

# Quality Assurance

## COMMITTEE MANUAL



SEDGWICK COUNTY  
**Department of  
Aging and Disabilities**

DEVELOPMENTAL DISABILITY ORGANIZATION

# Table of Contents

- I. Introduction: What is Quality Assurance Committee (QAC)
  - A. *QAC Workflow*
  - B. *Self-Directed Notification letter*
- II. Guiding Principles and Values
- III. Expectations
  - A. *HIPAA and Identification (October 2025)*
  - B. *HIPAA in Basic Training*
  - C. *Sedgwick County HIPAA Basic Training Acknowledgement Form*
  - D. *SCDDO Confidentiality Agreement for Non-Employees*
- IV. Utilizing Review Tools
- V. Conducting the On-Site Visit
- VI. Review Tools
  - A. *SCDDO QAC Review Checklist*
  - B. *QAC Cover Page*
  - C. *Employment Questionnaire*
  - D. *Life Enrichment Tool*
  - E. *Work Services & Supported Employment Tool*
  - F. *Residential Tool*
  - G. *Personal Care Services for Adults Tool*
  - H. *Personal Care Services (Adult) – Spanish (October 2025)*
  - I. *Personal Care Services for Children Tool*
  - J. *Personal Care Services (Child) – Spanish (October2025)*
  - K. *Support Plan Review*
  - L. *Support Plan Review Comments*

- M. *BSP and PMP Plan/Documentation Review***
- N. *BSP and PMP Plan/Documentation Review Comments***

**VII. Resources**

- A. *Adult Protective Service Fact Sheet***
- B. *Child Protective Service Fact Sheet***
- C. *Kansas Administrative Regulations (K.A.R.) Article 30-64-27***
- D. *Kansas Administrative Regulations (K.A.R.) Article 63***
- E. *SCDDO Policy G-01 Quality Assurance Committee***

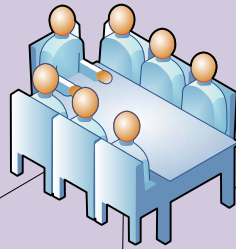
**VIII. Outcomes**

- A. *Scoring the Reviews***
- B. *Case Management File Review Resources***
- C. *Quarterly Report Template***
- D. *Service Modification Plans and Agency Intervention Plan***
- E. *Service Modification Example***
- F. *Agency Intervention Guide***
- G. *Observations and Interpretations Template***
- H. *Agency Intervention Plan Template***

**IX. Appendix A**

- A. *Life Enrichment Tool – Pandemic***
- B. *Work Services Tool – Pandemic***
- C. *Residential Tool – Pandemic***
- D. *Personal Care Services (Adult) – Pandemic***
- E. *Personal Care Services (Child) - Pandemic***

# Quality Assurance Committee



## Quality Assurance Committee (QAC)

Is made up of SCDDO QA, TCM Agency Representatives, and On-Site Monitoring Teams



### SCDDO Quality Assurance

SCDDO Quality Assurance Coordinator or designated Quality Assurance staff



Generates a random sample of individuals to review quarterly.



Evaluates submitted reviews, sends feedback to agencies, and provides follow-up on concerns.



### Targeted Case Management (TCM) Agency Representatives

The person who maintains oversight of quality assurance or targeted case management department at the agency.



Established on-site monitoring team



Collects and assesses reviews and submits to SCDDO QA.



### On-Site Monitoring Teams

Team established By the TCM Representative.

The team may include any of the following:

- Individuals receiving services
- Family members
- Guardians
- Interested citizens



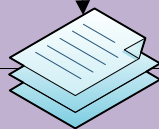
Performs service reviews such as:

- Day Service
- Residential Service
- TCM Service
- Supportive Home Care Service

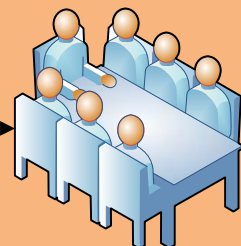


### Community Council

Reviews quarterly trend data and provides additional feedback. SCDDO QA staff performs follow-up on feedback provided.



QAC Meets quarterly to review trend data



### Intellectual and Developmental Disability Advisory Board

Reviews quarterly trend data and provides additional feedback. SCDDO QA staff performs follow-up on feedback provided.

**SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
Quality Assurance Committee**

**Introduction: What is Quality Assurance Committee (QAC)**

**Developmental Disabilities Reform Act (KSA 39-1802)**

In 1995, the Kansas Legislature enacted the Developmental Disabilities Reform Act. The purpose of this act was to assist individuals who have a developmental disability to have:

- a. services and supports which allow individuals the opportunities of choice to increase their independence and productivity and integration and inclusion into the community;
- b. access to a range of services and supports appropriate to such individuals; and
- c. the same dignity and respect as individuals who do not have a developmental disability.

This Act gave the Kansas Department for Aging and Disability Services (KDADS) certain powers and duties including the authority to establish the policies and procedures by which the Developmental Disabilities Reform Act would be implemented. Those policies and procedures include the regulations for licensing providers of community services and operation of Community Developmental Disabilities Organizations (CDDOs).

**Kansas Administrative Regulations Article 64**

The regulations for quality assurance require a local committee made up of individuals served, their families, guardians, interested citizens, and providers to determine the following:

- Services that are paid for are delivered;
- Services that are delivered are paid for in accordance with the terms of any agreement or contract in force, including any payment requirement that the individual being served or a third party acting on behalf of the individual being served has the responsibility to meet;
- Services are being provided in a manner, which meets the requirements provided for in Article 63;
- The provider is affording the individual being served all of the individual's legally protected rights; and
- The provider is reporting any suspicions of abuse, neglect, or exploitation and taking corrective action when needed.

**Determining Quality of Services**

The QAC process evaluates services based on the support plan documentation, individual support needs and satisfaction. Compliance with this requirement is determined by interviewing the individual and their support network to determine if they are receiving the services needed to work towards the individual's preferred lifestyle and that those services are meeting their expectations.

- Services should be person oriented. Community Service Providers (CSPs) should assure there are processes in place that are individually focused to meet the individual's needs.
- The guiding principles and values of QAC are followed to ensure appropriate services are being delivered.

### **Overview**

1. The committee will be comprised of SCDDO Quality Assurance (QA) Coordinator, Targeted Case Management (TCM) representatives, on-site monitoring teams and Community Council members representing the following categories: individual receiving services, their family members and/or guardians and interested citizens.
2. The committee will review a sample of individuals who receive TCM plus one additional service; individuals will be randomly selected by SCDDO QA team.
3. Each CSP which provides licensed TCM will be assigned at least one individual each quarter for review by the agency's monitoring team.
4. Each CSP serving ten or more individuals will receive a review by a QAC monitoring team at least annually.
5. The QAC review will consist of the following:
  - a. Review of the selected individual's documents pertaining to his/her individual services. At minimum, the support plan must be reviewed, as well as the Behavior Support Plan and Psychotropic Medication Plan when applicable.
  - b. Completion of an on-site review of each service received. This will include Personal Care Services (PCS), Day and Residential services. The review must be conducted in the home for Residential services or where the individual receives services in the case of PCS. In the case of Supported Employment, the individual receiving that service may choose where the interview will occur. Individuals who receive Day services from more than one CSP shall be reviewed at the site where the majority of their time is spent.
6. For individuals who receive self-directed PCS, the QAC Representative will utilize the Self-directed Notification Letter to inform the family/individual that they have been selected for a review. This letter not only provides notice prior to scheduling of the visit it also includes a copy of the on-site services tool as the caregiver prepares for the review.
7. On-site reviews will be conducted both with the individual AND his/her paid staff, if applicable. This includes paid family members. Exceptions can be made if review team can demonstrate to SCDDO that sufficient attempts have been made to conduct the review with staff present. It is the decision of the individual whether his/her interview is conducted confidentially or with staff present.
8. The monitoring team will use the review tools which correspond with the services documented and reviewed. See Using the Review Tools.
9. If any concerns are noted from the document review or on-site monitoring, the monitoring team is responsible for completing the review forms and adding any additional comments, questions or concerns. The monitoring team shall pass on agency concerns or praises regarding the reviews with the agency where the site visit was completed. This should be completed timely to allow the CSP to take action when necessary.

10. All original review tools and copies of reviewed documents will be submitted to SCDDO QA team along with the QAC packet by the due date assigned.
11. CSP's may request copies of the review tools for their records from either the TCM service provider performing the review or SCDDO QA Coordinator.
12. SCDDO QA Coordinator will provide feedback with any trends and positive items noted from the reviews on a quarterly basis to each CSP. See Service Modifications and Agency Intervention Plans.

### **How Individuals Are Selected**

Selection for a QAC review is completed by SCDDO QA staff in December of each year. SCDDO will identify all qualifying individuals and sort by TCM provider. This sort will complete the first step in randomizing individuals for selection. The second step will determine each TCM provider's selection size which is 10% the providers TCM service population. Once the 10% is determined, it is divided by 4 to determine the number of reviews which will be assigned each quarter for the following year's review. To select the individuals per agency, every 10<sup>th</sup> individual on the list is chosen until the correct sample size is selected. If the selected individual has received a QAC review within the last five years, the following individual on the list is selected.

Date

Name

Address

Address

Dear {insert name}

This letter is to inform you that {Name} has been selected to have a review completed on {his/her} services. These reviews are completed by your case management agency by interviewing the support worker and visiting the service location.

Someone from {Agency} will be contacting you within the next few months to schedule this review. Enclosed you will find a copy of the questions that will be discussed with the support worker, please use it to prepare for the review. If you have questions, please contact your targeted case manager.

Thank you,

QAC Rep

Info

Enclosure

For more information regarding service reviews, please see the Quality Assurance Committee information located on Sedgwick County CDDO's website at <https://www.sedgwickcounty.org/developmental-disabilities/forms/>

**SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
Quality Assurance Committee**

**Guiding Principles and Values**

**Minimum Health and Safety**

1. Individuals are free from abuse, neglect, and exploitation.
2. Individuals have their basic needs met including optimal health, safety, privacy, security, and personal well-being.

**Equality and Full Citizenship**

1. Individuals with developmental disabilities are people first.
2. All individuals are entitled to the same privileges and responsibilities.
3. Individuals are encouraged and assisted to exercise their rights.
4. Individual rights are not limited without due process.
5. Individuals are recognized for their abilities.
6. Individuals are full members of their communities.

**Opportunities for Choice**

1. Individuals have the opportunity to develop a broad base of experience and knowledge to use when making decisions.
2. Individuals participate in and contribute to their communities in unique and personalized ways they determine.
3. Individuals choose where they live, work and recreate.

**Self-Determination**

1. Individuals and their support network choose what services will be provided, who will provide the services and how those services will be delivered in accordance with the individual's preferred lifestyle.

**People will influence the Quality and Responsiveness of Services**

1. Individuals are given the opportunity to evaluate how effective and appropriate the services they receive are through the QAC process.
2. The opinion of the individual receiving services is given the most important consideration in evaluating service providers. In situations where the individual receiving services is a minor (under the age of 18), the opinion of the parent/guardian is given the most important consideration, however, the child should be included as deemed appropriate.

**SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
Quality Assurance Committee**

**Expectations**

**Community Service Provider (CSP) Expectations**

It is the expectation that each CSP which delivers Targeted Case Management (TCM) services will establish a Quality Assurance Committee (QAC) monitoring team and designate an agency representative to complete internal oversight of the QAC process. Refer to SCDDO policy G-01 Quality Assurance Committee.

**The Monitoring Team**

Each agency will establish one or more monitoring teams comprised of a representative from the TCM agency and at least one other member: an individual receiving service, a family member, a guardian or an interested citizen. The agency representative, or designee and at least one other member, not paid by the agency, must both be involved in the entire review process for the individual assigned to that team. To avoid any conflict of interest, case managers should not participate in the review of any individual for whom they are currently monitoring services. This limitation is applicable even in instances where the case manager did not write the current support plan for that individual. If it is requested by the family, a reviewee's case manager may assist the non-paid team member in conducting a visit to a family home for an individual with personal care services; however the case manager would function as a support to the family rather than a reviewer. The monitoring team will review all support plan documents prior to observing the individual within each service they receive.

**Quality Assurance Representative**

The agency's representative is the person who oversees TCM and/or QA department at the agency. This individual is the main contact between the agency and SCDDO during the review process and will communicate any difficulties during the review process. The quarterly assignments are sent directly to the agency representative to organize the team to complete the review. Once the document review, on-site visit and staff interviews are completed; the agency representative will review all documentation to ensure that the review is complete and there is no missing information. The agency representative will ensure that all concerns are addressed and submitted within the due dates established by SCDDO. The representative will also be expected to participate in the quarterly QAC meeting where County data and trends are discussed.

Agency representatives are required to complete on-line QAC Manual training via Relias as well as on-boarding with SCDDO QA Coordinator. The on-boarding may include an in-person review of the QAC manual, explanation of role and purpose, as well as, shadowing of individual/ staff interviews.

**SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
Quality Assurance Committee**

**HIPAA and Identification**

**HIPAA**

Every member of the Sedgwick County Quality Assurance Committee (QAC) is required to review and acknowledge the County's HIPAA Basic Training. This training will provide information regarding Sedgwick County expectations related to Health Insurance and Portability & Accountability Act (HIPAA) and Privacy Laws, which covers all information that is collected during a QAC review. Members will also review and sign the Sedgwick County Confidentiality Agreement for Non-Employees. The two forms will be collected and returned to SCDDO prior to any member participating with a monitoring team. Please indicate on the HIPAA acknowledgement form the role which the member holds: persons served, family of person served, guardian, interested citizen or service provider.

**Identification**

Each member of the QAC monitoring team, upon receipt of the HIPAA and Confidentiality Acknowledgment form, will be issued a QAC membership badge to wear while completing the QAC review. Annually, the QA Coordinator will verify the list of members with each designated agency representative to confirm on-going participation. If an agency receives a new monitoring team member at any time during the year, the agency is expected to go through this process prior to having the member take part in the review. If an individual is no longer participating in the committee, the agency representative will collect the badge and notify SCDDO QA department to remove the member from the listing. (October 2025)

# **HIPAA in BASIC TRAINING**

For SCDDO On-Site Monitoring Teams

## **What will you Learn about HIPAA in BASIC TRAINING?**

The BASIC Principles of Privacy.  
Who has to Follow the Privacy Regulations.  
Where Protected Health Information (PHI) is Found.  
What the Privacy Law means for Sedgwick County Clients.  
What the Privacy Law means for Sedgwick County Employees.

## **What is Privacy?**

Privacy is about who has the right to access personally identifiable health information. The HIPAA Privacy Law covers all protected health information in the hands of covered entities, including Sedgwick County. This means it protects health information that is transmitted electronically as well as on paper.

## **What is HIPAA?**

HIPAA, or the Health Insurance Portability & Accountability Act of 1996 Public Law 104-191, was enacted as part of a broad congressional attempt at incremental health care reform. There are two tenets with HIPAA: Portability and Accountability.

What do the Privacy Standards do?

Portability refers to the transfer of health insurance from one organization to another.

What are the Five Basic Principles of Privacy?

Accountability contains provisions to regulate and standardize information exchanges and to establish standards for the privacy and security of protected health information or PHI.

Who has to Follow the HIPAA Privacy Regulations?

Compliance with the Accountability or PRIVACY component of HIPAA will be required on April 14, 2003 for Sedgwick County.

## **What do the Privacy Standards do?**

- Limit the non-consensual use and release of private health information.
- Give clients new rights to access their medical records and know who else has accessed them.
- Restrict disclosure of health information to the "minimum necessary" for the intended purpose.
- Establish criminal and civil sanctions for improper use or disclosure.
- Establish new requirements for access to records by researchers and others.

## **What are the Five Basic Principles of Privacy?**

The HIPAA Privacy Regulation reflects the five basic principles:

- Consumer Control: Consumers have the right to control the release of their medical information.
- Boundaries: With few exceptions, an individual's health care information should be used for health purposes only, including treatment and payment.
- Accountability: Federal penalties will result if a client's right to privacy is violated.
- Public Responsibility: We need to balance privacy protections with the public responsibility to support such national priorities as protecting public health, conducting medical research, improving the quality of care, and fighting health care fraud and abuse.
- Security: We must protect health information against deliberate or inadvertent misuse or disclosure.

## **Who has to Follow the HIPAA Privacy Regulations?**

All health care providers who transmit health information electronically, including Sedgwick County.

- All health plans (insurance companies).
- All health care clearinghouses.

Sedgwick County may disclose health information to persons or organizations hired to perform functions on its behalf. These business partners are not permitted, and have agreed to not use or disclose protected health information in ways that would not be permitted for Sedgwick County.

### **What is Protected Health Information or PHI?**

Protected Health Information (PHI) relates to the physical or mental health of a client of Sedgwick County. This protected information includes the care provided to the client as well as payment for services. HIPAA protects all individually identifiable information transmitted or maintained electronically by a healthcare provider. This includes social security number, name, address, birth date or other information that could be used to identify a person if linked backed to protected health information.

### **Where is Protected Health Information (PHI) Found?**

Sedgwick County Health Department

- COMCARE
- Community Developmental Disability Organization (CDDO)
- Department on Aging
- Emergency Medical Services (EMS)
- Division of Human Resources
- Any other departments that collect, maintain, and transmit PHI in its daily provision of care to the public.

### **What are the Rules Concerning Use and Disclosure of Protected Health Information?**

The Privacy Law requires Sedgwick County to provide clients with notice of the client's privacy right and the privacy practices of the Covered Entity. Direct treatment providers are required to make a good faith effort to obtain a client's written acknowledgement of the Notice of Privacy Right and Practices.

### **What does the Privacy Law mean for Sedgwick County Clients?**

- Provides clients greater control over their health information and limits the release of protected health information without proper authorization.
- Provides clients' access to their health records and grants the right to request amendments or make corrections to their protected health information.
- Informs clients how their health information is being used.
- Limits the amount of disclosed information to the "minimum necessary."
- Limits the use and disclosure of health records to safeguard security and identifies responsibility for inappropriate use and disclosure of information.
- Creates a balance between public responsibility with privacy protections.

### **What does the Privacy Law mean for Sedgwick County Employees?**

- Provides greater awareness of the rights of our clients to access, amend, and restrict their protected health information.
- Increases internal security measures for protecting and safeguarding client records.
- Ensures that our business partners adhere to the same duty to protect the integrity and confidentiality of health information already mandated under federal and state law.
- Encourages County employees to treat all individual medical records as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
- Establishes a standard not to disclose financial or other client information except the minimum necessary for billing or other authorized purposes.

Makes us all more conscientious stewards of public health and the public trust.

**Sedgwick County**  
**Health Insurance Portability and Accountability Act**  
**BASIC Training Acknowledgement Form**

All Sedgwick County employees will be trained in the Privacy Regulations in accordance with the **Health Insurance Portability and Accountability Act (HIPAA)** 45 CFR Section 164.530 (b). The employee's role and access to Protected Health Information within Sedgwick County will be related to the level of training required.

I, the undersigned, hereby acknowledge that I have read and understand the above written Sedgwick County Basic Training and agree to abide by the HIPAA policies demonstrated through the training.

I understand this Acknowledgement does not in any way constitute an employment contract, and Sedgwick County reserves the right to amend this training and dependent HIPAA policies at any time, without prior notice to me.

---

Employee Name-Printed

---

Date

---

Employee Signature

---

Sedgwick County Department

**SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION  
CONFIDENTIALITY AGREEMENT FOR NON-EMPLOYEES**

I, the undersigned, acknowledge that during the course of my voluntary participation or performance of duties with the Sedgwick County Developmental Disability Organization (hereinafter "SCDDO") that I may receive access to confidential information of SCDDO that is prohibited from disclosure to others.

"Confidential Information" means information provided by SCDDO that is not commonly available to the general public, or is required by law or regulation to be protected from disclosure to third parties not considered part of the facility's "workforce" as that term is defined by federal and state health information privacy regulations including, but not limited to the Health Information Portability and Accountability Act. Confidential Information includes information contained in patient medical records and any other health information which identifies a patient; quality assurance, research or peer review information; and information concerning the facility's employees, services or business operations. Such information can be acquired by any means and in any form, written, spoken or electronic.

In exchange for the opportunity to voluntarily participate or perform duties for the Sedgwick County Developmental Disability Organization, I agree not to share, disclose or discuss Confidential Information with anyone who does not have a legitimate interest in such information. I will abide by Sedgwick County's policies and procedures concerning the use or disclosure of Confidential Information and I will contact a SCDDO representative if I have any questions regarding these policies and procedures.

I will maintain and protect the privacy of SCDDO's employees, medical staff and patients in my use and disclosure of Confidential Information and I will not misuse or be careless with such information. I understand that any violation of this Agreement or SCDDO's policies related to access, use or disclosure of Confidential Information may result in significant legal ramifications for which I will be held solely responsible with respect to this Agreement.

