/MFP services, look for an annual attestation from the agency that LEIE reviews and TB testing was done for all ABI/MFP employees. For ABI/ MFP services, look for policy and procedure for screening staff to ensure that the agency screens everyone who drives as part of their job and that he/she	Staff were hired in accordance with requirements. When ABI/ MFP services are in place, rating in this indicator is a combination of whether the attestations are in place and # employees successfully screened over the number of items reviewed.	• Staff did not meet requirements • **and/or** screening did not occur.

		has a valid current Driver's license.		

INDICATOR	Regulations 7.05 (1)(a)(3):	3. All providers arranging or providing professional services or consultation shall assure that such professionals are licensed, certified, or registered as required by law to provide such professional services to the public.		
L75. The agency assures that staff have the required qualifications and certifications to do the job as applicable.	**GUIDELINES:** • There must be systems in place to assure that all staff have the necessary qualifications and certifications specific to the job description to support the individuals for whom they are responsible. • There should be applicable state licensure and certification requirements for specific professional designations and agency policies relative to staff qualifications. The agency needs to have a process to ensure that applicable licenses, certificates, and professional designations are renewed as necessary and remain current.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
APPLICABILITY All Services	Agency system Hiring, training, licensure, and certification information	The agency personnel system is reviewed to determine how the agency ensures they have qualified staff to support individuals. Applicable licensures for employees such as Nursing and Psychologists are checked to assure that they are present and current.	Staff have the required qualifications.	Staff do not have the required qualifications.

INDICATOR	Regulations 7.05 (a-i)	(6) Training. All providers shall meet the following training requirements for staff, relief staff and care providers except as otherwise noted in 115 CMR 7.05(6). (a) Training in the reporting of actual or suspected abuse, neglect, or omission as specified in M.G.L. c. 19C and 115 CMR 9.00: Investigations and Reporting Responsibilities. (b) Training in the reporting of incidents as required in 115 CMR, (c) Training in the implementation of positive behavioral supports and the requirements in 115 CMR 5.00: Standards to Promote Dignity. (d) For staff, relief staff and care providers who may be expected to use restraint, training on the requirements in 115 CMR 5.11: Seclusion, Locked Buildings, and Emergency Restraint and on the
L76. The agency has and utilizes a system to track		

required trainings. **APPLICABILITY** All Services		appropriate use of restraint using a curriculum approved by the Department. (e) For non-licensed staff who will be administering medication at a site that is required to be registered as a Medication Administration Program (MAP) site, training on the requirements of 115 CMR 5.15: Medication and on the safe administration of medications and are MAP certified. (f) Training in first aid. (g) Training in cardiopulmonary resuscitation (CPR) for all staff at every site providing 24 hour residential supports, employment supports, day supports or 24 hour site based respite supports. 115 CMR 7.05(6)(g) shall not apply to residential sites providing less than 24 hour supports. (h) Training in all aspects of the safety plan for sites required to have safety plans under 115 CMR 7.06(3). (i) At least one staff person trained in fire safety by an approved fire safety training agency, local fire department or from the Department shall be present at every site where residential supports, day supports or 24 hour site based respite services are provided. All other staff and care providers are trained in basic fire safety.

GUIDELINES:

There is a set of required trainings that all staff need to have. These baseline trainings are necessary regardless of the individuals a staff person supports. Additionally, there are trainings when one person per location needs to be trained. There needs to be a system that ensures staff have completed all trainings as required. Mandated trainings include some trainings that one person per location is required to receive (e.g. formal fire safety) as well as those trainings that all staff are required to have (e.g. first aid, fire safety, CPR, abuse and mistreatment). Finally training on specific topics is required depending on staff role (e.g. MAP; HRO) staff role. Mandated trainings reviewed as part of this indicator also include:
Universal Precautions, Transmission Precautions, Incident Reporting, and PBS. Please refer to the updated Provider Mandated Training information posted on DDS learning.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Agency system – administrative office Review of required trainings – at agency offices or on-site	Agency system for tracking required trainings and a sample of training records are reviewed to determine that the agency has an effective tracking system, and that mandated trainings are current. In addition, mandated trainings need to be conducted at the frequency and within the timelines required.	• The agency has an effective tracking system • **and/or** all required trainings being completed within identified timelines.	Required trainings have not been completed within identified timelines.

INDICATOR	**Regulation 7.05(1) (a) 1-5:**	(2) Staff Qualifications. All providers shall assure that the number, organization and qualifications of staff meet the training, care, support, health, safety, and evacuation needs of the individuals supported by the

L77. The agency assures that staff are familiar with and trained to support the unique needs of individuals.		provider. This shall be determined by all of the following:(a) The provider's ability to meet the objectives in the ISP of each individual while promoting independence and skill development.(b) The provider's ability to assist each individual to achieve the stated outcomes as set forth in his or her ISP.(c) The provider's ability to meet environmental, safety, administrative, and service delivery requirements as set forth in 115 CMR 7.07.(d) The provider's ability to develop and competently execute safety plans for all individuals at the location(s) where supports and services are provided as required in 115 CMR 7.06.		
APPLICABILITY All Services	**GUIDELINES:** Beyond the trainings required for all staff regardless of the individuals they support, it is important that staff are knowledgeable concerning the specific and unique needs that individuals they are supporting have. Staff have read the individuals' ISPs and have had training on any of the unique needs of each individual they are supporting. For example, training in such topics as seizures, Deaf culture, and cerebral palsy may be indicated.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Staff interview Training documentation	A sample of staff are interviewed to determine their knowledge of the individuals they support and what their role is in supporting those individuals. Training documentation for a sample of staff is reviewed.	Staff can describe each person they support and their specific needs and have received the requisite information / training.	Staff do not have a clear understanding of each person they support and their specific needs and/or have not received the requisite information / training.

