



The Arc of Rensselaer County

Quality Improvement Plan

2026

The Arc of Rensselaer County strives for excellence in the management and delivery of supports and services for people with intellectual and other developmental disabilities. Quality is holistic in nature and must consider all aspects of peoples' lives. The Arc of Rensselaer County maintains a long-term commitment to the people we serve, protecting and ensuring individuality, based on each person's preferences, capabilities, and safety needs. It exists when people experience support and are helped to live self-sufficient, productive lives.

Quality at The Arc of Rensselaer County focuses on a close family atmosphere between the people receiving services, Board members, staff, volunteers, and administration. It involves all persons communicating freely and working together toward the Mission, which expresses our commitment to, and the desired manner of, all interactions in fulfilling the Mission. The agency's Mission Statement is as follows:

The mission of The Arc of Rensselaer County is to advocate for the rights and safety of individuals of all ages who have an intellectual disability and/or a developmental disability or delay.

The Arc is a source of support, specialized knowledge, and available resources in assisting individuals and their families to meet their needs and goals.

The Arc works to influence societal attitudes and governmental policy so that people with intellectual and developmental disabilities will have access to the services, assistance, and opportunities they need for personal growth and development, and participation in the community.

The Arc of Rensselaer County is committed to exceeding the standards and regulations set forth by the NYS Office for People with Developmental Disabilities (OPWDD), NYS Justice Center, the Office of the Medicaid Inspector General (OMIG), Centers for Medicare and Medicaid (CMS), NYS Department of Health (DOH) and other relevant governmental oversight entities. The Arc will also align its practices with the expectations of its parent organization – The Arc New York. Also, The Arc intends to exceed these standards by maintaining The Council on Quality and Leadership (CQL) accreditation.

Personal Outcome Measures

The next component is the use of Personal Outcome Measures (POM), which help determine whether person-centered practices are truly present in someone's supports and services. While a formal CQL interview is one way to identify POMs, the same themes also emerge naturally through existing OPWDD-required processes such as person-centered planning conversations, satisfaction surveys, and HCBS questionnaires. Some Care Coordination Organizations use the IAM assessment or PATHS assessment, which include questions aligned with CQL outcomes and help highlight what is important to each person. Although not all CCOs use the same assessments, the core POM concepts—choice, safety, health, relationships, rights, goals, employment, and social connection—remain embedded throughout Life Plans and Staff Action Plans. These outcomes continue to guide supports because they are integrated into the statewide planning structure, not dependent on a single assessment tool.

The Council on Quality and Leadership (CQL) and Accreditation

CQL uses its voice to advocate and its tools to help improve the lives of people leading to a more independent and full life. Their vision is a world of dignity, opportunity, and community for all people. The CQL vision aligns with our belief. The accreditation is not passing a test it is checking to see if you

are on the journey of getting to your destination. The process involves CQL reviewers coming in to check to see if we are on the right course in the Basic Assurance area, make corrections if needed, and plan on enhancing that path to the vision.

During 2023, The Arc of Rensselaer County achieved CQL reaccreditation in the Plan of Excellence for another four-year term. The Arc of Rensselaer County is commended and congratulated for achieving accreditation with CQL's Person-centered Excellence Accreditation methodology and for its ongoing commitment and efforts to exemplify how a singular focus on the lives of people supported leads to making meaningful discoveries about *What Really Matters*. The agency utilizes Satisfaction Surveys in conjunction with the HCBS settings rule which is strongly aligned with the personal outcome measures. We engage with people to get a better understanding of their needs, wants and desires, in order to move forward using a person-centered approach. The agency's OPWDD-aligned planning and quality systems naturally reflect the core concepts of the Personal Outcome Measures, even when not using the POM tool directly.

The Arc of Rensselaer County's governing body ensures that there is a comprehensive plan for quality oversight and improvement. This plan is designed to ensure maximum transparency regarding agency operations and accountability to the governmental regulations, UN Convention's guiding principles and the CQL Basic Assurances. The CQL Basic Assurances function as a framework to address quality by covering ten factors relating to the provision of quality supports and valued outcomes for each person supported by The Arc of Rensselaer County. The factors are:

1. Rights Protection and Promotion
2. Dignity and Respect
3. Natural Support Networks
4. Protection from Abuse, Neglect, Mistreatment and Exploitation
5. Best Possible Health
6. Safe Environments
7. Staff Resources and Supports
8. Positive Services and Supports
9. Continuity and Personal Security
10. Basic Assurance System and ongoing monitoring of our quality improvement systems

Furthermore, as a component of CQL, The Arc of Rensselaer County is guided by the core principles of the United Nations Convention on the Rights of Persons with Disabilities in the purpose, design, and delivery of all agency support arrangements. The core principles are key components intertwined into a quality life. The Eight guiding principles underlie the Convention:

- Respect for inherent dignity and individual autonomy including the freedom to make one's own choices
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of persons with disabilities as part of diversity and humanity of all peoples
- Equality of opportunity in civic life and employment
- Accessibility
- Equality between men and women
- Respect for the evolving capacities of children and adults with disabilities and respect for the right of people with disabilities to preserve their identities

Stakeholders

Service Recipient Perspective

- Person-Centered individualized plans development and review
- Meetings of people receiving services
- Customer satisfaction surveys and follow-up
- Membership in Agency committees
- Self-Advocacy Group
- Member of the Board of Directors
- Participate in new employee selection process
- Participate in employee training program

These engagement methods provide ongoing insight into what matters most to people, aligning with the intent of the Personal Outcome Measures and informing Life Plans and supports.

Family/Advocate Perspective

- Person-Centered individualized plans development and review
- Ongoing dialogue between families and service providers
- Family satisfaction survey and follow up
- Membership on committees
- Membership in Board of Directors
- Guardianship Survey

Workforce Perspective

- New employee orientation
- Ongoing employee training & development
- Employee satisfaction surveys and follow up
- Knowledge of and commitment to The Arc of Rensselaer County's Mission Statement
- Job descriptions focused on quality and elements found within the agency's Mission
- Performance appraisals
- Employee appreciation efforts
- Expectation that quality of service shall be the major focus of fulfilling job role and responsibilities
- Ongoing support and leadership from Board, administration and supervisors, including advocating for appropriate wages.