I acknowledge that I have reviewed all of the information above. I understand that compliance with the principles, policies and procedures expressed above is a condition of my participation and continued presence at SCDDO.

---

Name (please print)

---

Signature

---

Date

## **CONFIDENTIALITY AGREEMENT USES INCLUDE:**

**Quality Assurance Committee (QAC):** As a member of the QAC on-site monitoring team, information will be provided which describes an individual's person-centered supports. Members will observe the individual and the services they receive as well as conduct interviews of the direct care staff. The Targeted Case Management agency establishes their review teams and will ensure that the Sedgwick County HIPPA Basic Training and Confidentially Agreement is completed prior to of review of services. Please contact SCDDO QA Coordinator for questions or concerns related to this role; SCDDO Main number 316-660-7630.

**Community Council Speakers Bureau:** As a Community Council Speakers Bureau participant, individuals or family members may disclose personal information related to an individual's health or disability and this information must be considered confidential. All relevant policies and procedures concerning the use or disclosure of confidential information are covered during orientation, but if you have any questions or require additional copies please contact Jeannette Livingston at the SCDDO 316-660-7630.

**SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
Quality Assurance Committee**

**Utilizing Review Tools**

**Documentation**

The tools used during the Quality Assurance Committee (QAC) review were developed using Developmental Disabilities Licensing Providers of Community Services K.A.R. 30-63-21 and the Guiding Principles and Values document. In addition, interview questions were added based on the SCDDO Affiliate Service Agreement and common practice.

The **Cover Sheet** is to be used for all reviews; this document identifies the service(s) which the individual receives as well basic information regarding the completed visit(s). The **QAC Review Checklist** will assist to ensure all documentation is submitted to SCDDO upon completion of the QAC review.

When an individual receives self-directed PCS the family/caregiver is provided an opportunity to review the services tool prior to the on-site review. Self-direction is a service model that allows an individual/guardian or designee to have decision making authority to manage, promote personal choice and control delivery of the service. This notification was originally created through an experiment to address low scores and has proven to be beneficial in not only reducing confusion and questions, it use has improved service outcomes. The QAC representative is responsible for delivery of the Self-directed Notification Letter prior to the scheduled visit.

**Service/Site Visit Reviews**

Each monitoring team will utilize the support plan review checklists and on-site review tools to collect, assess and document the QAC review. To evaluate whether the required information can be found in the individuals written documents the following tools were developed, please use when applicable: **Support Plan Review**, **Behavior Support Plan/Documentation Review and Psychotropic Medication Plan/Documentation Review**. There is also an **Employment Questionnaire** to complete when reviewing individuals between the ages of 18 to 65.

There are 5 on-site service tools created, they are as follows:

**Residential Services**- is to be used for adults who receive Residential services either in a group home setting or services in their own home.

**Life Enrichment**- is to be used for individuals who participate in a non-work day program.

**Work Services**- is to be used for individuals who participate in a work day program.

**Personal Care Services-Adult**- is for adults who receive in-home supports.

**Personal Care Services-Child**- is used for individuals under the age of 18 who receive in-home supports.

All members of the monitoring team shall become familiar with the questions asked on the review tool. The questions do not have to be asked in the order they are documented, but it is important for all the questions to be asked. All information which is gathered and documented assists in providing final feedback to the service provider reviewed.

There may be times when it is difficult to know how to rate a particular question, when this occurs document the response and observation. Discuss with the other member(s) of the monitoring team and agency representative.

Some review tool questions cannot be rated at particular locations, for these situations mark not applicable (N/A) within the document.

### **Comments/ Observations**

Each review tool includes a general observation section which each review team will complete. This section provides feedback regarding the individual's interactions with others in services as well as agency staff. In addition, the service site property is reviewed for cleanliness, space and accessibility. Use this section to record any observations which the reviewer feels should be noted for additional follow-up, these observations may include positive observations, concerns or important information to be passed on to the agency representative, service provider or the SCDDO.

**SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
Quality Assurance Committee**

**Conducting the On-Site Visit**

**Visit Arrangements**

Coordinate the details of all visits with the other members of the monitoring team and the agency representative for each provider where visits will be conducted. It should be decided what location will be visited, the time of the visit, and make sure all reviewers have directions to the location. Transportation arrangements for the reviewers should be worked out to ensure timely arrival at the designated service location and time. It may also be helpful to have contact information for the agency representative in case any questions or concerns arise when completing the visit.

**Upon Arrival**

If the review is at a residence, knock at the door, present the current QAC Member identification badge and introduce yourself. If the review is at a Day program location, check in at the agency's front desk and go through their visitor process. Additional identification, such as driver's license, may be requested by staff. Explain to the individual and their support staff the reason for the visit and determine if there is anything which could be done to minimize disruption of others at the home or day program. If you are refused entry at the location, leave and contact your agency representative at the first opportunity.

Examples of times when a visit may not be completed:

1. If medications are being administered, staff may not be able to answer specific questions until the task is completed.
2. If a particular individual is having a bad day or they are getting ready to leave for an appointment, it may be preferable to interview the individual at a later visit.

**During the Visit**

**Gathering Information:** The best way to prepare for a visit and gather information is to spend time reviewing the Support Plan prior to the visit. This will provide the opportunity to learn about the individual and their preferred lifestyle, support needs and goals prior to the visit. This knowledge will also allow a better understanding when interviewing support staff during the visit. Please become familiar with the specific areas covered by the review tool which may assist with avoiding implications of an inspection and help put the individual and support staff at ease.

**Respect Privacy:** Residential visits, whether they are at a privately owned or provider owned location, shall be completed with respect and privacy. Ask for permission before opening doors or going into rooms. Never enter an individual's bedroom or personal space without their permission. Do not intrude in situations that demand privacy.

Stick to the Review Tool: Ask adequate questions to understand and clarify the individual and/or support staff's responses to each question on the review tool. Do not request personal information unrelated to the services which are being reviewed.

Ask Staff for Assistance: When unsure about a particular response from the individual ask for assistance. Staff may be able to provide additional information or clarify the situation in a way which the review question is more accurately completed.

Discontinue the Visit if Necessary: If, at any time during the visit, the reviewer feels uncomfortable or unsafe, terminate the review process and leave the location. Notify the agency representative at the first available opportunity.

Health and Safety Concerns: If, during the visit, the reviewer has concerns regarding the health, safety, or well-being of the individual receiving services the following may occur discuss concerns with staff, continue the review or terminate the visit and leave the location. Record the concerns in the comments section of the review form and report the findings to the agency representative at the first available opportunity. If there is any concern of abuse, neglect or exploitation happening in the location, a call to Adult Protective Services or Child Protective Services shall be completed immediately.

Leaving: When the review is completed, thank everyone for their assistance and time and leave the location. If there is a need to discuss observations with other team members, find a private place away from the location. If individuals or support staff inquire about the review outcomes, explain that it will not be completed until final review by SCDDO. Assure them that they may access the final report through their agency.

Personal Care Services (PCS) Visits: Visits will be conducted in the family home, during which observations will be made of the caregiver(s) providing direct support to the individual. Prior to the site visit the agency representative or designee will contact the family to schedule the visit during a time when staff are present and when it would be least intrusive for the family. In lieu of the agency representative or designee, the TCM may assist the non-paid monitoring team member during the site visit at the request of the family.

### **After the Visit**

Complete all review forms along with any additional comments, questions or concerns identified during any portion of the QAC review. Return the written review to the agency representative.

### **Results of the Visit**

The agency representative will submit each QAC packet to SCDDO Quality Assurance staff. SCDDO will review all the documents submitted and conduct additional reviews or use other methods to ensure the following:

- reviews are being completed as necessary
- CSP's are responding to areas of concern
- CSP is taking appropriate action as needed
- policies and procedures are being followed

After SCDDO QA staff have completed the final review, reports are generated and distributed back to the CSPs which had a service review completed during the quarter.

## **SCDDO QAC Review Checklist** (submission of check list is not required)

Name of individual: [Click here to enter name.](#)

Due Date: [Click here to enter a date.](#)

Submitted to SCDDO [Click here to enter a date.:](#)

### **Required Documents** (Please submit in the order below.)

- QA Review Cover Sheet
- CDDO Employment Questionnaire
- Day Site Visit Review (if applicable)
- Residential Site Visit Review (if applicable)
- Personal Care Services Review (if applicable)
- Support Plan Review
- Behavior Support Plan / Psychotropic Medication Plan Review (if applicable)
- Support Plan
- Behavior Support Plan (if applicable)
- Psychotropic Medication Plan (if applicable)
- Psychotropic Consents (if applicable)
- Behavior Management Committee Reviews (if applicable)

### **Actions to be Taken Once Completed**

- Submit full packet to SCDDO
- Day Program Review
  - If the program is provided by another agency, send a copy to the assigned QA member at the agency
- Residential Review
  - If the program is provided by another agency, send a copy to the assigned QA member at the agency
- PCS Agency Directed Review
  - If the program is provided by another agency, send a copy to the assigned QA member at the agency

**SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION**

**Quality Assurance Review Cover Sheet**

<b>Name of Individual Reviewed:</b> <u>Click here to enter text.</u>	<b>Date of Birth:</b> <u>Click here to enter a date.</u>
<b>Review Team Agency:</b> <u>Click here to enter text.</u>	<b>Name of Agency Representative/Designee</b> <u>Click here to enter name.</u>  <b>Name of 2<sup>nd</sup> team member</b> <u>Click here to enter name.</u>
<b>Date Support Plan(s) were Review by QAC team:</b> <u>Click here to select date.</u>	
<b>Agency and Address of Day Site:</b> <u>Click here to enter agency name.</u>	<b>Date and Time of visit:</b> <u>Click here to enter a date.</u>
<u>Click here to enter address.</u>	<u>Click here to enter Time</u>
<b>Agency and Address of Residential Site:</b> <u>Click here to enter agency name.</u>	<b>Date and Time of visit:</b> <u>Click here to enter a date.</u>
<u>Click here to enter address.</u>	<u>Click here to enter Time</u>
<b>Agency and Location of PCS Site:</b> <u>Click here to enter agency name.</u>	<b>Date and Time of visit:</b> <u>Click here to enter a date.</u>
<u>Click here to enter address.</u>	<u>Click here to enter Time</u>
<b>Please select:</b> <input type="checkbox"/> <b>Agency Directed</b> <input type="checkbox"/> <b>Self-Directed</b>	

Complete on-site reviews **after** documentation reviews have been completed.

If completing this review with an individual who does not communicate verbally or has communication difficulties, the reviewer may also ask these questions to a staff person, guardian and/or family member. If completing the review in this manner, please indicate this in the appropriate box, which is located at the top of the review for all forms.

Reviews are to take place at both the residential and day sites, if both types of services are received.

If an adult attends two day programs, only the most attended program needs to be reviewed.

Additional information can be obtained within the QAC Manual. Copies are retained by Agency Representative and SG County CDDO website.

**Please complete all tools with as much detail as possible.**

# SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

## Employment Questionnaire

*To be completed for individuals age 18 through 65.*

Name of Individual: [Click here to enter name.](#)

1. Is the person currently (at this snapshot in time) in competitive employment?

**Competitive Employment** means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and for which the person is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same of similar work performed by persons who are not disabled.

Yes (If Yes, do not complete the remainder of this questionnaire)

No (If No, proceed to question #2)

2. If no to question #1, does the person centered support plan describe barriers and plans to overcome barriers to achieve competitive employment?

Yes (If Yes, proceed to question #3)

No (If No, do not complete the remainder of this questionnaire)

3. If yes to question #2, choose **one** primary barrier from the list below:

Person is currently in school

Person is near retirement age

Loss of government benefits

Lack of support from guardian, family member, or staff

Dislikes work

Enjoys current work/day environment more than competitive employment

Ongoing health concerns, fragile condition

Ongoing behavioral challenges

Transportation is not available

Appropriate jobs are not available

Workplace modifications/supports are not available or cannot be funded

Person chooses work crew type setting that is paid through the DD provider

Other

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: [Click here to enter name.](#)

### Life Enrichment

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) [Click here to enter text.](#)

#### Questions to ask the individual receiving services:

1. I understand that you like to [Click here to list their preferred activities from support plan.](#)  
Do you get to do these as often as you like? YES NO
2. Do you get to help choose the activities that you do? YES NO
3. Do you get to do something different if you don't like what the others are doing? YES NO
4. What do you like about this program? [Click here to enter text.](#)
5. What do you not like about this program? [Click here to enter text.](#)
6. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case the electricity goes out? [Click here to enter text.](#)
  - d. If someone hurts/mistreats/is mean to you? [Click here to enter text.](#)
7. Is your staff nice to you? YES NO  
If no, explain: [Click here to enter text.](#)
8. Does anyone ever take or keep things from you? YES NO  
If yes, explain: [Click here to enter text.](#)
9. Do you feel safe coming here? YES NO  
If no, explain: [Click here to enter text.](#)
10. Tell me what goals you are working on here. [Click here to enter text.](#)  
How does staff help you with that? [Click here to enter text.](#)
11. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

#### Questions to ask staff

Staff Name: [Click here to enter name.](#)  
How long has staff been working with this individual? [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

How long has staff been working for this agency? [Click here to enter text.](#)

1. How did you learn how to support this individual? [Click here to enter text.](#)
2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.)  YES  NO  
If yes, what? [Click here to enter text.](#)  
Require special food preparation/eating supports? (pureed, food cutting, etc.)  YES  NO  
If Yes, what? [Click here to enter text.](#)  
Is he or she OK with this diet?  YES  NO  
What do you do if the individual refuses to follow the diet? [Click here to enter text.](#)
3. The plan describes that the individual uses [Click here to enter description of the assistive equipment/technology.](#)  
What support do they need for these items? [Click here to enter text.](#)
4. What are the individuals' medical needs? [Click here to enter text.](#)  
How do you support these needs? [Click here to enter text.](#)  
If health services are needed, whom do you contact? [Click here to enter text.](#)  
Do you receive follow up as to the outcome?  YES  NO
5. Does this individual have any rights or restrictive procedures?  YES  NO  
If yes, what? [Click here to enter text.](#)  
Is this addressed in the individuals plan?  YES  NO
6. What behavior does this individual display? [Click here to enter text.](#)  
How do you support this need? [Click here to enter text.](#)
7. Does this individual take psychotropic medications?  YES  NO  
If so, what are the potential side effects or where do you go to find them? [Click here to enter text.](#)
8. Where do you keep the support plan? [Click here to enter text.](#)
9. According to the plan, what are the individual's Day Services goals? [Click here to enter text.](#)
10. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case of a power outage? [Click here to enter text.](#)
  - d. If the next shift does not show up? [Click here to enter text.](#)
11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? [Click here to enter text.](#)
12. Do you know how to make an ANE report directly to APS? (skip if mentioned above)  YES  NO

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

13. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

### **Questions the reviewer answers based on their observation/interview:**

Interactions were positive between the individual and others in services.  YES  NO  N/A

Interactions were positive between staff and the individual.  YES  NO  N/A

The individual expressed their own opinions.  YES  NO

The services are consistent with the support plan.  YES  NO

If no, please explain: [Click here to enter text.](#)

The individual was free of rights restrictions or restrictive interventions.  YES  NO

If no, please explain: [Click here to enter text.](#)

#### **The Property:**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| • Reasonably clean and well maintained.     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Safe and secure.                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Has adequate lighting inside and out.     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Has adequate space.                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Accessible to meet the individuals needs. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

**Kudos** (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): [Click here to enter text.](#)

**Comments/Concerns:** [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: [Click here to enter text.](#)

### Work Services & Supported Employment

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) [Click here to enter text.](#)

#### Questions to ask the individual receiving services:

1. I understand that you like to work at [Click here to enter the name of agency/ program.](#)  
Do you get to work on things you enjoy doing here?       YES       NO
2. How do you change it if you want to work on something else? [Click here to enter text.](#)
3. Do you have enough work?       YES       NO  
If no, explain: [Click here to enter text.](#)  
If you do not have work, what do you do during this time? [Click here to enter text.](#)  
Do you like doing that?       YES       NO  
If no, what would you rather be doing? [Click here to enter text.](#)
4. Does your staff help you learn your job if you need help?       YES       NO  
If no, explain: [Click here to enter text.](#)
5. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case the electricity goes out? [Click here to enter text.](#)
  - d. If someone hurts/mistreats/is mean to you? [Click here to enter text.](#)
6. Is your staff nice to you?       YES       NO  
If no, explain: [Click here to enter text.](#)
7. Does anyone ever take or keep things from you?       YES       NO  
If yes, explain: [Click here to enter text.](#)
8. Do you feel safe working here?       YES       NO  
If no, explain: [Click here to enter text.](#)
9. Tell me what goals you are working on here. [Click here to enter text.](#)  
How does staff help you with that? [Click here to enter text.](#)
10. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

#### Questions to ask staff

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Staff Name: [Click here to enter text.](#)

How long has staff been working with this individual? [Click here to enter text.](#)

How long has staff been working for this agency? [Click here to enter text.](#)

1. How did you learn how to support this individual? [Click here to enter text.](#)
2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.)  YES  NO  
If yes, what? [Click here to enter text.](#)  
Require special food preparation/eating supports? (pureed, food cutting, etc.)  YES  NO  
If Yes, what? [Click here to enter text.](#)  
Is he or she OK with this diet?  YES  NO  
What do you do if the individual refuses to follow the diet? [Click here to enter text.](#)
3. The plan describes that the individual uses [Click here to enter description of the assistive equipment/ technology.](#)  
What support do they need for these items? [Click here to enter text.](#)
4. What are the individuals' medical needs? [Click here to enter text.](#)  
How do you support these needs? [Click here to enter text.](#)  
If health services are needed, whom do you contact? [Click here to enter text.](#)  
Do you receive follow up as to the outcome?  YES  NO
5. Does this individual have any rights or restrictive procedures?  YES  NO  
If yes, what? [Click here to enter text.](#)  
Is this addressed in the individuals plan?  YES  NO
6. What behavior does this individual display? [Click here to enter text.](#)  
How do you support this need? [Click here to enter text.](#)
7. Does this individual take psychotropic medications?  YES  NO  
If so, what are the potential side effects or where do you go to find them? [Click here to enter text.](#)
8. Where do you keep the support plan? [Click here to enter text.](#)
9. According to the plan, what are the individual's Work/ Supported Employment Services goals? [Click here to enter text.](#)
10. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case of a power outage? [Click here to enter text.](#)
11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? [Click here](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

[to enter text.](#)

12. Do you know how to make an ANE report directly to APS? (skip if mentioned above)  YES  NO

13. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

### **Questions the reviewer answers based on their observation/interview:**

Interactions were positive between the individual and others in services.  YES  NO  N/A

Interactions were positive between staff and the individual.  YES  NO  N/A

The individual expressed their own opinions.  YES  NO

The services are consistent with the support plan.  YES  NO

If no, please explain: [Click here to enter text.](#)

The individual was free of rights restrictions or restrictive interventions?  YES  NO

If no, please explain: [Click here to enter text.](#)

#### **The Property:**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| • Reasonably clean and well maintained.     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Safe and secure.                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Has adequate lighting inside and out.     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Has adequate space.                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Accessible to meet the individuals needs. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

**Kudos** (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): [Click here to enter text.](#)

**Comments/Concerns:** [Click here to enter text.](#)

# SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: [Click here to enter text.](#)

## Residential Services

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) [Click here to enter text.](#)

### Questions to ask the individual receiving services:

1. I understand that you like to [Click here to list community & other preferred activities from support plan.](#)  
Do you get to do these as often as you like? YES NO
2. Do you do shopping for groceries and other things that you need? YES NO  
If no, who does? [Click here to enter text.](#) Are you OK with that? YES NO
3. Do you choose what you eat (i.e. for breakfast, lunch, dinner, snacks)? YES NO  
If no, who does? [Click here to enter text.](#) Are you OK with that? YES NO  
If you do not like what you have for a meal, do you get other choices? YES NO
4. In your home, what do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case the electricity goes out? [Click here to enter text.](#)
  - d. If someone hurts/mistreats/is mean to you? [Click here to enter text.](#)
  - e. If your staff does not show up for work? [Click here to enter text.](#)
5. Is your staff nice to you? YES NO  
If no, explain: [Click here to enter text.](#)
6. Does your staff answer your questions? YES NO  
If no, explain: [Click here to enter text.](#)
7. Does anyone ever take or keep things from you? YES NO  
If yes, what/who? [Click here to enter text.](#)
8. Do you feel safe living here? YES NO  
If no, explain: [Click here to enter text.](#)
9. Tell me what goals you are working on. [Click here to enter text.](#)  
How does staff help you with that? [Click here to enter text.](#)
10. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

### Questions to ask staff

Staff Name: [Click here to enter text.](#)

How long has staff been working with this individual? [Click here to enter text.](#)

How long has staff been working for this agency? [Click here to enter text.](#)