INDICATOR **L78.** Staff are trained to safely and consistently implement restrictive interventions.	**Regulation 7.05(6)c**	Training in the implementation of positive behavioral supports and the requirements in 115.CMR 5.00; Standards to Promote Dignity.		
	Regulation 5.14 (4) C (6)	The responsibilities of the PBS Leadership Team shall include… 6. providing PBS training, coaching and oversight to staff within the organization.		
	GUIDELINES: Staff have been trained in any restrictive behavioral interventions. Documentation confirms that plans have been implemented correctly, consistently and safely.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**

APPLICABILITY				
All Services	Staff training documentation Staff interview Behavior Plan Information	Sample of staff training is reviewed to determine if staff have been trained. Staff are interviewed to assess whether they understand how to implement any restrictive interventions. Behavior plan information is reviewed to determine if plan is implemented as written.	Staff have been trained to safely and consistently implement restrictive interventions.	Staff have not been trained to safely and consistently implement restrictive interventions.

INDICATOR				
L79. Staff are trained in safe and correct administration of restraint.	**Regulation 5.11 (1) (b) (1):**	Providers utilizing CPRR shall ensure that all direct care staff providing supports to an individual who has a Behavior Safety Plan are trained in the Department approved CPRR curriculum adopted for use by the Providers Leadership team....		
	GUIDELINES: It is critical that when the use of restraint is necessary, staff have the requisite training to assure its safe utilization. A list of approved restraint training is available through DDS CPRR committee. Training is either provided by the CPRR approved agency or by provider staff who are CPRR trainer in this DDS approved curriculum.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
☒24/hr Residential ☒IHS ☒Placement ☒Respite ☐RSMS ☒Employment Services ☒CBDS	Staff training documentation HCSIS restraint forms HSCIC forms regarding associated injuries with restraints Staff Log	Training documentation reviewed to determine if staff have been trained in administering restraints using an approved curriculum. Restraint forms in HCSIS are reviewed to determine whether all restraints were applied by staff trained in a DDS approved curriculum.	Applicable staff are trained in a DDS approved curriculum.	Applicable staff are not trained in an DDS approved curriculum.

		Staff log reviewed to determine whether there have been any instances of restraint not documented as required.		

INDICATOR	Regulation 7.04 (1) (f):	… promote optimal health of the individual by arranging for coordinated routine, preventive, specialty, and emergency health care, professional clinical services; make first aid supplies available; and assure prompt and appropriate response by staff to emerging health care issues.		
L80. Support staff are trained to recognize signs and symptoms of illness. **APPLICABILITY** All Services	**GUIDELINES:** Staff are often the first line of defense for individuals, particularly for individuals who may not be able to describe their symptoms of illness. It is critical, therefore, that staff are knowledgeable about general signs and symptoms of illness. There are two training modules/ topics that staff are expected to be knowledgeable in: o Health observations o Just not right			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Staff Interview Staff Log	A sample of staff is interviewed to determine if they have an understanding of the signs and symptoms of illness, such as fever, sudden acute pain, etc. Staff log is reviewed to determine the presence of any instances where staff did not respond as needed to signs and symptoms of illness.	• Staff demonstrate knowledge • **and** there are no identified instances of a lack of an appropriate response.	• Staff do not demonstrate knowledge • **and/or** there are identified instances of a lack of an appropriate response.

INDICATOR	Regulation 7.04(1) (f):	… promote optimal health of the individual by arranging for coordinated routine, preventive, specialty, and emergency health care, professional clinical services; make first aid supplies available; and assure prompt and appropriate response by staff to emerging health care issues…
L81. Support staff know what to do in a medical emergency.	**GUIDELINES:** Staff respond correctly to medical emergencies. Medical emergencies generally consist of acute episodic events that require intervention. For example, high fevers, cuts, injuries, and choking are a few of the types of situations that might require staff to seek outside assistance. There is no specific definition of a medical emergency. The providers need to follow general procedures for medical emergencies that typically occur. In addition, the agency needs to ensure that individual considerations are also taken as the same symptoms for one person may constitute a medical emergency for someone else. For example, a fever of 100 degrees may be more significant and alarming for someone whose typical body temperature runs around 96 degrees. Guidelines issued by Public Health agencies regarding training and protocols for responding to medical emergencies should be followed.	
APPLICABILITY All Services		

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Any policy, procedure, or protocols which outline what constitutes a medical emergency and what staff are instructed to do when these occur (e.g. call PCP; go to ER, etc.) HCSIS reports Staff Interview Staff Log	Practices at the location are reviewed to determine whether these are consistent with provider protocols. A sample of staff is interviewed to determine their knowledge of what to do in an emergency. Staff log reviewed for any instances of inappropriate response to an emergency. The presence and adequacy of first aid supplies are determined.	• Staff demonstrate knowledge, • **and** there are no identified instances of inappropriate response • **and** Staff are fully implementing all provider protocols and are responsive to medical emergencies.	• Staff do not demonstrate knowledge, • and/or there are identified instances of inappropriate response • **and/or** Staff are not fully implementing all provider protocols and there are instances when the provider/staff was not responsive to medical emergencies.