Quality Improvement Policy

It is the policy of The Arc of Rensselaer County to maintain a system to monitor and evaluate the presence of the ten factors (through our Basic Assurance System table below) that frame our organizational intentions to address the Basic Assurances. This quality system is described here-within the agency's Quality Improvement Plan (QIP). The Arc of Rensselaer County Board of Directors holds the primary responsibility to review and approve the QIP and its revisions. Approval of the plan is

reflected in The Board meeting minutes, and Board signed attestation on an annual basis. The minutes shall capture the discussion of targets for improvement.

At a minimum, QIPs will be submitted to The Arc New York State Office for review every three years, unless directed otherwise. The agency’s Administrative Team (including the Chief Executive Officer, Chief Financial Officer, the Associate Executive Directors (AED), and Directors) are responsible to operationally implement and monitor the features and functions of the QIP. The Quality Assurance/Compliance Department will be responsible for the collection, review and analysis of data used as the foundation of the quality improvement process. These quality systems incorporate multiple data sources—including Life Plans, person centered plans, satisfaction surveys, and HCBS compliance reviews—which collectively demonstrate the presence of POM-aligned outcomes across programs.

Core features of The Quality Improvement Plan (QIP), which operates as a Basic Assurance System, includes ongoing data collection in critical areas, administrative monitoring with actions in real time based on data analysis and the development and implementation of a Tactical Plan. A collection and analysis of data to identify actions to improve outcomes and performance in the factors above initiate the processes. The process includes ongoing assessments of service recipient, family and employee satisfaction, focus on quality of life of individuals supported by the agency, program compliance with applicable regulations, trends related to incidents, human resources (HR), and Board oversight.

Data is used to manage quality standards in real time and reviewed on a monthly, quarterly or annual basis by the Administrative Team in a dashboard report and on an annual basis in a Quality Metrics report to the Board of Directors and The Arc New York. Actions may be taken as a result of a quality dashboard review. Collected data additionally informs objectives and initiatives developed for the Tactical Plan. The Tactical Plan, as well as agency policy and procedures, is designed to continuously improve quality at all levels and areas of The Arc. The framework of the QIP includes the CQL ten key quality indicators. Each indicator reveals focus areas for data collection, analysis, and potential follow-up to quality improvement areas.

While CQL’s POM interview is one method of identifying outcomes, many Basic Assurance indicators are also informed by OPWDD-required processes, Life Plans, person-centered plans and satisfaction surveys, which capture the same underlying themes.

Factors	Quality Indicators	Qualitative Indicators
Rights and Protection	Policies, Procedures, and Structures that Promote Human Rights Individuals are Involved in Self-Advocacy and the Board of Directors Individual Rights Policy Individualized Protective Oversight Plan Objection to Service Policy Behavior Support Plan	Behavioral Plans (including rights restrictions) People Supported/Family Satisfaction Survey Incident Data/Trend Report Number of reports of Abuse and Neglect (and the number of which were substantiated) Personal Outcome Measures Interview

	Informed Consent HIPAA Policy Life Plan Admissions Process Sensitivity Manual Human Rights Committee & Minutes Brunswick Center Services Rights Group HCBS Compliance Final Rule (Appendix A)	
Dignity and Respect	Natural Support Policy People are referred to by their Chosen Name People can make their own choice Life Plan Sensitivity Manual Why We Are Here Training Agency-Wide Orientation Individual Rights Policy Objections to Service Policy Staff Action Plan Individual Rights Policy HCBS Compliance Final Rule (Appendix A)	Incident Data/Trend Report People Supported/Family Satisfaction Survey Personal Outcome Measures Interview

Natural Support Networks	Participation in Community Associations and having community connections People have access to Natural and Family Relationships Why We Are Here Training Sensitivity Training Life Plan Individualized Protective Oversight Plan Agency-Wide Orientation Face Sheets You and Your Rights Pamphlet Natural Supports Policy Incident Management Policy Individual Rights Policy HCBS Compliance Final Rule (Appendix A)	Community Involvement Log Personal Outcome Measures Interview People Supported/Family Satisfaction Survey
Protection from Abuse, Neglect, Mistreatment, and Exploitation	Employee Handbook Code of Conduct Prevention of Abuse and Neglect Training Adapted You and Your Rights Curriculum Incident Review Committee & Minutes Clinical Referrals Events Committee & Minutes Incident Management Policy	Incident Data/Trend Report Number of reports of Abuse and Neglect (and the number of which were substantiated) Personal Outcome Measures Interview People Supported/Family Satisfaction Survey

	Individual Rights Policy HCBS Compliance Final Rule (Appendix A)	
Best Possible Health	Notification of In-Patient Hospital Admissions Safe and Appropriate Medication Administration Supervisors are alerted to any Telemedicine Calls Right Care Right Now Plan of Nursing Services Medication Turnover Sheets Clinical Referral Medical PSR Behavior Support Plan Health Care Proxy Self-Medication Assessment Human Rights Committee Policy Standards of Care Patient Portal Access Innovative Triage Services HCBS Compliance Final Rule (Appendix A)	Number of ER Visits (Arc NY Metric) People Supported/Family Satisfaction Survey Personal Outcome Measures Interview
Safe Environments	Routine Fire Drills Physical Plant Checks Safe Patient Handling Individualized Protective Oversight Plan	Number of Statements of Deficiencies (requiring a plan of correction) 45- or 60-Day Letters Physical Plant PSR

	Time Alone Assessment Hot Water Assessment Fire Drill Report Physical and Occupational Therapy Assessment/Clinical referral process Right Care/Right Now Lock Down Procedure (BCS) HCBS Compliance Final Rule (Appendix A)	Fire Drill Reviews People Supported/Family Satisfaction Survey Personal Outcome Measures Interview
Staff Resources and Supports	Human Resources Policies Human Resources Dashboard Vacancy Report Manager/Assistant Manager Tracking Training Report Employee Stay Interview Sensitivity Training FTE Reviews/ FTE Charts Budget Overview 120-Hour Report Benefits Orientation Success Coach	Number of Vacant Positions Employee Turnover Numbers FTE Reports Worker Compensation Trends Number of Individuals in Specific Services Unemployment Numbers Workforce Satisfaction Survey Stay Interview Trend Analysis
Positive Services and Supports	Person-Centered Plans and Supports for Community, Day, and Residential Habilitation Behavioral Supports are Based on Informed Choice Individuals are Free from SCIP- R Restrictive Interventions	Incident Data/Trend Report Personal Outcome Measures Interview People Supported/Family Satisfaction Survey