1. How did you learn how to support this individual? [Click here to enter text.](#)
2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.)  YES  NO  
If yes, what? [Click here to enter text.](#)  
Require special food preparation/eating supports? (pureed, food cutting, etc.)  YES  NO  
If Yes, what? [Click here to enter text.](#)  
Is he or she OK with this diet?  YES  NO  
What do you do if the individual refuses to follow the diet? [Click here to enter text.](#)
3. The plan describes that the individual uses [Click here to enter description of the assistive equipment/ technology.](#)  
What support do they need for these items? [Click here to enter text.](#)
4. What are the individuals' medical needs? [Click here to enter text.](#)  
How do you support these needs? [Click here to enter text.](#)  
If health services are needed, whom do you contact? [Click here to enter text.](#)  
Do you receive follow up as to the outcome?  YES  NO
5. Does this individual have any rights or restrictive procedures?  YES  NO  
If yes, what? [Click here to enter text.](#)  
Is this addressed in the individuals plan?  YES  NO
6. What behavior does this individual display? [Click here to enter text.](#)  
How do you support this need? [Click here to enter text.](#)
7. Does this individual take psychotropic medications?  YES  NO  
If so, what are the potential side effects or where do you go to find them? [Click here to enter text.](#)
8. Where do you keep the support plan? [Click here to enter text.](#)
9. According to the plan, what are the individual's Residential Services goals? [Click here to enter text.](#)
10. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case of a power outage? [Click here to enter text.](#)
  - d. If the next shift does not show up? [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? [Click here to enter text.](#)

12. Do you know how to make an ANE report directly to APS? (skip if mentioned above)  YES  NO

13. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

### Questions the reviewer answers based on their observation/interview:

Interactions were positive between the individual and others in services.  YES  NO  N/A

Interactions were positive between staff and the individual.  YES  NO  N/A

The individual expressed their own opinions.  YES  NO

The services are consistent with the support plan.  YES  NO

If no, please explain: [Click here to enter text.](#)

The individual was free of rights restrictions or restrictive interventions (i.e. alarms on doors, locked refrigerator or cabinets, etc).  YES  NO

If no, please explain: [Click here to enter text.](#)

#### **The Property:**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| • Reasonably clean and well maintained.     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Safe and secure.                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Has adequate lighting inside and out.     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Has adequate space.                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Accessible to meet the individuals needs. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

**Kudos** (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): [Click here to enter text.](#)

**Comments/Concerns:** [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: [Click here to enter text.](#)

### Personal Care Services for Adults

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) [Click here to enter text.](#)

#### Questions to ask the individual receiving services:

1. I understand that you like to [Click here to list preferred activities from support plan.](#)  
Do you get to do these as often as you like?  YES  NO
2. I understand that you like to spend time with [Click here to list from support plan.](#)  
Do you get to spend as much time with them as you like?  YES  NO  
If no, why? [Click here to enter text.](#)
3. Do you go shopping for the things that you need?  YES  NO  
If no, who does? [Click here to enter text.](#) Are you OK with that?  YES  NO
4. If you do not like what you have for a meal, do you get other choices?  YES  NO  
If no, explain: [Click here to enter text.](#)
5. Is there anything you would change about where or with whom you are living?  YES  NO  
If yes, what? [Click here to enter text.](#)
6. Is there anything you would change about what you do during the day?  YES  NO  
If yes, what? [Click here to enter text.](#)
7. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case the electricity goes out? [Click here to enter text.](#)
  - d. If someone hurts/mistreats/is mean to you? [Click here to enter text.](#)
  - e. If you are hurt/ sick? [Click here to enter text.](#)
  - f. If your staff does not show up for work? [Click here to enter text.](#)
8. Tell me what goals you are working on. [Click here to enter text.](#)  
How does staff help you with that? [Click here to enter text.](#)
9. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

# SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

## Questions to ask staff

Staff Name: [Click here to enter text.](#)

How long has staff been working with this individual? [Click here to enter text.](#)

How long has staff been working for this agency? [Click here to enter text.](#)

1. How did you learn how to support this individual? [Click here to enter text.](#)
2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.)  YES  NO  
If yes, what? [Click here to enter text.](#)  
Require special food preparation/eating supports? (pureed, food cutting, etc.)  YES  NO  
If Yes, what? [Click here to enter text.](#)  
Is he or she OK with this diet?  YES  NO  
What do you do if the individual refuses to follow the diet? [Click here to enter text.](#)
3. The plan describes that the individual uses [Click here to enter description of the assistive equipment/ technology.](#)  
What support do they need for these items? [Click here to enter text.](#)
4. What are the individuals' medical needs? [Click here to enter text.](#)  
How do you support these needs? [Click here to enter text.](#)  
If health services are needed, whom do you contact? [Click here to enter text.](#)  
Do you receive follow up as to the outcome?  YES  NO
5. Does this individual have any rights or restrictive procedures?  YES  NO  
If yes, what? [Click here to enter text.](#)  
Is this addressed in the individuals plan?  YES  NO
6. What behavior does this individual display? [Click here to enter text.](#)  
How do you support this need? [Click here to enter text.](#)
7. Does this individual take psychotropic medications?  YES  NO  
If so, what are the potential side effects or where do you go to find them? [Click here to enter text.](#)
8. Where do you keep the support plan? [Click here to enter text.](#)
9. According to the plan, what are the individual's Personal Care Services goals? [Click here to enter text.](#)
10. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case of a power outage? [Click here to enter text.](#)
  - d. If the next shift does not show up? [Click here to enter text.](#)
  - e. If you suspect abuse, neglect or exploitation? [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

11. Do you know how to make an ANE report directly to APS? (skip if mentioned above)  YES  NO

12. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

### **Questions the reviewer answers based on their observation/interview:**

Interactions were positive between the individual and parent/family.  YES  NO  N/A

Interactions were positive between staff and the individual.  YES  NO  N/A

The individual expressed their own opinions.  YES  NO

The services are consistent with the support plan.  YES  NO

If no, please explain: [Click here to enter text.](#)

The individual was free of rights restrictions or restrictive interventions (i.e. alarms on doors, locked refrigerator or cabinets, etc).  YES  NO

If no, please explain: [Click here to enter text.](#)

#### **The Property:**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| • Reasonably clean and well maintained.     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Safe and secure.                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Has adequate lighting inside and out.     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Has adequate space.                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Accessible to meet the individuals needs. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

**Kudos** (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): [Click here to enter text.](#)

**Comments/Concerns:** [Click here to enter text.](#)

# ORGANIZACIÓN DE DISCAPACIDAD DEL DESARROLLO DEL CONDADO DE SEDGWICK

Nombre: Click or tap here to enter text.

## **Servicios de cuidado personal para adultos**

Si la persona utiliza un método de comunicación que no sea la verbalización, indique cómo se respondieron estas preguntas (es decir, la familia/el miembro del personal respondió las preguntas, la persona respondió con señales no verbales, etc.) Click or tap here to enter text.

### **Preguntas para hacerle a la persona que recibe los servicios:**

1. Entiendo que le gusta Click or tap here to enter text.  
Mencione sus actividades preferidas del plan de apoyo  
¿Puede hacerlas con la frecuencia que desea?  SÍ  NO
2. Entiendo que le gusta pasar tiempo con Click or tap here to enter text.  
Mencione del plan de apoyo  
¿Puede pasar con ellos todo el tiempo que le gustaría?  SÍ  NO  
Si la respuesta es No, ¿por qué? Click or tap here to enter text.
3. ¿Usted se encarga de hacer las compras de las cosas que necesita?  SÍ  NO  
Si la respuesta es No, ¿quién lo hace? Click or tap here to enter text. ¿Está de acuerdo con eso?  
 SÍ  NO
4. Si no le gusta lo que come, ¿tiene otras opciones?  SÍ  NO  
Si la respuesta es No, explique: Click or tap here to enter text.
5. ¿Hay algo que cambiaría sobre dónde o con quién vive?  SÍ  NO  
Si la respuesta es Sí, ¿qué cambiaría? Click or tap here to enter text.
6. ¿Hay algo que cambiaría de lo que hace durante el día?  SÍ  NO  
Si la respuesta es Sí, ¿qué cambiaría? Click or tap here to enter text.
7. ¿Qué hace usted en los siguientes casos?
  - a. Tornado Click or tap here to enter text.
  - b. Incendio Click or tap here to enter text.
  - c. Corte de electricidad Click or tap here to enter text.
  - d. Una persona lo lastima/maltrata/es cruel con usted Click or tap here to enter text.
  - e. Se lastima/se enferma Click or tap here to enter text.
  - f. El miembro del personal no se presenta a trabajar Click or tap here to enter text.
8. Cuénteme en qué objetivos está trabajando. Click or tap here to enter text.  
¿Cómo le ayuda el miembro del personal con eso? Click or tap here to enter text.
9. ¿Tiene alguna pregunta o hay algo más que le gustaría comentarme?  
Click or tap here to enter text.

## ORGANIZACIÓN DE DISCAPACIDAD DEL DESARROLLO DEL CONDADO DE SEDGWICK

### Preguntas para hacerle al personal

Nombre del miembro del personal: [Click or tap here to enter text.](#)

¿Cuánto tiempo lleva el miembro del personal trabajando con esta persona? [Click or tap here to enter text.](#)

¿Cuánto tiempo lleva el miembro del personal trabajando para esta agencia? [Click or tap here to enter text.](#)

1. ¿Cómo aprendió a brindarle apoyo a esta persona? [Click or tap here to enter text.](#)
2. ¿Esta persona tiene necesidades nutricionales especiales? (calorías, alergias a alimentos, bajo contenido de sodio, etc.)  SÍ  NO  
Si la respuesta es Sí, ¿cuáles son? [Click or tap here to enter text.](#)  
¿Necesita algún tipo de apoyo especial para la preparación de alimentos/comida? (pisar alimentos o hacerlos puré, cortarlos, etc.)  SÍ  NO  
Si la respuesta es Sí, ¿qué tipo de apoyo? [Click or tap here to enter text.](#)  
¿Esta persona está de acuerdo con esta dieta?  SÍ  NO  
¿Qué hace si la persona se niega a seguir la dieta? [Click or tap here to enter text.](#)
3. El plan describe que la persona utiliza (mencionar el equipo/la tecnología de asistencia) [Click or tap here to enter text.](#)  
¿Qué tipo de apoyo necesita para usar estos elementos? [Click or tap here to enter text.](#)
4. ¿Cuáles son las necesidades médicas de esta persona? [Click or tap here to enter text.](#)  
¿De qué manera brinda apoyo para satisfacer estas necesidades? [Click or tap here to enter text.](#)  
Si se necesitan servicios de salud, ¿con quién se comunica? [Click or tap here to enter text.](#)  
¿Recibe seguimiento con respecto al resultado?  SÍ  NO
5. ¿Esta persona tiene algún derecho o procedimiento restrictivo?  SÍ  NO  
Si la respuesta es Sí, ¿cuál? [Click or tap here to enter text.](#)  
¿Esto se aborda en el plan de la persona?  SÍ  NO
6. ¿Qué comportamiento muestra esta persona? [Click or tap here to enter text.](#)  
¿De qué manera brinda apoyo para satisfacer esta necesidad? [Click or tap here to enter text.](#)
7. ¿Esta persona toma medicamentos psicotrópicos?  SÍ  NO  
Si la respuesta es Sí, ¿cuáles son los posibles efectos secundarios y dónde acude para encontrar estos medicamentos? [Click or tap here to enter text.](#)
8. ¿Dónde guarda el plan de apoyo? [Click or tap here to enter text.](#)
9. Según el plan, ¿cuáles son los objetivos de los servicios de cuidado personal? [Click or tap here to enter text.](#)

## ORGANIZACIÓN DE DISCAPACIDAD DEL DESARROLLO DEL CONDADO DE SEDGWICK

10. ¿Qué hace usted en los siguientes casos?
- Tornado [Click or tap here to enter text.](#)
  - Incendio [Click or tap here to enter text.](#)
  - Corte de energía [Click or tap here to enter text.](#)
  - No se presenta el miembro del personal del siguiente turno [Click or tap here to enter text.](#)
  - Usted sospecha de abuso, negligencia o explotación [Click or tap here to enter text.](#)
11. ¿Sabe cómo hacer una denuncia por abuso, negligencia o explotación (ANE) directamente ante los Servicios de Protección para Adultos (APS)? (omitir si se menciona arriba)  SÍ  NO
12. ¿Tiene alguna pregunta o hay algo más que le gustaría comentarme? [Click or tap here to enter text.](#)

### **Preguntas que responde el revisor en función de sus observaciones/entrevistas:**

- Las interacciones fueron positivas entre la persona y los padres/la familia.  SÍ  NO  N/A
- Las interacciones fueron positivas entre el miembro del personal y la persona.  SÍ  NO  N/A
- La persona expresó sus propias opiniones.  SÍ  NO
- Los servicios son consistentes con el plan de apoyo.  SÍ  NO
- Si la respuesta es No, explique: [Click or tap here to enter text.](#)

- La persona estaba libre de restricciones de derechos o intervenciones restrictivas (es decir, alarmas en puertas, refrigeradores o gabinetes cerrados con llave, etc.).  SÍ  NO
- Si la respuesta es No, explique: [Click or tap here to enter text.](#)

#### La propiedad:

- |   |                             |                             |
|---|-----------------------------|-----------------------------|
| • Está razonablemente limpia y bien mantenida.                        | <input type="checkbox"/> SÍ | <input type="checkbox"/> NO |
| • Es segura y está protegida.   | <input type="checkbox"/> SÍ | <input type="checkbox"/> NO |
| • Cuenta con iluminación adecuada tanto en su interior como exterior. | <input type="checkbox"/> SÍ | <input type="checkbox"/> NO |
| • Tiene espacio adecuado.   | <input type="checkbox"/> SÍ | <input type="checkbox"/> NO |
| • Cuenta con accesos para satisfacer las necesidades de la persona.   | <input type="checkbox"/> SÍ | <input type="checkbox"/> NO |

**Reconocimientos** (observaciones positivas que el revisor ha anotado sobre el miembro del personal, la persona que recibe los servicios, el lugar, etc.): [Click or tap here to enter text.](#)

**Comentarios/observaciones:** [Click or tap here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: [Click here to enter text.](#)

### **Personal Care Services for Children (under the age of 18)**

The review is to be completed in the child's home with the child present.

Name of family member who participated in review: [Click here to enter text.](#)

#### **Questions to ask the family:**

1. Does the service meet your family's needs?  YES  NO  
Comments: [Click here to enter text.](#)
2. Do you feel comfortable with the person(s) who cares for your child?  YES  NO  
Comments: [Click here to enter text.](#)
3. What other services or support items will your child need this year? [Click here to enter text.](#)
4. Does your child have any unmet medical needs?  YES  NO  
Comments: [Click here to enter text.](#)
5. Does your child have any unmet mental health needs?  YES  NO  
Comments: [Click here to enter text.](#)
6. Have you been given information on what to do if you believe your child have been abused, neglected or exploited?  YES  NO
7. Is there anything you would like your case manager to follow up with?  YES  NO  
Comments: [Click here to enter text.](#)

#### **Questions to ask staff**

Staff Name: [Click here to enter text.](#)

How long has staff been working with this individual? [Click here to enter text.](#)

How long has staff been working for this agency? [Click here to enter text.](#)

1. How did you learn how to support this individual? [Click here to enter text.](#)
2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.)  YES  NO  
If yes, what? [Click here to enter text.](#)  
Require special food preparation/eating supports? (pureed, food cutting, etc.)  YES  NO  
If Yes, what? [Click here to enter text.](#)  
Is he or she OK with this diet?  YES  NO  
What do you do if the individual refuses to follow the diet? [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

3. The plan describes that the individual uses [Click here to enter description of the assistive equipment/technology.](#)  
What support do they need for these items? [Click here to enter text.](#)
4. What are the individuals' medical needs? [Click here to enter text.](#)  
How do you support these needs? [Click here to enter text.](#)  
If health services are needed, whom do you contact? [Click here to enter text.](#)  
Do you receive follow up as to the outcome?  YES  NO
5. What behavior does this individual display? [Click here to enter text.](#)  
How do you support this need? [Click here to enter text.](#)
6. Does this individual take medications?  YES  NO  
If so, what are the potential side effects or where do you go to find them? [Click here to enter text.](#)
7. Where do you keep the support plan? [Click here to enter text.](#)
8. According to the plan, what are the individual's Personal Care Services goals? [Click here to enter text.](#)
9. What do you do:  
a. In case of a tornado? [Click here to enter text.](#)  
b. In case of a fire? [Click here to enter text.](#)  
c. In case of a power outage? [Click here to enter text.](#)  
d. If the next shift does not show up? [Click here to enter text.](#)  
e. If you suspect abuse, neglect or exploitation? [Click here to enter text.](#)
10. Do you know how to make an ANE report directly to APS? (skip if mentioned above)  YES  NO
11. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

### **Questions the reviewer answers based on their observation/interview:**

Interactions were positive between the individual and parent/family.  YES  NO  N/A

Interactions were positive between staff and the individual.  YES  NO  N/A

The services are consistent with the support plan.  YES  NO

If no, please explain: [Click here to enter text](#)

The individual was free of rights restrictions or restrictive interventions (i.e. alarms on doors, locked refrigerator or cabinets, etc).  YES  NO

If no, please explain: [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

### The Property:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| • Reasonably clean and well maintained.     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Safe and secure.                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Has adequate lighting inside and out.     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Has adequate space.                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Accessible to meet the individuals needs. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

**Kudos** (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): [Click here to enter text.](#)

**Comments/Concerns:** [Click here to enter text.](#)

## ORGANIZACIÓN DE DISCAPACIDAD DEL DESARROLLO DEL CONDADO DE SEDGWICK

Nombre: [Click or tap here to enter text.](#)

### **Servicios de cuidado personal para niños (menores de 18 años)**

La revisión se debe completar en el hogar del niño con este presente.

Nombre del familiar que participó en la revisión: [Click or tap here to enter text.](#)

#### **Preguntas para hacerle a la familia:**

1. ¿El servicio satisface las necesidades de su familia?  SÍ  NO  
Comentarios: [Click or tap here to enter text.](#)
2. ¿Se siente cómodo con la(s) persona(s) que cuidan a su hijo?  SÍ  NO  
Comentarios: [Click or tap here to enter text.](#)
3. ¿Qué otros servicios o elementos de apoyo necesitará su hijo este año? [Click or tap here to enter text.](#)
4. ¿Su hijo tiene alguna necesidad médica no cubierta?  SÍ  NO  
Comentarios: [Click or tap here to enter text.](#)
5. ¿Su hijo tiene alguna necesidad médica de salud mental no cubierta?  SÍ  NO  
Comentarios: [Click or tap here to enter text.](#)
6. ¿Le han proporcionado información sobre qué hacer si cree que su hijo sufrió abuso, negligencia o explotación?  SÍ  NO
7. ¿Le gustaría que su administrador de casos hiciera un seguimiento sobre algo en particular?  SÍ  NO  
Comentarios: [Click or tap here to enter text.](#)

# ORGANIZACIÓN DE DISCAPACIDAD DEL DESARROLLO DEL CONDADO DE SEDGWICK

## Preguntas para hacerle al personal

Nombre del miembro del personal: [Click or tap here to enter text.](#)

¿Cuánto tiempo lleva el miembro del personal trabajando con esta persona? [Click or tap here to enter text.](#)

¿Cuánto tiempo lleva el miembro del personal trabajando para esta agencia? [Click or tap here to enter text.](#)

1. ¿Cómo aprendió a brindarle apoyo a esta persona? [Click or tap here to enter text.](#)

2. ¿Esta persona tiene necesidades nutricionales especiales? (calorías, alergias a alimentos,

bajo contenido de sodio, etc.)

SÍ  NO

Si la respuesta es Sí, ¿cuáles? [Click or tap here to enter text.](#)

¿Necesita algún tipo de apoyo especial para la preparación de alimentos/comida? (pisar alimentos o hacerlos

puré, cortarlos, etc.)

SÍ  NO

Si la respuesta es Sí, ¿cuáles? [Click or tap here to enter text.](#)

¿Esta persona está de acuerdo con esta dieta?

SÍ  NO

¿Qué hace si la persona se niega a seguir la dieta? [Click or tap here to enter text.](#)

3. El plan describe que la persona utiliza (mencionar el equipo/la tecnología de asistencia) [Click or tap here to enter text.](#)

¿Qué tipo de apoyo necesita para usar estos elementos? [Click or tap here to enter text.](#)

4. ¿Cuáles son las necesidades médicas de esta persona? [Click or tap here to enter text.](#)

¿De qué manera brinda apoyo para satisfacer estas necesidades? [Click or tap here to enter text.](#)

Si se necesitan servicios de salud, ¿con quién se comunica? [Click or tap here to enter text.](#)

¿Recibe seguimiento con respecto al resultado?