INDICATOR	Regulation 5.15 (5): …	For non-self-medicating individuals, prescription medication shall be administered by licensed professional staff, provided, however, that for non-self-medicating individuals receiving services in the community, prescription medication may be administered by community program staff who have successfully

⚐ **L82.** Medications are administered by licensed professional staff, MAP certified staff (or authorized PCA staff) for individuals unable to administer their own medications. **APPLICABILITY** ☐24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ♦● ☒Respite ☒Employment Services ☒CBDS		completed the Department approved Medication Administration Program training and have been certified by the Department in accordance with 105 CMR 700.003(F)(2): *Training*		
	GUIDELINES: There is documentation that for non-self-medicating individuals, prescription medication is administered by licensed professional staff, PCA staff or by MAP certified staff. For PCAs, there is documentation of an assessment of need for assistance and authorization from MassHealth.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	License/MAP certification documentation Medication review	Documentation of required training is reviewed to determine that certification is present as needed. Medications for the individuals in the sample are reviewed to determine if medication was administered by licensed, certified or PCA staff. There must be a separate storage and documentation when medication is administered by anyone other than licensed/MAP certified staff.	Staff administering medication have required license or MAP certification or are PCA staff.	Staff administering medication do not have required license or MAP certification and are not PCA staff working for the person.

INDICATOR **L83.** Support staff are trained in human rights. **APPLICABILITY**	**Regulation 7.05 (6)(a):**	Training in the reporting of actual or suspected abuse, neglect, or omission as specified in M.G.L. c. 19C and 115 CMR 9.00: *Investigations and Reporting Responsibilities.*
	Regulation 7.05 (2)	All providers shall assure that the number, organization and qualifications of staff meet the training, care, support, health, safety, and evacuation needs of the individuals supported by the provider.
	Regulation 3.09 (3) b	The head of every provider subject to 115 CMR 3.00 shall for each location where services are provided, and the head of every specialized home care placement agency subject to 115 CMR 5.00 shall designate and empower a person employed or affiliated with the provider or agency to serve as the provider's or agency's human rights officer and to undertake the following responsibilities as a

All Services		formal component of his or her job description for the provider or agency: … (b) Under the general direction of the human rights coordinator and with technical assistance of the Department, to develop and implement means: 1. to inform the staff, individuals served, and their families of the individuals' rights,…		
	GUIDELINES: Staff are trained and knowledgeable of individual rights including basic rights and what constitutes mistreatment. Staff need to be trained in reporting responsibilities to DPPC for abuse and mistreatment. Often Human Rights training is provided in concert with Abuse and Mistreatment training.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Training documentation	A sample of training documentation is reviewed to determine whether required training has occurred. Training includes individual rights and what constitutes mistreatment as well as DPPC reporting responsibilities. DDS Mandated Reporter Training or a Training in a DDS Approved Curriculum is required.	Documentation of DDS Mandated Reporter training is present.	Documentation of DDS Mandated Reporter training is not present

INDICATOR **L84.** Staff are trained in the correct utilization of health-related protections per regulation. **APPLICABILITY**	**Regulation 7.05 (2):**	All providers shall assure that the number, organization and qualifications of staff meet the training, care, support, health, safety and evacuation needs of the individuals supported by the provider		
	GUIDELINES: Staff are trained, knowledgeable and capable of safely implementing any health related protections.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Staff Interview	Staff are interviewed to assess their understanding of how to safely and effectively implement health related protections authorized in individual's ISP.	Staff demonstrate understanding of safe implementation as referenced through ISP. There is evidence that implementation correctly occurred.	Staff lack knowledge of safe and effective implementation and/or there is information available that implementation was not correctly performed.

☐24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Respite ☒Employment Services ● ☒CBDS●				

INDICATOR	Regulation 7.05 (3) (a-c):	All providers shall have adequate staff as determined by all of the following: (a) The skills demonstrated by staff in helping individuals to achieve outcomes identified in the individual's ISP… (b) The level of ongoing supervision that supports staff in increasing their skills and ability to assist individuals supported by the provider. (c) The ongoing staff development and training activities that are provided.		
L85. The agency provides on-going supervision and staff development. **APPLICABILITY** All Services	**GUIDELINES:** Staff receive supervision in ways determined by the provider that ensure staff are competent to support individuals to achieve ISP goals and outcomes that support increased skills and ability to support individuals. The agency has a process in place that supports the retention of qualified staff. This may include supervision, training, opportunities for further education, staff evaluations etc. The agency has a process for annual, and as needed performance evaluations and follow-up on personnel issues. The agency needs to have an orientation for new employees as well as options for additional trainings. The agency is expected to ensure that policies and procedures and systems that are established on an agency-wide basis, are being implemented across each location. Often agencies have established protocols and procedures in the following areas: money management, medication administration, maintenance and repair, health care, communication, human rights, staff training, supervision, and individual support strategy implementation. Monthly financial audits of homes, medication reviews, and frequent reviews to ensure compliance with recent Public Health or other directives, individual supervision, and monthly group staff meetings need to be established to ensure that direct support staff receive the ongoing support and supervision to perform their job duties.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Administrative interview	Review of policies and procedures and administrative interview to determine the presence of a	• The agency has a system of ongoing supervision that is being followed	• The agency does not have a system of ongoing supervision

	Administrative documentation including performance evaluation forms and process Staff Interview Staff Log	supervisory structure, frequency and expectations for supervision and expectations for staff development. Compare the expectations (e.g. weekly supervision or monthly group staff meetings), to what is occurring.	• **and** Agency monitoring systems effectively identify areas for improvement and positive changes/ corrections are made as a result of this monitoring.	• **and/or** it is not being consistently followed. **and/or** Agency monitoring systems do not effectively identify areas for improvement and /or positive changes/ corrections are not made.