	Psychoactive Medications are Appropriately Administered and Reviewed IPSIDD Services Life Plan Staff Action Plan Intake Forms for Residential and Day Services Transition Packet Clinical Referral Admissions Policy Human Rights Committee Policy Monthly and Six-Month Summary Annual Clinical QIDP summary Work Alone Packet WOW Schedule Updates Behavior Support Plan/Staff Strategies/10-5/Psychotropic Medication Monitoring Plan SCIP-R Training Annual Medication Regimen Review Person-Centered Behavioral Intervention Policy Functional Behavioral Assessment Survey/Interview Form HCBS Compliance Final Rule (Appendix A)	
Continuity and Personal Security	Sound Fiscal Practices Mission Statement Supports	Physical Plant PSR Financial PSR

	Citizenship and Inclusion Business Functions Enable Individual Supports Support/Service Opportunities Mission Statement Life Plan Self-Advocate Committee Individualized Protective Oversight Plan Financial Policies and Procedure Personal Expenditure Plan – Money Management Assessment Confidentiality Policy Admissions Dashboard	People Supported/Family Satisfaction Survey Personal Outcome Measures Interview
Basic Assurance System	Board Reports Tactical Plan, Including Documents and Administrative Team Minutes QIP Board Reports and Board Minutes, Including Board Committee Minutes	ARC NY Metrics Dashboard (QIP, Incident Management, Human Resources, Compliance, Finance, Admission, Transportation, Behavioral Health, DQI (BPC Surveys))

Key Areas for Quality Improvement

OPWDD Bureau of Program Certification (BPC) Surveys

The Arc of Rensselaer's quality assurance and improvement practices are reinforced by the external ongoing service audits performed by the New York State Office for People with Developmental Disabilities (OPWDD) Division of Quality Improvement. These program certification reviews, along with an Arc internal incident management review, external accreditation, agency program self-audits, individual, family, and employee satisfaction surveys, human resource management practices, and ongoing board governance oversight collectively aspire to assure quality in all of The Arc's supports and services.

OPWDD certification reviews provide valuable feedback relative to The Arc's performance in meeting critical regulatory requirements. The Arc will proactively maintain compliance with all applicable regulations, monitor our degree of compliance, and adjust practices to remain compliant as necessary. The Arc welcomes the regulatory review by OPWDD program surveyors and is committed to responding to specific feedback promptly and systematically when warranted. Features and steps involved in the OPWDD certification process include:

- **Exit Conference Form:** In some cases, OPWDD will only make recommendations or identify minor issues which do not rise to the level at which they issue a SOD and which can be resolved at the time of the visit.
 - **Recommendations:** OPWDD surveyors may offer recommendations at the time of the survey.
 - **Best Practices:** OPWDD surveyors may commend Best Practices found at the time of the survey.
- **Statements of Deficiency:** OPWDD issues statements of Deficiency (SOD) (including incidents of imminent danger and 45-60 day letters) following a site survey in which there is at least one significant deficiency noted during the survey process; this kind of finding is generally defined as systemic, pervasive and/or egregious. The review includes areas such as fire safety, medication administration, health services, physical plant, personal allowance, habilitation, and other regulatory areas. ~~These~~
- **Plans of Corrective Action:** When the organization receives the SOD, a plan of corrective action is developed by the appropriate staff. This plan addresses the specific matter identified by the citation, as well as incorporates a systemic correction when that is necessary.
- **OPWDD Response to Plan of Correction:** OPWDD accepts or returns the Plan of Corrective Action for further consideration.
- **The Arc New York Quarterly and Annual Data from Quality Metric Dashboards:** A comprehensive method for Chapters of the Arc New York to submit and track key Chapter specific data for a more proactive view of the overall organization. This information is compiled from the Human Resource, Residential, Business Office, Day Services, and Quality Assurance departments and submitted through a portal by the Director of Quality Assurance quarterly and annually.

- **The Arc New York Quarterly Statements of Deficiency Report on Organization-Wide Trends:** A comprehensive quarterly report provided by the Arc New York Chapters through data compiled from OPWDD Bureau of Program Certification (BPC) surveys of Chapter. The report reflects data collected from Statements of Deficiencies (SODs), as well as survey data submitted by Chapters through the Chapter Information System. Along with general data, the report identifies the top survey deficiencies, as well as deficiency trends as a result of Agency Reviews completed within the quarter.

The AED of the associated program that was surveyed oversees and coordinates all OPWDD Bureau of Program Certification activities and responses, including a Plan of Corrective Action should a SOD be issued. AED of Family and Community Supports aggregates and analyzes data on all the OPWDD surveys.

From 2022 through 2025, The Arc of Rensselaer County continued to strengthen its quality improvement systems through sustained monitoring, data analysis, and program enhancements across all service areas. During this multi-year period, the agency advanced its work in regulatory compliance, person-centered practices, Basic Assurances, and CQL accreditation, while also modifying internal processes in response to OPWDD, Justice Center, DOH, and Arc New York expectations. The progress made across these years informs the priorities and goals outlined in the 2026 Quality Improvement Plan, reflecting a cycle of evaluation, learning, and improvement that positions the agency for ongoing success.

2026 Goals

1. To ensure all Plan of Corrective Actions (POCAs) are completed within 21 days and receive approval from OPWDD.
2. The program AED would ensure an internal review of any recommendations identified in the Exit Conference Form (ECF) or verbal recommendations are completed within 30 days.
3. To continue to maintain minimal ECF deficiencies/citations/recommendations related to fire safety, physical plant, and medical oversight when comparing the 2024/2025 survey cycle to the 2025/2026 cycle.
4. To be compliant with all regulatory requirements pertaining to Emergency Preparedness Plan and Infection Control by April 1, 2026.

Measurable Action

1. Data will be compiled on the Division of Quality Improvement (DQI) dashboard with a column focused on the date of the deficiency and a column with the date the POCA was completed. The comparison of the dates will determine if the POCA was completed within 21 days.
2. Data will be compiled on the DQI dashboard with a column focused on the date of the ECF, a column identifying the recommendation and a column with the date for which the review of the recommendation(s) were completed. The comparison of the dates will determine if the response to the ECF finding was completed within 30 days.

3. The DQI dashboard will include a column that identifies the nature of the deficiency/citation/recommendation in order to establish measurable data. This information will establish the totals by nature, which will help to identify any potential trends.
4. Ongoing development and monitoring of implementation of Emergency Preparedness Plans, as well as Infection Control. This will entail plan development, as well as training for all staff.