SÍ  NO

5. ¿Qué comportamiento muestra esta persona? [Click or tap here to enter text.](#)

¿De qué manera brinda apoyo para satisfacer esta necesidad? [Click or tap here to enter text.](#)

6. ¿Esta persona toma medicamentos?

SÍ  NO

Si la respuesta es Sí, ¿cuáles son los posibles efectos secundarios y dónde acude para encontrar estos medicamentos? [Click or tap here to enter text.](#)

7. ¿Dónde guarda el plan de apoyo? [Click or tap here to enter text.](#)

8. Según el plan, ¿cuáles son los objetivos de los servicios de cuidado personal? [Click or tap here to enter text.](#)

9. ¿Qué hace usted en los siguientes casos?

a. Tornado [Click or tap here to enter text.](#)

b. Incendio [Click or tap here to enter text.](#)

c. Corte de energía [Click or tap here to enter text.](#)

d. No se presenta el miembro del personal del siguiente turno [Click or tap here to enter text.](#)

e. Usted sospecha de abuso, negligencia o explotación [Click or tap here to enter text.](#)

## ORGANIZACIÓN DE DISCAPACIDAD DEL DESARROLLO DEL CONDADO DE SEDGWICK

10. ¿Sabe cómo hacer una denuncia por abuso, negligencia o explotación (ANE) directamente ante los Servicios de Protección para Adultos (APS)? (omitir si se menciona arriba)  SÍ  NO
11. ¿Tiene alguna pregunta o hay algo más que le gustaría comentarme? [Click or tap here to enter text.](#)

### **Preguntas que responde el revisor en función de sus observaciones/entrevistas:**

- Las interacciones fueron positivas entre la persona y los padres/la familia.  SÍ  NO  N/A
- Las interacciones fueron positivas entre el miembro del personal y la persona.  SÍ  NO  N/A
- Los servicios son consistentes con el plan de apoyo.  SÍ  NO

Si la respuesta es No, explique: [Click or tap here to enter text.](#)

- La persona estaba libre de restricciones de derechos o intervenciones restrictivas (es decir, alarmas en puertas, refrigeradores o gabinetes cerrados con llave, etc.).  SÍ  NO

Si la respuesta es No, explique: [Click or tap here to enter text.](#)

La propiedad:

- Está razonablemente limpia y bien mantenida.  SÍ  NO
- Es segura y está protegida.  SÍ  NO
- Cuenta con iluminación adecuada tanto en su interior como exterior.  SÍ  NO
- Tiene espacio adecuado.  SÍ  NO
- Cuenta con accesos para satisfacer las necesidades de la persona.  SÍ  NO

**Reconocimientos** (observaciones positivas que el revisor ha anotado sobre el miembro del personal, la persona que recibe los servicios, el lugar, etc.): [Click or tap here to enter text.](#)

**Comentarios/observaciones:** [Click or tap here to enter text.](#)

SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
**Support Plan Review**

Name of Individual Reviewed: \_\_\_\_\_ Effective Date of Plan: \_\_\_\_\_

<b>Areas to Review</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Comments</b>
Lead Coordinator of Plan and Lead Medical Coordinator are identified				
<i>What I Have Now:</i> includes current lifestyle- residential setting, individuals they live with, work or valued activity, who they socialize with, and social/leisure/religious activities				
<i>What I Want in the Future:</i> includes dreams for the future, changes in current circumstances, or inclusion in things they do not currently participate in				
<i>Opportunities for Choice and Control:</i> it is clear how the individual indicates their preferences/choices				
Barriers to achieving preferred lifestyle are identified				
Goals are directly related to barriers and/or preferred lifestyle				
<b>All Support Sections – Supports should be specific to the needs of the person. These sections should indicate the individual’s preferences and explain how they would like to be supported for each need.</b>				
<i>Support at Home</i>				
<i>Support with Work, School &amp; Daily Activity</i>				
If unemployed, barriers to community employment are identified				
If community employment is not being pursued, informed choice is clearly documented				
<i>Community and Social Support</i>				
<i>Wellness Support</i>				
<i>Medical Support</i>				
<i>Legal and/or Financial Support</i>				

Transition from school to adulthood (age 14-18): guardianship has been established and/or documented				
<i>Communication/Decision Making Support</i>				
<b>Areas to Review</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Comments</b>
Plan describes the need for restrictions or limitations of the individual's rights or possessions				
If limitations or restrictions are present, Behavior Management Committee approval has been obtained				
Behavior Support Plan/documentation is in place (complete checklist)				
Psychotropic Medication Plan/documentation is in place (complete checklist)				
Plan signed by individual and guardian (within 365 days)				
Upon review, support plan accurately reflects the individuals' current situation				
If No explain:				

Reviewer Comments:

SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
**Support Plan Review**

Name of Individual Reviewed: \_\_\_\_\_ Effective Date of Plan: \_\_\_\_\_

<b>Areas to Review</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Comments</b>
Lead Coordinator of Plan and Lead Medical Coordinator are identified				30-63-21 (b) and 30-63-24 (d)
<i>What I Have Now:</i> includes current lifestyle- residential setting, individuals they live with, work or valued activity, who they socialize with, and social/leisure/religious activities				30-63-21 (2)(A-E)
<i>What I Want in the Future:</i> includes dreams for the future, changes in current circumstances, or inclusion in things they do not currently participate in				Content should reflect what the individual wants
<i>Opportunities for Choice and Control:</i> it is clear how the individual indicates their preferences/choices				30-63-21 (4) (A-C)
Barriers to achieving preferred lifestyle are identified				30-63-21 (5) (A-D)
Goals are directly related to barriers and/or preferred lifestyle				30-63-21 (a)(7) - evidence that the plan contributes to the continuous movement towards preferred lifestyle
<b>All Support Sections – Supports should be specific to the needs of the person. These sections should indicate the individual’s preferences and explain how they would like to be supported for each need.</b>				
<i>Support at Home</i>				
<i>Support with Work, School &amp; Daily Activity</i>				
If unemployed, barriers to community employment are identified				Employment First Initiative; contractual obligation
If community employment is not being pursued, informed choice is clearly documented				Employment First Initiative; contractual obligation
<i>Community and Social Support</i>				
<i>Wellness Support</i>				
<i>Medical Support</i>				30-63-24 (c) training required to be identified, if needed
<i>Legal and/or Financial Support</i>				

Transition from school to adulthood (age 14-18): guardianship has been established and/or documented				
<i>Communication/Decision Making Support</i>				
<b>Areas to Review</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Comments</b>
Plan describes the need for restrictions or limitations of the individual's rights or possessions				
If limitations or restrictions are present, Behavior Management Committee approval has been obtained				30-63-23 Needed when there is restrictive intervention used to manage behavior
Behavior Support Plan/documentation is in place (complete checklist)				
Psychotropic Medication Plan/documentation is in place (complete checklist)				
Plan signed by individual and guardian (within 365 days)				30-63-21 (8) - reasonable measures to obtain approval need to be documented
Upon review, support plan accurately reflects the individuals' current situation				
If No explain:				

Reviewer Comments:

SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
**Behavior Support Plan/Documentation Review**

Name of Individual Reviewed: \_\_\_\_\_

Date of Plan: \_\_\_\_\_

<i>Areas to Review</i>	<b>Yes</b>	<b>No</b>	<i>Comments</i>
Purpose for Behavior Support Plan is documented through a description of targeted/maladaptive behaviors			
Safeguards are in place to minimize risk: could include Environmental Modifications and/or evidence of attempts of less restrictive alternatives			
Plan is signed by individual and guardian (within 365 days)			
If restrictive elements are present, evidence of review/approval by a Behavior Management Committee is obtained and current (within 365 days)			

**Psychotropic Medication Plan/Documentation Review**

Date of Plan: \_\_\_\_\_

<i>Areas to Review</i>	<b>Yes</b>	<b>No</b>	<i>Comments</i>
Purpose of Psychotropic Medication Plan is documented through a description of diagnosis			
Description of behavior related to diagnosis is listed			
Safeguards are in place to minimize risk: could include Positive Behavior Programming and/or Environmental Modifications			
Plan describes possible side effects of medication (signs/symptoms)			
Plan describes how staff will respond to side effects (signs/symptoms)			
Reviewed by Behavior Management Committee annually			
Informed consent signed by individual and guardian (within 365 days)			

**Regulation (Article 63) does not require a “plan”; rather the expectation is that there is documentation of the above mentioned items with approval from BMC/HRC if there are psychotropic medications or restrictive interventions being utilized.**

Reviewer Comments:

SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
**Behavior Support Plan/Documentation Review**

Name of Individual Reviewed: \_\_\_\_\_

Date of Plan: \_\_\_\_\_

<i>Areas to Review</i>	<b>Yes</b>	<b>No</b>	<i>Comments</i>
Purpose for Behavior Support Plan is documented through a description of targeted/maladaptive behaviors			30-63-23 (2)(A)(i)
Safeguards are in place to minimize risk: could include Environmental Modifications and/or evidence of attempts of less restrictive alternatives			30-63-23 (1) (A-D) - initial and ongoing assessment and responsive modifications that may be needed; evidence of least restrictive
Plan is signed by individual and guardian (within 365 days)			30-63-23 (3)(c) - reasonable efforts to obtain signature must be documented
If restrictive elements are present, evidence of review/approval by a Behavior Management Committee is obtained and current (within 365 days)			30-63-23 (3)(B)

**Psychotropic Medication Plan/Documentation Review**

Date of Plan: \_\_\_\_\_

<i>Areas to Review</i>	<b>Yes</b>	<b>No</b>	<i>Comments</i>
Purpose of Psychotropic Medication Plan is documented through a description of diagnosis			30-63-23 Required for individuals on medication to manage behaviors or to treat diagnosed mental illnesses
Description of behavior related to diagnosis is listed			30-63-23 (2)(A)(i)
Safeguards are in place to minimize risk: could include Positive Behavior Programming and/or Environmental Modifications			30-63-23 (1) (A-D) - initial and ongoing assessment and responsive modifications that may be needed; evidence of least restrictive
Plan describes possible side effects of medication (signs/symptoms)			30-63-23 (1, C)
Plan describes how staff will respond to side effects (signs/symptoms)			30-63-24
Reviewed by Behavior Management Committee annually			30-63-23 (3)
Informed consent signed by individual and guardian (within 365 days)			30-63-23 (3)(c) - reasonable efforts to obtain signature must be documented

**Regulation (Article 63) does not require a “plan”; rather the expectation is that there is documentation of the above mentioned items with approval from BMC/HRC if there are psychotropic medications or restrictive interventions being utilized.**

June 2019

## Adult Protective Services Fact Sheet

### Program Description

Adult Protective Services (APS) are intervention activities directed towards safeguarding the well-being and general welfare of adults in need of protection. Intervention is available to adults age 18 and above who are unable to protect themselves and who need assistance in dealing with abusive, neglectful or exploitative situations.

Adult Protective Services Social Workers investigate reports and provide protective services to adults, **with their consent**, who reside in the community, adults residing in facilities licensed/certified by Kansas Department for Aging and Disability Services (KDADS), and to adults residing in adult care homes and other facilities licensed by the Kansas Department of Health and Environment. Emergency Support Services and Guardianship and Conservatorship services are also available. The intent of Adult Protective Services is to protect the most vulnerable adults from harm while safeguarding their civil liberties.

### Definitions

**Adult:** individuals age 18 or older who are alleged to be unable to protect their own interests and who are harmed or threatened with harm through action or inaction by either another individual or themselves.

**Abuse:** any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm, including: infliction of physical or mental injury; sexual abuse; unreasonable use of physical or chemical restraints, isolation, medications; threats or menacing conduct; fiduciary abuse or omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.

**Neglect:** failure or omission by one's self, caretaker or another person to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

**Exploitation:** misappropriation of an adult's property or intentionally taking unfair advantage of an adult's physical or financial resources.

**Fiduciary Abuse:** occurs when any person who is the caretaker of, or who stands in a position of trust to an adult takes, secretes or appropriates their money or property to any use or purpose not in the due and lawful execution of the adult's trust.

### Who Should Report?:

The Kansas statute (K.S.A. 39-1431) requires the following persons to report suspected abuse, neglect, exploitation or fiduciary abuse immediately:

- any person licensed to practice any branch of the healing arts
- a licensed psychologist
- a licensed master level psychologist
- the chief administrative officer of a medical care facility
- a licensed social worker
- a licensed professional nurse
- a licensed dentist
- a licensed practical nurse
- a licensed clinical psychotherapist

- a licensed marriage and family therapist
- a licensed clinical marriage and family therapist
- a licensed professional counselor
- a licensed clinical professional counselor
- a registered alcohol and drug abuse counselor
- a law enforcement officer
- a teacher
- a case manager
- guardian or conservator
- bank trust officer
- rehabilitation counselor
- holder of power of attorney
- an owner or operator of a residential care facility
- an independent living counselor
- a chief administrative officer of a licensed home health agency
- a chief administrative officer of an adult family home
- a chief administrative officer of a provider of community services and affiliates thereof operated or funded by the KDADS or licensed under K.S.A. 7503307b.

It is a class B misdemeanor for a mandatory reporter to knowingly fail to report if they suspect a vulnerable adult is being neglected, abused, or exploited.

Any other person who suspects or believes abuse, neglect or exploitation may also report.

### **Immunity of Reporter**

Persons who report, participate in any follow-up activity or who testify in any administrative or judicial proceeding as a result of the report are immune to any civil or criminal liability unless the reporter made a malicious report. The statute prohibits an employer from imposing sanctions on an employee for making a report or cooperating with an investigation.

### **Confidentiality of Reporter**

The name of the reporter or any person mentioned in the report will not be disclosed without the reporter's permission in writing, or through court order.

### **How To Report**

Telephone the local APS toll-free hotline at **1-800-922-5330**. The hotline is staffed twenty-four hours a day, seven days a week. The statute also makes provision for reports to be made to law enforcement when DCF offices are closed. Law enforcement should submit the report and appropriate information to DCF on the first working day that DCF is open.

### **What to Report**

Name and address of the person who is reported to be abused, neglected or exploited; name of the reporter and how to contact him/her; any information which the reporter believes might be helpful in the investigation and protection of the alleged victim. This includes specific addresses, telephone numbers and directions to the home(s) of relatives, caretakers, the alleged perpetrators, other collaterals. Risk factors to the alleged victim or social worker.

Information regarding the nature and extent of the abuse, neglect, exploitation, such as what the reporter saw, why the reporter considers it to be abuse, neglect or exploitation, and does the reporter believe the alleged victim is in immediate danger.

**Report Suspected Abuse, Neglect, Exploitation or Fiduciary Abuse When:**

- the adult is in a harmful situation or is in danger of being harmed.
- the adult is unable to protect him/herself.
- a specific incident or pattern of incidents suggests abuse, neglect or exploitation.
- the adult is unable to provide for or obtain the services necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

**What APS Will Do When a Report Is Received**

- Initiate a personal visit with the adult within 24 hours to five working days depending on the risk of imminent danger to the individual.
- With the consent of the adult, interview the alleged perpetrator if one has been named.
- Interview collaterals when appropriate (service providers, relatives, neighbors, etc.).
- Discuss with the adult, guardian, conservator, and/or caretaker what actions are needed and, **with the adult's consent**, develop service plans or corrective action plans with recommendations to prevent further harm.
- With the adult's consent, assist in locating services which are necessary to maintain physical or mental health: i.e., legal services, medical care, appropriate living arrangements, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from maltreatment, and transportation.
- Provide advocacy to assure protection of personal rights.

### **Child Protective Services (CPS) Fact Sheet**

If you suspect a child is being abused, neglected or exploited please telephone Kansas Protection Report Center (PRC) at **1-800-922-5330**. Every call is taken seriously and every effort will be made to protect your identity. Telephone lines at the Protection Report Center are staffed 24 hours a day. In the event of an emergency contact your local law enforcement or call 911. When a report of abuse or neglect is made to CPS, it is first screened to determine if CPS should become involved. If the report meets the criteria for CPS involvement, a social worker or special investigator investigates it. Law enforcement may also investigate concerns if a social worker is not available or a joint investigation is warranted. If it is determined that the child's safety is at risk, then a recommendation is made to the court regarding the necessary action that should be taken.

The court is ultimately responsible for the decision to remove a child from the home. This may require placing the child in foster care or with a relative. When making a recommendation to remove a child, CPS has to weigh the emotional harm of being removed from the home, with the likelihood of harm if the child stays.

Child Protective Services (CPS) may also be provided in non-abuse or neglect situations, such as an out-of-control child, truancy, overwhelmed parents, and runaways. Investigations often result in families receiving an array of services such as family preservation, foster care, or other services available in the community.

**Article 64 – Developmental Disabilities  
Community Developmental Disability Organizations**

**Excerpt**

**30-64-27. Quality assurance.**

(a) Each contracting CDDO shall ensure the quality of the services being provided to persons being served by the CDDO or by an affiliate. Ensuring quality shall include providing for on-site monitoring by a local committee made up of persons served, their families, guardians, interested citizens, and providers. The type and intensity of on-site review shall be determined by the local committee and shall include at least a determination of all of the following:

(1) Services that are paid for are delivered.

(2) Services that are delivered are paid for in accordance with the terms of any agreement or contract in force, including any payment requirement that the person being served or a third party acting on behalf of the person being served has the responsibility to meet.

(3) Services are being provided in a manner meeting applicable requirements provided for in article 63.

(4) The CDDO or affiliate is affording the person being served all of the person's legally protected rights.

(5) The CDDO or affiliate meets both of these requirements:

(A) Is reporting any suspicions of abuse, neglect, or exploitation to the appropriate state agency;  
and

(B) has corrected or is actively in the process of correcting the cause of any confirmed violation.

(b) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-1801, et seq.)

## **Article 63 – Developmental Disabilities – Licensing Providers of Community Services**

(Revised February 2010)

**30-63-1. Definitions.** (a) Words and phrases used in this article shall have the same meanings as set forth in K.S.A 39-1803, and amendments thereto. In addition, the following terms shall have the meaning ascribed to them in this regulation.

(1) "Agent" means any individual utilized by a provider to carry out any activity done by that provider, whether being paid or serving as a volunteer.

(2) "Commissioner" means the commissioner of mental health and developmental disabilities.

(3) "Commission" means the division of mental health and developmental disabilities within the department of social and rehabilitation services.

(4) "Department" means the department of social and rehabilitation services.

(5) "Person" means an individual with a developmental disability.

(6) "Provider" means a community services provider or any other entity required to be licensed pursuant to this article.

(7) "Services" means community services.

(8) "Support network" means the one or more individuals selected by a person or by the person and the person's guardian, if one has been appointed, to provide assistance and guidance to that person in understanding issues, making plans for the future, or making complex decisions.

(b) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A 75-3307b and K.S.A 1997 Supp. 39-1801, et seq.)

**30-63-10. License required; exceptions.** (a) Each individual, group, association, corporation, local government department, or local quasi-government agency providing services to persons 18 years of age or older in need of services greater than those provided in a boarding care home as defined in K.S.A. 39-923(a) (8), and amendments thereto, shall be licensed in accordance with the provisions of this article, except when those services are provided in or by any of the following:

(1) In a medical care facility, as defined and required to be licensed in K.S.A. 65-425 et seq. and amendments thereto;

(2) in a nursing facility, nursing facility for mental health, intermediate care facility for the mentally retarded, assisted living facility, or residential health care facility, or in a home plus setting, as defined and required to be licensed in K.S.A. 39-923 et seq. and amendments thereto;

(3) by a home health agency, as defined and provided for the licensing of in K.S.A. 65-5101 et seq. and amendments thereto; or

(4) in a manner so that the services constitute in-home services, funded under the federal home- and community- based services/mental retardation waiver or with state funding under terms like those of the federal home and community-based services/mental retardation waiver, and are provided in compliance with all of the following conditions:

(A) The services are directed and controlled by an adult receiving services, the parent or parents of a minor child receiving services, or the guardian of an adult receiving services.

(B) The person or person's representative directing and controlling the services selects,

trains, manages, and dismisses the individual or business entity providing the services and coordinates payment.

(C) The person or person's representative directing and controlling the services owns, rents, or leases the whole or a portion of the home in which services are provided.

(D) If any individual providing services also lives in the home in which services are provided, there is a written agreement specifying that the person receiving services will not be required to move from the home if there is any change in who provides services, and that any individual or business entity chosen to provide services will be allowed full and reasonable access to the home in order to provide services.

(E) The person receiving services does not receive services in a home otherwise requiring a license pursuant to these regulations.

(F) Any individual providing services is at least 16 years of age, or at least 18 years of age if a sibling of the person receiving services, unless an exception to this requirement has been granted by the commission, based upon the needs of the person receiving services.

(G) Any individual or business entity providing services receives at least 15 hours of prescribed training, or the person or person's representative directing and controlling the services has provided written certification to the community developmental disability organization (CDDO) that sufficient training to meet the person's needs has been provided.