GOAL DEVELOPMENT AND IMPLEMENTATION

INDICATOR	Regulation 6.21 (6) (a):	The responsibilities of the provider in the ISP process are to complete assessments or professional consultations of the individual that are within the legal or contractual responsibility of the provider …		
L86. Required assessments concerning individual needs and abilities are completed in preparation for the ISP.	**GUIDELINES:** The completion of assessments are critical to the development of objectives and supports that address the needs of the individual. Assessments must be submitted at least 15 days in advance of the ISP meeting. Required assessments include an assessment of the general type of supports needed by the individual, of the individual's ability to make informed decisions regarding financial & personal affairs & of financial status eligibility for services or benefits from other entities. DDS funded supports conduct safety assessment & other assessments required by their contract. Residential provider ensures annual health & dental assessments occur.			
APPLICABILITY	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ☒Placement ☒ABI/MFP Placement	Individual Record	The individual records are reviewed for presence of ISP assessments and date of submission.	• Required assessments are present • **and** submitted at least 15 days in advance of the ISP.	• One or more required assessments are not present • **and/or** not submitted within required timelines

☒Employment Services ☒CBDS ☒RSM				

INDICATOR	Regulation 6.21 (6) (c):	Within 15 days of the ISP meeting, to develop and forward to the service coordinator for incorporation into the ISP, strategies for the provision of the supports identified during the ISP meeting.		
L87. Support strategies necessary to assist an individual to meet their goals and objectives are completed and submitted as part of the ISP.	**GUIDELINES:** The submission of support strategies by the provider designed to assist an individual to achieve agreed upon objectives is an important component of the ISP. They must be submitted within 15 days of the ISP meeting.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ☒Placement ☒ABI/MFP Placement	Individual Record	The individual record is reviewed for the presence of support strategies and date of submission.	Support strategies are submitted within required timelines.	Support strategies were not submitted within required timelines.

☐Respite ☒Employment Services ☒CBDS ☒RSM				

INDICATOR	Regulation 6.21 (6) (d):	To implement the ISP by providing the agreed upon supports.		
L88 Services and support strategies identified and agreed upon in the ISP for which the provider has designated responsibility are being implemented.	***GUIDELINES:*** Staff need to have a clear understanding of the needed services and supports identified in the ISP and their responsibility in delivery in order to support individuals in reaching their goals. It is important that staff, even if they are not directly responsible for ISP support implementation, understand the goals an individual is working on in order to fully support goal implementation. It is important that the Provider implement agreed upon strategies and actions to support the individual to accomplish his/her ISP objectives.			
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ☒Placement ☒ABI/MFP Placement	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Individual record Progress notes Staff interview	The individual record is reviewed for documentation of service & support strategy implementation (progress notes). The staff are interviewed for knowledge about the needed supports and their role in delivery or can identify who is responsible.	• Staff are knowledgeable of support strategies • **and** they are being implemented as designed.	• Staff are not knowledgeable of support strategies • **and/or** they are not being implemented as designed.

☒Employment Services ☒CBDS ☒RSM				

INDICATOR	MRC/ DDS engagement guidelines for ABI services			
L89. The provider has a complaint and resolution process that is effectively implemented at the local level.	**GUIDELINE** Note: effective as of 7/1/14, DDS began to license ABI/ MFP residential and placement services. MRC required, and DDS will continue to require locations serving individuals in ABI/ MFP residential habilitation or placement services, to abide by certain additional requirements. DDS continues to expect: There should be a policy and procedure from the provider outlining their complaint resolution process. Each location should follow the agency's policy and procedures, and documentation that the staff, participants and guardians have been trained should be available. Each location should have a log, either on paper or electronic which records the complaint with date, short description, name of the complainant, date resolved and who and how this was resolved.			
APPLICABILITY ☒ABI/MFP 24/hr Residential ☒ABI/MFP Placement	**INFORMATION SOURCE**	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Individual record Progress notes Administrative documentation including policies and procedures Staff Interview Staff Log	Review of policies and procedures and administrative interview to determine the presence of a complaint resolution system and structure, frequency and expectations for reporting and responding and frequency of training to staff.	The agency has a system of ongoing complaint resolution that is being followed.	• The agency does not have a system of ongoing complaint resolution • **<u>and/or</u>** it is not being consistently followed.

		Compare the expectations to what is occurring.		