BPC Review and Follow-Up

- Data will be monitored and reported to the Administrative team as a part of the quarterly DQI dashboard.
- Results of BPC Surveys will be shared with the applicable program administration (e.g., Residential, Day Services) and advisory boards.
- Data will be compiled and submitted as part of the Arc NY Metric Dashboard.
- The Arc NY Quarterly Statements of Deficiency Report on Organization-Wide Trends is reviewed amongst administration as a means to ensure the agency is aware of any potential concerns. A review of systemic or operational practices will be reviewed and the need for improvements or systemic changes will be evaluated.

2025 Goals Review

1. To ensure all Plan of Corrective Actions (POCAs) are completed within 21 days.
 - This goal was achieved. While minimal, all POCAs were completed on time.
2. The program AED would ensure an internal review of any recommendations identified in the Exit Conference Form (ECF) is completed within 30 days.
 - This goal was obtained. Results from all ECF's were provided during the Residential Administrative meeting.
3. To reduce the number of ECF deficiencies/citations/recommendations related to fire safety, medical oversight and incident investigations.
 - When comparing the 2023/2024 survey cycle to the 2024/2025 cycle, matters related to medical oversight stayed the same at one per cycle. In terms of fire safety, there was an increase from 1 in 2023/2024, which was a SOD, to 4 in 2024/2025, only one of which was an SOD. All findings were reviewed and addressed. There were no findings related to incident investigations.

Incident Management Review

The Arc of Rensselaer County is committed to ensuring all service recipients' health, safety, rights, and freedom from abuse/neglect and exploitation. The agency reports and subsequently investigates all delegated incidents as defined in the OPWDD Part 624. The agency also responds to events/situations as defined by OPWDD Part 625. All parties defined by the New York State Justice Center and OPWDD as mandated reporters are provided with training and information on all incident types, including Allegations of Abuse/Neglect.

After a Reportable incident is reported and delegated to the agency, a credentialed investigator is assigned to investigate the incident (there may be times that OPWDD or the Justice Center will be assigned the investigation). Upon completion of the investigation, a written report is completed. The investigator

provides a verbal summarization of their investigation to the Incident Review Committee (IRC). IRC carefully considers the investigatory process, factual findings, conclusions and recommendations. The committee may request additional information, and/or make recommendations of its own. The minutes of each meeting are documented and entered into OPWDD's Incident Report and Management Application (IRMA). The investigation report and committee minutes are submitted to OPWDD and, in cases of Abuse/Neglect, the Justice Center. All requirements for entering information into the OPWDD IRMA and Justice Center data system (VCPR) shall be completed on time.

Upon completion of an investigation, regardless of the delegated agency, recommendations may be made by the investigator, as derived from conclusions. The Arc of Rensselaer responds to each recommendation by developing a Corrective Action Plan (CAP), which is subsequently completed by the Director of Quality Assurance. The Director of Quality Assurance ensures to capture all actions completed or assigned to a program or specified agency employee to complete, in the CAP. CAPs are implemented to further protect the health and safety of the service recipients and help to reduce the likelihood of an incident of a similar nature from reoccurring. The CAP may include staff retraining, policy review and updates, or review and update of a service recipient's treatment plan. All CAPs are tracked to ensure each recommendation is completed.

2026 Goals

1. Ensure, minimally, the agency maintains 90% of Reportable Incident and Serious Notable Incident investigations are completed within 30 days per CMS/OPWDD requirements.
2. To reduce the substantiated/conclusive speeding incidents by 50%.
3. To reduce the substantiated Neglect and conclusive Mistreatment incidents associated with breaches of a service recipient's alone time by 20%.
4. To reduce the number of incidents reported after 24 hours of occurrence and/or discovery by 25%.

Measurable Action

1. An agency tracking system is also implemented to maintain oversight of ongoing investigations to ensure completion within 30 days. A report will be run quarterly using OPWDD's IRMA "Report Menu" in order to maintain ongoing oversight of incident investigation completion dates.
2. The agency incident dashboard includes a column that provides a brief description of the circumstance that led to the report of the incident. This will allow for an ongoing assessment of incidents related to speeding and Neglect/Mistreatment.
3. The agency incident dashboard will include data focused in the date/time of occurrence, date/time of discovery, and date/time of reporting. The information will allow for the identification of incidents that were reported beyond the required 24-hour window of occurrence or discovery, depending on the circumstance.

Incidents Review Evaluation and Follow-Up

1. The ongoing monthly assessment, as well as quarterly report, will be reviewed as part of the agency dashboard report out. Any incidents that were not completed within 30 days, without acceptable reasons, will be evaluated pertaining to lack of adherence to the regulatory requirement.
2. The review of the incident circumstance will be a part of the monthly incident dashboard report out. The report out will help to identify real-time trends that may require more immediate corrective action.
3. The timeliness of reporting will be evaluated as part of the monthly incident dashboard report out.
 - The new hire and annual certification incident reporting training will be evaluated to ensure there is an emphasis on reporting potential incidents within the required timeframe.
 - Representation from the Quality Assurance Department will attend the Manager's Meeting to train on the importance of reporting incidents in a timely manner.

Twice annually the Director of Quality Assurance, or designee, completes a review and analysis of all incident data and develops an Incident Trend Report. The first report focuses on the first half of the year to ensure trends are identified and addressed. The second report compares the most recently completed year to prior years. Ultimately, the goal is to compare data across a five-year span. The analysis identifies trends, key issues, and recommendations. The analysis will help guide the agency's QIP goal(s) and will be included the Incident Trend Report. The report is provided, along with a presentation, to senior leadership, mid-managers, and The Board of Directors. Along with the Incident Trend Report, quarterly and annual data from the Quality Metric Dashboards are completed and provided to The Arc New York.

2025 Goals Review

1. Ensure, minimally, 90% of Reportable Incident and Serious Notable Incident investigations are completed within 30 days per CMS/OPWDD requirements.
 - The agency achieved the goal by obtaining 100% completion of Reportable and Serious Notable Incident investigations within 30 days.
2. To reduce the substantiated Neglect and conclusive Mistreatment incidents associated with breaches of a service recipient's alone time by 20%.
 - This goal was not achieved. In 2024, there were three incidents that were substantiated/conclusive. In 2025, there were eight incidents that were substantiated/conclusive. The total number of incidents related to this incident nature increased from five to 10. The agency will continue to implement trainings and incident recommendations in an effort to reduce incidents related to breaches of alone time.
3. To reduce the number of incidents reported after 24 hours of occurrence and/or discovery by 25%.

- This goal was not achieved. In 2024, there were eight incidents reported beyond 24 hours of occurrence and/or discovery. In 2025, there were 12. However, it should be noted there was an increase in total incidents from 63 in 2024, to 74 in 2025. The agency will continue address the concern and stress the importance of timely reporting of incidents.