(H) The person or person's representative directing and controlling the services has chosen case management from the CDDO or an agency affiliated with the CDDO. That case management may be limited, at the choice of the person or person's representative directing and controlling the services, to reviewing the services on a regular basis to ensure that the person's needs are met, annual reevaluation of continued eligibility for funding, and development of the person's plan of care.

(I) The person or person's representative directing and controlling the services cooperates with the CDDO's quality assurance committee and allows review of the services as deemed necessary by the committee to ensure that the person's needs are met. In addition, the person directing and controlling the services cooperates with the commission and allows monitoring of the person's services to ensure that the case manager and the CDDO's quality assurance committee have adequately reviewed and determined that the person's needs are met.

(J) The person or person's representative directing and controlling the services agrees to both of the following:

(i) If it is determined by the CDDO or the commission that the person receiving services is or could be at risk of imminent harm to the person's health, safety, or welfare, the person or person's representative directing and controlling the services shall correct the situation promptly.

(ii) If the situation is not so corrected, after notice and an opportunity to appeal, funding for the services shall not continue.

(b) Each license issued pursuant to this article shall be valid only for the provider named on the license. Each substantial change of control or ownership of either a corporation or other provider previously licensed pursuant to this article shall void that license and shall require a reapplication for licensure.

(Authorized by K.S.A. 39-1810 and K.S.A. 75-3304; implementing K.S.A. 39-1806 and K.S.A. 2008 Supp. 75-3307b; effective July 1, 1996; amended Oct. 1, 1998; amended Jan. 15, 2010.)

**30-63-11. Two types of license; display.** (a) Two types of license may be issued by the secretary pursuant to this article to operate as a provider. One type shall be a “full license,” and the other type shall be a “limited license.” Both types of license may be issued on a “temporary” or on a “with requirements” basis as specified in K.A.R. 30-63-12.

(b) Both licenses issued pursuant to this article shall be prepared by the commission.

(c) Each holder of a license shall prominently display the license in the holder’s principal place of business.

(d) A full license shall apply to all providers except those providers specified in subsection (e).

(e) A “limited license” shall apply to providers who provide services only to either one or two specified persons to whom the provider is related or with whom the provider has a preexisting relationship. The services shall be provided in the home of the person being served. A provider operating with a limited license shall be afforded greater flexibility in the means by which that provider is required to comply with all of the requirements of this article if the services are provided in a manner that protects the health, safety, and welfare of the specific person being served, as determined by the commission. (Authorized by and K.S.A. 39-1810 and K.S.A. 75-3304; implementing K.S.A. 39-1806 and K.S.A. 2008 Supp. 75-3307b; effective July 1, 1996; amended Jan. 15, 2010.)

**30-63-12. Licensing procedure; requirements; duration of license.** (a) Each provider required to be licensed pursuant to this article shall submit an application for an appropriate license to the commissioner, on a form provided by the commission.

(b) For a full license, each applicant shall provide the following:

(1) Certification that the applicant’s chief director of services, regardless of title, is qualified to develop and modify, if appropriate, a program of individualized services to be provided to persons as defined in K.A.R. 30-63-1, as evidenced by that individual’s having either of the following:

(A) A bachelor’s or higher degree in a field of human services awarded by an accredited college or university; or

(B) work experience in the area of human services at the rate of 1,040 hours of paid work experience substituted for a semester of higher education, which shall mean 15 undergraduate credit hours, with at least eight full-time semester’s worth of either satisfactorily passed education or work experience;

(2) certification that the applicant’s chief director of services, regardless of title, is qualified to supervise the delivery of a program of services to persons, as evidenced by that individual’s having one of the following:

(A) At least one year of experience in a senior management-level position with a licensed provider;

(B) at least two years of experience as either a case manager or a services manager with supervisory authority over at least two other individuals providing direct services to persons; or

(C) at least five years of experience delivering direct care services to persons;

(3) three letters of reference concerning the applicant’s chief director of services, regardless of title. Each letter written shall be by an individual knowledgeable both of the applicant and of the delivery of services to persons;

(4) evidence of completion of a background check meeting the requirements of the “SRS/CSS policy regarding background checks,” dated September 8, 2009 and hereby adopted by reference, done on the applicant’s chief director of services, regardless of title;

(5) a set of written policies and procedures specifying how the applicant intends to comply with the requirements of this article;

(6) a written business plan that shows how the applicant intends to market its services, to accommodate growth or retrenchment in the size of its operations without jeopardizing consumer health or safety issues, to respond to other risk factors as could be foreseeable in the specific case of that applicant, and to keep the operation fiscally solvent during the next three years, unless the application is for a renewal of a succession of licenses that the applicant has had for at least three years. In this case, the viability of the applicant’s operation shall be presumed, unless the commissioner determines that there is reason to question the viability of the licensed provider applying for license renewal and requires the submission of a written business plan despite how long the renewal applicant has been previously licensed; and

(7) if required of the applicant by the United States department of labor, a subminimum wage and hour certificate.

(c) For a limited license, each applicant shall provide the following:

(1) A description of the preexisting relationship with the one or two persons proposed to be provided services;

(2) documentation that the individual who will be chiefly responsible for providing services is qualified to do so, as evidenced by that individual’s having either of the following:

(A)(i) At least one year of work experience in providing services to a person; and

(ii) completion of the curriculum of studies designated by the commission and accessed through the commission’s web site; or

(B) the qualifications specified in paragraph (b)(1);

(3) evidence of completion of a background check meeting the requirements of the background check policy adopted by reference in paragraph (b)(4), done on the individual who will be chiefly responsible for the operations of the applicant;

(4) a written plan that shows how the applicant intends to comply with the requirements of this article applicable to the specific circumstances of the one or two persons to whom those services are proposed to be provided; and

(5) a written business plan that shows how the applicant intends to keep the applicant’s proposed provider operation fiscally solvent during the next three years, except as specified in this paragraph. If the application is for a renewal of a succession of licenses that the applicant has had for at least three years, the viability of the applicant’s operation shall be presumed, unless the commissioner determines that there is reason to question the viability of the licensed provider applying for license renewal and requires the submission of a written business plan, regardless how long the applicant has been previously licensed.

(d) Upon receipt of an application, the commission shall determine whether the applicant is in compliance with the requirements of subsection (b) or (c) and with this article.

(e) The applicant shall be notified in writing if the commission finds that the applicant is not in compliance with the requirements of subsection (b) or (c) or with this article.

(f) A temporary license or a temporary license with requirements may be issued by the secretary to allow an applicant to begin the operations of a new provider. A license with requirements may be issued by the secretary to allow a provider seeking renewal of a previously

issued license to continue operations. A license with requirements shall be designated as contingent upon the provider's developing, submitting to the commission, and implementing an acceptable plan of corrective action intended to bring the provider into continuing compliance with the requirements of this article.

(1) Findings made by the commission with regard to the implementation of a plan of corrective action shall be given to the provider in writing.

(2) Failure of a provider to be in compliance with the requirements of this article or to implement an acceptable plan of corrective action may be grounds for denial of a license whether or not a temporary license or a license with requirements has been issued.

(g) Based upon findings made by the commission regarding compliance with or the implementation of an acceptable plan of corrective action, the commissioner shall determine whether to recommend issuance or denial of the full or limited license applied for. The applicant shall be notified in writing of any decision to recommend denial of an application for a license. The notice shall clearly state the reasons for a denial. The applicant may appeal this denial to the administrative appeals section pursuant to article seven of these regulations.

(h)(1) A full or limited license issued pursuant to this article shall remain in effect for not more than two years from the date of issuance. The exact date on which the license expires shall be stated upon the license. However, the license shall earlier expire under any of the following circumstances:

(A) The license is revoked for cause.

(B) The license is voided.

(C) For a temporary license or a license with requirements, the license is superseded by the issuance of a full or a limited license as applied for.

(D) The license is voluntarily surrendered by the provider.

(2) Each license term shall be determined by the commissioner based upon the commission's findings regarding the history and strength of the applicant's provider operations, including evidence of the provider's having earned certification from a nationally recognized agency or organization that specializes in certifying providers of services.

(i) Each license with requirements shall specify the length of time for which the license is valid, which shall not exceed one year. Successive licenses with requirements may be issued by the secretary, but successive licenses with requirements shall not be issued for more than two years.

(j) Each temporary license shall be valid for six months. If, at the expiration of that six months, the licensee has not yet commenced providing services to any person but the licensee wishes to continue efforts to market the licensee's services, a successive temporary license may be issued for another six-month period. No further extensions of a temporary license shall be granted.

(k) A license previously issued shall be voided for any of the following reasons:

(1) Issuance by mistake;

(2) a substantial change of control or ownership, as provided for in K.A.R. 30-63-10(b); or

(3) for a limited license, the licensee's cessation of provision of services to the person or persons for whom the license was specifically sought and obtained.

(l) In order to renew a license, the licensee shall reapply for a license in accordance with this regulation.

(m) If a provider is licensed pursuant to this article on or before the effective date of the

amendments to this regulation, the requirements specified in either paragraphs (b)(1) and (b)(2) or paragraph (c)(2) shall not apply to any renewal request of that licensee made during the one-year period following the effective date of these amendments. (Authorized by K.S.A. 39-1810 and K.S.A. 75-3304; implementing K.S.A. 39-1806 and K.S.A. 2008 Supp. 75-3307b; effective July 1, 1996; amended Jan. 15, 2010.)

**30-63-13. Compliance reviews; mediation; enforcement actions; emergency orders.**

(a) At any time deemed necessary by the commissioner, a licensed provider may be reviewed by the commission to ensure continuing compliance with the requirements of this article.

(b) If a finding indicates that the licensed provider is not in compliance, the provider shall be given by the commissioner a written copy of the finding setting out each specific deficiency and a notice of the provider's right to seek mediation of any dispute regarding the finding.

(c) If the provider disagrees with any finding made by the commission, the provider may request mediation, in writing, within 14 days of receipt of the finding. An independent entity shall be selected by the commissioner and the provider to serve as the mediator, unless the parties are not able to agree upon a mediator, in which case an independent mediator shall be designated by the secretary. The mediator shall assist the parties in attempting to come to an agreement on the following:

- (1) The nature and extent of any noncompliance;
- (2) any course of corrective actions necessary to bring the provider into compliance;

and

- (3) a time limit within which the provider shall have to come into compliance.

(d)(1) Written notice may be issued by the commissioner to the provider of a determination of noncompliance under any of the following circumstances.

- (A) The provider does not request mediation.
- (B) Mediation does not resolve the issues.
- (C) The commission finds that the provider has not complied with the requirements of this article by the deadline established in a mediated agreement or a deadline that has been extended by the commissioner for good cause.

(2) If the commissioner issues written notice to the provider of a determination of noncompliance in accordance with paragraph (d)(1), a written plan of correction from the provider shall be required by the commissioner, to be submitted within 14 days of receipt of the notice.

(3) If the commissioner determines that the provider has failed to satisfactorily comply with the plan of correction within 30 days of the date of the plan, or within a deadline that has been extended by the commissioner for good cause, any or all of the following enforcement actions may be imposed:

(A) Civil penalties in an amount not to exceed \$125.00 per day for each violation from the date specified by the commissioner within the notice until the provider comes into compliance. The date specified by the commissioner may be any date from or after 45 days following the date of the commissioner's notice requiring a plan of correction;

(B) an order that the provider shall cease providing specified services and shall make all necessary arrangements to have any person or persons then receiving services transferred to another provider. The order may include provisions requiring the provider to continue the

provision of those or other services until the transfer can be accomplished. The order shall remain in effect until the provider comes into compliance;

(C) suspension or revocation of the provider's license as provided for in K.A.R. 30-63-14.

(e) A provider may appeal any enforcement action taken to the administrative appeals section pursuant to article seven of these regulations.

(f) If the commission additionally finds that the provider's noncompliance creates a situation of imminent danger to the health, safety, or welfare of any person or persons, an emergency order may be issued by the commissioner, making any provisions that the commissioner deems necessary for the immediate protection of the health, safety, or welfare of the person or persons. Written notice of any emergency order shall be given to the provider and shall specify the following:

(1) The actions that the provider shall take;

(2) the reason the commissioner has determined an emergency order is needed; and

(3) notice that the provider will be given an emergency hearing regarding the emergency order by the administrative appeals section pursuant to article seven of these regulations if the provider makes a written request for a hearing within 15 days after receiving the order.

(g) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.)

**30-63-14. Revocation of a license; suspension.** (a) Any license issued pursuant to this article may be suspended or revoked before the expiration date for failure of the provider to comply with the requirements of this article.

(b) A provider's license may be suspended during the revocation proceedings only upon a determination by the commissioner that the continued operation of the provider during the revocation proceedings would constitute an imminent danger to the health, safety or welfare of any person or persons who would be receiving services from the provider during the revocation proceedings. This determination shall be made in writing and clearly state the reasons for it.

(c) Before revocation of a provider's license, a written notice of the intent to revoke shall be sent to the provider by registered mail, along with a copy of the commissioner's determination to suspend the license during the revocation proceedings, if applicable. The notice shall:

(1) specify the date the license shall be revoked if an appeal is not timely taken;

(2) clearly state the reasons for the revocation of the license;

(3) instruct the provider to immediately cease providing services if the commissioner has determined to suspend the license during the revocation proceedings; and

(4) advise the provider that the revocation may be appealed to the administrative appeals section pursuant to article seven of these regulations, and that an appeal shall stay the revocation, but shall not stay any suspension of the license during the pendency of the appeal, except as may be provided for in any order issued after an emergency hearing held as a result of a request made under K.A.R. 30-63-13(f)(3).

(d) If at any time during the pendency of an appeal the commissioner finds that the provider now complies with all of the requirements of this article, and that it is in the best interests of the public that the revocation be withdrawn, the commissioner shall notify all parties to the revocation proceedings that the revocation action has been withdrawn and the appeal

proceedings shall be terminated.

(e) If, after notice to the provider of the commissioner's intent to revoke, the provider does not timely appeal, the license shall be revoked by the commission effective on the date stated within the notice.

(f) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et.seq.)

**30-63-20. Mandated requirements.** (a) In order to be eligible to be licensed as a provider, each applicant shall demonstrate that the applicant either complies with or can comply with all applicable requirements of this article and all applicable requirements of article 64.

(b) For good cause shown by an applicant, or by any person being served or proposed to be served by that applicant, one or more of the specific requirements of this article may be waived by the commissioner, and some other requirement or requirements that may be proposed by the applicant or person may be substituted by the commissioner, if the waiver or substitution would neither jeopardize the health, safety, or well-being of any person or persons served or proposed to be served by the applicant, nor substantially deviate from meeting the intent or purpose of the requirement or requirements being waived.

(c) Attainment of national accreditation by an applicant from an organization that evaluates and accredits providers of mental retardation or developmental disabilities services, or the recommendation of a local CDDO's quality assurance committee, shall be considered by the commissioner in determining compliance by the applicant with any one or more of the requirements of this article.

(Authorized by K.S.A. 39-1810 and K.S.A. 2005 Supp. 75-3307b ; implementing K.S.A. 39-1806; effective July 1, 1996; amended Oct. 1, 1998; amended Dec. 8, 2006.)

**30-63-21. Person-centered support planning; implementation.** (a) The provider shall prepare a written person-centered support plan for each person served that shall meet these requirements:

- (1) Be developed only after consultation with the following:
  - (A) The person;
  - (B) the person's legal guardian, if one has been appointed; and
  - (C) other individuals from the person's support network as the person or the person's guardian chooses;
- (2) contain a description of the person's preferred lifestyle, including describing the following:
  - (A) In what type of setting the person wants to live;
  - (B) with whom the person wants to live;
  - (C) what work or other valued activity the person wants to do;
  - (D) with whom the person wants to socialize; and
  - (E) in what social, leisure, religious, or other activities the person wants to participate;
- (3) list and describe the necessary activities, training, materials, equipment, assistive technology, and services that are needed to assist the person to achieve the person's preferred lifestyle;
- (4) describe how opportunities of choice will be provided, including specifying

means for the following:

(A) Permitting the person to indicate the person's preferences among options presented to the person, by whatever communication methods that person may possess, including a description of the effective communication methods utilized by the person;

(B) providing the necessary support and training to allow the person to be able to indicate the person's preferences, including a description of any training and support needed to fully participate in the planning process and other choice making; and

(C) assisting the person or the person's guardian to understand the negative consequences of choices the provider knows the person might make and that may involve risk to that person;

(5) describe when it is necessary to do so, to the person and the person's support network, how the preferred lifestyle might be limited because of imminent significant danger to the person's health, safety, or welfare based on an assessment of the following:

(A) The person's history of decision-making, including any previous experience or practice the person has in exercising autonomy, and the person's ability to learn from the natural negative consequences of poor decision-making;

(B) the possible long- and short-term consequences that might result to the person if the person makes a poor decision;

(C) the possible long- and short-term effects that might result to the person if the provider limits or prohibits the person from making a choice; and

(D) the safeguards available to protect the person's safety and rights in each context of choices;

(6) prioritize and structure the delivery of services toward the goal of achieving the person's preferred lifestyle;

(7) contribute to the continuous movement of the person towards the achievement of the person's preferred lifestyle. In evaluating this outcome, the provider may include assessments made by professionals and shall perform either of the following:

(A) Include consideration of the expressed opinions of the person, the person's legal guardian, if one has been appointed, and other individuals from the person's support network; or

(B) account for the following:

(i) The financial limitations of the person and the provider;

(ii) the supports and training needed, offered, and accepted by the person; and

(iii) matters identified in paragraph(a)(5). Next best options may be considered as responsive if the person cannot specifically have what the person prefers due to limitations identified by this methodology; and

(8) be approved, in writing, by the person or the person's guardian, if one has been appointed. Requirements for approval from or consultation with the person's guardian shall be considered to have been complied with if the provider documents that it has taken reasonable measures to obtain this approval or consultation and that the person's guardian has failed to respond.

(b) Whenever two or more providers provide services to the same person, the providers shall work together to prepare a single person-centered support plan. Each provider shall be responsible for the preparation and implementation of any portion of the plan relating to its services. The person, the guardian if one has been appointed, a member of the person's support

network, or a provider shall take the lead coordination role in preparation of the plan, and a designation of that person or entity shall be noted in the plan.

(c) The provider shall regularly review and revise the plan, by following the same procedures as set out above, whenever necessary to reflect any of the following:

- (1) Changes in the person's preferred lifestyle;
- (2) achievement of goals or skills outlined within the plan; or
- (3) any determination made according to the methodology provided for in paragraph (a)(7) above that any service being provided is unresponsive.

(d) The provider shall deliver services to the person only in accordance with the person's person-centered support plan.

(e) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.)

**30-63-22. Individual rights and responsibilities.** (a) Each provider shall at all times encourage and assist each person served to understand and exercise the person's individual rights and to assume the responsibilities that accompany these rights.

(b) Each person served shall be guaranteed the same rights afforded to individuals without disabilities. These rights may be limited only by provisions of law or court order, including guardianship, conservatorship, power of attorney or other judicial determination. These rights shall include the following:

- (1) Being free from physical or psychological abuse or neglect, and from financial exploitation;
- (2) having control over the person's own financial resources;
- (3) being able to receive, purchase, have, and use the person's personal property;
- (4) actively and meaningfully making decisions affecting the person's life;
- (5) having privacy;
- (6) being able to associate and communicate publicly or privately with any person or group of people of the person's choice;
- (7) being able to practice the religion or faith of the person's choice;
- (8) being free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment, for the convenience of a provider or agent, in conflict with a physician's orders or as a substitute for treatment, except when physical restraint is in furtherance of the health and safety of the person;
- (9) not being required to work without compensation, except when the person is living and being provided services outside of the home of a member of the person's family, and then only for the purposes of the upkeep of the person's own living space and of common living areas and grounds that the person shares with others;
- (10) being treated with dignity and respect;
- (11) receiving due process; and
- (12) having access to the person's own records, including information about how the person's funding is accessed and utilized and what services were billed for on the person's behalf.

(c) Each provider shall train its agents regarding the rights specified in subsection (b). In addition, each provider shall offer training at least annually regarding these rights and effective ways to exercise them to each person served, to the guardian if one has been appointed,

and to the person's parent and other individuals from each person's support network.

(Authorized by K.S.A. 39-1810 ; implementing K.S.A. 39-1802 and K.S.A. 39-1806; effective July 1, 1996; amended Oct. 1, 1998; amended Dec. 8, 2006.)

**30-63-23. Medications; restrictive interventions; behavioral management committee.** (a) A provider shall take proactive and remedial actions to ensure appropriate, effective, and informed use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness. These actions shall be taken before the provider initiates the use of any medication or other restrictive intervention to manage behavior, unless the needs of the person served clearly dictate otherwise and the provider documents that need. Otherwise, these actions shall be taken promptly following the initiation of, or any change in, the use of any medication or other restrictive intervention to manage behavior or to treat diagnosed mental illness.