INDICATOR		
L90. Individuals are able to have privacy in their own personal space.	**CMS § 441.530 Home and Community-Based Setting (a) (1) (iii)**	Ensures an individual's rights of privacy...
	Regulations 7.07 (7) f	Bedroom doors are lockable unless clinically contraindicated or unless an individual, or his or her guardian, if applicable, chooses a bedroom with access to egress and consents to the bedroom door not having any lock.
APPLICABILITY ☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ★ ☒Placement ☒ABI/MFP Placement ☐RSM	**GUIDELINES:** Privacy for individuals in 24-hour residential supports and placement services begins with each individual having clearly defined private living, sleeping and personal care spaces. There should be a lock on the bedroom door, unless otherwise contraindicated and documented through the ISP process or unless the bedroom door leads to an egress. Even if individuals are sharing a room, there is an expectation that their sleeping area and furniture is their private space. Staff (Home providers) knock before entering a person's room. Staff /Home providers encourage and support other people to respect others' privacy. Staff (Home providers) do not enter people's rooms without permission. This permission can be given prior to entry. For example, staff obtained permission to enter the bedroom, but needs to step away and return momentarily, and don't need to ask for permission to reenter when she/he returns. Staff /Home providers do not open people's closets or drawers without permission. Individuals are supported to be alone when they want. They can spend time alone in their rooms, with the door closed, if they choose. They are allowed and even encouraged to close the bedroom door when they want or need privacy. For individuals with roommates, there are opportunities to be alone. Staff facilitate these opportunities and work with roommates to come to agreements that respect and foster privacy of all roommates. Individuals may have certain safety and supervision needs; however, these needs to be balanced with the individual's inherent right to privacy. Therefore, unless reviewed and approved as the least restrictive / least intrusive means to keep an individual safe and healthy, audio/ visual monitoring of individuals when in their bedrooms is not supported.	

	INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
	Site visit Individual interview/ observation Staff interview	The site is reviewed to determine whether there is environmental support for privacy (e.g. private meeting space; private bedrooms). Staff are interviewed and individuals are interviewed/ observed to determine whether individuals understand that they have privacy in their own personal space. The Observation to determine whether privacy is supported in practice (i.e., staff knock on doors, individuals are able to be in their rooms).	• There is substantial interview and observational evidence that individuals have privacy in their own personal space(s), • **and** the individual has a lockable bedroom door (unless contraindicated by ISP team or leading to egress).	• There is minimal indication through interview and/or observational evidence that individuals have privacy in their own personal spaces • **and/or** the individual does not have a lockable bedroom door.

INDICATOR	Regulations 13.02 – 05	Reportable Incidents (1) A reportable incident is any event or occurrence in the life of an individual that must be reported to the Department. The categories of incidents that are subject to the reporting requirements of 115 CMR 13.00 include, but are not limited to, the following: (a) unanticipated or suspicious death; (b) inappropriate sexual behavior; (c) significant behavioral incident; (d) unexpected hospital visit; (e) fire; (f) suspected mistreatment; (g) theft; (i) missing person; (j) criminal activity; (k) transportation accident; (l) emergency relocation;
L91. Incidents are reported and reviewed as mandated by regulation **APPLICABILITY** All Services		

(m) suicide attempt;
(n) property damage;
(o) victim of physical altercation; and
(p) medical/psychiatric intervention not requiring a hospital visit.
(2) The Department may modify the categories and definitions of reportable incidents at its discretion.

Reporting needs to be completed in accordance to the requirements set forth in 115 CMR 13.03-13.05. The Department may modify the categories and definitions of reportable incidents at its discretion

GUIDELINES:

All staff need to be knowledgeable concerning what constitutes a reportable incident, and practices and timing for filing, and reporting to supervisory personnel.

Supervisory staff need to take immediate actions to protect health, safety and welfare of the individual(s) and to ensure that the incident notes the people involved in the incident including any eyewitnesses to the incident.

Guardians need to be informed of all major incidents as soon as reasonably practical after the incident, and of minor incidents in accordance with the preferences of the guardians.

INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
Policies and procedures for reporting incidents. Incident reports (HCSIS) Communication and locations Logs Individual Record Staff interview Individual interview	A review of incidents filed to identify those that have been filed, and the timelines for these. Notification of all major incidents to all parties, including the guardians is checked. A review of a sample of documentation (individual and location) is conducted to assess whether reportable items noted within communication log, individual record, or interview were also filed as incident reports.	• Review of incidents indicates that staff are filing incidents that meet the definition of reportable • And these are reported and finalized within timelines • **and** there is no evidence of unreported incidents.	• Review of incidents indicates that staff are not filing incidents that meet the definition of reportable, • And/or • These are not reported or finalized within timelines • **and/or** there is evidence of unreported incidents.

		Staff interviewed to determine knowledge of what constitutes reportable incidents.		