External Accreditation

The Arc is subject to oversight by OPWDD, ACCES-VR (Adult Continuity Educational Services and Vocational Rehabilitation), OFPC (Office of Fire Prevention and Control) and Department of Health. Also, the Arc actively works to maintain accreditation by the Council on Quality Leadership (CQL). To this purpose, a comprehensive system to routinely monitor the CQL Basic Assurances has been implemented. The Arc Administrative Team has put in place a management dashboard to review critical data collected on the Basic Assurance factors. The team members discuss data and/or consider developing objectives and initiatives for inclusion in the Tactical Plan. The Basic Assurance Dashboard will be used to identify critical need areas on an annual basis.

2026 Goal

1. To maintain CQL Accreditation through showing progress in the established CQL Person Centered Excellence (PCE) long-term plan by visit that will occur 12 months before current accreditation period expires.
2. Demonstrate alignment between CQL Personal Outcome Measures and OPWDD-required planning processes, ensuring that POM-related outcomes are reflected through Life Plans, Staff Action Plans, satisfaction surveys, and person-centered practices.

Measurable Action

1. Continue to integrate a trauma-informed framework into staff training to enhance supportive relationships and deepen staff understanding of individual experiences.
2. Continue to engage in the Community of Practice experience.
3. Compile stories that illustrate progress and success in people's lives.
4. Continue to utilize Personal Outcome Measures data analysis and learning.
5. Data pertaining to the Basic Assurances Factor.

Accreditation Review and Follow-Up

- Data will be reviewed and reported out quarterly at Administrative meetings through the QIP dashboard.
- Stories that illustrate progress and success in people's lives will be highlighted and reported through various avenues, to include:
 1. "Why We Are Here" curriculum.
 2. Discussions on POM data by analyzing the outcomes of work completed as a direct result of agency satisfaction survey tool, CQL interviews, person centered plans or Home and Community-Based Services (HCBS) questionnaire.
- Present recommendations from CQL/POM work groups to Agency Administration to determine what will be adopted for next steps as it relates back to the CQL Plan and use of POM data, outcomes, and / or interviews.

- Utilizing a developed tool, compile stories that illustrate progress and success for the service recipients.
- Results will be reviewed amongst the Administrative Team on a quarterly basis to monitor the progress related to the utilization of POMs.
- Results will be reported to Mid-Managers, as they play a critical role in implementing action items pertaining to CQL Accreditation.

2025 Goal Review

1. To maintain CQL Accreditation through showing progress in the established CQL Person Centered Excellence (PCE) short term plan by the 18-month visit.
 - The agency had a successful 18-month visit from CQL. The agency demonstrated a continued effort to implement a person-centered culture. Data was compiled for 25 people served and results were shared with Mid-Managers

Agency/Program Self-Audits/Surveys

Agency/Program self-audits are an important component of assuring continuous quality improvement in the agency and across programs. Audits function as feedback systems to alert agency to issue areas needing attention and correction. The Arc of Rensselaer engages in multiple self-audit/survey activities focused on regulatory compliance, meeting HCBS billing standards, adhering to corporate compliance expectations, assurance of quality, maintaining physical plant and vehicles in good working order, and ensuring appropriate staffing levels. Many of the self-audits feed into the Compliance monthly dashboard reports. Specifically, audits are routinely conducted in the following areas:

- **Periodic Service Reviews (PSR):** the PSR is a specific methodology for identifying target areas, establishing criteria, conducting frequent, routine monitoring of these areas, and validating the results of a self-audit. Currently, The Arc conducts a self-audit using the PSR methodology to evaluate Medication Administration, Financial Oversight and Physical Plant.
- **Pre-Billing Validation:** 100% of all Medicaid claims are subject to a compliance review by Quality Assurance/Compliance staff before being submitted for payment.
- **Quality Assurance/Corporate Compliance Audits:** In addition to the 100% prebilling validation, examples of Corporate Compliance reviews include: assuring that Board and senior management staff attest to conflicts of interest, if any; that proper securities are in place relative to electronic health records; and that all excluded providers have been identified and barred from employment or other contact with vulnerable people supported by the agency.
- **Vehicle Inspections:** Routine inspections and maintenance of the fleet of vehicles is conducted on a planned and an as-needed-basis.
- **Fire Safety/Fire Drill Administrative Review:** Fire drills are conducted according to a program-specific schedule to meet OPWDD standards. Drills are unannounced and observed each month by management in residential services and quarterly for site-based day services. Arc Administrators are required to conduct an unannounced observation of a fire drill on an overnight shift and an additional shift (chosen by the agency) at our supervised IRA's on an annual basis. All fire drill reports are reviewed within 24 hours of the drill.

- **Annual Risk Assessment:** Each member of the Administrative Team completes an analysis by utilizing a tool provided by The Arc New York that identifies key areas (e.g., Human Resources, Financial, Compliance Program) within the agency in which risks have the most potential to occur. Each area is further broken down into topics, specific to that area, that could potentially have impactful risks to the organization. Results of each individual assessment are compiled and emphasis is placed on risks that were viewed as having a medium to high potential of failure and/or could subsequently have a medium to high impact of failure. The Administrative Team further identifies risks specific to the agency and the corrective actions that have been or would be implemented to address said risk.
- **Additional Self-Audits/Surveys:** Additional audits/surveys may be developed based identified risks. Examples of the identification of risk may stem from the results of:
 - OPWDD DQI reviews resulting in SODs or 45-60-day letters
 - Reports (anonymous or otherwise) of critical problems at a program site
 - 2nd Friday (monthly) reports for monitoring
 - Annual Risk Assessment
 - OMIG Abbreviated and Full Self-Disclosures
 - Human Resources File Audit

Self-Audits/Surveys templates may come from a variety of avenues, including OMIG Audit Protocols, OPWDD Universal Protocols, Arc NY Tools, or Chapter-designed tools. Sample sizes and frequency will vary based on the nature of the audit, size of the program, and the identified level of risk. The QA/Compliance Department will be responsible for working with the identified program to determine the type of audit, sample size, and frequency.

2026 Goals

1. To reduce the number OMIG Self-Disclosures related to staff conducting personal business while providing services to individuals.
2. To reduce the number of unbilled days/units as a result of documentation not being completed within the agency's contemporaneous timeframe or due to other billing errors.
3. To utilize the PrecisionCare Data Warehouse (Power of BI) to develop meaningful data reports associated with quality and efficiency improvements (e.g., incident trends, medical oversight).