(b) These proactive and remedial actions shall include all the following:

(1) **Safeguards**, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and document the following, in consultation with the person, the person's guardian, and the person's support network:

(A) All other potentially effective, less restrictive alternatives have been tried and shown ineffective, or a determination using best professional clinical practice indicates that less restrictive alternatives would not likely be effective;

(B) positive behavior programming, environmental modifications and accommodations, and effective services from the provider are present in the person's life;

(C) voluntary, informed consent has been obtained from the person or the person's guardian if one has been appointed, after a review of the risks, benefits, and side effects, as to the use of any restrictive interventions or medications; and

(D) medications are administered only as prescribed, and no "PRN" (provided as needed) medications are utilized without both the express consent of the person or the person's guardian if one has been appointed, and per usage approval from the prescribing physician or another health care professional designated by the person or the person's guardian if one has been appointed;

(2) **management**, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and document the following:

(A)(i) When restrictive intervention or medication is being used to manage specific behaviors, those behaviors are documented as to the frequency and objective severity of occurrence;

(ii) the provider periodically reviews and reports to the person, the person's guardian if one has been appointed, the person's support network, and the physician prescribing any medication to manage behavior, the frequency and objective severity of the specific behaviors, and the effectiveness of the restrictive intervention or medication and any side effects experienced from any medication used to manage specific behaviors, in conjunction with safeguard measures; and

(iii) the provider recommends to the person, the person's guardian if one has been appointed, the person's support network, and the physician prescribing any medication to manage behavior, reducing the use of the restrictive intervention or medication being used to manage specific behaviors, when appropriate, based upon the documented effectiveness of those efforts in

conjunction with safeguard measures; or

(B) when medication is used to treat specifically diagnosed mental illness, the medication has been prescribed and is being managed by a psychiatrist who is periodically provided information regarding the effectiveness of and any side effects experienced from the medication. The prescription and management may be by a physician, rather than a psychiatrist, only when requested and agreed to by the person or the person's guardian if one has been appointed, and when based upon the documented need of the person; and

(3) **review** by a behavior management committee established by the provider, which shall meet these criteria:

(A) Be made up of a selected number of persons served, guardians of persons served, family members of persons served, interested citizens, and providers, at least 1/3 of whom shall be otherwise unassociated with the provider; and

(B) periodically review the use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness, to ensure that the provisions of this regulation are met and to report to the provider each instance in which the committee determines that any provision of this regulation has not been met. The provider shall immediately correct any instance of noncompliance reported by the behavior management committee.

(c) Requirements for consent from or consultation with the person's guardian shall be considered to have been complied with if the provider documents that it has taken reasonable measures to obtain the consent or consultation and that the person's guardian has failed to respond.

(d) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.)

**30-63-24. Individual health.** (a) A provider shall assist each person served, as necessary, in obtaining the medical and dental services to which the person has access and that may be required to meet the person's specific health care needs, including the following:

(1) Scheduling and receiving preventative examinations and physicals;

(2) practicing for obtaining emergency services;

(3) developing individualized procedures for the administration of medications and other treatments, including training for self-medication or administration; and

(4) obtaining necessary supports, including adaptive equipment, and speech, hearing, physical, or occupational therapies, as appropriate.

(b) Non-licensed personnel shall administer medications and perform nursing tasks or activities in conformance with the provisions of K.S.A. 65-1124, and amendments thereto.

(c) A provider shall train staff who shall be responsible to implement the service provider's written policies and procedures for carrying out medication administration, including the following:

(1) Self-administration by any person;

(2) medication checks and reviews;

(3) emergency medical procedures; and

(4) any other health care task.

(d) Whenever two or more providers provide services to the same person, the providers shall work together to meet the health care needs of the person. The person, the guardian if one has been appointed, a member of the person's support network, or a provider may take the lead coordination role, and a designation of that person or entity shall be noted in the person-centered

support plan.

(e) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.)

**30-63-25. Nutrition assistance.** (a) Except when a provider is providing services to a person living in the home of a member of that person's family, the provider shall assist each person served in obtaining daily access to a well-balanced, nutritious diet consistent with the provisions of K.A.R. 30-63-21 regarding opportunities of choice. If a person being served lives in the home of a family member, a provider shall assist that person similarly with any meals provided outside of that home setting.

(b) A provider that serves a person meals shall serve each modified or special diet meal in a form consistent with both the person's needs and desires and any medical directions with regard thereto.

(c) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.)

**30-63-26. Staffing; abilities; staff health.** (a) A provider shall provide professional and direct service staff in numbers sufficient to meet the support and service needs of each person being served.

(b) Each employee shall be able to perform the employee's job duties before working without oversight by another trained staff person.

(c) Each employee shall consistently satisfactorily perform the employee's assigned job duties throughout the term of the employee's employment.

(d) Staff who have been certified by a recognized training agency to give CPR and first aid shall be available in sufficient numbers whenever persons being provided services are present.

(e) All staff or consultants representing themselves as professionals subject to national, state, or local licensing, certification or accreditation standards shall be in compliance and maintain compliance with those standards.

(f) Each staff member shall monitor the member's personal health and avoid circumstances in which the member risks exposing a person to whom the member is providing services to contagious disease or other health endangerment.

(g) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et.seq.)

**30-63-27. Emergency preparedness.** (a) Each agent of each provider shall be:

(1) trained in general fire, safety and emergency procedures;  
(2) trained and able to effectively and efficiently evacuate any building within which the agent is providing services, including knowing:

(A) alternative exit routes;

(B) methods of accounting for persons who might be present in the building at any time;

and

(C) a designated meeting place outside the building to which all persons will go in the event of an evacuation;

(3) trained and able to effectively and efficiently seek shelter in any building within which the agent is providing services, in the event of a tornado or other dangerous storm; and

(4) trained and able to respond effectively and efficiently to other emergency conditions, including power outages or flooding.

(b) This regulation shall effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et.seq.)

**30-63-28. Abuse; neglect; exploitation.** (a) Whenever any agent of a provider suspects that abuse, neglect, or exploitation is or has taken place, that agent shall immediately take appropriate action to ensure that any specifically involved person or persons and all others are protected while an investigation is conducted.

(b) Each agent shall exercise any authority that the agent has for the purpose of the prevention of abuse, neglect, or exploitation of each person served.

(c) A provider shall regularly conduct training and take other steps to ensure that any agent, person, parent, guardian, and any other individual from each person's support network is advised about how to contact the appropriate state agency charged with providing adult protective services whenever abuse, neglect, or exploitation is suspected or witnessed.

(d) The provider shall immediately report any incident of suspected abuse, neglect, or exploitation of which the provider has become aware to the appropriate state agency charged with providing adult protective services. Any agent shall immediately report any incident of suspected abuse, neglect, or exploitation, in either manner:

(1) Directly to the appropriate state agency; or

(2) in accordance with the provider's written policy for reporting an incident. A provider shall inform each agent that any report of an incident of suspected abuse, neglect, or exploitation may be made directly or anonymously to the appropriate state agency, shall ensure that each agent has ready access to the phone number for making any report, and shall take no steps to interfere with an agent making any report directly or anonymously.

(e) Each agent shall fully cooperate with any state agency conducting an investigation resulting from a report of abuse, neglect, or exploitation.

(f) A provider shall not employ any individual who is known by a provider to have had a conviction for or a prior employment history of abuse, neglect, or exploitation of children or vulnerable adults.

(g) A provider shall adhere to all laws, regulations, and procedures related to the reporting of, protecting from, and correcting the cause of abuse, neglect, or exploitation.

(h) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.)

**30-63-29. Records** (a) A provider shall maintain records for each person served. These records shall include the following:

(1) any application or agreement for services;

(2) any financial agreement made between the provider and the person;

(3) any incident or accident reports;

(4) a health profile, which shall be reviewed for accuracy by a licensed medical practitioner at least every two years, and shall include the following:

(A) notations regarding the person's health status;

(B) any medications the person takes; and

- (C) any other special medical or health considerations which might exist for that person;
- (5) basic assessment and service information system (BASIS) documents and other evaluation materials;
- (6) the person's person-centered support plan;
- (7) the plan of care for recipients of the home and community based services for persons who are mentally retarded or developmentally disabled program (HCBS/MR);
- (8) releases of information, authorizations for publication, and consents for emergency and other medical treatment; as applicable; and
- (9) a discharge summary, if applicable.
- (b) A provider shall maintain each record confidentially and shall not release any record except:
  - (1) as authorized in writing by the person or the person's legal guardian, if one has been appointed;
  - (2) as otherwise authorized by law; or
  - (3) as necessary to comply with the requirements of this article.
- (c) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et.seq.)

**30-63-30. Physical facilities.** (a) A provider shall maintain each site in which services are provided to any person and that is owned, leased, or made available by contract to be operated by a provider, any employee or board member of a provider, or any entity owned or controlled by a provider, a provider's employee or a provider's board member, so that the site shall meet these requirements:

- (1) Have appropriate fire and safety equipment that is in good repair and is kept on site and readily accessible;
- (2) not have any combustible or flammable materials kept in an unsafe location;
- (3) be kept clean and well maintained;
- (4) be kept safe and secure;
- (5) have furniture and equipment in good repair and working order;
- (6) be capable of maintaining a comfortable temperature and adequate ventilation;
- (7) have adequate lighting;
- (8) be free of insect and rodent infestation;
- (9) have main routes of travel that are kept free of obstacles and stored materials;
- (10) have appropriate assistive devices and any necessary structural modifications so that the facility meets the needs of persons with physical disabilities;
- (11) be sufficiently sized to meet the living space needs of the person or persons residing there as well as the additional space needs of staff working within the premises, specifically including appropriate space or spaces for the following:
  - (A) Meal preparation;
  - (B) dining;
  - (C) sleeping;
  - (D) bathing, toileting, and hand washing;
  - (E) recreation and day living; and
  - (F) storage of personal items; and
- (12) meet the needs of each person being served, consistent with the preferred lifestyle of the person or persons; and

(13) be in compliance with all applicable fire and life safety, health, sanitation, and occupancy codes.

(b)(1)A provider shall monitor each facility in which services are provided, but that is not included in subsection (a) above, to determine whether or not the facility meets these requirements:

(A) Is maintained in compliance with all applicable fire and life safety, health, sanitation, and occupancy codes; and

(B) is of sufficient size and is equipped and stocked to permit the provider to provide the necessary services, activities, and training required by the person-centered support plan of any person being served at that site.

(2) If the provider is made aware of circumstances that create a violation of any fire and life safety, health, sanitation, or occupancy code, or that place a person's health, safety, or welfare in imminent danger, or if the provider determines that the facility fails to meet any required standard as specified by any person's person-centered support plan, the provider shall perform the following:

(A) Notify the person's support network of the nature of the deficiency; and

(B) implement any necessary corrective action by appropriate means, including any appropriate revisions to the person's person-centered support plan.

Each facility intended to accommodate eight or more persons or in which eight or more persons are living shall be licensed by the Kansas department of health and environment as a lodging establishment pursuant to K.S.A. 36-501, et seq., and amendments thereto.

A provider shall maintain each facility used for job training or production work in compliance with any applicable occupational health or safety code or regulation, including any provisions applicable to any equipment or machinery located or used within that facility.

(e) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.)

**30-63-31. Registration with the community developmental disability organizations (CDDOs).** (a) Anytime a provider does not have an affiliation agreement in force with the CDDO for that service area, the provider shall:

(1) register with the CDDO, listing the types of services that the provider provides; and

(2) periodically give notice to the CDDO of the provider's current availability to offer services.

(b) This regulation shall take effect on and after July 1, 1996. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 39-1801, et seq.)

**30-63-32. Case management.** (a) Each community services provider providing case management services shall perform the following:

(1) Develop and implement policies and procedures concerning the provision of case management services that are consistent with the requirements of this regulation;

(2) provide those services in a manner meeting all applicable requirements of this article; and

(3) ensure that all case management services are provided by case managers who meet the following requirements:

(A) No case manager shall provide any other direct service except case management

services to any person receiving any other type of direct service from the same agency that employs the case manager;

(B) no case manager shall be supervised by anyone directly responsible for the provision of any other type of direct service provided to any person or responsible for supervision of those services;

(C) each case manager shall comply with the division's "rules of conduct for case managers serving people with developmental disabilities," as adopted on October 25, 2003, and hereby adopted by reference;

(D) each case manager shall maintain documentation that shows that within 90 calendar days of either the case manager's initial employment or following an announcement by the division posted upon the division's web site of a revision of the division's required assessment, whichever comes later, the case manager has completed and passed the required assessment that has been established by the division and that has been included in the division's case management-related training; and

(E) each case manager shall have the following documented qualifications:

(i) A minimum of six months of full-time experience in the field of human services; and

(ii) either a bachelor's degree or additional full-time experience in the field of developmental disabilities services, which may be substituted for the degree at the rate of six months of full-time experience for each missing semester of college.

(b) Case management services shall assist the person and the person's support network to identify, select, obtain, coordinate, and use both paid services and natural supports that are available to that person to enhance the person's independence, integration, and productivity consistent with the person's capabilities and preferences as outlined in the person's person-centered support plan. Case management services shall include the following:

(1) Assessment, including an ongoing process for the identification of the person's needs, the determination of a person's preferred lifestyle, and the resources that are available to the person, through both formal and informal evaluation methods;

(2) (A) Support planning, with the participation of the person and the person's support network, including the development or assistance in the development, updating, and reviewing of the person's person-centered support plan and any related service or support plan, building upon assessment information to assist the person in meeting the person's needs and achieving the person's preferred lifestyle; and

(B) providing assistance to the person in being knowledgeable about the types and availability of community services and support options, in receiving information regarding the rights of persons served pursuant to the developmental disabilities reform act and implementing regulations, the content of which shall be approved by the commission, and in obtaining the community services and supports of the person's choice;

(3) support coordination, including the following:

(A) Arranging for and securing supports outlined in the person's person-centered support plan; and

(B) developing and accessing natural supports and generic community support systems, including pursuing means for gaining access to needed services and entitlements, and seeking modification of service systems when necessary to increase the accessibility to those systems by the person;

(4) monitoring and follow-up, including ongoing activities that are necessary to ensure

that the person-centered support plan and related supports and services are effectively implemented and adequately addressing the needs of the person; and

(5) assisting transition and portability, including the planning of and arranging for services to follow the person when the person moves between any of the following:

- (A) From school to the adult world;
- (B) from an institution to community alternatives;
- (C) from one kind of service setting to another kind of service setting;
- (D) from one provider to another provider; or
- (E) from one service area to another service area. (Authorized by K.S.A. 39-1810; implementing K.S.A. 39-1805 and 39-1806; effective May 30,2008.)

## Sedgwick County Developmental Disability Organization

Policy Section	<b>Quality Assurance</b>	Policy Number	<b>G-01</b>
Policy Name	<b>Quality Assurance Committee</b>	Revision Date	<b>09/2017</b>
Former Number	<b>H-08-01</b>	SRS Approval Date	<b>7/2011</b>
		KDADS Approval Date	<b>01/24/2018</b>

### **PURPOSE:**

This policy outlines the membership and procedures for the Sedgwick County Developmental Disability Organization (SCDDO) Quality Assurance Committee (QAC) consistent with K.A.R. 30-64-27.

### **POLICY:**

Community service providers (CSP) delivering targeted case management (TCM) services shall develop an on-site monitoring team to work in collaboration with members of the QAC. The members will ensure that quality services are being provided to individuals served by any CSP as required by the provisions of K.A.R 30-64-27.

### **PROCEDURES:**

1. The QAC members will be comprised of the SCDDO QA Coordinator, TCM representatives, on-site monitoring teams, and Community Council members representing the following categories: individuals receiving services, their family members and/or guardians, and interested citizens.
2. Each CSP delivering TCM services will designate a representative from their organization to participate in the local quality review process. This individual shall be the individual who maintains oversight of the agency's quality assurance and/or TCM department.
3. The representative is responsible for the following:

- a. Establish and maintain an on-site monitoring team to complete on-site reviews. The team may include individuals receiving services, their family members and/or guardians, and interested citizens.
  - b. Provide training to the on-site review committee on the SCDDO QAC manual and review tools.
  - c. Collect, assess, and submit review packets to SCDDO designated QA staff by the due date assigned.
  - d. Provide copies of completed review tools to the reviewed CSPs.
4. SCDDO will assign a sample, quarterly, of individuals randomly selected for QAC review as defined in the QAC manual, available upon request.
5. The on-site review will consist of the following activities:
  - a. Review of the Person Centered Support Plan (PCSP), Behavior Support Plan (BSP), and Psychotropic Medication Plan (PMP) for quality.
  - b. Evaluate the delivery of each service as defined in the above mentioned documents.
  - c. Complete site visit with the individual and their paid staff which may include family at the location of service.
  - d. Complete the review tools specified in the QAC manual and include additional documentation of comments, questions, or concerns identified by the review team.
6. The representative or their designee and at least one other member, not paid by the agency, will be involved throughout the entire review process for the individual assigned to that team. In lieu of the representative or designee, the TCM may assist the non-paid team member during the site visit at the request of the family.
7. The representative will submit all QAC review tools and corresponding documentation to SCDDO designated QA staff by the due date assigned. Submitting late QAC reviews may result in a request for an agency continuous quality improvement plan.
8. SCDDO will evaluate each QAC review using a standardized tool and provide feedback to the CSP whose performance was reviewed during the quarter.

- a. If concerns are identified regarding an individual's services, the CSP will receive notification requesting improvement. The CSP is responsible for assuring improvements are made to address the deficiencies through the agency's internal quality assurance policy and procedures. The CSP is responsible for submitting within 30 days documentation of service modifications based on the review.
  - b. If systemic quality concerns are identified, the CSP will receive written notification identifying the deficient area. The CSP is responsible for submitting a continuous quality improvement plan. The written plan shall be submitted within 30 days for review and agreement by SCDDO.
9. Upon review, SCDDO may request additional information which will be due no later than 15 days or as specified by SCDDO staff.
10. SCDDO will meet quarterly with all designated representatives to review local trend data including, but not limited to the following:
  - a. Services that are paid for are delivered;
  - b. Services that are delivered are paid for in accordance with the terms of any agreement or contract in force;
  - c. Services are provided consistent with Article 63;
  - d. The CSP is affording the individual being served all of the individual's legally protected rights;
  - e. The CSP is reporting any suspicions of abuse, neglect or exploitation and taking corrective action when needed;
  - f. Services are provided consistent with the PCSP;
  - g. Services are provided in a manner that offers opportunities of choice to the individual being served.
11. The Community Council will review quarterly trend data, consider CSP recommendations and provide additional observations to ensure that any identified concerns are addressed through follow up by SCDDO QA staff.

**SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
Quality Assurance Committee**

**Scoring the Reviews**

To score the reviews, the SCDDO QA Department reviews each individual packet to determine that the requirements from SCDDO Affiliate Service Agreement, SCDDO policy and Article 63 are being followed. Such as:

K.A.R. 30-63-21

- Has the support plan been reviewed in the last 365 days? Was there team involvement along with signatures to show team and guardian's approval? Are there any contradictions in the plan? Is competitive community employment and barriers easily found in the plan? Is there a description of the individual living their preferred lifestyle?

K.A.R. 30-63-21,22

- Does the support plan state any violations in rights as being okay to follow without review and approval by a behavior management committee (BMC) or other explanation? During the interviews with direct care staff, is it reported things are taken away from the individual as a punishment without approval? When the individual is being interviewed do they state they don't feel respected or safe in the environment in question?

K.A.R. 30-63-21, 23

- Are all the restrictions and psychotropic medications approved by the BMC and individual/guardian? Are signature pages included to show approval? Do the medications prescribed match between the support plan and consents? Is the direct care staff aware of all the psychotropic medications, side effects, and other approved restrictions?

K.A.R. 30-63-25

- If there is a diet in place, how is it managed? Is it approved by the doctor? Is the direct care staff aware of the diet specifics? If staff report specific diets, are they found in the support plan? Does the direct care staff relay all nutritional modifications/ supports? Are calorie restrictions accurate?

K.A.R. 30-63-27

- Are the emergency procedures known?

K.A.R. 30-63-28

- Does the support plan state that the individual and/or guardian understand how to report abuse, neglect or exploitation? Does direct care staff understand the agency's reporting process?

K.A.R. 30-63-21/ K.A.R. 30-64-26

- Are there clear instructions in the support plan to help staff provide all the needed supports? Are the needed medical devices mentioned? During the review does it appear that staff know and understand the support and the medical needs? Does the staff know the goals which the individual is working towards?

K.A.R. 30-63-21

- Does the support plan describe the choices the person can and likes to make? Are choices regularly offered? Does the individual feel like they have the opportunity to choose different appropriate activities? Can the individual choose to go shopping or what they want to have for dinner?