INDICATOR	Regulations 7.07(1):	All homes and work/day supports must meet all applicable building, sanitary, health, safety, and zoning requirements.
Environmental Safety **L92.** The Provider has ensured that all Provider owned/ operated sub-locations have the required licenses and inspections. **APPLICABILITY** ☒Employment Services ☒CBDS	**GUIDELINES:** This indicator applies to provider owned or operated sub-locations which consist of provider owned, leased or operated buildings/ space, social enterprises, worksites, meaningful day activity sites and enclaves serving a group of individuals within a community setting. Definitions of sub-locations: agency owned/rented/leased locations in which the agency provides support to individuals. Some examples include coffee shops, farms, farm stands, art studios, paper shredding/recycling. Social enterprise or other business used as either a day service training location or a group employment location. The provider owned/ operated sub-location may be used for some portion of programming or work support (e.g. to learn a particular work skill). The sub-location may be used for some but not all individuals on a routine and ongoing basis, and/ or the sub-location may not serve a particular group of individuals on a routine basis, but rather, is used to serve as a service option for individuals. The Provider is responsible for assuring that the relevant inspections are obtained and current for all provider owned/ operated sub-locations. Required inspections may include: • Certificate of Occupancy • Signed building permits for any renovations; CO if needed for major renovations performed prior to occupancy. • Certificate of inspection from Board of Health for any location that prepares food for retail sale • Annual inspection of sprinkler • Annual inspection of elevator • Annual inspection for oil/gas furnaces (note: gas furnace inspections need to be done by a certified/licensed entity; electric heat systems do not require inspections) • Annual inspections for fireplaces, wood-burning and pellet stoves, cooking stoves (ex. wood fired pizza oven) • Annual inspection of smoke detector and carbon monoxide detectors • Barns, riding arenas, stables, and the surrounding grounds are primarily regulated by the Department of Agriculture, and require a Stable License	

	• Any necessary license/inspection required for the business/ specific service being provided (ex. dog grooming/boarding; child care)			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Inspections	Inspections for all sub locations are reviewed as part of the administrative review.	All relevant inspections are present and current for each provider owned/ operated sub-location	One or more required inspections are not present and/or current for each sub-location

INDICATOR	**REGULATIONS: 7.04 (1) f 4**	……Assure safety and well-being in both home and work environments.		
L93 The provider has emergency back-up plans to assist the individual to plan for emergencies and/or disasters. **APPLICABILITY** **All Services**	**GUIDELINES:** The provider has an emergency back-up plan or has assisted the individual to develop his/her own backup plan. The provider is aware of what this plan is and assists the individual to be knowledgeable about the plan and to know who to call in an emergency. Emergency back up plans can consist of a provider on-call system, an on-call system to the area office/service coordinator; and/or use of generic resources such as 911. These are individually focused back up plans to ensure that the provider has a plan to assist each individual. Systemic back up plans related to Remote Supports is not the subject of this indicator. The provider must periodically check to assure that the individual is knowledgeable about plans for emergencies and/or disasters. Review of individual needs and of the adequacy of the emergency plan(s) must occur periodically. As of 7/1/21, this indicator will be rated for sampled individuals (rather than for the location), with the following expectations: • The individual and/or staff know who to call from the provider in the event of an emergency. • Provider needs to ensure that there is a system to provide back up when individuals call. • Contingencies need to be in place when the individual is in the community and an emergency such as a disaster occurs. Training on generic and employer emergency backup systems needs to be provided.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**

	Documentation, in cluding on-call procedures Staff interview	Review the emergency back-up plans, and staff's knowledge of the plans.	• Provider has emergency back-up plans and/ staff are aware of them. • **And/or** individuals are aware of the back-up plan.	• Provider does not have emergency back-up plans **and/or** staff are unaware of them. • **And/or** individuals are not aware of the back-up plan.

INDICATOR	REGULATIONS	SUPPORTIVE TECHNOLOGY FOR AUTONOMY AND INDEPENDENCE
L94 Individuals have the assistive technolo gy and/or modifications to maximize independence, **APPLICABILITY** ☐24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Placement ☒ABI/MFP Placement ☐Respite ☒RSM ☒Employment Services ☒CBDS	**7.04 (1) e 1** **CMS 441.53**	Assessment, training, education, supports and services necessary for the individual to meet the goals in the individual's ISP, to acquire skills that increase self-reliance and that are necessary to achieve desired and valued outcomes 1. For providers of residential supports and individualized home supports, the supports and services include skills training and supports 1to maximize an individual's independence and performance of household activities and routines, participation in community recreational, cultural and leisure activities, … Major environmental controls, including those for lighting, appliances, plumbing, windows, and shades shall be operable by and accessible to individuals. Optimizes but does not regiment individual initiative, autonomy, and independence in making life choices.

GUIDELINES:

There are many occasions in which use of technology or assistive device can aid in fostering someone's independence. Assistive technology is a great equalizer and includes not only computers and high-tech devices, but everyday technology and low-tech items such as smart phones, cameras, day planners, and highlighters. For example, an individual who receives hand over hand assistance to shave may be able to independently shave with an electric razor. The provider should review and assess the individual's needs to determine whether the individual would benefit from any assistive tools and devices. Targeting a particular area in which the individual desires increased independence, and then exploring AT technology options can assist in overcoming limitations.

Assistive technology and modifications are provided to encourage, teach, communicate, and foster maximum independence in home routines and activities. With the use of any necessary assistive technology, staff support individuals' development of skills on a routine and ongoing basis. Examples of assistive technology include but are not limited to computers, electric toothbrushes, and alarm clocks.

Even given health issues, there are very few circumstances in which the promotion of greater independence and the development of home/personal care skills cannot occur.

The first step is to engage in an assessment of the individual's desire for independence and autonomy, and to thoughtfully consider what assistive technology might be engaged to promote further independence. For example, the individual would like to dress more independently and various tools and assistive technology such a grab instruments; Velcro in place of buttons are recommended. An example of an AT assessment tool is posted on the web.

	INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
	Observation Site review Individual interview Staff interview	Review whether individual's barriers to independence have been assessed and assistive technology to enable the individual to be more independent and reach their goals has been explored and is being used.	• Individuals have been assessed to identify any assistive technology that may be of benefit. • **and** assistive technology and modifications to maximize independence are provided when needed.	• Individuals have not been assessed to identify any assistive technology that may be of benefit. • **and/or** assistive technology and modifications to maximize independence are not provided when needed.

INDICATOR	REGULATIONS:	

⚐ **L95** Remote Supports and Monitoring Technology system requirements have been met. **APPLICABILITY** **RSMS**	**GUIDELINES:** Remote Supports and Monitoring Services Provider must provide: • Two-way, real-time, on-demand or individual-initiated communication system for contact between the individual and remote support staff. Systems communication capabilities necessary for the monitoring center/remote caregivers to effectively interact with and address the needs of individuals at each of their locations, including emergency situations when the individual may not be able to use the telephone/communication device. Visual or other indicator that informs the individual to know when remote support systems are activated. • A discrete location for the Remote Support Monitoring Center, separate from the locations at which individuals are receiving Remote Supports. Remote Support Software with Dashboard that has alert system to notify staff of individuals' status and/or ability for individuals to activate and interact immediately with a staff. Staff can simultaneously respond to multiple signals. • Safeguards and/or backup system such as battery and generator for the electronic devices in place at the remote monitoring center and used by individuals are in place. Detailed and written Backup procedures to address/manage system failure (e.g. prolonged power outage), fire or weather emergency, individual medical issue or personal emergency, etc. for each location utilizing the system and included in each individual's remote support plan. • Remote Support Platform with upload functionality to store information regarding an individual's unique support needs, such as health management plan, PBS plan, clinical needs, etc. • Personal Emergency Response System (PERS) functionality (**Level B** only). The PERS must be capable of operating without external power, e.g. during a power failure at the individual's home, in accordance with UL requirements for home health care signaling equipment with standby capability and must be portable. • Procedures for conducting tests of the functionality of monitoring devices and system on a quarterly basis. These procedures must include strategies to repair/replace devices that are not functioning properly and address associated potential risk(s) until devices are fully operational.

	INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
	Policies and procedures for addressing system failures and emergencies. Verification of HIPPA compliance Data tracking system for	Review of the real-time, two-way communication system live and in use at the monitoring center. Review of policies and procedures	• All Remote Supports and Monitoring technology and systems requirements are in place.	• All Remote Supports and Monitoring technology and systems requirements are not in place.

	functionality testing.			

INDICATOR	REGULATIONS:			
L96 Staff is competent and knowledgeable in the use of the individual's technology devices and applications. **APPLICABILITY** **All services**	**GUIDELINES:** Many individuals have among their personal possessions, and technology devices such as iPad, iPhone, laptops, PCs, smart phones, GPS enabled applications, and the like. Additionally, individuals may use Assistive Technology to enable them to be as independent as possible. Assistive technology that individuals use may consist of low, medium or high-tech devices or tools. The individual may utilize these items for any variety of purposes from entertainment, communication, organization, scheduling, socialization and health and safety. The Provider needs to support the individuals in the use of these devices. As such, staff need to be familiar with the basic functions of devices/tools, how to turn them on/ off, how to charge the device, use the basic features such as closed captioning, video calling, looking something up, adding an application, using a calendar application, and ensuring that the devices are secure through such means as password protection. Staff need to support the individual to utilize Assistive technology and other technological devices consistent with their interests and abilities.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Training documentation	Observation Staff interview Individual interview	• Staff trained and knowledgeable in the AT or technology individuals use and how to support them to use on a regular and on-going basis.	• Staff are not trained and/or knowledgeable in the AT or technology individuals use and how to support them to use on a regular and on-going basis.

INDICATOR	REGULATIONS:
L97	**GUIDELINES:** Remote support plan, which outlines how the specific remote support(s) will be implemented.

The agreed upon remote support and monitoring plan includes the required components and is implemented as developed. **APPLICABILITY RSMS**	• A description of when the remote support system is scheduled to be activated and when it is in on-demand mode. This should include when Interactive Live Instruction/Support for goal accomplishment is to be provided, if applicable. • An outline of when remote supports and monitoring and in-person direct support is recommended. • The outcomes that will be supported by technology. • Specific limits on when the technology can be used and when it cannot be used; • Instructions on how the individual can turn off the remote supports and monitoring. • Identification of how the individual is notified that the remote supports and monitoring system is activated. • Identification of what specialized remote support and monitoring devices are in place (e.g. sensors, doorbell ring, etc) to foster independence and safety, if applicable. • The remote support plan *must* specify the staff to be contacted by the monitoring center/remote caregiver, who are responsible for responding to situations requiring in person assistance and traveling to the individual's location. In situations requiring an in-person visit the plan should include a response time for staff to arrive at the individual's location. In emergency situations staff should call 911. • A detailed description of how the technology will be responded to, maintained, and reported on, including regular review by supervisory staff.

	INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
	Remote Support and Monitoring Plan	Review of Remote Support and monitoring plan. Interview with Staff Interview with Individual Review of log notes and progress notes	• A remote support plan with the required components is in place **and** • The plan is being implemented as written.	• A remote support plan with the required components is not in place **and/or** • The plan is not being implemented as written.