Measurable Action

1. The Corporate Compliance dashboard will include data pertaining to the nature of the self-disclosure and the accompanying monetary amount voided/adjusted. The accumulated annual total will be compared to totals disclosed from the previous year.
2. Upon completion of pre-billing validation, the Quality Assurance/Compliance Specialist will provide data of total days/units that were unable to be billed due to errors, to include not completing billing within the contemporaneous timeframe. The information will be sent to the Corporate Compliance Officer, who will forward to the Associate Executive Director of the respective program. The data will be maintained on the Compliance dashboard and broken down per program.

3. The agency will utilize current reports found within the Data Warehouse, as well as develop new reports, that will provide useful data to analyze and monitor as it relates to quality components.

Self-Audit/Survey Evaluation and Follow-Up

- Data will be monitored and reported to the Administrative team as a part of the monthly Compliance dashboard.
- Audit findings are discussed with the applicable program staff associated with the audit.
- During an audit, immediate corrections are made in cases of dangerous or potentially dangerous situations while auditors are present.
- When the audit for a specific site is complete and tabulated, results will be reported to the AED, Director, and other necessary staff (e.g., Residential Manager) for review.
- It is expected that all identified areas needing improvement or correction are completed. If expectations are not met the program leadership shall discuss and set a plan to address.
- Audit results can be used in several ways. Identifying areas of excellence, identifying areas in need of improvement, comparing year to year, and comparing specific key areas. All comparisons shall be carried out in a positive productive manner avoiding blame, reprimand, or other negative behavior not conducive to the quality culture.
- It is important that good results and practices are shared amongst program staff through the team meetings or other avenues.
- The Quality Assurance/Compliance Department will compile appropriate statistical information from audits in order to monitor improvement, decline, problem areas, and areas of excellence.

2025 Goals Review

1. To reduce the number OMIG Self-Disclosures related to Staff Action Plans.
 - The goal was achieved. There were no self-disclosures related to Staff Action Plans in 2025.
2. To reduce the number of unbilled days/units as a result of documentation not being completed within the agency's contemporaneous timeframe or due to other billing errors.
 - As data pertaining to this goal was sparse in 2024, it was difficult to determine if there was a reduction in 2025. However, there was increased data collected in 2025, which can be utilized to compare to losses in 2026. In 2025, there was nearly \$12,000 in losses related to unbilled days/units as a result of documentation not being completed contemporaneously or other billing errors. This is not factoring in losses related to self-disclosures.

Quality of Life/Satisfaction of People Supported/Families

The Arc of Rensselaer believes that ongoing feedback from individuals and families supported by the agency is an important way to improve service quality. The Arc will solicit feedback from the individuals supported, their family members, guardians and advocates through a variety of means. Agency administrators and Board shall review the results of such surveys/interviews and used to enhance operations and service effectiveness.

In addition to surveys, the agency utilizes other avenues to assessing the quality of life of service recipients. Content may be found in:

- Information from an informal grievance process
- Results from OPWDD Bureau of Program Certification Person-Centered Planning and Agency Review Surveys
- CQL Personal Outcome Measures

The Arc of Rensselaer focuses on enhancing and evaluating the quality of an individual's life through numerous other avenues. Those areas of focus include:

- Key to the quality process shall be the individual's progress toward values outcomes as outlined in their Life Plan, Person-Centered Plan (PCP) and/or CQL Interview.
- A well-developed meaningful Life Plan shall be the basis for providing the best quality life for persons receiving services. Each person will be supported in facilitating and fully participating in their Life Plan review with participants of their choice.
- The safety of the people receiving services in all living situations shall be maintained. Initial instruction and ongoing review of safety procedures at home and in the community will be provided.
- Safety and security concerns shall be addressed by:
 - Recommendations from physical plant audits, maintenance inspections, and any other safety inspection conducted.
 - Fire drills.
 - Appropriate individualized training.
 - Corrective action on audits, satisfaction surveys, PCP, CQL Interview, and incident reporting.
- Service environments shall be clean, safe, and well maintained in order to provide people with pleasant, comfortable living conditions. Residents of their home engage in the selection of home furnishings and décor.
- The rights and choices of the person shall be of paramount concern in all service arrangements.
- The exercise of rights and choices shall also consider the needs of the person and related risks. Rights and choices will be limited only as a last resort and with the review and approval of the person's team and Human Rights Committee.

- Creative services shall ensure the constant effort to improve the emotional, physical, intellectual, and spiritual well-being of the person.
- Health care will focus not only on illness and maintenance, but on improvements and promotion of a healthy life style.
- Service Recipient input will be valued and encouraged.
 - People receiving services shall have the opportunity to complete satisfaction surveys.
 - People shall be encouraged and supported in facilitating their meetings. Staff involvement shall be at the minimal level possible. Review of the meeting minutes will take place at staff meetings to ensure support and follow through.
 - Membership on committees and Board of Directors.
 - Family/Advocate satisfaction surveys.
- A strong Self-Advocacy group will be supported at the agency and all people receiving services will be encouraged to participate in self-advocacy activities.
- The service recipient and their team will focus on individual choices, needs, and enhanced quality of life in the preparation of the Life Plan through a person-centered model.
- Day activities, services and employment opportunities will reflect the person's choices, preferences, needs, and abilities.
- The Care Manager is chosen by, and is accountable to, the person receiving services.
- The person's Life Plan and staff efforts to support the person in reaching their fullest potential will focus on promoting independence.

2026 Goal

1. To complete a Satisfaction Survey for 95% of the individuals served in the Residential and Day Services settings.
2. Develop a response to the Satisfaction Survey for Residential and Day Service settings.

Measurable Outcome

1. Data will be compiled comparing the total number of service recipients per program to the total number of surveys completed.
2. Agency Satisfaction Surveys, CQL interview, person-centered plans, and Home and Community Based Services (HCBS) questionnaires will all be utilized as evidence of measuring satisfaction.
3. Agency Satisfaction Surveys, CQL interview, person-centered plans, and Home and Community Based Services (HCBS) questionnaires will all be used to capture CQL POM data.

Evaluation and Follow-Up of People Supported/Family Satisfaction Surveys

- Satisfaction survey results are reported to the manager and supervisor, then at staff meetings, meetings held by persons served, Quality Assurance/Compliance Team meetings.