## File Review Form

Individual:	Date:
TCM/Agency:	Reviewer:

Yes	No	N/A	Item	Comments
-----	----	-----	------	----------

### Records required (Article 30-63-29)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incident/Accident Reports, if applicable	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Health Profile/Physical (q 2yrs)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current BASIS - Functional Assessment	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Financial / Services Agreement	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current Releases of Information	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Person Centered Service Plan (formerly ISP)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Guardianship documentation is in place, when applicable	

### General Information

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Identification; Social Security Card, Birth Certificate	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Proof of Insurance	

### Comments

--

### Support Plan

Date:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Evidence of regular review/revisions	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead coordinator of plan / health care identified	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Evidence of support team consultation / participation	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current lifestyle (What I have Now); setting person wants to live, who person wants to live with, work or other activity, who person wants to socialize with, activities to participate in	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Preferred lifestyle (What I Want in the Future)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Barriers to achieving preferred lifestyle identified	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Support needs identified to overcome barriers	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe how opportunities of choice will be provided	

### GOALS

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are the goals specific and directly related to preferred lifestyle and / or barriers?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Training / support needs identified	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are there measurable outcomes included in all goals?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Monitoring of goals includes reasonable time frames	

### SUPPORTS

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Support at home	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Support with work, school, and daily activity	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Community / Social Support	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wellness support	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical support	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal / Financial Support	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Communication / Decision Making Support	

### EMPLOYMENT

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If unemployed, are barriers to community employment identified	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strategies to overcome these barriers are identified	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If community employment is not being pursued, is informed choice clearly documented?	

### TRANSITION SERVICES FROM SCHOOL TO ADULTHOOD (14-18 years old)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has guardianship been established and/or documented?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Preferred lifestyle as an adult / access to services	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discussion about access to SSI	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Information regarding employment	

Yes	No	N/A	Item	Comments
			Risk Assessment / Intervention Plans section	
			Restrictive Procedures, Limitations, and Modifications section	
			Rights and Responsibilities training completed (will review supporting documentation)	
			ANE training completed and information shared about how to report (will review supporting documentation)	
			Approval in writing by the person or guardian	
<b>Psychotropic Medication Plan (PMP) / Documentation</b>				<b>Date:</b>
			PMP / required documentation is in place	
			Psychotropic Medications indicated	
			Psychotropic Medication prescribed by a psychiatrist	
			Psychiatric Diagnosis is indicated	
			Description of behaviors related to diagnosis are provided	
			Safeguards in place to minimize risk; which could include Positive Behavior Programming / Environmental modifications considered	
			Description of how staff will respond to Side Effects	
			If medication is prescribed to manage specific behaviors, a titration plan is documented	
			If medication is prescribed as PRN, when to use the medication is clearly documented	
			Plan describes how the provider will document effectiveness and recommend potential reduction in the medication	
			<b>Informed consent signed by individual/guardian (within 365 days)</b>	
			<i>If the medication is not taken, potential risks have been identified</i>	
			<i>Possible side effects are identified</i>	
			<i>Benefits of taking the medication are identified</i>	
			<b>Reviewed by Behavior Management Committee at least annually</b>	
<b>Behavior Support Plan (BSP) / Documentation</b>				<b>Date:</b>
			Behavior Support Plan / required documentation is in place	
			Plan is approved by individual/guardian	
			Safeguards in place to minimize risk; to include Environmental modifications and evidence of less restrictive alternatives tried	
			<b>Targeted / Maladaptive Behaviors</b>	
			<i>Behaviors are identified and clearly defined for the individual</i>	
			<i>Frequency and severity of behaviors are documented</i>	
			<i>Desired alternative behaviors identified</i>	
			<i>Methods for teaching alternative behaviors documented</i>	
			<i>Description of staff response to target behaviors</i>	
			Plan describes how the provider will document effectiveness and recommend potential reduction in the restrictive intervention	
			Evidence of periodic review and needed revisions throughout year	
			<b>If restrictive elements are present - is there evidence of approval by a Behavior Management Committee?</b>	
<b>Comments</b>				

## File Review Form

Yes	No	N/A	Item	Comments	
<b>Records required (Article 30-63-29)</b>				<b>Regulations under review</b>	
			Incident/Accident Reports, if applicable	applicable if in the file, needed if other information in the file reflects the need for a report	30-63-29 (a) (3)
			Health Profile/Physical (q 2yrs)	health profile reviewed every 2 years and includes health status, medication list, and any other medical/health considerations	30-63-29 (a) (4) (A-C)
			Current BASIS - Functional Assessment	BASIS documents and other evaluation materials	30-63-29 (a) (5)
			Financial / Services Agreement	any financial agreement between person and provider	30-63-29 (a) (2)
			Current Releases of Information (ISP)	releases of information, authorizations for publication, and consents for emergency and other medical treatment as applicable	30-63-29 (a) (8)
			Guardianship documentation is in place, when applicable	the plan of care for recipients of HCBS looking for court documentation if guardian is noted within file	30-63-29 (a) (7)
<b>General Information</b>					
			Identification; Social Security Card, Birth Certificate	best practice; will not be scored in totals	
			Proof of Insurance	best practice; will not be scored in totals	
<b>Comments</b>					
<b>Support Plan</b>					
				<b>Date:</b>	
			Evidence of regular review/revisions	Records regulation requires plan to be in the file; evaluating if the plan is current, within 365 days, reflects current supports provided	30-63-29 (a) (6) and 30-63-21 (c)
			Lead coordinator of plan / health care identified	Are they designated in the plan?	30-63-21 (b) - designation of the lead coordination role shall be noted in the plan
			Evidence of support team consultation / participation	information about support team participation - to include PCS worker	30-63-21 (a)(1)(A-C) - plan shall be developed only after consultation with designated individuals
			Current lifestyle (What I have Now); setting person wants to live, who person wants to live with, work or other activity, who person wants to socialize with, activities to participate in	is the information provided consistent with the descriptions needed based on the crosswalk	description of current lifestyle provided
			Preferred lifestyle (What I Want in the Future)	is preferred lifestyle present; needs to reflect what the individual wants	30-63-21 (2)(A-E) - plan shall contain a description of the person's preferred lifestyle, including specific information
			Barriers to achieving preferred lifestyle identified	are barriers identified	
			Support needs identified to overcome barriers	what support is needed to assist individual in moving towards preferred lifestyle	
			Describe how opportunities of choice will be provided	Is the information provided consistent with regulations?	30-63-21 (4) (A-C)
<b>GOALS</b>					
			Are the goals specific and directly related to preferred lifestyle and / or barriers?	evidence that the goal is directly related	evidence that the plan meets 30-63-21 (a)(7) - contribute to the continuous movement towards preferred lifestyle; providers will do this by using goals with measurable outcomes
			Training / support needs identified	How is the person going to achieve the outcome?	
			Are there measurable outcomes included in all goals?	steps identified to reach the goal	

			Monitoring of goals includes reasonable time frames (evaluation at 2-4 months)	monitoring of goal is documented - yearly is not appropriate	
<b>SUPPORTS</b>					
			Support at home is addressed	Supports are to be specific to the individual. These are descriptions of the specifics regarding how the support is to be provided, what should do or not do, and include participation level of the individual. Any behaviors that do not require restrictive interventions should be included within support sections of the plan.	30-63-21 (a)(3) - Lists/describes necessary activities, training, materials, equipment, assistive technology, and services needed to achieve preferred lifestyle. 30-63-21 (a) (5) (A-D) describe when it is necessary to do so, to the person and person's support network how the preferred lifestyle might be limited because of imminent significant danger to the person's health, safety, or welfare
			Support with work, school, and daily activity		
			Community / Social Support		
			Wellness support		
			Medical support		
			Legal / Financial Support		
			Communication / Decision Making Support		
<b>EMPLOYMENT</b>					
			If unemployed, are barriers to community employment identified	looking at barriers for employment	Employment First Initiative; contractual obligation
			Strategies to overcome these barriers are identified	Is there discussion about how to overcome the barriers for employment?	Employment First Initiative; contractual obligation
			If community employment is not being pursued, is informed choice clearly documented?	Is it documented that barriers cannot be overcome or is there sufficient documentation about informed choice?	Employment First Initiative; contractual obligation
<b>TRANSITION SERVICES FROM SCHOOL TO ADULTHOOD (14-18 years old)</b>					
			Has guardianship been established and/or documented?	is guardianship done; are there discussions about it	30-63-31 (b) (5) (A) - assisting transition and portability, including planning of and arranging for services to follow the person when the person moves between any of the following: from school to adult world
			Preferred lifestyle as an adult / access to services	what does the individual want when they become an adult related to services; is this identified within the plan	
			Discussion about access to SSI	has information been shared about SSI	
			Information regarding employment	documentation about employment after school	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Item</b>	<b>Comments</b>	
			Risk Assessment / Intervention Plans section	If BSP is in place, this box should be checked	30-63-23
			Restrictive Procedures, Limitations, and Modifications section	does the information provided meet KDADS guidelines provided in June 2020	30-63-23
			Rights and Responsibilities training completed (will review supporting documentation)	acknowledgment form or info in plan; box on signature page needs to be checked	30-63-22 (c) - provider shall offer training at least annually regarding these rights to individuals and/or guardians
			ANE training completed and information shared about how to report (will review supporting documentation)	acknowledgment form or info in plan; box on signature page needs to be checked	30-63-28 (c) - regular training and ensure individual is advised how to contact for ANE
			Approval in writing by the person or guardian	has appropriate signatures or 2 attempts to obtain	30-63-21 (a) (8) - reasonable measures to obtain approval need to be documented

Item	Comments
<b>Psychotropic Medication Plan / Documentation</b>	
Psychotropic Medication Plan / required documentation is in place	30-63-23 Required for individuals on medication to manage behaviors or to treat diagnosed mental illnesses
Psychotropic Medications listed	not regulatory, best practice
Psychotropic Medication prescribed by a psychiatrist	30-63-23 (2)(B)
Psychiatric Diagnosis is indicated	not regulatory, best practice
Description of behaviors related to diagnosis are provided	30-63-23 (2)(A)(i)
Safeguards in place to minimize risk; which could include Positive Behavior Programming / Environmental modifications considered	30-63-23 (1) (A-D) - initial and ongoing assessment and responsive modifications that may be needed; evidence of least restrictive
Description of how staff will respond to Side Effects	30-63-24
If medication is prescribed to manage specific behaviors, a titration plan is documented	30-63-23 (2) (A) (iii)
If medication is prescribed as PRN, when to use the medication is clearly documented	30-63-23 (1) (D)
Plan describes how the provider will document effectiveness and recommend potential reduction in the medication	30-63-23 (2)(A)(ii), (2)(A)(iii)
Informed consent signed by individual/guardian (within 365 days)	30-63-23 (3)(c) - reasonable efforts to obtain signature must be documented
If the medication is not taken, potential risks have been identified	30-63-23 (1, C)
Possible side effects are identified	30-63-23 (1, C)
Benefits of taking the medication are identified	30-63-23 (1, C)
Reviewed by Behavior Management Committee at least annually	30-63-23 (3)
<b>Behavior Support Plan / Documentation</b>	
Behavior Support Plan / required documentation is in place	30-63-23 Needed when there is restrictive intervention used to manage behavior
Approved by individual/guardian	30-63-23 (3)(c) - reasonable efforts to obtain signature must be documented
Safeguards in place to minimize risk; to include Environmental modifications and evidence of less restrictive alternatives tried	30-63-23 (1) (A-D) - initial and ongoing assessment and responsive modifications that may be needed; evidence of least restrictive
<b>Targeted / Maladaptive Behaviors</b>	
Behaviors are identified and clearly defined for the individual	30-63-23 (2)(A)(i)
Frequency and severity of behaviors are documented	30-63-23 (2)(A)(i)
Desired alternative behaviors identified	not regulatory, best practice
Methods for teaching alternative behaviors documented	not regulatory, best practice
Description of staff response to target behaviors	not regulatory, best practice
Plan describes how the provider will document effectiveness and recommend potential reduction in the restrictive intervention	30-63-23 (2)(A)(ii), (2)(A)(iii)
Evidence of periodic review and needed revisions throughout year	30-63-23 (3)(B) - at least annual, 3-4 times a year is better
If restrictive elements are present - is there evidence of approval by a Behavior Management Committee?	30-63-23 (3)(B)
<b>NOTES</b>	
<p>Regulations do not require a "plan", they require documentation of the above mentioned items with approval from BMC/HRC if there are psychotropic medication or restrictive interventions being utilized.</p>	

**SEDGWICK COUNTY  
DEVELOPMENTAL DISABILITY ORGANIZATION  
Quality Assurance Committee**

**Service Modifications and Agency Intervention Plans**

Once SCDDO has evaluated each Quality Assurance Committee (QAC) packet, scored and identified trends, the community service provider (CSP) will receive a summary of their agency reviews for the quarter. If deficiencies are identified, the CSP will receive a request for individual service modifications and/or an agency intervention plan.

Each section of the review is assigned a score upon evaluation. Scores are assigned as follows:

2- all information is present

1- some information is missing

0- all information is missing

**Service Modifications**

Scores below 2 indicate that a service modification is being requested for at least one deficiency within a review section. Deficiencies will be identified within the QAC review report and the CSP is responsible for assuring improvements are made through use of the agency's internal quality assurance policy and procedures.

Each service modification shall be returned within 30 days or by the assigned due date; one service modification form per individual. If there are multiple deficiencies identified for an individual, each deficiency should be addressed within the plan. The service modification and supporting documentation will be added to the original QAC packet and maintained in the individual's records at the SCDDO.

**Agency Intervention Plan**

An intervention plan is requested when there is an average agency score of 1.5 or below in any section of the review for 2 consecutive quarters, as this outcome identifies a negative systemic trend within the agency. The CSP will identify needed improvements by reviewing the assigned deficiencies and submitting a written intervention plan within 30 days, demonstrating action steps to address the identified trend. The intervention plan will be reviewed and monitored by the SCDDO.

# Sedgwick County Developmental Disability Organization Quality Assurance Review Report

Quarter,

Sample Size

Agency Name:

T = TCM Services

Individuals' Names:

D = Day Services

R = Res Services

Score key: 0=Not Met 1=Partially Met 2=Met

KAR#	Requirement	Document	Score	QAC Comments
30-63-21	Person Centered Support Planning: Developed after consultation with the person, guardian, others from the support network which describes the persons preferred lifestyle, is regularly reviewed for needed revisions	<ul style="list-style-type: none"> <li>- Review current PCP and look for movement towards preferred lifestyle</li> <li>- Evidence of reviews and revisions if needed</li> <li>- Consider if all necessary elements are present</li> </ul>	T:	
30-63-21 (3), 22	Individual Rights and Responsibilities: Free of abuse, control of resources, having privacy, choice of visitors, religion, pay for work, free from inappropriate restraints, treated with dignity and respect	<ul style="list-style-type: none"> <li>- Evidence of training considerations in PCSP</li> <li>- Site visit review tools, evidence of upholding rights</li> </ul>	T:	
			D:	
			R:	
30-63-21 (5), 23	Restrictive interventions, medications, BMC: Only if all else failed, safeguards, management, informed consent, BMC committee review	<ul style="list-style-type: none"> <li>- PCP/BSP/PMP review</li> <li>- Evidence of Behavior Management Committee review</li> <li>- Site visit review tools, evidence of proper use and knowledge of restrictions</li> </ul>	T:	
			D:	
			R:	

30-63-25	Nutrition assistance: Well balanced diet w/choice, meeting modifications and medical directions	- Diet needs documented in PCSP - Site visit review tool, staff aware of diet needs	T:	
			D:	
			R:	
30-63-27	Emergency preparedness: Training in procedures for evacuation, designated meeting place, emergency shelter	- Site visit review tool, staff knowledge of response to emergency situations	T: N/A	
			D:	
			R:	
30-63-28	Abuse, Neglect, Exploitation: prevention, training, reporting procedures in accordance with agency policy	- Consideration of training needs in PCSP - Evidence of staff knowledge of agency reporting procedures	T:	
			D:	
			R:	
30-63-21(8)(3)(d) 30-64-26	Services are being provided consistent to Person Centered Support Plan and needed supports	- PCSP describes needed supports - Site visit review tool - Evidence of staff knowledge of consumer	T:	
			D:	
			R:	
30-63-21(4)	Opportunities for choice are provided	- PCSP describes opportunities for choices - Site visit review tool	T:	
			D:	
			R:	

## Agency Intervention Plan

An Intervention Plan is outlining a specific set of activities that the agency will complete to address deficiencies observed through Quality Assurance activities.

The first step in any intervention plan is to diagnose the situation. One strategy to diagnosing the situation is to distinguish between technical and adaptive work.

**Technical problems** are problems that can be solved by experts or authorities, which can usually be solved quickly and easily. The technical elements include things such as: imagining different organizational charts, changing where people sit, creating new processes, crafting termination agreements, etc. These technical elements are important, not necessarily easy and are far from the complete picture.

**Adaptive challenges** require a different level of effort and generally learning is required. We usually need to learn—to the best of our ability—exactly what the problem is and then how to proceed in the best way. Stakeholders must work on adaptive challenges, not just authority figures. With no clear roadmap, you must experiment to test possible ways of moving forward. The adaptive elements include things such as: shifting loyalties from the old manager to the new, helping the staff to see their part in the failed reorganization, generating high morale despite shrinking the department and increasing productivity in the face of significant disequilibrium.

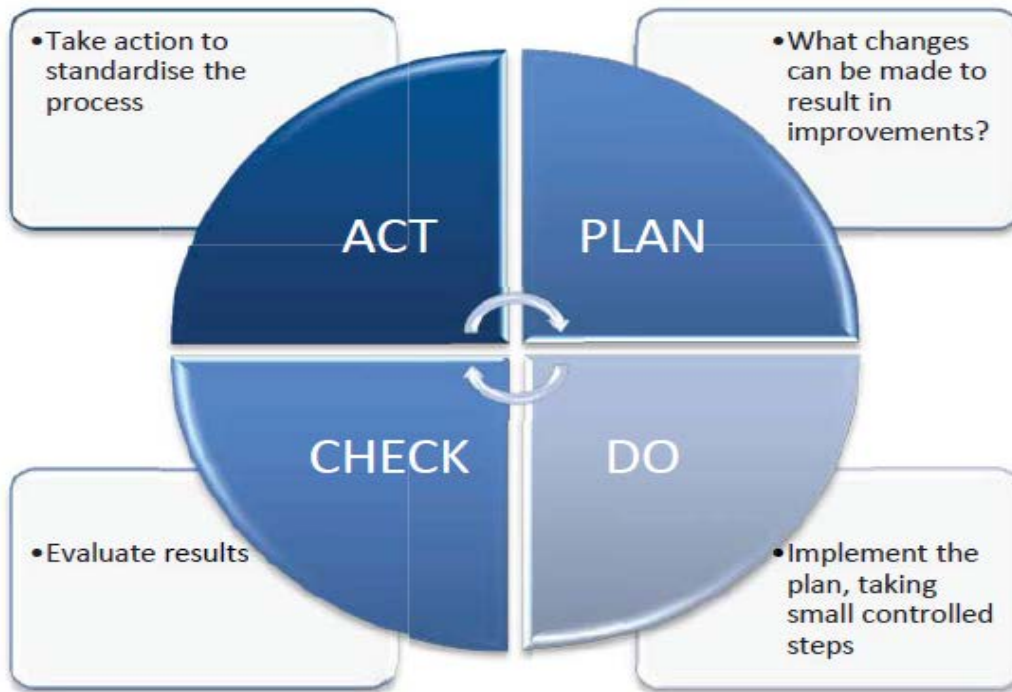
Reflect on the following questions if you're trying to explore the idea **distinguish technical and adaptive work**.

- What could the right person fix right now? (These are the technical aspects of the challenge.)
- What feels really, really difficult? (That's probably adaptive.)
- What values, behaviors or attitudes might be in conflict with the work that needs to be done? (The changing of behaviors, attitudes and values is adaptive.)
- Of our current company or team practices, what is essential? What is expendable? (Deciding what's essential and what's expendable is adaptive work.)

Utilizing observations and interpretations is another strategy for diagnosis. Observations are facts with no interpretations and should not be disputable. Interpretations are a way of assigning meaning to an observation, or in other words, making sense of what is going on. Interpretations are the means of informing interventions.

Utilize the Observations and Interpretations as a way to explore what is going on with the deficiency noted. Once that is complete, then move to the Intervention Plan to develop action steps to make corrections.