INDICATOR	REGULATIONS:
L98 Monitoring staff are trained and knowledgeable	**GUIDELINES:** Staff need to be trained in each individual's unique Remote Support and Monitoring Plan to ensure they are knowledgeable of any and all unique needs and what supports that may be needed if certain situations arise.

in the individual's remote supports and monitoring plan. **APPLICABILITY** **RSMS**	Remote Supports Services staff must: Successfully participate in regular trainings on how to support individuals with the use of and to use the monitoring system and any devices that interface with the RSM system, evaluate functionality and report issues related to its functionality.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Assistive Technology/ Remote Supports and Monitoring Support Plan	Review of Remote Support and monitoring plan. Interview with RSM center/location Staff Training Documentation Review of log notes and progress notes	• Staff trained and knowledgeable in individuals Remote Support and Monitoring Plan and any unique strategies needed to successfully support them.	• Staff are not trained and/or knowledgeable in individuals Remote Support and Monitoring Plan and any unique strategies needed to successfully support them.

INDICATOR	**REGULATIONS:**
L99 Medical monitoring devices needed for health and safety are authorized, agreed to, used and data collected appropriately. (eg seizure watches; fall sensors).	**GUIDELINES:** Medical equipment and devices needed for medical treatment and monitoring, including remote monitoring, are evaluated here. This indicator covers equipment and devices needed for medical reasons/conditions, not for behavioral/clinical reasons, and for which the Provider has a role, e.g., staff instructions or guidelines on how to use, maintain and clean, and monitor for proper operation and repair. This indicator evaluates the use of devices which monitor health status via sensors, audio and/or video, or other means of electronic transmission to measure heart rate, respiration, blood sugar, seizure activity, falls, sleep pattern etc. Some examples include: Oxygen concentrators and accessories Portable ECG/EKG monitoring equipment CPAP/BIPAP machines and accessories Nebulizer compressor and accessories Remote Patient monitoring equipment for pacemakers

APPLICABILITY	
☒24/hr Residential ☒ABI/MFP 24/hr Residential ☒IHS ● ☒Placement ☒ABI/MFP Placement ☒Respite ● ☒Employment Services● ☒CBDS ● ☒RSM ●	Continuous glucose monitoring (CGM) sensors affixed to the skin VNS magnet Seizure watches Falls sensor These devices enable staff or healthcare practitioner to monitor and respond to an individual's medical needs by electronically conveying pertinent information regarding an individual's health and safety status to a support staff/caregiver or healthcare practitioner. Documentation for all devices must include rationale for use, authorization from a medical professional, instructions for use, correct implementation, and guidelines for cleaning and maintenance. Remote Patient Monitoring devices that are exclusively monitored solely by the individual's healthcare practitioner with no role for the provider do not need to be evaluated here.

	INFORMATION SOURCE	HOW MEASURED	CRITERIA FOR STANDARD MET	CRITERIA FOR STANDARD NOT MET
	Documentation (individual record, ISP) Observation Staff Interview	Review instructions for use, including if it is included in ISP and the rationale, implementation strategies, and communication links are outlined. Review practices and implementation to determine whether equipment is utilized in accordance with required approval.	• Medical monitoring devices are authorized with completion of components for use and • Are implemented as directed.	• Medical monitoring devices are not authorized and do not include one or more components of the criteria for use **and/ or** • the device is not being implemented correctly.

INDICATOR	REGULATIONS:			
L100 An assessment for use of Remote supports and monitoring has been included within the ISP. On-going review for the continued need occurs. **APPLICABILITY** **RSMS**	**GUIDELINES:** When an individual is interested in RSM service a comprehensive AT evaluation is completed to identify AT needs for greater independence and to address any potential *Risk* that needs to be mitigated with the use of AT and/or RSM technologies. This is completed to determine if the person would be a successful candidate to live more independently with the use of AT and Remote Supports and Monitoring and to establish goals and intended outcomes to be supported with technology. The Assistive Technology assessment and Remote Support Plan should be included in each individuals ISP. This is not an annual assessment, however if individuals' abilities or needs significantly change another evaluation should be completed.			
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	AT Assessment Remote Support Plan	Review of Remote Support and monitoring plan. Review of AT Assessment	• AT assessment and Remote Support plan needs to be completed **and** included in the ISP.	• AT assessment and Remote Support plan needs to be completed **and/or** is not included in the ISP.

INDICATOR	REGULATIONS:
L101 The individual is trained on how to use the remote supports and monitoring system.	**GUIDELINES:** The individual who receives remote support and monitoring shall be provided initial and ongoing training on how to use the remote support system as specified in the individual remote support plan. This should include how to turn off the Remote Supports and Monitoring and report issues of technology malfunctions.

APPLICABILITY RSMS				
	INFORMATION SOURCE	**HOW MEASURED**	**CRITERIA FOR STANDARD MET**	**CRITERIA FOR STANDARD NOT MET**
	Training or Instruction Manual	Individual Interview RSM staff Interview	• The individual is knowledgeable of how to use the system, including how to get assistance if needed (e.g. emergency) • **and** is able to report malfunctions • **and** how to turn off the system.	• The individual is not knowledgeable of how to use the system, including how to get assistance if needed (e.g. emergency) • **and** is not able to report malfunctions • **and** does not know how to turn off the system.