- Satisfaction survey results can be used in several ways. Identifying areas of excellence, identifying areas in need of improvement, comparing year to year, and comparing specific key areas. All comparisons shall be carried out in a positive productive manner avoiding blame, reprimand, or other negative behavior not conducive to the quality culture.
- Enhance the dashboard to show the total number of surveys, the number with concerns, and the number that received follow-up action.
- Data is collected from audits and satisfaction surveys for specific key measures in the following areas:
 - Supports & services are self-directed and person-centered.
 - People are satisfied with their home environment.
 - People have supports to develop and maintain close satisfying relationships with family and friends.
 - People have supports necessary to promote good health and wellbeing.
 - People have supports to be productive by participating in meaningful activities.
- An annual report will be developed by the Quality Assurance/Compliance Department that identifies trends found within the satisfaction surveys. This report will be provided to agency leadership. When comments need clarification, the Quality Department staff contacts the person who completed the survey.

2025 Goal Review

1. To complete a Satisfaction Survey for 90% of the individuals served in the Residential and Day Services settings.
 - Both Residential and Day Services both achieved over 90% completion of Satisfaction Surveys.

Quality and Satisfaction Levels of Workforce/Human Resources Management

A key element of quality is the degree to which employees are committed to the mission and purpose of The Arc of Rensselaer County. Employees that feel that they are an integral part of the agency are effective in their job, supported by their supervisor and are resourced to get results to have a significant impact on quality outcomes.

The Arc of Rensselaer will solicit feedback from its employees on a regular basis through a variety of mechanisms, two main components that are measured are Employee Vacancies and Exit Interviews.

a. Employee Vacancies and the use of Exit Interviews

Feedback through the exit interview process will be considered when developing the Tactical Plan, as well as goals found within the QIP. Staffing data is also devised and reported through The Arc NY quarterly and annual Quality Metric Dashboards.

Key to providing quality service is staff effectiveness, therefore:

- Employee training and development will be provided in an ongoing manner so that all personnel will complete training as outlined by regulations and agency policy and procedures.
- If an internal or external audit or survey results or other monitoring reveals a need for training, such training will be implemented.
- Communication and action on improvements are achieved by staff meetings which will focus on the immediate service environment issues and quality improvements.
- Employees shall receive the training, support, supervision and feedback they need in order for them to provide the highest quality services to all individuals.
 - All new employees will receive a brief orientation to the agency and developmental disability field.
 - All new employees shall receive training in The Arc of Rensselaer Mission Statement.
 - All employees will receive training specific to their role and responsibilities, as required by OPWDD regulations and agency policy.
 - On-going training will include quality improvement and other topics relative to providing quality services.
 - All supervisors in conjunction with the Administrative Team will be responsible for ensuring effective employee training.
 - All employees will be aware of and comply with the Code of Conduct and Standards of Conduct.
- Ongoing Administrative meetings will ensure consistent quality services through ongoing leadership support, and the promotion and fulfillment of the Mission.
- The Tactical Plan, which includes goals and objectives under the overall agenda item of “Address the Workforce challenge to enhance continuity of care”.
- **Monitoring of staffing:** The number of employees required at any service location is determined based on the collective needs of the people being supported at that location. This is identified as “ minimum staffing levels.”
 - To ensure there are sufficient numbers of staff available to deliver the necessary supports and services, managers are to submit their monthly schedules to their supervisors each month.
 - A full-time position can be defined as an FTE; each payroll, residential administration is provided an FTE report that identifies how many FTE’s were utilized at each site for that pay period; this report can also be used to assist in identifying sites that may be under or over staffing any particular site.
- **The Arc NY Quarterly and Annual Data from Quality Metric Dashboards:** A comprehensive method for Chapters of the Arc New York to submit and track key Chapter specific data for a more proactive view of the overall organization. This information is compiled from the Human Resource, Residential, Business Office, Day Services, and Quality Assurance departments and submitted through a portal by the Director of Quality Assurance quarterly and annually.

2026 Goals

1. To decrease the overall turnover of positions from 25% to under 22%.
2. To implement stay interviews for new hires at 3, 6, and 12-month increments. This will be completed in-person or via telephone. The goal is to complete 75% of interviews at each timeframe based on the staff who are still employed.

Measurable Action

1. Review turnover and recruiting metrics monthly and quarterly through standard reporting methods and the use of dashboards.
2. Review stay interviews on a monthly basis to evaluate trends and identify areas of repetitive concerns.

Evaluation and Follow-Up of Workforce Satisfaction

- Review Turnover and Recruiting metrics with the administration team will keep the team on track with the goals aligned in the Tactical Plan, employee turnover.
- Review data from the stay interviews on areas over opportunity to implement additional trainings, additional supervision, updated policy or way to improve the overall work environment. Action items may be developed as a result of the reviews.
- Review stay interview and assess trends of common reasons for staff continuing to stay with the agency, as well as identify concerns that could lead to staff leaving the organization.
- Stay interview data will be monitored and reported to the Administrative team as a part of the monthly HR dashboard.
- Data will be compiled and submitted as part of the Arc NY Metric Dashboard related to HR.

2025 Goal Review

1. To decrease the overall turnover of positions from 22% to under 20%.
 - This goal was not achieved. Turnover rates increased from 22% to 25%.
2. Send a web-based Exit Interview survey to 100% of employees who voluntarily leave the agency.
 - This goal was achieved. However, despite sending Exit Interviews to all staff who voluntarily left, very few responded.

b. Employee Satisfaction and Employee Satisfaction Survey Processes

The Arc believes that quality is best expressed and assured by the actions of our employees. Given this, The Arc philosophy of human resource management places a great emphasis on the potential of each employee to contribute to the success of the agency and management plays a critical role in developing this individual/organizational potential. Our human resource management practices address five basic objectives. They are:

- Obtain, maintain and develop a quality workforce;
- Ensure that each employee is effectively integrated into the agency;
- Operate efficient record keeping systems;
- Ensure that there is no discrimination in hiring, promoting or terminating;
- Maintain a safe and professional work climate.

The Arc is actively engaged in supporting employees in developing the skills and capacity to deliver quality person-centered supports. To that purpose, The Arc operates under extensive guidance from Board approved human resource management policies and procedures. These progressive policies extend from recruitment to onboarding, to staff development and training, total compensation, and other employee-related areas. To ensure that policies and practices are up-to-date, responsive and meet our ongoing needs for a quality workforce, a comprehensive

collection and review of data related to position vacancy, staff turnover, staff training, OSHA reportable injuries, and employee satisfaction surveys.