The model shown below is the four phase, Plan-Do-Check-Act cycle



<b><i>Plan the improvement</i></b>	Analyse the current situation of your organisation, gather information and research different ways to make improvements. Seek input and feedback from stakeholders. Establish goals and identify actions to implement the plan.
<b><i>Implement the improvement</i></b>	<ul style="list-style-type: none"> <li>• Test the suggested alternatives to identify the preferred improvement.</li> <li>• Allocate resources to ensure the improvement is a success.</li> <li>• Keep your stakeholders informed and involve those with a direct benefit from the outcome.</li> <li>• Document the decisions made during the implementation phase.</li> </ul>
<b><i>Evaluate the improvement activity</i></b>	<p>Evaluate if the improvement is delivering what you intended; are changes required or should an alternative improvement be used.</p> <p>Measure the improvements for example, audits, assessments and surveys. Document the evaluation methods and results. Take your time; incremental steps may deliver better results.</p>
<b><i>Take action to standardize the process</i></b>	<p>There are two possible situations in this step:</p> <ul style="list-style-type: none"> <li>• If the improvement isn't successful, analyse what can be done differently next time and go through the cycle again with a different plan.</li> <li>• If successful, ensure all stakeholders are informed of the new process, all necessary staff are trained and educated, policies and procedures are implemented and change within the organisation is managed.</li> </ul>

References:

Retrieved from Kansas Leadership Center: [www.yourleadershipedge.com](http://www.yourleadershipedge.com)

Australian Government: Aged Care Quality and Safety Commission - Retrieved from <https://www.agedcarequality.gov.au>

Individual's Name  
Service Modification Plan

DUE DATE:

Location of Concern	Concern	Actions to be Taken Activities/ Tasks/Monitoring	Responsible Person	Date of Completion	Additional Documentation
PCSP, Rights, Restrictions, Nutrition, Emergency Preparedness, ANE, Services, Choice	What concern was noted during the review?	List detailed tasks which will occur to address concern.  What are you going to do? How will it be done? How will progress be monitored? List methods/tools which will be used.	Who will be assigned each task?  Who will monitor?	When will the improvement take place?  List projected dates for each task.	Is there any additional documentation attached to show action was taken?  Examples would include PCSP changes, staffing notes, follow up documentation, etc.

## Observations and Interpretations

<p><b>Observations: Describe each observation that was made during the review.</b></p>	1.
	2.
	3.
	4.
	5.
<p><b>Interpretations: Provide interpretation(s) of why each observation is occurring.</b></p> <p>Benign Interpretations are comfortable and easier to accept. They fit into the current way of thinking and often put the agency in the best light.</p> <p>Conflictual Interpretations may be more difficult to accept or admit. They point out inconsistencies in what is believed and how the agency behaves.</p>	

**Once this information is complete, please develop the Agency Intervention Plan.**

## Agency Intervention Plan

Agency Name:

Due Date:

**Trend Identified through Observations and Interpretations:**

**Objective** *(What is the goal):*

<b>Activities to Achieve Objective</b> <i>What will be done?</i>	<b>Lead Accountability</b> <i>Who will do it?</i>	<b>Target Date</b> <i>By When?</i>
1.		
2.		
3.		
4.		
5.		

**Measure of Success:** *(How will the agency know that progress is being made? What are the benchmarks?)*

**Monitoring of Plan:** *(How will the agency determine that the goal has been reached? In what ways should the plan be monitored and for what timeframe?)*

**Trend Identified through Observations and Interpretations:**

**Objective** *(What is the goal):*

<b>Activities to Achieve Objective</b> <i>What will be done?</i>	<b>Lead Accountability</b> <i>Who will do it?</i>	<b>Target Date</b> <i>By When?</i>
1.		
2.		
3.		
4.		
5.		

**Measure of Success:** *(How will the agency know that progress is being made? What are the benchmarks?)*

**Monitoring of Plan:** *(How will the agency determine that the goal has been reached? In what ways should the plan be monitored and for what timeframe?)*

## **Appendix A**

The following documents were used during the Quality Assurance Committee review during the COVID-19 pandemic. These documents may be utilized at the direction of SCDDO should there be any pandemics in the future.

# SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: [Click here to enter name.](#)

## Life Enrichment- Pandemic

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) [Click here to enter text.](#)

### Questions to ask the individual receiving services:

1. What do you like about this program? [Click here to enter text.](#)
2. What do you not like about this program? [Click here to enter text.](#)
3. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case the electricity goes out? [Click here to enter text.](#)
  - d. If someone hurts/mistreats/is mean to you? [Click here to enter text.](#)
4. Is your staff nice to you? YES NO  
If no, explain: [Click here to enter text.](#)
5. Does anyone ever take or keep things from you? YES NO  
If yes, explain: [Click here to enter text.](#)
6. Do you feel safe coming here? YES NO  
If no, explain: [Click here to enter text.](#)
7. Tell me what goals you are working on. [Click here to enter text.](#)  
How does staff help you with that? [Click here to enter text.](#)
8. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

### Questions to ask staff

Staff Name: [Click here to enter name.](#)  
How long has staff been working with this individual? [Click here to enter text.](#)  
How long has staff been working for this agency? [Click here to enter text.](#)

1. How did you learn how to support this individual? [Click here to enter text.](#)
2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.)  
YES NO  
If yes, what? [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Require special food preparation/eating supports? (pureed, food cutting, etc.)  YES  NO

If Yes, what? [Click here to enter text.](#)

Is he or she OK with this diet?  YES  NO

What do you do if the individual refuses to follow the diet? [Click here to enter text.](#)

3. The plan describes that the individual uses (assistive equipment/ technology [Click here to enter description.](#))

What support do they need for these items? [Click here to enter text.](#)

4. What are the individuals' medical needs? [Click here to enter text.](#)

How do you support these needs? [Click here to enter text.](#)

If health services are needed, whom do you contact? [Click here to enter text.](#)

Do you receive follow up as to the outcome?  YES  NO

5. Does this individual have any rights or restrictive procedures?  YES  NO

If yes, what? [Click here to enter text.](#)

Is this addressed in the individuals plan?  YES  NO

6. What behavior does this individual display? [Click here to enter text.](#)

How do you support this need? [Click here to enter text.](#)

7. Does this individual take psychotropic medications?  YES  NO

If so, what are the potential side effects or where do you go to find them? [Click here to enter text.](#)

8. Where do you keep the support plan? [Click here to enter text.](#)

9. According to the plan, what are the individual's Day Program goals? [Click here to enter text.](#)

10. What do you do:

a. In case of a tornado? [Click here to enter text.](#)

b. In case of a fire? [Click here to enter text.](#)

c. In case of a power outage? [Click here to enter text.](#)

11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? [Click here to enter text.](#)

12. Do you know how to make an ANE report directly to APS? (skip if mention above)

YES  NO

13. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.?](#)

**Questions the reviewer answers based on their observation/interview:**

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Interactions were positive between the individual and others in services?

YES  NO  N/A

Interactions were positive between staff and the individual?

YES  NO  N/A

The individual expressed their own opinions?  YES  NO  N/A

**Kudos** (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): [Click here to enter text.](#)

**Comments/Concerns:** [Click here to enter text.](#)

Name and role of QAC member(s) completing interview: [Click here to enter name\(s\).](#)

How did the interview take place? (Ex: Zoom, WebEx, Phone, Etc.) [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: [Click here to enter text.](#)

### **Work Services & Supported Employment- Pandemic**

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) [Click here to enter text.](#)

#### **Questions to ask the individual receiving services:**

1. I understand that you like to work at [Click here to enter name of agency/ program.](#)  
Do you get to work on things you enjoy doing here?       YES       NO
2. How do you change it if you want to work on something else? [Click here to enter text.](#)
3. Do you have enough work?       YES       NO  
If no, explain: [Click here to enter text.](#)  
If you do not have work, what do you do during this time? [Click here to enter text.](#)  
Do you like doing that?       YES       NO  
If no, what would you rather be doing? [Click here to enter text.](#)
4. Does your staff help you learn your job if you need help?       YES       NO  
If no, explain: [Click here to enter text.](#)
5. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case the electricity goes out? [Click here to enter text.](#)
  - d. If someone hurts/mistreats/is mean to you? [Click here to enter text.](#)
6. Is your staff nice to you?       YES       NO  
If no, explain: [Click here to enter text.](#)
7. Does anyone ever take or keep things from you?       YES       NO  
If yes, explain: [Click here to enter text.](#)
8. Do you feel safe working here?       YES       NO  
If no, explain: [Click here to enter text.](#)
9. Tell me what goals you are working on. [Click here to enter text.](#)  
How does staff help you with that? [Click here to enter text.](#)
10. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

# SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

## Questions to ask staff

Staff Name: [Click here to enter text.](#)

How long has staff been working with this individual? [Click here to enter text.](#)

How long has staff been working for this agency? [Click here to enter text.](#)

1. How did you learn how to support this individual? [Click here to enter text.](#)
2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.)  YES  NO  
If yes, what? [Click here to enter text.](#)  
Require special food preparation/eating supports? (pureed, food cutting, etc.)  YES  NO  
If Yes, what? [Click here to enter text.](#)  
Is he or she OK with this diet?  YES  NO  
What do you do if the individual refuses to follow the diet? [Click here to enter text.](#)
3. The plan describes that the individual uses (assistive equipment/ technology [Click here to enter description.](#) ).  
What support do they need for these items? [Click here to enter text.](#)
4. What are the individuals' medical needs? [Click here to enter text.](#)  
How do you support these needs? [Click here to enter text.](#)  
If health services are needed, whom do you contact? [Click here to enter text.](#)  
Do you receive follow up as to the outcome?  YES  NO
5. Does this individual have any rights or restrictive procedures?  YES  NO  
If yes, what? [Click here to enter text.](#)  
Is this addressed in the individuals plan?  YES  NO
6. What behavior does this individual display? [Click here to enter text.](#)  
How do you support this need? [Click here to enter text.](#)
7. Does this individual take psychotropic medications?  YES  NO  
If so, what are the potential side effects or where do you go to find them? [Click here to enter text.](#)
8. Where do you keep the support plan? [Click here to enter text.](#)
9. According to the plan, what are the individual's (insert applicable service: [Click here to enter text.](#)) goals? [Click here to enter text.](#)
10. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case of a power outage? [Click here to enter text.](#)
11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? [Click here](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

to enter text.

12. Do you know how to make an ANE report directly to APS? (skip if mention above)  YES  NO

13. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

### **Questions the reviewer answers based on their observation/interview:**

Interactions were positive between the individual and others in services?  YES  NO  N/A

Interactions were positive between staff and the individual?  YES  NO  N/A

The individual expressed their own opinions?  YES  NO  N/A

**Kudos** (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): [Click here to enter text.](#)

**Comments/Concerns:** [Click here to enter text.](#)

Name and role of QAC member(s) completing interview: [Click here to enter text.](#)

How did the interview take place? (Ex: Zoom, WebEx, Phone, Etc.) [Click here to enter text.](#)

# SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: [Click here to enter text.](#)

## **Residential Services- Pandemic**

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) [Click here to enter text.](#)

### **Questions to ask the individual receiving services:**

1. Do you choose what you eat (i.e. for breakfast, lunch, dinner, snacks)?  YES  NO  
If no, who does? [Click here to enter text.](#) Are you OK with that?  YES  NO  
If you do not like what you have for a meal, do you get other choices?  YES  NO
2. In your home, what do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case the electricity goes out? [Click here to enter text.](#)
  - d. If someone hurts/mistreats/is mean to you? [Click here to enter text.](#)
  - e. If your staff does not show up for work? [Click here to enter text.](#)
3. Is your staff nice to you?  YES  NO  
If no, explain: [Click here to enter text.](#)
4. Does your staff answer your questions?  YES  NO  
If no, explain: [Click here to enter text.](#)
5. Does anyone ever take or keep things from you?  YES  NO  
If yes, what/who? [Click here to enter text.](#)
6. Do you feel safe living here?  YES  NO  
If no, explain: [Click here to enter text.](#)
7. Tell me what goals you are working on. [Click here to enter text.](#)  
How does staff help you with that? [Click here to enter text.](#)
8. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

### **Questions to ask staff**

Staff Name: [Click here to enter text.](#)  
How long has staff been working with this individual? [Click here to enter text.](#)  
How long has staff been working for this agency? [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

1. How did you learn how to support this individual? [Click here to enter text.](#)
2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.)  YES  NO  
If yes, what? [Click here to enter text.](#)  
Require special food preparation/eating supports? (pureed, food cutting, etc.)  YES  NO  
If Yes, what? [Click here to enter text.](#)  
Is he or she OK with this diet?  YES  NO  
What do you do if the individual refuses to follow the diet? [Click here to enter text.](#)
3. The plan describes that the individual uses (assistive equipment/ technology [Click here to enter description.](#) ).  
What support do they need for these items? [Click here to enter text.](#)
4. What are the individuals' medical needs? [Click here to enter text.](#)  
How do you support these needs? [Click here to enter text.](#)  
If health services are needed, whom do you contact? [Click here to enter text.](#)  
Do you receive follow up as to the outcome?  YES  NO
5. Does this individual have any rights or restrictive procedures?  YES  NO  
If yes, what? [Click here to enter text.](#)  
Is this addressed in the individuals plan?  YES  NO
6. What behavior does this individual display? [Click here to enter text.](#)  
How do you support this need? [Click here to enter text.](#)
7. Does this individual take psychotropic medications?  YES  NO  
If so, what are the potential side effects or where do you go to find them? [Click here to enter text.](#)
8. Where do you keep the support plan? [Click here to enter text.](#)
9. According to the plan, what are the individual's (insert applicable service: [Click here to enter text.](#)) goals? [Click here to enter text.](#)
10. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case of a power outage? [Click here to enter text.](#)
  - d. If the next shift does not show up? [Click here to enter text.](#)
11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? [Click here to enter text.](#)
12. Do you know how to make an ANE report directly to APS? (skip if mention above)  YES  NO
13. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

text.

### Questions the reviewer answers based on their observation/interview:

- Interactions were positive between the individual and others in services?  YES  NO  N/A  
Interactions were positive between staff and the individual?  YES  NO  N/A  
The individual expressed their own opinions?  YES  NO  N/A

**Kudos** (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): [Click here to enter text.](#)

**Comments/Concerns:** [Click here to enter text.](#)

Name and role of QAC member(s) completing interview: [Click here to enter text.](#)

How did the interview take place? (Ex: Zoom, WebEx, Phone, Etc.) [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: [Click here to enter text.](#)

### **Personal Care Services for Adults- Pandemic**

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) [Click here to enter text.](#)

#### **Questions to ask the individual receiving services:**

1. If you do not like what you have for a meal, do you get other choices?  YES  NO  
If no, explain: [Click here to enter text.](#)
2. Is there anything you would change about where or with whom you are living?  YES  NO  
If yes, explain: [Click here to enter text.](#)
3. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case the electricity goes out? [Click here to enter text.](#)
  - d. If someone hurts/mistreats/is mean to you? [Click here to enter text.](#)
  - e. If you are hurt/ sick? [Click here to enter text.](#)
  - f. If your staff does not show up for work? [Click here to enter text.](#)
4. Tell me what goals you are working on. [Click here to enter text.](#)  
How does staff help you with that? [Click here to enter text.](#)
5. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

#### **Questions to ask staff**

Staff Name: [Click here to enter text.](#)  
How long has staff been working with this individual? [Click here to enter text.](#)  
How long has staff been working for this agency? [Click here to enter text.](#)

1. How did you learn how to support this individual? [Click here to enter text.](#)
2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.)  YES  NO  
If yes, what? [Click here to enter text.](#)  
Require special food preparation/eating supports? (pureed, food cutting, etc.)  YES  NO  
If Yes, what? [Click here to enter text.](#)  
Is he or she OK with this diet?  YES  NO  
What do you do if the individual refuses to follow the diet? [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

3. The plan describes that the individual uses (assistive equipment/ technology [Click here to enter description.](#) ).  
What support do they need for these items? [Click here to enter text.](#)
4. What are the individuals' medical needs? [Click here to enter text.](#)  
How do you support these needs? [Click here to enter text.](#)  
If health services are needed, whom do you contact? [Click here to enter text.](#)  
Do you receive follow up as to the outcome?  YES  NO
5. Does this individual have any rights or restrictive procedures?  YES  NO  
If yes, what? [Click here to enter text.](#)  
Is this addressed in the individuals plan?  YES  NO
6. What behavior does this individual display? [Click here to enter text.](#)  
How do you support this need? [Click here to enter text.](#)
7. Does this individual take psychotropic medications?  YES  NO  
If so, what are the potential side effects or where do you go to find them? [Click here to enter text.](#)
8. Where do you keep the support plan? [Click here to enter text.](#)
9. According to the plan, what are the individual's (insert applicable service: [Click here to enter text.](#)) goals? [Click here to enter text.](#)
10. What do you do:  
a. In case of a tornado? [Click here to enter text.](#)  
b. In case of a fire? [Click here to enter text.](#)  
c. In case of a power outage? [Click here to enter text.](#)  
d. If the next shift does not show up? [Click here to enter text.](#)  
e. If you suspect abuse, neglect or exploitation? [Click here to enter text.](#)
11. Do you know how to make an ANE report directly to APS? (skip if mention above)  YES  NO
12. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

### **Questions the reviewer answers based on their observation/interview:**

- Interactions were positive between the individual and others in services?  YES  NO  N/A  
Interactions were positive between staff and the individual?  YES  NO  N/A  
The individual expressed their own opinions?  YES  NO  N/A

**Kudos** (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

**Comments/Concerns:** [Click here to enter text.](#)

Name and role of QAC member(s) completing interview: [Click here to enter text.](#)

How did the interview take place? (Ex: Zoom, WebEx, Phone, Etc.) [Click here to enter text.](#)

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: [Click here to enter text.](#)

### **Personal Care Services for Children (under the age of 18)- Pandemic**

The review is to be completed in the child's home with the child present.

Name of family member who participated in review: [Click here to enter text.](#)

#### **Questions to ask the family:**

1. Does the service meet your family's needs?  YES  NO  
Comments: [Click here to enter text.](#)
2. Do you feel comfortable with the person(s) who cares for your child?  YES  NO  
Comments: [Click here to enter text.](#)
3. What other services or support items will your child need this year? [Click here to enter text.](#)
4. Does your child have any unmet medical needs?  YES  NO  
Comments: [Click here to enter text.](#)
5. Does your child have any unmet mental health needs?  YES  NO  
Comments: [Click here to enter text.](#)
6. Have you been given information on what to do if you believe your child have been abused, neglected or exploited?  YES  NO
7. Is there anything you would like your case manager to follow up with?  YES  NO  
Comments: [Click here to enter text.](#)

#### **Questions to ask staff**

Staff Name: [Click here to enter text.](#)

How long has staff been working with this individual? [Click here to enter text.](#)

How long has staff been working for this agency? [Click here to enter text.](#)

1. How did you learn how to support this individual? [Click here to enter text.](#)
2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.)  YES  NO  
If yes, what? [Click here to enter text.](#)  
Require special food preparation/eating supports? (pureed, food cutting, etc.)  YES  NO  
If Yes, what? [Click here to enter text.](#)  
Is he or she OK with this diet?  YES  NO

## SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

What do you do if the individual refuses to follow the diet? [Click here to enter text.](#)

3. The plan describes that the individual uses (assistive equipment/ technology [Click here to enter description.](#) ).  
What support do they need for these items? [Click here to enter text.](#)
4. What are the individuals' medical needs? [Click here to enter text.](#)  
How do you support these needs? [Click here to enter text.](#)  
If health services are needed, whom do you contact? [Click here to enter text.](#)  
Do you receive follow up as to the outcome?  YES  NO
5. Does this individual have any rights or restrictive procedures?  YES  NO  
If yes, what? [Click here to enter text.](#)  
Is this addressed in the individuals plan?  YES  NO
6. What behavior does this individual display? [Click here to enter text.](#)  
How do you support this need? [Click here to enter text.](#)
7. Does this individual take medications?  YES  NO  
If so, what are the potential side effects or where do you go to find them? [Click here to enter text.](#)
8. Have you received a copy of the support plan? [Click here to enter text.](#)
9. According to the plan, what are the individual's (insert applicable service: [Click here to enter text.](#)) goals? [Click here to enter text.](#)
10. What do you do:
  - a. In case of a tornado? [Click here to enter text.](#)
  - b. In case of a fire? [Click here to enter text.](#)
  - c. In case of a power outage? [Click here to enter text.](#)
  - d. If the next shift does not show up? [Click here to enter text.](#)
  - e. If you suspect abuse, neglect or exploitation? [Click here to enter text.](#)
11. Do you know how to make an ANE report directly to APS? (skip if mention above)  YES  NO
12. Do you have any questions or is there anything else that you would like to tell me? [Click here to enter text.](#)

### **Questions the reviewer answers based on their observation/interview:**

- Interactions were positive between the individual and parent/family?  YES  NO  N/A
- Interactions were positive between staff and the individual?  YES  NO  N/A

**Kudos** (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): [Click here to enter text.](#)

**SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION**

**Comments/Concerns:** [Click here to enter text.](#)

Name and role of QAC member(s) completing interview: [Click here to enter text.](#)

How did the interview take place? (Ex: Zoom, WebEx, Phone, Etc.) [Click here to enter text.](#)