Employee-related information gleaned from these and other areas are analyzed and responded to ongoing and on an annual basis. Annually data analysis feeds into the Tactical Plan and the Human Resources Operational Plan. The AED of Human Resources is responsible for overseeing and coordinating activities in this area with support from all other areas within the agency as needed.

2026 Goal

1. To send an employee satisfaction survey to 100% of the workforce who worked 1000 hours within the previous 12 months of sent date, with a goal of receiving a response from 75 employees of those surveyed.
2. To complete an analysis of survey data within 45 days of survey closure and produce a written Action Plan that identifies at least two priority improvement areas, recommended strategies, and designates a staff person as the lead to follow up on those items.

Measurable Action

1. Data will be complied through the use of an electronic survey based on employee satisfaction will be used and it will be delivered to each employee.
2. Data will be captured on the number of surveys completed.

Evaluation and Follow-Up of Employee Surveys

- Create action items to improve number of participants, employee satisfaction to set standards for measurements for the next survey conducted.
- Identify trends that show areas of opportunity based on survey results and comments.
- Any areas that show an opportunity for improvement based on survey data and trends will be discussed at the Administration level with recommendations from the Associate Executive Director of Human Resources on ways to improve and also align with the Arc NY metric dashboards.
- Review the key areas within the survey that show trends and opportunities for improvement in regards to the current level of job satisfaction and trainings we conduct.
- Integration of results into agency planning documents
- Report out all survey results and all other dashboard data to Administration showing the current level of employee satisfaction.
- Trends established through surveys will be reported, minimally, annually to the Administrative team.
- Review data from the survey to assess the opportunities for improvement based directly on feedback given within the survey.

2025 Goal Review

1. To send an employee satisfaction survey to 100% of the workforce who worked 1000 hours within the previous 12 months of sent date, with a goal of receiving a response from 20% of those surveyed.

- This goal was not completed. No satisfaction surveys were sent to employees in 2025. This goal will be carried over.

Board Governance and Review with Attestation of the Quality Improvement Plan

The Arc of Rensselaer County Board of Directors embraces its oversight role for the agency. It is committed to actively engage this role through the full board of directors and its various committees that focus on program, finance, corporate compliance, and human resource issues. Specifically, to quality improvement, The Arc Board of Directors will:

- Review of the Chapter's programs and services to ensure conformity with the Chapter's mission through membership on and participation on program committees;
- Be members of, and participate in, the standing committee for incident review and bi-annual program reports to the full board;
- Board visits are scheduled twice annually for supervised IRA's that have greater than three participants;
- Advocate to federal and state government representatives for support of sufficient funding for service provision, including for employee wages and benefits;
- Visit program sites in concert with their obligations as corporate guardians volunteers in program activities and program committee meetings on site. Site observation will include physical plant condition, staff interaction with individuals located at the site, and general impressions related to agency mission and values. Board members on committees will be trained as observers of respectful interaction and treatment, site safety and condition and general community orientation. Feedback will be provided to staff committee meetings, and if necessary directly to the CEO and/or the AED of Quality Assurance. The agency Administrative Team has the responsibility to follow through on any risk areas or deficiencies in a timely manner;
- Remain aware of State or Federal regulatory authorities' communications regarding deficiencies in any agency program or operation through director board reports, annual board compliance training and program committee meetings;
- Assure that senior management has the means to continually assess the adequacy of staffing levels, staff competence and staff performance with a mechanism to address deficiencies primarily through the HR dashboard and AED of HR Board Reports;
- Assure that the agency has a plan for ongoing staff development and training through monitoring by senior leadership and AED of HR Board Reports;
- Assure that expectations for ethical conduct be communicated and reinforced for all employees, volunteers, and Board members through the required signing of the code of conduct;
- Assure that agency practices will encourage the development and expression of self-advocacy by the people receiving supports and services; and assure that a process is in place for self-advocates to provide input to agency practices and governance through agency board membership, self-

advocacy participation on board committees (with an assigned mentor) and a formal link to the self-advocacy group to the agency Board of Directors; and

- Attest on an annual basis that the agency has an up-to-date QIP and has performed a review of quality metrics on a yearly basis.

Quality Improvement Plan Quarterly Dashboard and Summary

The QIP Dashboard is developed by the Quality Assurance/Compliance Department and reported on quarterly to the agency Administrative team. The dashboard will review progress made pertaining to the QIP goals established for each aforementioned area. Annually, a progress summary will be developed that identifies the quality improvement actions and the results and effectiveness of the implemented actions.

QIP Communication

Along with review and approval by The Board of Directors, the QIP will be made readily available to all stakeholders. The plan will be posted on The Arc of Rensselaer County's website on the Corporate Compliance page (<https://www.renarc.org/about/corporate-compliance>). The AED of Quality Assurance will be responsible for notifying stakeholders, in writing (e.g., email, letter), of the annual update to the QIP.

Revised: 12/31/2018, 1/9/2019, 1/29/2021

Updated: 2/12/2020, 2/14/2020, 2/10/2021, 5/9/2023, 8/7/2023, 12/27/2024, 4/13/2026

HCBS Final Rule: List of Federal Requirements

Requirements 1-5 and 10 pertain to all Medicaid Waiver eligible programs and facilities. 6-9 are specific to residential settings.

1. **Access to the Community** The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including
 - Opportunities to seek employment and work in competitive integrated settings,
 - Engage in community life,
 - Control personal resources, and
 - Receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. **Choice of Setting** The setting is selected by the individual from among setting options, including non-disability-specific settings and an option for a private unit in a residential setting.
 - The setting options are identified and documented in the person-centered service plan and
 - are based on the individual's needs, preferences, and,
 - for residential settings, resources available for room and board.
3. **Right to be Treated Well** Ensures an individual's rights of
 - Privacy,
 - Dignity and respect, and
 - Freedom from coercion and restraint.
4. **Independence** Optimizes but does not regiment individual
 - Initiative,
 - Autonomy, and independence in making life choices,
 - Including, but not limited to, daily activities, physical environment, and with whom to interact.
5. **Choice of Services and Supports** Facilitates individual choice regarding services and supports, and who provides them.
6. **Residential Agreement** The unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city or other designated entity.
7. For settings in which landlord/tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.
8. **Privacy**
 - Each individual has privacy in his/her sleeping or living unit:

- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed.
Individuals sharing units have a choice of roommates in that setting. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

- 9. Schedule and Access to Food** Individuals have the freedom and support to control their own
- schedules and activities, and
 - have access to food at any time.

- 10. Right to Visitors** Individuals are able to have visitors of their choosing at any time.

- 11. Accessibility** The setting is physically accessible to the individual